By Senator Bennett

21-00695-11 2011542__

1 A bill to be entitled
2 An act relating to the nursing home diversion program;
3 amending s. 409.912, F.S.; directing the Agency for
4 Health Care Administration to expand the nursing home
5 diversion program to include Medicaid recipients who
6 meet certain criteria; specifying locations for
7 phased-in implementation of the program; revising
8 conditions for enrollment in the program; providing
9 for Medicaid recipient choice with regard to
10 contractors; requiring the nursing home diversion
11 contractor to provide an enrollee with information
12 regarding alternative service providers; requiring
13 certain enrollees to participate in the program;
14 requiring the program to combine funding for Medicaid
15 services provided to specified individuals; removing
16 an exception; excluding specified individuals from
17 participation in the program; revising provisions
18 relating to entities eligible to participate in the
19 program; requiring the Department of Elderly Affairs
20 and the agency to seek federal waivers to limit the
21 number of nursing home diversion contractors in
22 additional locations; directing the agency to impose
23 certain requirements on contractors in the program;
24 requiring the Office of Program Policy Analysis and
25 Government Accountability, in consultation with the
26 Auditor General, to evaluate the nursing home
27 diversion contractors in the program; removing an
28 obsolete provision relating to an appropriation for
29 implementation of a pilot program; amending s.

30 408.040, F.S.; removing a reporting requirement, to
31 conform; providing an effective date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Subsection (5) of section 409.912, Florida
36 Statutes, is amended to read:
37 409.912 Cost-effective purchasing of health care.—The
38 agency shall purchase goods and services for Medicaid recipients
39 in the most cost-effective manner consistent with the delivery
40 of quality medical care. To ensure that medical services are
41 effectively utilized, the agency may, in any case, require a
42 confirmation or second physician's opinion of the correct
43 diagnosis for purposes of authorizing future services under the
44 Medicaid program. This section does not restrict access to
45 emergency services or poststabilization care services as defined
46 in 42 C.F.R. part 438.114. Such confirmation or second opinion
47 shall be rendered in a manner approved by the agency. The agency
48 shall maximize the use of prepaid per capita and prepaid
49 aggregate fixed-sum basis services when appropriate and other
50 alternative service delivery and reimbursement methodologies,
51 including competitive bidding pursuant to s. 287.057, designed
52 to facilitate the cost-effective purchase of a case-managed
53 continuum of care. The agency shall also require providers to
54 minimize the exposure of recipients to the need for acute
55 inpatient, custodial, and other institutional care and the
56 inappropriate or unnecessary use of high-cost services. The
57 agency shall contract with a vendor to monitor and evaluate the
58 clinical practice patterns of providers in order to identify

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

21-00695-11 2011542__

59 trends that are outside the normal practice patterns of a
60 provider’s professional peers or the national guidelines of a
61 provider’s professional association. The vendor must be able to
62 provide information and counseling to a provider whose practice
63 patterns are outside the norms, in consultation with the agency,
64 to improve patient care and reduce inappropriate utilization.
65 The agency may mandate prior authorization, drug therapy
66 management, or disease management participation for certain
67 populations of Medicaid beneficiaries, certain drug classes, or
68 particular drugs to prevent fraud, abuse, overuse, and possible
69 dangerous drug interactions. The Pharmaceutical and Therapeutics
70 Committee shall make recommendations to the agency on drugs for
71 which prior authorization is required. The agency shall inform
72 the Pharmaceutical and Therapeutics Committee of its decisions
73 regarding drugs subject to prior authorization. The agency is
74 authorized to limit the entities it contracts with or enrolls as
75 Medicaid providers by developing a provider network through
76 provider credentialing. The agency may competitively bid single-
77 source-provider contracts if procurement of goods or services
78 results in demonstrated cost savings to the state without
79 limiting access to care. The agency may limit its network based
80 on the assessment of beneficiary access to care, provider
81 availability, provider quality standards, time and distance
82 standards for access to care, the cultural competence of the
83 provider network, demographic characteristics of Medicaid
84 beneficiaries, practice and provider-to-beneficiary standards,
85 appointment wait times, beneficiary use of services, provider
86 turnover, provider profiling, provider licensure history,
87 previous program integrity investigations and findings, peer

