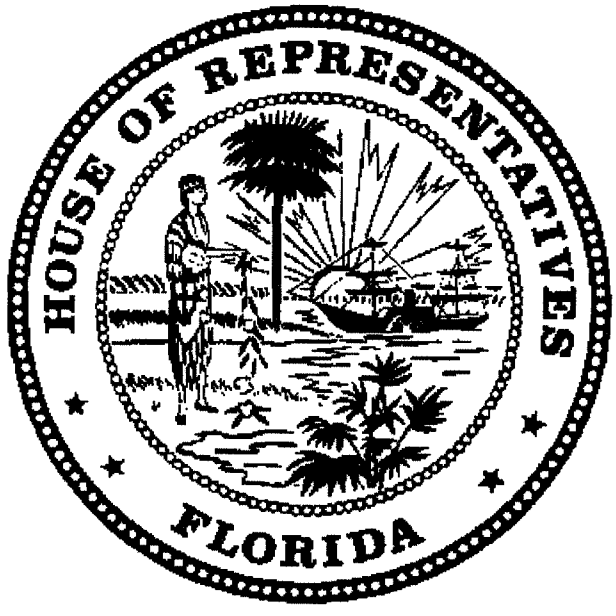


Health & Family Services Policy Council

Tuesday, March 16, 2010
8:00 AM - 10:00 AM
Webster Hall (212 Knott)

Larry Cretul
Speaker

Ed Homan
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Family Services Policy Council

Start Date and Time: Tuesday, March 16, 2010 08:00 am

End Date and Time: Tuesday, March 16, 2010 10:00 am

Location: Webster Hall (212 Knott)
Duration: 2.00 hrs

Consideration of the following proposed council bill(s):

PCB HFPC 10-01 -- Medicaid

Consideration of the following bill(s):

CS/HB 479 Driver License Records by Health Care Services Policy Committee, Reed
CS/HB 573 Physician Assistants by Health Care Regulation Policy Committee, Kreegel

Pursuant to rule 7.13, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Monday, March 15, 2010.

By request of the Chair, all council members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, March 15, 2010.

NOTICE FINALIZED on 03/12/2010 16:26 by Alison.Cindy

The Florida House of Representatives

Health & Family Services Policy Council

AGENDA

March 16, 2010
8:00 AM – 10:00 AM
Webster Hall (212 Knott)

I. Opening Remarks by Chair Homan

II. Consideration of the following Proposed Council Bill:

PCB HFPC 10-01 – Medicaid

III. Consideration of the following Bill(s):

CS/HB 479 – Driver License Records by Health Care Services Policy Committee and Rep. Reed

CS/HB 573 – Physician Assistants by Health Care Regulation Policy Committee and Rep. Kreegel

IV. Closing Remarks

V. Adjournment

1302 The Capitol, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 414-6692

PCB HFPC 10-01

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HFPC 10-01 Medicaid
SPONSOR(S): Health & Family Services Policy Council
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Health & Family Services Policy Council		Shaw	Gormley
1)				
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

A medical home is a system for providing health care where the primary care provider is the patient's first contact as well as his continuing contact throughout the delivery of a comprehensive range of health care services. Medical homes are characterized by use of health information technology, the coordination of specialty and inpatient care, preventive services, disease management, behavioral health care, patient education, and the diagnosis and treatment of acute illness

The PCB creates a medical home program centered on primary care providers. Primary care providers will form medical homes either through provider services networks (PSNs) or by joining other primary care providers and health professionals and facilities who agree to cooperate with one another in order to coordinate care. Medicaid recipients may be assigned to a medical home provider, but must choose to participate.

The PCB:

- Clarifies when a PSN may provide behavioral health care services for its Medicaid enrollees.
- Provides that PSNs may not cancel a Medicaid provider contract without at least a 90 day notice and members of the PSN must continue to provide services to enrollees during this 90 day period.
- Requires prepaid plans to spend 85% of their capitation revenue on services to enrollees or be subject to recoupment.
- Provides that a provider who receives low income pool funds shall serve Medicaid recipients regardless of their Florida county of residence.
- Extends the period in which a PSN in the managed care pilot project can be paid a fee-for-services rate to 2015.
- Changes the assignment ratio for Medicaid enrollees who do not choose a provider by directing AHCA to assign 65 percent to PSNs designated as a medical home and 35 percent to other types of managed care; thereby eliminating any auto assignment to MediPass providers who are not medical homes.
- Requires Medicaid providers to fully comply with AHCA's medical encounter data system.
- Requires a report that summarizes data regarding AHCA's medical encounter data system, including the number of participating providers, the level of compliance of each provider, and an analysis of service utilization, service trends, and specific problem areas.
- Provides that beginning October 1, 2010, AHCA shall begin a budget neutral adjustment of capitation rates based on aggregate risk scores for each provider's enrollees and provides that a technical advisory panel shall advise the agency in the area of risk adjusted rate setting during the transition to risk adjusted capitation.

The PCB will have both positive and negative fiscal impacts on state government. See the Fiscal Analysis & Fiscal Impact Statement for details.

