1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.912, F.S.;
3 requiring the Agency for Health Care Administration to
4 implement federal waivers to administer an integrated,
5 fixed-payment delivery program for Medicaid recipients 60
6 years of age or older; providing for voluntary enrollment
7 in the program in specified locations, in accordance with
8 certain requirements; requiring selection of managed care
9 entities to operate the program; providing that such
10 managed care entities shall be considered prepaid health
11 plans; providing for the establishment of informal and
12 formal provider grievance systems; requiring payment of
13 certain nursing home claims within a time certain;
14 providing a timeframe for evaluation of the program by the
15 Office of Program Policy Analysis and Government
16 Accountability; extending the deadline for submission of
17 the evaluation report; authorizing the agency to seek
18 Medicaid state plan amendments; requiring the agency to
19 submit a report to the Legislature; amending s. 408.040,
20 F.S.; conforming terminology to changes made by the act;
21 providing an effective date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Subsection (5) of section 409.912, Florida
26 Statutes, is amended to read:
27 409.912 Cost-effective purchasing of health care.--The
28 agency shall purchase goods and services for Medicaid recipients
29 in the most cost-effective manner consistent with the delivery of

30 quality medical care. To ensure that medical services are
31 effectively utilized, the agency may, in any case, require a
32 confirmation or second physician's opinion of the correct
33 diagnosis for purposes of authorizing future services under the
34 Medicaid program. This section does not restrict access to
35 emergency services or poststabilization care services as defined
36 in 42 C.F.R. part 438.114. Such confirmation or second opinion
37 shall be rendered in a manner approved by the agency. The agency
38 shall maximize the use of prepaid per capita and prepaid
39 aggregate fixed-sum basis services when appropriate and other
40 alternative service delivery and reimbursement methodologies,
41 including competitive bidding pursuant to s. 287.057, designed to
42 facilitate the cost-effective purchase of a case-managed
43 continuum of care. The agency shall also require providers to
44 minimize the exposure of recipients to the need for acute
45 inpatient, custodial, and other institutional care and the
46 inappropriate or unnecessary use of high-cost services. The
47 agency shall contract with a vendor to monitor and evaluate the
48 clinical practice patterns of providers in order to identify
49 trends that are outside the normal practice patterns of a
50 provider's professional peers or the national guidelines of a
51 provider's professional association. The vendor must be able to
52 provide information and counseling to a provider whose practice
53 patterns are outside the norms, in consultation with the agency,
54 to improve patient care and reduce inappropriate utilization. The
55 agency may mandate prior authorization, drug therapy management,
56 or disease management participation for certain populations of
57 Medicaid beneficiaries, certain drug classes, or particular drugs
58 to prevent fraud, abuse, overuse, and possible dangerous drug

59 interactions. The Pharmaceutical and Therapeutics Committee shall
60 make recommendations to the agency on drugs for which prior
61 authorization is required. The agency shall inform the
62 Pharmaceutical and Therapeutics Committee of its decisions
63 regarding drugs subject to prior authorization. The agency is
64 authorized to limit the entities it contracts with or enrolls as
65 Medicaid providers by developing a provider network through
66 provider credentialing. The agency may competitively bid single-
67 source-provider contracts if procurement of goods or services
68 results in demonstrated cost savings to the state without
69 limiting access to care. The agency may limit its network based
70 on the assessment of beneficiary access to care, provider
71 availability, provider quality standards, time and distance
72 standards for access to care, the cultural competence of the
73 provider network, demographic characteristics of Medicaid
74 beneficiaries, practice and provider-to-beneficiary standards,
75 appointment wait times, beneficiary use of services, provider
76 turnover, provider profiling, provider licensure history,
77 previous program integrity investigations and findings, peer
78 review, provider Medicaid policy and billing compliance records,
79 clinical and medical record audits, and other factors. Providers
80 shall not be entitled to enrollment in the Medicaid provider
81 network. The agency shall determine instances in which allowing
82 Medicaid beneficiaries to purchase durable medical equipment and
83 other goods is less expensive to the Medicaid program than long-
84 term rental of the equipment or goods. The agency may establish
85 rules to facilitate purchases in lieu of long-term rentals in
86 order to protect against fraud and abuse in the Medicaid program

87 as defined in s. 409.913. The agency may seek federal waivers
88 necessary to administer these policies.
89 (5) ~~By December 1, 2005,~~ The Agency for Health Care
90 Administration, in partnership with the Department of Elderly
91 Affairs, shall create an integrated, fixed-payment delivery
92 program ~~system~~ for Medicaid recipients who are 60 years of age or
93 older. The Agency for Health Care Administration shall implement
94 the integrated program ~~system~~ initially on a pilot basis in two
95 areas of the state. ~~In one of the areas~~ Enrollment in the pilot
96 areas shall be on a voluntary basis and in accordance with
97 approved federal waivers and this section. The integrated program
98 must transfer all Medicaid services for eligible elderly
99 individuals who choose to participate into an integrated-care
100 management model designed to serve Medicaid recipients in the
101 community. The integrated program must combine all funding for
102 Medicaid services provided to individuals 60 years of age or
103 older into the integrated program ~~system~~, including funds for
104 Medicaid home and community-based waiver services; all Medicaid
105 services authorized in ss. 409.905 and 409.906, excluding funds
106 for Medicaid nursing home services unless the agency is able to
107 demonstrate how the integration of the funds will improve
108 coordinated care for these services in a less costly manner; and
109 Medicare coinsurance and deductibles for persons dually eligible
110 for Medicaid and Medicare as prescribed in s. 409.908(13).
111 (a) Individuals who are 60 years of age or older and
112 enrolled in the developmental disabilities waiver program, the
113 family and supported-living waiver program, the project AIDS care
114 waiver program, the traumatic brain injury and spinal cord injury
115 waiver program, the consumer-directed care waiver program, and