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

88 review, provider Medicaid policy and billing compliance records,
89 clinical and medical record audits, and other factors. Providers
90 shall not be entitled to enrollment in the Medicaid provider
91 network. The agency shall determine instances in which allowing
92 Medicaid beneficiaries to purchase durable medical equipment and
93 other goods is less expensive to the Medicaid program than long-
94 term rental of the equipment or goods. The agency may establish
95 rules to facilitate purchases in lieu of long-term rentals in
96 order to protect against fraud and abuse in the Medicaid program
97 as defined in s. 409.913. The agency may seek federal waivers
98 necessary to administer these policies.
99 (5) The Agency for Health Care Administration, in
100 partnership with the Department of Elderly Affairs, shall expand
101 the nursing home diversion program into ~~create~~ an integrated,
102 fixed-payment delivery program for all Medicaid recipients who
103 meet nursing home admission criteria and are 60 years of age or
104 older and ~~or~~ dually eligible for Medicare and Medicaid. The
105 Agency for Health Care Administration shall implement the
106 integrated program initially in ~~on a pilot basis in two~~ Areas 5,
107 6, and 7 ~~of the state~~. The program shall be implemented in Areas
108 8, 9, 10, and 11 in 2013 and in Areas 1, 2, 3, and 4 in 2014.
109 All Medicaid recipients shall be given a choice of nursing home
110 diversion contractors in each area. In order to ensure enrollee
111 choice, when an enrollee is determined to be likely to require
112 the level of care provided in a hospital or nursing home, the
113 enrollee shall be informed by the nursing home diversion
114 contractor of any feasible alternatives available and given the
115 choice of either institutional or home and community-based
116 services ~~pilot areas shall be Area 7 and Area 11 of the Agency~~

21-00695-11 2011542__

117 ~~for Health Care Administration~~. Enrollment ~~in the pilot areas~~
118 shall be ~~on a voluntary basis and~~ in accordance with approved
119 federal waivers and this section. ~~The agency and its program~~
120 ~~contractors and providers shall not enroll any individual in the~~
121 ~~integrated program because the individual or the person legally~~
122 ~~responsible for the individual fails to choose to enroll in the~~
123 ~~integrated program. Enrollment in the integrated program shall~~
124 ~~be exclusively by affirmative choice of the eligible individual~~
125 ~~or by the person legally responsible for the individual. The~~
126 ~~integrated program must transfer all Medicaid services for~~
127 ~~eligible elderly individuals who choose to participate into an~~
128 ~~integrated-care management model designed to serve Medicaid~~
129 ~~recipients in the community.~~ The integrated program must combine
130 all funding for Medicaid services provided to individuals who
131 are 60 years of age or older and ~~or~~ dually eligible for Medicare
132 and Medicaid into the integrated program, including funds for
133 Medicaid home and community-based waiver services; all Medicaid
134 services authorized in ss. 409.905 and 409.906, including
135 ~~excluding~~ funds for Medicaid nursing home services ~~unless the~~
136 ~~agency is able to demonstrate how the integration of the funds~~
137 ~~will improve coordinated care for these services in a less~~
138 ~~costly manner~~; and Medicare coinsurance and deductibles for
139 persons dually eligible for Medicaid and Medicare as prescribed
140 in s. 409.908(13).
141 (a) Individuals who are 60 years of age or older, ~~or~~ dually
142 eligible for Medicare and Medicaid, and enrolled in the
143 ~~developmental disabilities waiver program, the family and~~
144 ~~supported-living waiver program, the project AIDS care waiver~~
145 ~~program, the traumatic brain injury and spinal cord injury~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

146 ~~waiver program, the consumer-directed care waiver program, and~~
147 ~~the program of~~ all-inclusive care for the elderly program~~, and~~
148 ~~residents of institutional care facilities for the~~
149 ~~developmentally disabled,~~ must be excluded from the integrated
150 program.
151 (b) ~~Managed care entities who meet or exceed the agency's~~
152 ~~minimum standards are eligible to operate the integrated~~
153 ~~program.~~ Entities eligible to participate include ~~managed care~~
154 ~~organizations licensed under chapter 641, including entities~~
155 ~~eligible to participate in the~~ nursing home diversion program
156 contractors~~, other qualified providers~~ as defined in s.
157 430.703(6) and (7). The Department of Elderly Affairs and the
158 agency shall comply with s. 430.705(3) prior to approval of any
159 additional contractors~~, community care for the elderly lead~~
160 ~~agencies, and other state-certified community service networks~~
161 ~~that meet comparable standards as defined by the agency, in~~
162 ~~consultation with the Department of Elderly Affairs and the~~
163 ~~Office of Insurance Regulation, to be financially solvent and~~
164 ~~able to take on financial risk for managed care~~. ~~Community~~
165 ~~service networks that are certified pursuant to the comparable~~
166 ~~standards defined by the agency are not required to be licensed~~
167 ~~under chapter 641. Managed care entities who operate the~~
168 ~~integrated program shall be subject to s. 408.7056. Eligible~~
169 ~~entities shall choose to serve enrollees who are dually eligible~~
170 ~~for Medicare and Medicaid, enrollees who are 60 years of age or~~
171 ~~older, or both.~~
172 (c) The agency must ensure that the capitation-rate-setting
173 methodology for the integrated program is actuarially sound and
174 reflects the intent to provide quality care in the least