The bill has an effective date of July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

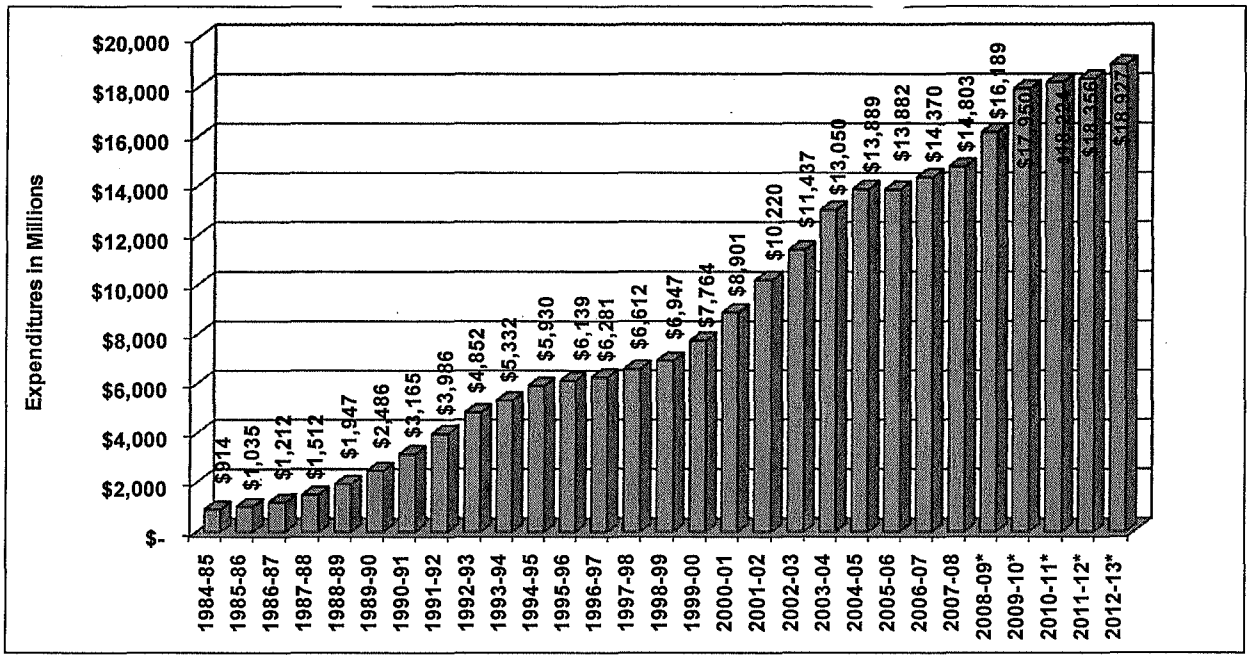
Medicaid Overview

Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration and financed by federal and state funds. Key characteristics[1] of Florida's Medicaid program may be summarized as follows:

- 2.7 million eligibles.
- $17.9 billion estimated spending in Fiscal Year 2009-10.
- Florida will spend approximately $6,625 per eligible in Fiscal Year 2009-2010.
- 45 percent of all Medicaid expenditures cover:
  - Hospitals;
  - Nursing homes;
  - Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs); and,
  - Low Income Pool and Disproportionate Share supplemental payments.
- Of the 2.7 million eligibles, 1.9 million are enrolled in some type of managed care.
- Approximately 80,000 providers participate in fee-for-service Medicaid'
- 23 managed care organizations, which includes 16 HMOs and 7 PSNs.

Florida, like most other states, turned to managed care for improving access to care, containing costs and enhancing quality. The history of Medicaid provides ample documentation of the impact of low reimbursements on provider participation. Despite these low payment rates, costs for Medicaid exploded over the years due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. Between 1984 and 1990, Medicaid enrollment nationally increased to 36 million, up from an average of 20-23 million in the prior 15 years.[2] Spending also grew rapidly, increasing from $51.3 billion nationally in 1993 to $125.2 million just five years later. Growth in Florida's Medicaid population and expenditures mirrored the national trends as shown in the figures below.[3]

[1] Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the Medical Home Task Force, September 2009.
[2] Between Welfare, Medicine, and Mainstream Entitlement: Medicaid at the Political Crossroads.
[3] *Supra*, note 1.



Trends toward higher caseloads and higher spending, coupled with economic pressures on states, led to the next wave of managed care expansion. In the early 1990s, President Clinton eased federal regulations affecting Medicaid managed care, making it easier for states to expand these programs. By the late 1990s, more than half of all Medicaid beneficiaries were in managed care arrangements. As of 2006, more than 65 percent of Medicaid participants were enrolled in managed care, although these arrangements cover a broad range of managed care models.

The managed care models used in Florida include prepaid health plans (HMOs), primary care case management (MediPass), provider service networks (PSNs)[4], minority physician networks (MPNs), MediPass disease management, prepaid mental health plans (PMHP), prepaid dental health plans (PDHP) and pediatric emergency room diversion[5].

Primary care case management was the state's first managed care initiative and was begun in the early 1980s. Although the program includes gatekeeping and care management by a primary care practitioner, this program is generally considered as a fee-for-service system since no entity bears risk as part of the MediPass program.

Florida began contracting with prepaid health plans in the early 1990s and by 1994,[6] more than 400,000 of the state's then 1.6 million beneficiaries were enrolled. Inadequate state oversight and involvement by speculative HMO entrepreneurs led to a number of problems and the state temporarily froze enrollment while conducting an investigation and establishing new forms of control. Following these adjustments, enrollment grew steadily, though not uniformly, across the state. Many rural counties continue to rely exclusively on MediPass since no HMOs have entered the market. The most recent surge in managed care enrollment occurred as part of Medicaid Reform, where all beneficiaries including those on public assistance and persons with disabilities were required to select a managed care organization—either an HMO or a PSN.

[4] s. 409.912(4)(d), F.S., defines a provider service network as "a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, 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."

[5] 2009-2010 Florida Medicaid Summary of Services, Agency for Health Care Administration.

