A bill to be entitled

An act relating to Medicaid provider service networks; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to contract with a specialty provider service network that exclusively enrolls Medicaid beneficiaries who have psychiatric disabilities; defining "psychiatric disabilities"; requiring the specialty provider to offer the same physical and behavioral health services that are required from other Medicaid health maintenance organizations and provider service networks; requiring that beneficiaries be assigned to a specialty provider service network under certain circumstances; amending s. 409.91211, F.S.; requiring that the agency modify eligibility assignment processes for managed care pilot programs to include specialty plans that specialize in care for beneficiaries who have psychiatric disabilities; requiring the agency to provide a service delivery alternative to provide Medicaid services to persons having psychiatric disabilities; providing an additional criterion for the agency in making assignments; requiring that enrollment and choice counseling materials contain an explanation concerning the choice of a network or plan; providing for an additional open enrollment period following the availability of specialty services; providing an effective date.

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

Section 1. Paragraph (d) of subsection (4) of section 409.912, Florida Statutes, is amended to read:

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

patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider

network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(d) A provider service network, which may be reimbursed on a fee-for-service or prepaid basis. A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis is ~~shall be~~ exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

1. Except as provided in subparagraph 2., Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care

providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

2. The agency shall seek applications for and is authorized to contract with a specialty provider service network that exclusively enrolls Medicaid beneficiaries who have psychiatric disabilities. For purposes of this section, "psychiatric disability" includes schizophrenia, schizoaffective disorder, major depression, bipolar disorder, manic and depressive disorders, delusional disorders, psychosis, conduct disorder and other emotional disturbances, attention deficit hyperactivity disorder, panic disorder, and obsessive-compulsive disorder or any person who, during the past year, has met at least one of the following severity criteria: inpatient psychiatric hospitalization or use of antipsychotic medications. The Medicaid specialty provider service network shall provide the full range of physical and behavioral health services that other Medicaid health maintenance organizations and provider

service networks are required to provide. Medicaid beneficiaries having psychiatric disabilities who are required but fail to select a managed care plan shall be assigned to the specialty provider service network in those geographic areas where a specialty provider service network is available. For purposes of enrollment, in addition to beneficiaries who meet the diagnostic criteria indicating a mental illness or emotional disturbance, beneficiaries served by Medicaid-enrolled community mental health agencies or who voluntarily choose the specialty provider service network shall be presumed to meet the plan enrollment criteria. The agency is not required to complete an assessment to determine the eligibility of beneficiaries for enrollment in a specialty provider service network. For current beneficiaries with a claims history, a determination shall be based on current Medicaid data. New beneficiaries without a claims history who have not made a choice are not eligible for assignment to a specialty provider service network. However, during the open enrollment period when beneficiaries may change their plan, a beneficiary's request to be assigned to a specialty provider service network is sufficient for the agency to determine that the beneficiary qualifies for the specialty provider service network.

Section 2. Paragraphs (o) and (aa) of subsection (3) and paragraphs (a), (b), (c), (d), and (e) of subsection (4) of section 409.91211, Florida Statutes, are amended, and paragraph (ee) is added to subsection (3) of that section, to read:

409.91211 Medicaid managed care pilot program.--

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

(o) To implement eligibility assignment processes to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe. The eligibility assignment process shall be modified as specified in paragraph (aa).

(aa) To implement a mechanism whereby Medicaid recipients who are already enrolled in a managed care plan or the MediPass program in the pilot areas shall be offered the opportunity to change to capitated managed care plans on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of capitated managed care plans. Those Medicaid recipients who do not make a choice shall be assigned to a capitated managed care plan in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a capitated managed care plan, the agency shall determine whether the SSI recipient has an ongoing relationship with a provider, including a community mental health provider or capitated managed care plan, and, if so, the agency shall assign the SSI recipient to that provider or capitated managed care plan where feasible. Those SSI recipients who do not have such a provider relationship shall be assigned to a capitated managed care plan provider in accordance

with this paragraph and paragraphs (4)(a)-(d) ~~and shall be exempt from s. 409.9122~~.

(ee) To develop and implement a service delivery alternative within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 for persons who have psychiatric disabilities, which are sufficient to meet the medical, developmental, and emotional needs of those persons.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency and the recipient shall be exempt from s. 409.9122. When making assignments, the agency shall take into account the following criteria:

1. A capitated managed care network has sufficient network capacity to meet the needs of members.

2. The capitated managed care network has previously enrolled the recipient as a member, or one of the capitated managed care network's primary care 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 capitated managed care

network as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The capitated managed care network's primary care providers are geographically accessible to the recipient's residence.

5. The extent of the psychiatric disability of the Medicaid beneficiary.

(b) When more than one capitated managed care network provider meets the criteria specified in paragraph (3)(h), the agency shall assess a beneficiary's psychiatric disability before making an assignment and make recipient assignments consecutively by family unit.

(c) If a recipient is currently enrolled with a Medicaid managed care organization that also operates an approved reform plan within a demonstration area and the recipient fails to choose a plan during the reform enrollment process or during redetermination of eligibility, the recipient shall be automatically assigned by the agency into the most appropriate reform plan operated by the recipient's current Medicaid managed care plan. If the recipient's current managed care plan does not operate a reform plan in the demonstration area which adequately meets the needs of the Medicaid recipient, the agency shall use the automatic assignment process as prescribed in the special terms and conditions numbered 11-W-00206/4. All enrollment and choice counseling materials provided by the agency must contain an explanation of the provisions of this paragraph for current managed care recipients and an explanation of the choice of any

specialty provider service network or specialty managed care plan.

(d) Except as provided in paragraph (b), the agency may not engage in practices that are designed to favor one capitated managed care plan over another or that are designed to influence Medicaid recipients to enroll in a particular capitated managed care network in order to strengthen its particular fiscal viability.

(e) After a recipient has made a selection or has been enrolled in a capitated managed care network, the recipient shall have 90 days in which to voluntarily disenroll and select another capitated managed care network. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the capitated managed care network's grievance process as specified in paragraph (3)(q) prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the capitated managed care network, as a result of the grievance process, approves an enrollee's request to disenroll,

the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding. When a specialty provider service network or a specialty managed care plan first becomes available in a geographic area, beneficiaries meeting diagnostic criteria shall be offered an open enrollment period during which they may choose to reenroll in a specialty provider service network or specialty managed care plan.

Section 3. This act shall take effect July 1, 2008.