Amendment No.

CHAMBER ACTION

Senate		House
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1 Representative Zapata offered the following:
2
3 **Amendment to Senate Amendment (780200) (with title**
4 **amendment)**
5 Between lines 1543 and 1544, insert:
6 Section 32. Subsection (17) of section 409.912, Florida
7 Statutes, is amended to read:
8 409.912 Cost-effective purchasing of health care.--The
9 agency shall purchase goods and services for Medicaid recipients
10 in the most cost-effective manner consistent with the delivery
11 of quality medical care. To ensure that medical services are
12 effectively utilized, the agency may, in any case, require a
13 confirmation or second physician's opinion of the correct
14 diagnosis for purposes of authorizing future services under the
15 Medicaid program. This section does not restrict access to
16 emergency services or poststabilization care services as defined

17 in 42 C.F.R. part 438.114. Such confirmation or second opinion
18 shall be rendered in a manner approved by the agency. The agency
19 shall maximize the use of prepaid per capita and prepaid
20 aggregate fixed-sum basis services when appropriate and other
21 alternative service delivery and reimbursement methodologies,
22 including competitive bidding pursuant to s. 287.057, designed
23 to facilitate the cost-effective purchase of a case-managed
24 continuum of care. The agency shall also require providers to
25 minimize the exposure of recipients to the need for acute
26 inpatient, custodial, and other institutional care and the
27 inappropriate or unnecessary use of high-cost services. The
28 agency shall contract with a vendor to monitor and evaluate the
29 clinical practice patterns of providers in order to identify
30 trends that are outside the normal practice patterns of a
31 provider's professional peers or the national guidelines of a
32 provider's professional association. The vendor must be able to
33 provide information and counseling to a provider whose practice
34 patterns are outside the norms, in consultation with the agency,
35 to improve patient care and reduce inappropriate utilization.
36 The agency may mandate prior authorization, drug therapy
37 management, or disease management participation for certain
38 populations of Medicaid beneficiaries, certain drug classes, or
39 particular drugs to prevent fraud, abuse, overuse, and possible
40 dangerous drug interactions. The Pharmaceutical and Therapeutics
41 Committee shall make recommendations to the agency on drugs for
42 which prior authorization is required. The agency shall inform
43 the Pharmaceutical and Therapeutics Committee of its decisions
44 regarding drugs subject to prior authorization. The agency is

45 authorized to limit the entities it contracts with or enrolls as
46 Medicaid providers by developing a provider network through
47 provider credentialing. The agency may competitively bid single-
48 source-provider contracts if procurement of goods or services
49 results in demonstrated cost savings to the state without
50 limiting access to care. The agency may limit its network based
51 on the assessment of beneficiary access to care, provider
52 availability, provider quality standards, time and distance
53 standards for access to care, the cultural competence of the
54 provider network, demographic characteristics of Medicaid
55 beneficiaries, practice and provider-to-beneficiary standards,
56 appointment wait times, beneficiary use of services, provider
57 turnover, provider profiling, provider licensure history,
58 previous program integrity investigations and findings, peer
59 review, provider Medicaid policy and billing compliance records,
60 clinical and medical record audits, and other factors. Providers
61 shall not be entitled to enrollment in the Medicaid provider
62 network. The agency shall determine instances in which allowing
63 Medicaid beneficiaries to purchase durable medical equipment and
64 other goods is less expensive to the Medicaid program than long-
65 term rental of the equipment or goods. The agency may establish
66 rules to facilitate purchases in lieu of long-term rentals in
67 order to protect against fraud and abuse in the Medicaid program
68 as defined in s. 409.913. The agency may seek federal waivers
69 necessary to administer these policies.
70 (17) An entity contracting on a prepaid or fixed-sum basis
71 shall, in addition to meeting any applicable statutory surplus
72 requirements, also maintain at all times in the form of cash,

73 investments that mature in less than 180 days allowable as
74 admitted assets by the Office of Insurance Regulation, and
75 restricted funds or deposits controlled by the agency or the
76 Office of Insurance Regulation, a surplus amount equal to one-
77 and-one-half times the entity's monthly Medicaid prepaid
78 revenues. As used in this subsection, the term "surplus" means
79 the entity's total assets minus total liabilities. If an
80 entity's surplus falls below an amount equal to one-and-one-half
81 times the entity's monthly Medicaid prepaid revenues, the agency
82 shall prohibit the entity from engaging in marketing and
83 preenrollment activities, shall cease to process new
84 enrollments, and shall not renew the entity's contract until the
85 required balance is achieved. The requirements of this
86 subsection do not apply:
87 (a) Where a public entity agrees to fund any deficit
88 incurred by the contracting entity; ~~or~~
89 (b) Where the entity's performance and obligations are
90 guaranteed in writing by a guaranteeing organization which:
91 1. Has been in operation for at least 5 years and has
92 assets in excess of $50 million; or
93 2. Submits a written guarantee acceptable to the agency
94 which is irrevocable during the term of the contracting entity's
95 contract with the agency and, upon termination of the contract,
96 until the agency receives proof of satisfaction of all
97 outstanding obligations incurred under the contract; or
98 (c) Where the entity is majority owned or controlled by
99 one or more of the following:
100 1. A federally qualified health center;

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101 2. A federally qualified health center controlled network;
102 or
103 3. Any not-for-profit entity which is itself majority
104 owned or controlled by one or more federally qualified health
105 centers or a federally qualified health center controlled
106 network and where such entity meets the surplus and reserve
107 requirements of s.641.225. For purposes of this section, the
108 terms "federally qualified health center," and "federally
109 qualified health center controlled network" shall have the
110 meanings ascribed to them by the United States Department of
111 Health and Human Services, Health Resources and Services
112 Administration.
113
114
115 ---
116 **T I T L E A M E N D M E N T**
117 Between lines 2077 and 2078, insert:
118 amending s. 409.912, F.S.; providing additional exceptions to
119 requirements for certain entities contracting on a prepaid or
120 fixed-sum basis;