[6] *Health Policy Report: Medicaid and Managed Care*, John Iglehart, New England Journal of Medicine, Vol. 332, No. 25 (1995).

Medicaid Payment and Risk Adjusted Capitation Rates

The Florida Medicaid Program pays for services in three ways: fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements; capitated payments to certain managed care organizations (HMOs) or capitated PSNs which create provider networks by contracting with health care providers and which bear full risk for the care of Medicaid recipients who enroll in the managed care organization; and fee-for-service reimbursement to certain managed care organizations (PSNs) which create provider networks by contracting with health care providers and which must share any savings with the Medicaid program or pay Medicaid for lack of savings.

Medicaid uses a capitated payment model for Health Maintenance Organizations (HMOs), capitated PSNs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s.

Rates for HMOs are set for specific demographic cohorts based on age, sex, geographic location and eligibility group. While these factors are linked with utilization patterns to some extent, they do not capture or reflect any detailed understanding of a person's clinical risk. Medicaid reform initiated a process for adjusting rates to reflect clinical risk. The adjustments were phased in over a three-year period with a 10 percent risk corridor to limit any dramatic changes in payment levels.

Medicaid uses fee-for-service reimbursement for Provider Service Networks (PSNs) such as minority physician networks. Provider service networks are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN. Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments. While all minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized the Agency for Health Care Administration (AHCA) to seek and implement a federal waiver for a managed care pilot program. AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law sets a goal of statewide expansion by 2011.

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially based, risk-adjusted, capitated rates. Reform allowed AHCA to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements.

In reform, risk-adjusted rates are achieved by considering the four factors used for non-reform HMOs (age, sex, geographic location and eligibility group), and an additional factor: clinical history. Recipients' clinical risk is scored based on a combination of historic drug claims and historic diagnosis information gleaned from encounter data submitted to AHCA by the health plans. Without clinical risk adjustment, managed care organization payments might not reflect the level of risk they actually assume, and any one managed care plan may be overpaid or underpaid depending on the health status of the recipients who choose to enroll in that plan. This kind of risk adjustment creates disincentives for managed care plans to market to healthier recipients or to promote disenrollment by sicker individuals, often called "cherry picking." Rather, it creates incentives for managed care plans that have sicker patients to identify them as early as possible and work to manage their care to avoid experiencing high costs.

Similarly, clinical risk adju ient creates opportunity for innovative naged care organizations to create plans that specialize in meeting the needs of high-risk patient groups.

The terms and conditions of the Medicaid Reform waiver created a Low Income Pool to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. Based on the waiver, Florida was able to increase these payments to hospitals and other providers by approximately $250 million. The federal waiver sets a capped annual allotment of $1 billion for each year of the 5-year demonstration period for the LIP.[7] The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

In 2009, $1 billion in LIP payments were made to hospitals and other providers.

Managed Care Enrollment

Federal regulations require Medicaid beneficiaries to have a choice of providers. This requirement may be satisfied with a choice of HMOs, or a choice between an HMO and MediPass, or a choice among MediPass providers.

Upon enrollment in Medicaid, recipients have 30 days to exercise their choice of providers. Choice counseling is available during this period through a toll-free help line in non-reform counties and through telephone, face-to-face counseling, mailings and outreach activities in Reform. Those who select a managed care plan are enrolled for a 12-month period. After enrollment, beneficiaries have 90 days to try the plan and request a change. After 90 days, they must stay in the plan for the next nine months.

For those who do not make a choice, current law requires AHCA in non-reform counties to assign recipients "until an enrollment of 35 percent in Medipass and 65 percent in managed care plans" is achieved. The law further requires enrollment procedures to maintain this same proportionate distribution over time. After these considerations, assignment procedures may consider past choices of the participants.

In reform areas, all participants are assigned to managed care plans, but mandatory assignments are "based on the assessed needs of the recipient as determined by the agency."[8] In making such assignments, the agency must take into account several factors: the plan's network capacity; a prior relationship between the recipient and the plan or one of the plan's primary care providers; the recipient's preference for a particular network, as demonstrated by prior claims data; and geographic accessibility.

Medical Homes

The term "medical home" was first coined by the American Academy of Pediatrics in 1967. The model is supported by the American Academy of Family Physicians and the American College of Physicians. The National Committee for Quality Assurance (NCQA) released standards in January 2008 for patient centered medical homes. A medical home is a patient-centered model of care that provides a home base—a personal health care professional, usually a physician, who coordinates and facilitates access to medical care. The personal provider is the patient's first contact as well as his continuing contact throughout the delivery of a comprehensive range of services. Medical homes are characterized by use of health information technology, the coordination of specialty and inpatient care, preventive services, disease management, behavioral health care, patient education, and the diagnosis and treatment of acute illness. A variety of studies have validated the model and indicated that this approach to services results in lower hospitalization rates, lower rates of death for heart disease, cancer and stroke, and reduced rates of medical errors.

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[7] Centers For Medicare & Medicaid Services Special Terms and Conditions, Section 1115 Demonstration Waiver No. 11-W-00206/4, Florida Agency for Health Care Administration, at 24.

[8] s. 409.91211(4), F.S.

Medical Home Pilot Project and Task Force

In 2009, AHCA was directed to develop a plan to implement a medical home pilot project, but not to implement the plan until it was approved by the legislature.[9] The pilot was to utilize primary care case management enhanced by medical home networks to provide coordinated and cost-effective care. The providers would be reimbursed on a fee-for-service basis. AHCA was directed to submit an implementation plan for the medical home pilot project to the legislature and the Governor by February 1, 2010.

