By Senator Lynn

7-02894-08 20081570__

A bill to be entitled

An act relating to the Medicaid managed care pilot program; amending s. 409.1211, F.S.; providing exceptions to mandatory enrollment in the pilot program; providing for the expiration of such exceptions; requiring that the Agency for Health Care Administration provide Medicaid recipients with certain information; requiring that the agency's encounter database collect certain information relating to prescription drugs; requiring that the encounter database collect certain information related to health care costs and utilization from managed care plans participating in demonstration sites; imposing upon the agency certain powers, duties, and responsibilities with respect to the pilot program; requiring that the agency adopt certain rules; requiring that the managed care plan allow an SSI-related Medicaid recipient to select a specialist within the provider network who is willing to serve as the recipient's primary care physician upon the request of the recipient; providing an effective date.

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

Section 1. Subsection (1), paragraphs (i) and (p) of subsection (3), and paragraph (f) of subsection (4) of section 409.91211, Florida Statutes, are amended, and paragraphs (ee), (ff), (gg), (hh), (ii), (jj), and (kk) are added to subsection (3) of that section, to read:

409.91211 Medicaid managed care pilot program.--

(1)(a) The agency is authorized to seek and implement experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One demonstration site shall include only Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. Persons with developmental disabilities as defined by s. 393.063(9), children found to be dependent pursuant to s. 39.01(14), persons with severe and persistent mental illness, and recipients who meet the institutional or "ICP" level of care required for Medicaid nursing home care or enrollment in a Medicaid home-based or community-based waiver are excluded from mandatory enrollment in the pilot program until the service delivery systems described in paragraphs (3)(cc) and (dd) have been developed and evaluated for a period of at least 1 year and until the Legislature expressly authorizes their mandatory enrollment. The agency shall implement expansion of the program to include the remaining counties of the state and ~~remaining eligibility groups~~ in accordance with the process specified in the federally approved special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services on October 19, 2005, with a goal of full statewide implementation by June 30, 2011.

(b) This waiver authority is 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 a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services.

(c) It is the intent of the Legislature that the low-income pool plan required by the terms and conditions of the Medicaid reform waiver and submitted to the federal Centers for Medicare and Medicaid Services propose the distribution of the above-mentioned program funds based on the following objectives:

1. Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

2. Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

3. Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;

4. Promote teaching and specialty hospital programs;

5. Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;

6. Recognize the extent of hospital uncompensated care costs;

7. Maintain and enhance essential community hospital care;

8. Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;

9. Promote measures to avoid preventable hospitalizations;

10. Account for hospital efficiency; and

11. Contribute to a community's overall health system.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(i) To implement a mechanism for providing information to Medicaid recipients for the purpose of selecting a capitated managed care plan. For each plan available to a recipient, the agency, at a minimum, shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data~~, if available~~.

4. An explanation of benefit limitations.

5. Contact information, including identification of providers participating in the network, geographic locations, and transportation limitations.

6. Plan standards for granting services in excess of the plan's service caps.

7. Plan preferred drug lists, including listings of covered drugs according to the same therapeutic classification used in the agency's preferred drug list, and utilization review criteria for granting coverage of drugs not on the preferred drug list.

8. Information on the right to transitional coverage of services the recipient is receiving prior to enrollment in the plan.

9.~~6.~~ Any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(p) To implement standards for plan compliance, including, but not limited to, standards for quality assurance and performance improvement, standards for peer or professional reviews, grievance policies, and policies for maintaining program integrity. The agency shall develop a data-reporting system, seek input from managed care plans in order to establish requirements for patient-encounter reporting, and ensure that the data reported is accurate and complete.

1. In performing the duties required under this section, the agency shall work with managed care plans to establish a

uniform system to measure and monitor outcomes for a recipient of Medicaid services.

2. The system shall use financial, clinical, and other criteria based on pharmacy, medical services, and other data that is related to the provision of Medicaid services, including, but not limited to:

a. The Health Plan Employer Data and Information Set (HEDIS) or measures that are similar to HEDIS.

b. Member satisfaction.

c. Provider satisfaction.

d. Report cards on plan performance and best practices.

e. Compliance with the requirements for prompt payment of claims under ss. 627.613, 641.3155, and 641.513.

f. Utilization and quality data for the purpose of ensuring access to medically necessary services, including underutilization or inappropriate denial of services.

3. The agency shall require the managed care plans that have contracted with the agency to establish a quality assurance system that incorporates the provisions of s. 409.912(27) and any standards, rules, and guidelines developed by the agency.

4. The agency shall establish an encounter database in order to compile data on health services rendered by health care practitioners who provide services to patients enrolled in managed care plans in the demonstration sites. The encounter database shall:

a. Collect the following for each type of patient encounter with a health care practitioner or facility, including:

(I) The demographic characteristics of the patient.