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

175 restrictive setting. The agency must also require nursing home
176 diversion contractors ~~integrated-program providers~~ to develop a
177 credentialing system for service providers and to contract with
178 all Gold Seal nursing homes, where feasible, and exclude, where
179 feasible, chronically poor-performing facilities and providers
180 as defined by the agency. The integrated program must develop
181 and maintain an informal provider grievance system that
182 addresses provider payment and contract problems. The agency
183 shall also establish a formal grievance system to address those
184 issues that were not resolved through the informal grievance
185 system. The integrated program must provide that if the
186 recipient resides in a noncontracted residential facility
187 licensed under chapter 400 or chapter 429 at the time of
188 enrollment in the integrated program and the recipient's needs
189 cannot be met in a less restrictive environment, the recipient
190 must be permitted to continue to reside in the noncontracted
191 facility as long as the recipient desires. The integrated
192 program must also provide that, in the absence of a contract
193 between the nursing home diversion contractor ~~integrated-program~~
194 ~~provider~~ and the residential facility licensed under chapter 400
195 or chapter 429, current Medicaid rates must prevail. The nursing
196 home diversion contractor ~~integrated-program provider~~ must
197 ensure that electronic nursing home claims that contain
198 sufficient information for processing are paid within 10
199 business days after receipt. Alternately, the nursing home
200 diversion contractor ~~integrated-program provider~~ may establish a
201 capitated payment mechanism to prospectively pay nursing homes
202 at the beginning of each month. The agency and the Department of
203 Elderly Affairs must jointly develop procedures to manage the

204 services provided through the integrated program in order to
205 ensure quality and recipient choice.
206 (d) The Office of Program Policy Analysis and Government
207 Accountability, in consultation with the Auditor General, shall
208 comprehensively evaluate ~~the pilot project for~~ the integrated,
209 fixed-payment delivery program for Medicaid recipients created
210 under this subsection. The evaluation shall begin as soon as
211 Medicaid recipients are enrolled in the managed care ~~pilot~~
212 program plans and shall continue for 24 months thereafter. The
213 evaluation must include assessments of each nursing home
214 diversion contractor ~~managed care plan~~ in the integrated program
215 with regard to cost savings; consumer education, choice, and
216 access to services; coordination of care; and quality of care.
217 The evaluation must describe administrative or legal barriers to
218 the implementation and operation of the ~~pilot~~ program ~~and~~
219 ~~include recommendations regarding statewide expansion of the~~
220 ~~pilot program~~. The office shall submit its evaluation report to
221 the Governor, the President of the Senate, and the Speaker of
222 the House of Representatives no later than December 31, 2014
223 ~~2009~~.
224 (e) The agency may seek federal waivers or Medicaid state
225 plan amendments and adopt rules as necessary to administer the
226 integrated program. The agency may implement the approved
227 federal waivers and other provisions as specified in this
228 subsection.
229 ~~(f) The implementation of the integrated, fixed-payment~~
230 ~~delivery program created under this subsection is subject to an~~
231 ~~appropriation in the General Appropriations Act.~~
232 Section 2. Paragraph (e) of subsection (1) of section

21-00695-11 2011542__

233 408.040, Florida Statutes, is redesignated as paragraph (d), and
234 present paragraph (d) of that subsection is amended to read:
235 408.040 Conditions and monitoring.—
236 (1)
237 ~~(d) If a nursing home is located in a county in which a~~
238 ~~long-term care community diversion pilot project has been~~
239 ~~implemented under s. 430.705 or in a county in which an~~
240 ~~integrated, fixed-payment delivery program for Medicaid~~
241 ~~recipients who are 60 years of age or older or dually eligible~~
242 ~~for Medicare and Medicaid has been implemented under s.~~
243 ~~409.912(5), the nursing home may request a reduction in the~~
244 ~~percentage of annual patient days used by residents who are~~
245 ~~eligible for care under Title XIX of the Social Security Act,~~
246 ~~which is a condition of the nursing home's certificate of need.~~
247 ~~The agency shall automatically grant the nursing home's request~~
248 ~~if the reduction is not more than 15 percent of the nursing~~
249 ~~home's annual Medicaid-patient-days condition. A nursing home~~
250 ~~may submit only one request every 2 years for an automatic~~
251 ~~reduction. A requesting nursing home must notify the agency in~~
252 ~~writing at least 60 days in advance of its intent to reduce its~~
253 ~~annual Medicaid-patient-days condition by not more than 15~~
254 ~~percent. The agency must acknowledge the request in writing and~~
255 ~~must change its records to reflect the revised certificate-of-~~
256 ~~need condition. This paragraph expires June 30, 2011.~~
257 Section 3. This act shall take effect July 1, 2011.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.