The Secretary of Health Care Administration was directed to appoint a task force by August 1, 2009, to assist the agency in the development and implementation of the medical home pilot project. The task force was to include, but not be limited to, representatives of providers who could potentially participate in a medical home network, Medicaid recipients, and existing MediPass and managed care providers.

In July 2009 ten members were appointed to the Medicaid Medical Home Task Force which met five times between September 2009 and January 2010. The Task Force reviewed information on the Florida Medicaid program and delivery systems as well as information on medical home concepts and models. Presentations were made by Medicaid staff from four states that have implemented medical home programs – North Carolina, Oklahoma, Pennsylvania, and Washington.[10]

The Medicaid Medical Home Task Force presented its report the legislature in February 2010 and made recommendations for implementing the Medical Homes Pilot Project:

The Task Force concluded that while the pilot may require significant investment of staff time and dollars up-front, Florida will achieve savings through a medical home model, as other states have reported. The Task Force anticipates that more coordination of care will result in lower costs and will reduce the potential for fraud and abuse to occur.

Effect of Proposed Changes

Behavioral Health Services

In counties where the Medicaid managed cared pilot project is not authorized, AHCA is directed to contract with a single entity to provide comprehensive behavioral health care services to Medicaid recipients not enrolled in a managed care plan or HMO and are not children covered by a specialty plan.[11] The PCB clarifies that if there is a Medicaid provider service network in the AHCA area, then it may provide behavioral health care services for its Medicaid enrollees.

Contracts to provide behavioral health services to Medicaid enrollees must require 80 percent of the capitation paid to the manage care plan be expended for the provision of behavioral health services.[12] The PCB includes provider service networks in the types of providers who are subject to this requirement.

Contracts with Provider Service Networks (PSNs)

AHCA contracts with PSNs on both a fee-for-service and prepaid basis.[13] Currently any contract previously awarded to a PSN operated by a hospital shall remain in effect for three years after the current contract expiration date.[14] The PCB increases the contract extension period to five years.

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[9] s. 409.91207, F.S. (created by s. 17, Chapter 2009-223, Laws of Florida)
[10] *Medicaid Medical Home Task Force Report: Recommendations for Designing and Implementing a Medical Home Pilot Project for Florida Medicaid*, Florida Agency For Health Care Administration (February 2010) available at: http://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/2010-02-02-MedicalHomeTaskForce%20ReportPress%20Release.pdf
[11] s. 409.912(4)(a), F.S.
[12] Id.
[13] S. 409.912(4)(d), F.S.

The PCB also provides that any contract awarded to a PSN shall require that the network may not cancel the contract without at least a 90 day notice. All members of the network must continue to provide services to Medicaid recipients assigned to that network during the 90 day period.

Medicaid Services Loss Ratios

A provider who contracts with AHCA to provide Medicaid services on a prepaid or fixed-sum basis must provide services for the Medicaid enrollee and may use the remaining funds received for administration and for profit.

The PCB creates the requirement that the service provider must spend on average 85% percent of the Medicaid payments for medical services to enrollees or be required to repay funds. If a plan's 3-year average medical loss ratio in a county is less than 85% percent, AHCA shall recoup funds from the plan. The recouped funds shall be equal to the difference between 85% percent of the funds paid to the plan and the amount the plan paid for of services averaged over a three year period. These recouped funds shall be dispersed to plans that have used more than 85 percent of payments directly on the provision of medical services.

Medical Homes

The PCB directs AHCA to develop a method of recognizing as a Medical Home a primary care provider, who is a member of an informal network, or a PSN who provide medical services using the principles of a Medical Home.

A medical home follows these guiding principles:

- A personal medical provider leads an interdisciplinary team of professionals who share the responsibility for providing ongoing care to a specific panel of patients.
- The personal medical provider identifies a patient's health care needs and responds to those needs through direct care or arrangements with other qualified providers.
- Care is coordinated or integrated across all areas of health service delivery.
- Information technology is integrated into delivery systems to enhance clinical performance and monitor patient outcomes.

Requirements & Qualifications

The Medical Home is centered on the primary care provider. The PCB defines a "primary care provider" as any of the following:

- a federally qualified health center[15],
- a health professional practicing in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine who is licensed as a physician under chapter 458 or chapter 459,
- a physician's assistant performing services delegated by a supervising physician pursuant to s. 458.347 or s. 459.022, or
- a registered nurse certified as a nurse practitioner performing services pursuant to a protocol established with a supervising physician in accordance with s. 464.012.

If a primary care provider chooses to become a Medical Home then the provider must be member of a medical home network. The network is a group of primary care providers and other health professionals and facilities who agree to cooperate with one another in order to coordinate care for Medicaid beneficiaries assigned to primary care providers in the network. Additionally, each network

[14] Id.
[15] Federally Qualified Health Centers (FQHCs) are private, non-profit community-based organizations that receive a federal grant under Section 330 of the Public Health Service Act. FQHC services include primary care—medical, dental, and behavioral health services.

must designate a principa :twork provider who is a member of a dical home network who serves as the principal liaison between the agency and that network.

There is no requirement for composition of or number of participants in a medical home network; however, the PCB provides that each medical home network shall provide primary care, coordinate services to control chronic illnesses, provide or arrange for pharmacy services, provide or arrange for outpatient diagnostic and specialty physician services, and provide for or coordinate with inpatient facilities and rehabilitative service providers.

A PSN can also be a Medical Home if it and its member physicians meet the same service requirements as a medical home network. Additionally, a PSN may also certify to the agency that it intends to serve a specific target population based on disease, condition, or age.

