A bill to be entitled

An act relating to Medicaid reimbursement rates; amending s. 409.912, F.S.; requiring entities under contract with the Agency for Health Care Administration to reimburse noncontracted hospitals and physicians at certain rates; providing an exception; amending s. 409.915, F.S.; providing for semiannual calculation of Medicaid county participation rates for the purpose of determining a county's contribution to Medicaid for certain hospital services; providing for publication of participation rates; providing an effective date.

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

Section 1. Subsection (19) 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.

(19) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall:

(a) Reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated

with the hospital or physician for the provision of services or according to the lesser of the following:

1.~~(a)~~ The usual and customary charges made to the general public by the hospital or physician; or

2.~~(b)~~ The Florida Medicaid reimbursement rate established for the hospital or physician.

(b) Reimburse any otherwise noncontracted hospital or physician that is within the entity's authorized geographic service area as specified in its contract with the agency, and that provides services to its members, at the usual or customary charges made to the general public by the hospital or physician.

This subsection does not apply to emergency services.

Section 2. Subsection (8) is added to section 409.915, Florida Statutes, to read:

409.915 County contributions to Medicaid.--Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(8) A county's contribution to Medicaid for hospital services prescribed under this section shall be based on the Medicaid county participation rate, which shall be calculated on a semiannual basis by the agency. Except for the agency's internal calculations used to determine target, ceiling, and exempt rates, as required from time to time, Medicaid county participation rates shall be published only for the purpose of

determining the amount of counties' contributions to Medicaid for hospital services.

Section 3. This act shall take effect July 1, 2009.