By Senator Garcia

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1 A bill to be entitled
2 An act relating to a Medicaid utilization management
3 program; amending s. 409.912, F.S.; deleting a provision
4 that requires the Agency for Health Care Administration to
5 develop and implement a utilization management program for
6 Medicaid-eligible recipients for the management of
7 occupational, physical, respiratory, and speech therapies;
8 amending s. 409.91211, F.S.; conforming a cross-reference;
9 providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
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13 Section 1. Subsections (43) through (52) of section
14 409.912, Florida Statutes, are renumbered as subsections (42)
15 through (51), respectively, and present subsection (42) of that
16 section is amended to read:
17 409.912 Cost-effective purchasing of health care.--The
18 agency shall purchase goods and services for Medicaid recipients
19 in the most cost-effective manner consistent with the delivery of
20 quality medical care. To ensure that medical services are
21 effectively utilized, the agency may, in any case, require a
22 confirmation or second physician's opinion of the correct
23 diagnosis for purposes of authorizing future services under the
24 Medicaid program. This section does not restrict access to
25 emergency services or poststabilization care services as defined
26 in 42 C.F.R. part 438.114. Such confirmation or second opinion
27 shall be rendered in a manner approved by the agency. The agency
28 shall maximize the use of prepaid per capita and prepaid
29 aggregate fixed-sum basis services when appropriate and other

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30 alternative service delivery and reimbursement methodologies,
31 including competitive bidding pursuant to s. 287.057, designed to
32 facilitate the cost-effective purchase of a case-managed
33 continuum of care. The agency shall also require providers to
34 minimize the exposure of recipients to the need for acute
35 inpatient, custodial, and other institutional care and the
36 inappropriate or unnecessary use of high-cost services. The
37 agency shall contract with a vendor to monitor and evaluate the
38 clinical practice patterns of providers in order to identify
39 trends that are outside the normal practice patterns of a
40 provider's professional peers or the national guidelines of a
41 provider's professional association. The vendor must be able to
42 provide information and counseling to a provider whose practice
43 patterns are outside the norms, in consultation with the agency,
44 to improve patient care and reduce inappropriate utilization. The
45 agency may mandate prior authorization, drug therapy management,
46 or disease management participation for certain populations of
47 Medicaid beneficiaries, certain drug classes, or particular drugs
48 to prevent fraud, abuse, overuse, and possible dangerous drug
49 interactions. The Pharmaceutical and Therapeutics Committee shall
50 make recommendations to the agency on drugs for which prior
51 authorization is required. The agency shall inform the
52 Pharmaceutical and Therapeutics Committee of its decisions
53 regarding drugs subject to prior authorization. The agency is
54 authorized to limit the entities it contracts with or enrolls as
55 Medicaid providers by developing a provider network through
56 provider credentialing. The agency may competitively bid single-
57 source-provider contracts if procurement of goods or services
58 results in demonstrated cost savings to the state without

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59 limiting access to care. The agency may limit its network based
60 on the assessment of beneficiary access to care, provider
61 availability, provider quality standards, time and distance
62 standards for access to care, the cultural competence of the
63 provider network, demographic characteristics of Medicaid
64 beneficiaries, practice and provider-to-beneficiary standards,
65 appointment wait times, beneficiary use of services, provider
66 turnover, provider profiling, provider licensure history,
67 previous program integrity investigations and findings, peer
68 review, provider Medicaid policy and billing compliance records,
69 clinical and medical record audits, and other factors. Providers
70 shall not be entitled to enrollment in the Medicaid provider
71 network. The agency shall determine instances in which allowing
72 Medicaid beneficiaries to purchase durable medical equipment and
73 other goods is less expensive to the Medicaid program than long-
74 term rental of the equipment or goods. The agency may establish
75 rules to facilitate purchases in lieu of long-term rentals in
76 order to protect against fraud and abuse in the Medicaid program
77 as defined in s. 409.913. The agency may seek federal waivers
78 necessary to administer these policies.
79 ~~(42) The agency shall develop and implement a utilization~~
80 ~~management program for Medicaid-eligible recipients for the~~
81 ~~management of occupational, physical, respiratory, and speech~~
82 ~~therapies. The agency shall establish a utilization program that~~
83 ~~may require prior authorization in order to ensure medically~~
84 ~~necessary and cost-effective treatments. The program shall be~~
85 ~~operated in accordance with a federally approved waiver program~~
86 ~~or state plan amendment. The agency may seek a federal waiver or~~
87 ~~state plan amendment to implement this program. The agency may~~

88 ~~also competitively procure these services from an outside vendor~~
89 ~~on a regional or statewide basis.~~
90 Section 2. Paragraph (e) of subsection (3) of section
91 409.91211, Florida Statutes, is amended to read:
92 409.91211 Medicaid managed care pilot program.--
93 (3) The agency shall have the following powers, duties, and
94 responsibilities with respect to the pilot program:
95 (e) To implement policies and guidelines for phasing in
96 financial risk for approved provider service networks over a 3-
97 year period. These policies and guidelines must include an option
98 for a provider service network to be paid fee-for-service rates.
99 For any provider service network established in a managed care
100 pilot area, the option to be paid fee-for-service rates shall
101 include a savings-settlement mechanism that is consistent with s.
102 409.912<u>(43)</u> ~~(44)~~. This model shall be converted to a risk-adjusted
103 capitated rate no later than the beginning of the fourth year of
104 operation, and may be converted earlier at the option of the
105 provider service network. Federally qualified health centers may
106 be offered an opportunity to accept or decline a contract to
107 participate in any provider network for prepaid primary care
108 services.
109 Section 3. This act shall take effect July 1, 2008.

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