A medical home network or a PSN certified as a medical home shall provide primary care, coordinate services to control chronic illnesses, provide disease management and patient education, provide or arrange for pharmacy services, provide or arrange for outpatient diagnostic and specialty physician services, and provide for or coordinate with inpatient facilities, behavioral, mental health, and rehabilitative service providers. The network shall place a priority on methods to manage pharmacy and behavioral services.

In order to be a Medical Home each primary care provider or PSN must certify to AHCA that the requirements are met to be a Tier One, Two, or Three medical home. A primary care provider or PSN who has a change in service capabilities may have the designation changed. AHCA shall develop a form[16] to be used by the primary care providers and PSNs to certify[17] to the agency that they meet the necessary requirements for the tier in which they seek to be designated. The providers must annually make a certification that the provider meets the service requirements of the providers designated tier.

Tier One medical homes shall have the capability to:

- Communicate electronically.
- Provide and coordinate all needed primary care..
- Track and coordinate referrals and community care.
- Support and educate the individual patient.

Tier Two medical homes shall have all of the capabilities of a Tier One medical home and shall have the additional capability to:

- Have available at all times a way for patients to speak to a licensed health care professional who triages and forwards calls.
- Implement and document behavioral health and substance abuse screening procedures and make referrals as needed.
- Use data to identify and track patients' health and service use patterns so there can be coordinate care and follow-ups.

Tier Three medical homes shall have all of the capabilities of Tier One and Tier Two medical homes and shall have the additional capability to:

- Maintain electronic medical records.
- Supply postvisit followup care for patients.
- Implement specific evidence-based clinical practice guidelines for preventive and chronic care.
- Implement a medication reconciliation procedure to avoid interactions or duplications.
- Offer at least 4 hours per week of after-hours care to patients.

A primary care provider must certify that the provider meets all the requirements of the Tier for which certification is sought. A PSN must certify that that at least 85 percent of its members who are primary

[16] The PCB directs that the form shall have a check box for each of the three tiers, a line to indicate whether a primary care network intends to specialize in a target population, a line to specify the target population, if any, and a line for the signature of the provider or principal of an entity.

[17] Checking the appropriate tier box and signing the form shall be deemed certification.

care providers meet the s ce capabilities of the tier in which cert ation is sought and the remainder qualify for the next lower tier.

A PSN may only cease participation as a medical home with at least 90 days notice to the agency. All members of the provider service network must continue to serve the enrollees during this 90 day period. A provider service network that is reimbursed by the agency on a prepaid basis shall not receive any additional reimbursements for this 90 day period.

Enrollment

Each Medicaid beneficiary already served by a medical home provider shall be given a choice to enroll in a medical home network or a PSN certified as a Medical Home. Enrollment shall be effective upon the agency's receipt of a participation agreement signed by the beneficiary. AHCA shall develop the participation agreement.

Provider Payments

Services provided by a medical home network or a PSN with a fee-for-service contract with the agency shall be reimbursed based on claims filed for Medicaid fee-for-service payments. Services by a PSN with a contract with the agency for prepaid services shall be paid pursuant to the contract

If there is a specific appropriation in the General Appropriations Act, medical home network members shall be eligible to receive an enhanced case management fee as follows:

- The Tier One medical homes shall receive:
  - $3.58 per child in a panel of enrollees; and
  - $5.02 per adult in a panel of enrollees.
- The Tier Two medical homes shall receive:
  - $4.65 per child in a panel of enrollees; and
  - $6.52 per adult in a panel of enrollees.
- The Tier Three medical homes shall receive:
  - $6.12 per child in a panel of enrollees; and
  - $8.69 per adult in a panel of enrollees.

Hospital Credits

Section 395.701, F.S., imposes an assessment on net operating revenues of hospitals at the rate of 1.5% for inpatient services and 1% for outpatient services. The funds are deposited into the Public Medical Assistance Trust Fund. Collections for Fiscal Year 2010-2011 are estimated to be $420.7 million.

Any hospital participating in a medical home network or PSN and employing case managers[18] for the network shall be eligible to receive a credit against the assessment. The credit is compensation for participating in the medical home network by providing case management and other medical home network services.

The credit shall be prorated based on the number of full-time equivalent case managers hired but shall not be more than $75,000 for each full-time equivalent case manager. The total credit may not exceed $450,000 for any hospital for any state fiscal year.

To qualify for the credit, the hospital must employ each full-time equivalent case manager for the entire hospital fiscal year for which the credit is claimed.

Agency Duties

[18] The PCB defines a "Case manager" as the person or persons employed by a medical home network or by a member of the network to work with primary care providers in the delivery of outreach, support services, and care coordination for medical home patients.

In addition to the duties di ssed previously, AHCA shall:

- Maintain a record of certified primary care providers and provider service networks by classification as Tier One, Tier Two, or Tier Three medical homes.
- Track the spending for and utilization of services by all enrolled medical home network patients..
- Ensure that any provider service network is cost-effective as defined in s. 409.912(44). The evaluation shall be made at least annually.

Advisory Panel

The PCB provides that a seven-member statewide advisory panel shall be established. The members will be appointed from the medical community and will advise and assist the agency in developing a methodology for an annual evaluation of each medical home network and provider service network certified as a medical home. The panel shall promote communication among medical home networks and provider service networks certified as medical homes.

The statewide advisory panel shall establish a medical advisory group consisting of licensed physicians who shall act as ambassadors to their communities for the promotion of and assistance in the establishment of medical home networks..

When the statewide advisory panel has been appointed, the Medicaid Medical Home Task Force shall dissolve.