(II) The principal, secondary, and tertiary diagnosis.

(III) The procedure performed.

(IV) The date and location where the procedure was performed.

(V) The payment for the procedure, if any.

(VI) If applicable, the health care practitioner's universal identification number.

(VII) If the health care practitioner rendering the service is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

b. Collect appropriate information relating to prescription drugs for each type of patient encounter including, but not limited to:

(I) Data showing the unduplicated number of recipients whose prescription coverage, by therapeutic class, was rejected each month at the point of service because the drug was not on the plan's preferred drug list, and, of those rejections:

(A) The number of recipients receiving the original prescription;

(B) The number of recipients receiving a therapeutic brand alternative;

(C) The number of recipients receiving a therapeutic generic alternative; and

(D) The number of recipients who did not receive a medication in this therapeutic class.

(II) The number of recipients whose prescription coverage was rejected each month due to:

(A) The recipient reaching the plan cap on the number of covered prescriptions; or

(B) The recipient reaching the dollar cap on the cost of covered prescriptions.

c. Collect appropriate information related to health care costs and utilization from managed care plans participating in the demonstration sites including, but not limited to:

(I) The number of recipients reaching the annual benefit maximum cost cap;

(II) The number of recipients receiving the maximum number of services for each service category;

(III) The number of notices sent to recipients meeting the plan cap for a specific service advising them that services have been terminated due to reaching the cap;

(IV) The number of notices sent to recipients meeting the plan cap for a specific service and advising them of the opportunity to request prior authorization for additional services in excess of the plan cap;

(V) The number of recipients requesting additional services; and

(VI) The number of recipients granted services in excess of the plan cap.

5. To the extent practicable, when collecting the data the agency shall use a standardized claim form or electronic transfer system that is used by health care practitioners, facilities, and payors.

6. Health care practitioners and facilities in the demonstration sites shall electronically submit, and managed care plans participating in the demonstration sites shall electronically receive, information concerning claims payments

and any other information reasonably related to the encounter database using a standard format as required by the agency.

7. The agency shall establish reasonable deadlines for phasing in the electronic transmittal of full encounter data.

8. The system must ensure that the data reported is accurate and complete.

(ee) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons meeting Medicaid nursing home level-of-care requirements sufficient to meet the medical, developmental, and emotional needs of these persons.

(ff) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons with severe and persistent mental illness sufficient to meet the medical, developmental, and emotional needs of these persons.

(gg) To implement contractual requirements and adopt rules that will require capitated managed care plans and provider services networks to continue providing any current service, including those services subject to prior authorization, during the period of time in which prior authorization is being requested, processed, or appealed. Services must be continued at the current level until a notice conforming with 42 C.F.R. s. 431.200 is sent and at least 10 days after the date of the notice has passed and a hearing is not requested, or, if a hearing is requested, the hearing decision affirms the adverse action.

(hh) To ensure that policies and procedures are in place to identify individuals excluded from mandatory enrollment pursuant

to paragraph (1)(a), including written materials provided to all prospective enrollees, current reform enrollees, and choice counselors.

(ii) To adopt rules to establish policies by which exceptions to mandatory Medicaid reform enrollment may be made on a case-by-case basis, in addition to those groups specified in paragraph (1)(a). The rules shall include the specific criteria to be applied when making a determination regarding whether to exempt a recipient from mandatory enrollment.

(jj) To develop improvement benchmarks in the areas of health plan and system readiness, timely claims processing, implementation of a consolidated complaint-tracking system that has analytical capabilities for producing trending reports, and receipt and validations of encounter data, including paid and denied claims. Before the program may be expanded beyond the pilot project counties, the improvement benchmarks must be met and encounter data sufficient to conduct assessments of cost-effectiveness and quality, and access to care must be available. Future audits or evaluations of cost-effectiveness must examine indicators of cost-shifting, including, but not limited to, increases in emergency room admissions, incarceration rates, use of indigent drug program funds, outsourcing, and administrative costs.

(kk) To perform monthly audits of reports of health plan provider networks by comparing them with enrollee handbooks for discrepancies and contacting a statistically significant sample of providers to ensure accuracy.

(4)

(f) The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a capitated managed care network for 12 months after an open enrollment period. After 12 months of enrollment, a recipient may select another capitated managed care network. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the capitated managed care network during the 12-month period. When there is a request by an SSI-related recipient for a specialist to serve as his or her primary physician due to a recipient's particular health condition, the managed care plan shall allow the recipient to select a specialist within the provider network who is willing to serve as the recipient's primary care physician.

Section 2. This act shall take effect July 1, 2008.