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

116 the program of all-inclusive care for the elderly program, and
117 residents of institutional care facilities for the
118 developmentally disabled, must be excluded from the integrated
119 program ~~system~~.
120 (b) The integrated program must use a competitive
121 procurement process to select managed care entities to operate
122 the integrated program ~~system~~. For the purpose of this section,
123 managed care entities shall be considered prepaid health plans as
124 provided in s. 408.7056(1)(e). Entities eligible to submit bids
125 include managed care organizations licensed under chapter 641,
126 including entities eligible to participate in the nursing home
127 diversion program, other qualified providers as defined in s.
128 430.703(7), community care for the elderly lead agencies, and
129 other state-certified community service networks that meet
130 comparable standards as defined by the agency, in consultation
131 with the Department of Elderly Affairs and the Office of
132 Insurance Regulation, to be financially solvent and able to take
133 on financial risk for managed care. Community service networks
134 that are certified pursuant to the comparable standards defined
135 by the agency are not required to be licensed under chapter 641.
136 (c) The agency must ensure that the capitation-rate-setting
137 methodology for the integrated program ~~system~~ is actuarially
138 sound and reflects the intent to provide quality care in the
139 least restrictive setting. The agency must also require
140 integrated-program ~~integrated-system~~ providers to develop a
141 credentialing system for service providers and to contract with
142 all Gold Seal nursing homes, where feasible, and exclude, where
143 feasible, chronically poor-performing facilities and providers as
144 defined by the agency. The integrated program must develop and

145 maintain an informal provider grievance system that addresses
146 provider payment and contract problems. The agency shall also
147 establish a formal grievance system to address those issues that
148 were not resolved through the informal grievance system. The
149 integrated program ~~system~~ must provide that if the recipient
150 resides in a noncontracted residential facility licensed under
151 chapter 400 or chapter 429 at the time of enrollment in the
152 integrated program ~~system is initiated~~, the recipient must be
153 permitted to continue to reside in the noncontracted facility as
154 long as the recipient desires. The integrated program ~~system~~ must
155 also provide that, in the absence of a contract between the
156 integrated-program ~~integrated-system~~ provider and the residential
157 facility licensed under chapter 400 or chapter 429, current
158 Medicaid rates must prevail. The integrated-program provider must
159 ensure that electronic nursing home claims that contain
160 sufficient information for processing are paid within 10 business
161 days after receipt. Alternately, the integrated-program provider
162 may establish a capitated payment mechanism to prospectively pay
163 nursing homes at the beginning of each month. The agency and the
164 Department of Elderly Affairs must jointly develop procedures to
165 manage the services provided through the integrated program
166 ~~system~~ in order to ensure quality and recipient choice.
167 (d) ~~Within 24 months after implementation,~~ The Office of
168 Program Policy Analysis and Government Accountability, in
169 consultation with the Auditor General, shall comprehensively
170 evaluate the pilot project for the integrated, fixed-payment
171 delivery program ~~system~~ for Medicaid recipients created under
172 this subsection ~~who are 60 years of age or older~~. The evaluation
173 shall begin as soon as Medicaid recipients are enrolled in the

174 managed care pilot program plans and shall continue for 24 months
175 thereafter. The evaluation must include assessments of each
176 managed care plan in the integrated program with regard to cost
177 savings; consumer education, choice, and access to services;
178 coordination of care; and quality of care. The evaluation must
179 describe administrative or legal barriers to the implementation
180 and operation of the pilot program and include recommendations
181 regarding statewide expansion of the pilot program. The office
182 shall submit its ~~an~~ evaluation report to the Governor, the
183 President of the Senate, and the Speaker of the House of
184 Representatives no later than December 31, 2009 ~~June 30, 2008~~.
185 (e) The agency may seek federal waivers or Medicaid state
186 plan amendments and adopt rules as necessary to administer the
187 integrated program ~~system~~. The agency may implement the approved
188 federal waivers and other provisions as specified in this
189 subsection ~~must receive specific authorization from the~~
190 ~~Legislature prior to implementing the waiver for the integrated~~
191 ~~system~~.
192 (f) No later than December 31, 2007, the agency shall
193 provide a report to the President of the Senate and the Speaker
194 of the House of Representatives containing an analysis of the
195 merits and challenges of seeking a waiver to implement a
196 voluntary program that integrates payments and services for
197 dually enrolled Medicare and Medicaid recipients who are 65 years
198 of age or older.
199 Section 2. Paragraph (d) of subsection (1) of section
200 408.040, Florida Statutes, is amended to read:
201 408.040 Conditions and monitoring.--
202 (1)

203 (d) If a nursing home is located in a county in which a
204 long-term care community diversion pilot project has been
205 implemented under s. 430.705 or in a county in which an
206 integrated, fixed-payment delivery program ~~system~~ for Medicaid
207 recipients who are 60 years of age or older has been implemented
208 under s. 409.912(5), the nursing home may request a reduction in
209 the percentage of annual patient days used by residents who are
210 eligible for care under Title XIX of the Social Security Act,
211 which is a condition of the nursing home's certificate of need.
212 The agency shall automatically grant the nursing home's request
213 if the reduction is not more than 15 percent of the nursing
214 home's annual Medicaid-patient-days condition. A nursing home may
215 submit only one request every 2 years for an automatic reduction.
216 A requesting nursing home must notify the agency in writing at
217 least 60 days in advance of its intent to reduce its annual
218 Medicaid-patient-days condition by not more than 15 percent. The
219 agency must acknowledge the request in writing and must change
220 its records to reflect the revised certificate-of-need condition.
221 This paragraph expires June 30, 2011.
222 Section 3. This act shall take effect July 1, 2007.