Achieved Savings

The PCB provides that it is the intent of the Legislature that the savings that result from the implementation of the medical home model be used to enable Medicaid fees to physicians participating in medical home networks and fee-for-service PSNs to be equivalent to 100 percent of Medicare rates as soon as possible.

If there is a appropriation, each medical home network or provider service network certified as a medical home that participates on a fee-for-service basis and that achieves savings equal to or greater than the spending that would have occurred if its enrollees participated in prepaid health plans will be eligible to receive funding based on the identified savings. The funds must be distributed on a pro rata basis to the physicians who are members of the medical home network to enable the compensation for their services to be as close as possible to 100 percent of Medicare rates.

Collaboration with Private Insurers

AHCA is directed to collaborate with the Office of Insurance Regulation to encourage Florida insurers to medical home principles into the design of their individual and employment-based plans. If Florida's overall medical costs decline, the state will be able to participate in federal gainsharing programs.

The Department of Management Services is directed to develop a medical home option in the state group insurance program.

Low Income Pool Funds

The PCB provides that a provider in the managed care pilot who receives low income pool funds shall serve Medicaid recipients regardless of their Florida county of residence. The provider shall not restrict access to care based on residency in a Florida county other than the one in which the provider is located.

PSN Financial Risk

Any PSN that is part of the managed care pilot project had an option to initially be paid fee-for-services rates.[19] After five years of operation, the payment model must be adjusted to a risk-adjusted capitated rate.

The PCB extends this period in which a PSN can be paid a fee-for-services rate to 2015 for PNSs already having existing contracts. Any new PSN will still have up to five years of payments at fee-for-services rates.

Managed Care Assignments

If a Medicaid recipient is subject to mandatory assignment to managed care but fails to make a choice of a plan, then AHCA shall assign the recipient.[20] Currently Medicaid recipients are assigned to managed care plans until an enrollment is achieved of 35 percent in MediPass and 65 percent in managed care plans. Managed care plans include health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs. Once the assignment ratio is achieved, the assignments continue in a manner that will maintain the same ratio.

The PCB changes the assignment ratio to provide an assignment of 65 percent to provider service networks designated as a medical home and of 35 percent in other types of managed care. Enrollees may still chose MediPass, but if they fail to choose, they will not be assigned to a MediPass provider who is not an HMO.

Provider Agreement Requirements

AHCA may only make payment for services rendered to a Medicaid recipient to a provider that has entered into a provider agreement. Section 409.907, F.S., sets forth the mandatory requirements for a provider agreement.

The PCB adds that a provider agreement must contain a requirement that the provider fully comply with the agency's medical encounter data system.

Encounter Data Reporting

The PCB provides that by January 1, 2011, and annually thereafter until full compliance is reached, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that summarizes data regarding the agency's medical encounter data system, including the number of participating providers, the level of compliance of each provider, and an analysis of service utilization, service trends, and specific problem areas.

Risk Adjusted Capitation Rates

The PCB provides that beginning October 1, 2010, the AHCA shall begin a budget neutral adjustment of capitation rates of all plans based on aggregate risk scores for each provider's enrollees. During the first two years of the adjustment, the agency shall ensure that no provider has an aggregate risk score that varies by more than 10 percent from the aggregate weighted average for all providers. The risk adjusted capitation rates shall be phased in over a 3-year period.

A technical advisory panel shall advise the agency in the area of risk adjusted rate setting during the transition to risk adjusted capitation. The panel shall include representatives of prepaid plans in counties not included in demonstration sites. The panel shall advise the agency regarding:

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[19] S. 409.91211(3)(e), F.S.
[20] S. 409.9122(2)(f), F.S..

- The selection of a e year of encounter data to be used t t risk adjusted rates.
- The completeness and accuracy of the encounter dataset.
- The effect of risk adjusted rates on prepaid plans based on a review of a simulated rate setting process.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.

Section 2: Amends s. 409.91207, F.S., relating to medical homes.

Section 3: Amends s. 409.91211, F.S., relating to Medicaid managed care pilot program.

Section 4: Amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment.

Section 5: Amends s. 409.907, F.S., relating to Medicaid provider agreements.

Section 6: Amends s. 409.908, F. S., relating to reimbursement of Medicaid providers.

Section 7: Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The credits against their Public Medical Assistance Trust Fund (PMATF) assessment for participating hospitals who hire case managers will have a negative fiscal impact on the trust fund. The provision has not yet been reviewed by the Revenue Estimating Conference. Since the number of hospitals who will choose to participate in unknown, the precise fiscal impact is indeterminate. Revenues to the PMATF totaled $428 million in 2008.

2. Expenditures:

   The implementation of the Medical Home program will have an operational impact on AHCA. Preliminary estimates by the agency indicate a need for additional FTEs and other resources.

   While the bill authorizes several enhanced payment rates, each of these are subject to specific authority in the General Appropriations Act.

   Increased costs may be associated with the movement of Medicaid participants from prepaid managed care plans to the medical home network. Enrollment of Medicaid participants in prepaid health plans guarantees savings due to the discount factor built into the capitated rate compared to fee-for-service spending. Savings associated with the medical home model are indeterminate although similar models in other states have demonstrated savings compared to prior fee-for-service utilization and expenditure patterns.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that medical home principles are applied by participating providers to all patients, regardless of payer, some of the quality and cost improvements may affect privately insured patients.

