By Senator Grimsley

26-00434A-17 2017916__

A bill to be entitled

An act relating to the statewide Medicaid managed care program; amending s. 409.912, F.S.; deleting the fee-for-service option as a basis for the reimbursement of Medicaid provider service networks; amending s. 409.964, F.S.; deleting an obsolete provision; amending s. 409.966, F.S.; requiring that a required databook consist of data that is consistent with actuarial rate-setting practices and standards; revising the designation and county makeup of regions of the state for purposes of procuring health plans that may participate in the Medicaid program; adding a factor that the Agency for Health Care Administration must consider in the selection of eligible plans; deleting a requirement related to fee-for-service provider service networks; amending s. 409.968, F.S.; requiring provider service networks to be prepaid plans; deleting a fee-for-service option for Medicaid reimbursement for provider service networks; amending s. 409.971, F.S.; deleting an obsolete provision; amending s. 409.974, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state; deleting an obsolete provision; amending s. 409.978, F.S.; deleting an obsolete provision; amending s. 409.981, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state; deleting a requirement that the agency consider a specific factor relating to the selection

of managed medical assistance plans; providing an effective date.

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

Section 1. Subsection (2) 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. s. 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 are not 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.

(2) The agency may contract with a provider service network~~, which may be reimbursed on a fee-for-service or prepaid basis~~. Prepaid provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be~~

~~received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

(a) A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis 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.

(b) A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, 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.

Section 2. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the ~~time~~ period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region. ~~The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.~~

Section 3. Subsection (2) and paragraphs (a), (d), and (e) of subsection (3) of section 409.966, Florida Statutes, are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data <u>consistent with actuarial rate-setting practices and standards</u> ~~for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region~~

~~or county. The source of the data in the report must include both historic fee-for-service claims and validated data from the Medicaid Encounter Data System. The report must be available in electronic form and delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score~~. Separate and simultaneous procurements shall be conducted in each of the following regions:

(a) Region A ~~Region 1~~, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, ~~and~~ Walton, and Washington Counties.

(b) Region B ~~Region 2~~, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia ~~Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington~~ Counties.

(c) Region C ~~Region 3~~, which consists of Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk ~~Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union~~ Counties.

(d) Region D ~~Region 4~~, which consists of Brevard, Orange, Osceola, and Seminole ~~Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia~~ Counties.

(e) Region E ~~Region 5~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota ~~Pasco and Pinellas~~ Counties.

(f) Region F ~~Region 6~~, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie ~~Hardee, Highlands, Hillsborough, Manatee, and Polk~~ Counties.

(g) Region G ~~Region 7~~, which consists of Broward County ~~Brevard, Orange, Osceola, and Seminole Counties~~.

(h) Region H ~~Region 8~~, which consists of Miami-Dade and Monroe ~~Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota~~ Counties.

~~(i) Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.~~

~~(j) Region 10, which consists of Broward County.~~

~~(k) Region 11, which consists of Miami-Dade and Monroe Counties.~~

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization’s record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitting a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

11. Whether a plan is proposing to establish a comprehensive long-term care plan.

(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.

~~1.~~ For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.

~~2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.~~

(e) To ensure managed care plan participation in Regions A and E ~~Regions 1 and 2~~, the agency shall award an additional contract to each plan with a contract award in Region A ~~Region 1~~ or Region E ~~Region 2~~. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region A ~~Region 1~~ or Region E ~~Region 2~~, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.

Section 4. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks shall ~~may~~ be prepaid plans and receive per-member, per-month payments negotiated pursuant

to the procurement process described in s. 409.966. ~~Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 5. Section 409.971, Florida Statutes, is amended to read:

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. ~~By January 1, 2013, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all~~

~~regions by October 1, 2014.~~

Section 6. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

(a) The agency shall procure at least two plans and up to four plans for Region A ~~Region 1~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure at least three plans and up to five ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure at least four ~~three~~ plans and up to seven ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) The agency shall procure at least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(e) The agency shall procure at least two plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) The agency shall procure at least two ~~four~~ plans and up

to four ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) The agency shall procure at least two ~~three~~ plans and up to four ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) The agency shall procure at least five ~~two~~ plans and up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency~~

~~shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.~~

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submits ~~submitting~~ a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). The agency shall exercise a preference for plans with a provider network in which more than ~~over~~ 10 percent of the providers use electronic health records, as defined in s. 408.051. ~~When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.~~

Section 7. Subsection (1) of section 409.978, Florida Statutes, is amended to read:

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. ~~By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.~~

Section 8. Subsection (2) and paragraphs (c), (d), and (e)

of subsection (3) of section 409.981, Florida Statutes, are amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. The agency shall procure:

(a) At least two plans and up to four plans for Region A ~~Region 1~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(b) At least three ~~Two~~ plans and up to five plans for Region B ~~Region 2~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(c) At least four ~~three~~ plans and up to seven ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) At least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service network submits a responsive bid.

(e) At least two plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) At least two ~~four~~ plans and up to four ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) At least two ~~three~~ plans and up to four ~~six~~ plans for

Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) At least five ~~two~~ plans and up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid in a region other than Region 1 or Region 2, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.~~

(3) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider the following factors in the selection of eligible plans:

~~(c) Whether a plan is proposing to establish a~~

~~comprehensive long-term care plan and whether the eligible plan has a contract to provide managed medical assistance services in the same region.~~

(c) ~~(d)~~ Whether a plan offers consumer-directed care services to enrollees pursuant to s. 409.221.

(d) ~~(c)~~ Whether a plan is proposing to provide home and community-based services in addition to the minimum benefits required by s. 409.98.

Section 9. This act shall take effect July 1, 2017.