D. FISCAL COMMENTS:

If the Medical Home program results in lower rates of hospitalization and better treatment of ambulatory sensitive conditions, the state should realize a savings in Medicaid expenditures. The analysis required by the PCB will allow the legislature to evaluate expenses, cost savings, and outcomes of the pilot.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The PCB does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The PCB has several technical and formatting errors that can be corrected by House Bill Drafting if the PCB is favorably passed by the Council.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Medicaid; amending s. 409.912, F.S., providing instructions to the Agency for Health Care Administration regarding seeking federal approval for certain contracts; providing that contacts with provider service networks must meet certain standards for expenditures for behavioral health care service; providing that certain contracts with providers service networks may not be cancelled without specified notice; providing additional terms for cancelation; providing contracts for Medicaid services that are prepaid or for fixed-sum must meet certain medical loss ratios or the agency shall recoup and redistribute payments; amending s. 409.91207, F.S.; providing purposes and principals for creating medical homes; providing definitions; providing for the organization of medical home networks and provider service networks certified as medical homes; requiring each medical home to provide specified services; providing for the establishment of a statewide advisory panel; providing for membership and duties of the panel; providing for travel expenses and per diem for members of the statewide advisory panel and medical advisory group; directing the agency to provide staff support to the panel; directing the panel to establish a medical advisory group to promote and assist in the establishment of medical homes; providing for enrollment of Medicaid beneficiaries in medial homes; providing for financing of medical home networks; providing responsibilities of the agency;

requiring the agency to adopt rules; providing for distribution of savings achieved by network providers under certain circumstances; requiring the agency to collaborate with the Office of Insurance Regulation to encourage licensed insurers to incorporate the principles of the medical home network in insurance plans; requiring medical home network providers to maintain certain records and data; amending s. 409.91211, F.S., providing that a hospital who receives low income pool funds shall serve Medicaid recipients regardless of county of residence; revising the period for phasing in financial risk for certain provider service networks; amending s. 409.9122, F.S., revising the assignment of Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice; amending s. 408.907, F.S., revising the requirements of a Medicaid provider agreement to include certain data; providing that the agency shall submit a specified report on the agency's medical encounter data; amending s. 409.908, F.S., providing the agency shall adjust capitation rates for certain Medicaid providers; providing criteria for the adjustments; providing a phase in schedule; creating a technical advisory panel to advise the agency in the area of risk adjusted rate setting; providing membership; providing duties; providing an effective date.

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

Section 1. Paragraphs (b) and (d) of subsection (4) of section 409.912, Florida Statutes, are amended to read and subsection (54) is created 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.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the

agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a Medicaid provider service network authorized under paragraph (d) of this subsection, or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations or provider service networks, to be expended for the provision of behavioral health care services. If the managed

care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less

than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations are eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts must be with the existing provider service network pilot project, as described in

paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric

program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider may not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the HomeSafeNet system, shall receive their

behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network 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. Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this

subsection shall remain in effect for a period of 5 ~~3~~ years following the current contract expiration date, regardless of any contractual provisions to the contrary. Any contract awarded to a provider service network shall require that the network may not cancel the contract without at least a 90 day notice. All members of the network must continue to provide services to Medicaid recipients assigned to that network during that 90 day period. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, 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.

(54) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall spend 85% percent of the Medicaid capitation revenue for health services to enrollees. The agency shall monitor medical loss ratios for all prepaid plans on a county-by-county basis. When a plan's 3-year average medical loss ratio in a county is less

than 85% percent, the agency is authorized to recoup an amount equivalent to the difference between 85% percent of the capitation paid to the plan and the amount the plan paid for provision of services over the three year period. These recouped funds shall be dispersed in proportionate amounts to plans that have spent in excess of 85 percent of their capitation on the provision of medical services.

Section 2. Section 409.91207, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 409.91207, F.S., for present text.)

409.91207 Medical Homes.—

(1) PURPOSE AND PRINCIPLES.—The agency shall develop a method for recognizing the certification of a primary care provider or a provider service network as a medical home. The purpose of this certification is to foster and support improved care management through enhanced primary care case management and dissemination of best practices for coordinated and cost-effective care. The medical home modifies the processes and patterns of health care service delivery by applying the following principles:

(a) A personal medical provider leads an interdisciplinary team of professionals who share the responsibility for providing ongoing care to a specific panel of patients.

(b) The personal medical provider identifies a patient's health care needs and responds to those needs through direct care or arrangements with other qualified providers.

(c) Care is coordinated or integrated across all areas of health service delivery.

(d) Information technology is integrated into delivery systems to enhance clinical performance and monitor patient outcomes.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Case manager" means the person or persons employed by a medical home network, provider service network, or by a member of the network to work with primary care providers in the delivery of outreach, support services, and care coordination for medical home patients.

(b) "Medical home network" means a group of primary care providers and other health professionals and facilities who agree to cooperate with one another in order to coordinate care for Medicaid beneficiaries assigned to primary care providers in the network.

(c) "Primary care provider" means a health professional practicing in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine who is licensed as a physician under chapter 458 or chapter 459, a physician's assistant performing services delegated by a supervising physician pursuant to s. 458.347 or s. 459.022, or a registered nurse certified as a nurse practitioner performing services pursuant to a protocol established with a supervising physician in accordance with s. 464.012.

(d) "Principal network provider" means a member of a medical home network or provider service network who serves as the principal liaison between the agency and that network and

who accepts responsibility for communicating the agency's directives concerning the project to all other network members.

(e) "Provider service network" means a provider service network as defined by s. 409.912(4)(d).

(f) "Tier One medical home" means:

1. a primary care provider who certifies to the agency that the provider meets the service capabilities established in paragraph (4)(a), or

2. a provider service network who certifies to the agency that all of its members who are primary care providers meet the service capabilities established in paragraph (4)(a)

(g) "Tier Two medical home" means:

1. a primary care provider who certifies to the agency that the provider meets the service capabilities established in paragraph (4)(b), or

2. a provider service network who certifies to the agency that at least 85 percent of its members who are primary care providers meet the service capabilities established in paragraph (4)(b) and the remainder of the primary care providers meet the service capabilities established in paragraph (4)(a) .

(f) "Tier Three medical home" means:

1. a primary care provider who certifies to the agency that the provider meets the service capabilities established in paragraph (4)(c), or

2. a provider service network who certifies to the agency that at least 85 percent of its members who are primary care providers meet the service capabilities established in paragraph

(4)(c) and the remainder of the primary care providers meet the service capabilities established in paragraph (4)(b) .

(3) ORGANIZATION.—

(a) Each participating primary care provider shall be a member of a medical home network or a provider service network and shall be classified by the agency as a Tier One, Tier Two, or Tier Three medical home upon certification by the provider of compliance with the service capabilities for that tier. A primary care provider or a provider service network may change classification by certifying service capabilities consistent with the standards for another tier. Certifications shall be made annually.

(b) Each participating provider service network shall be classified by the agency as a Tier One, Tier Two, or Tier Three medical home upon certification by the network that the network's primary care providers meet the service capabilities for that tier. The provider service network may also certify to the agency that it intends to serve a specific target population based on disease, condition, or age.

(c) The members of each medical home network or provider service network shall designate a principal network provider who shall be responsible for maintaining an accurate list of participating providers, forwarding this list to the agency and updating the list as requested by the agency, and facilitating communication between the agency and the participating providers.

(d) A provider service network may only cease participation as a medical home with at least 90 days notice to the agency.

All members of the provider service network must continue to serve the enrollees during this 90 day period. A provider service network that is reimbursed by the agency on a prepaid basis shall not receive any additional reimbursements for this 90 day period.

(4) SERVICE CAPABILITIES.—A medical home network or a provider service network certified as a medical home shall provide primary care, coordinate services to control chronic illnesses, provide disease management and patient education, provide or arrange for pharmacy services, provide or arrange for outpatient diagnostic and specialty physician services, and provide for or coordinate with inpatient facilities, behavioral, mental health, and rehabilitative service providers. The network shall place a priority on methods to manage pharmacy and behavioral services.

(a) Tier One medical homes shall have the capability to:

1. Maintain a written copy of the mutual agreement between the medical home and the patient in the patient's medical record.

2. Supply all medically necessary primary and preventive services and provide all scheduled immunizations.

3. Organize clinical data in paper or electronic form using a patient-centered charting system.

4. Maintain and update patients' medication lists and review all medications during each office visit.

5. Maintain a system to track diagnostic tests and provide followup services regarding test results.

6. Maintain a system to track referrals, including self-referrals by members.

7. Supply care coordination and continuity of care through proactive contact with members and encourage family participation in care.

8. Supply education and support using various materials and processes appropriate for individual patient needs.

(b) Tier Two medical homes shall have all of the capabilities of a Tier One medical home and shall have the additional capability to:

1. Communicate electronically.

2. Supply voice-to-voice telephone coverage to panel members 24 hours per day, 7 days per week, to enable patients to speak to a licensed health care professional who triages and forwards calls, as appropriate.

3. Maintain an office schedule of at least 30 scheduled hours per week.

4. Use scheduling processes to promote continuity with clinicians, including providing care for walk-in, routine, and urgent care visits.

5. Implement and document behavioral health and substance abuse screening procedures and make referrals as needed.

6. Use data to identify and track patients' health and service use patterns.

7. Coordinate care and followup for patients receiving services in inpatient and outpatient facilities.

8. Implement processes to promote access to care and member communication.

(c) Tier Three medical homes shall have all of the capabilities of Tier One and Tier Two medical homes and shall have the additional capability to:

1. Maintain electronic medical records.

2. Develop a health care team that provides ongoing support, oversight, and guidance for all medical care received by the patient and document contact with specialists and other health care providers caring for the patient.

3. Supply postvisit followup care for patients.

4. Implement specific evidence-based clinical practice guidelines for preventive and chronic care.

5. Implement a medication reconciliation procedure to avoid interactions or duplications.

6. Use personalized screening, brief intervention, and referral to treatment procedures for appropriate patients requiring specialty treatment.

7. Offer at least 4 hours per week of after-hours care to patients.

8. Use health assessment tools to identify patient needs and risks.

(5) TASK FORCE; ADVISORY PANEL.—

(a) The Secretary of Health Care Administration shall appoint a task force by August 1, 2009, to assist the agency in the development and implementation of the medical home pilot project. The task force must include, but is not limited to, representatives of providers who could potentially participate in a medical home network, Medicaid recipients, and existing MediPass and managed care providers. Members of the task force

shall serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061. When the statewide advisory panel created pursuant to paragraph (b) has been appointed, the task force shall dissolve.

(b) A statewide advisory panel shall be established to advise and assist the agency in developing a methodology for an annual evaluation of each medical home network and provider service network certified as a medical home. The panel shall promote communication among medical home networks and provider service networks certified as medical homes. The panel shall consist of seven members, who shall be appointed as follows:

1. Two members appointed by the Speaker of the House of Representatives, one of whom shall be a primary care physician licensed under chapter 458 or chapter 459 and one of whom shall be a representative of a hospital licensed under chapter 395.

2. Two members appointed by the President of the Senate, one of whom shall be a physician licensed under chapter 458 or chapter 459 who is a board-certified specialist and one of whom shall be a representative of a Florida medical school.

3. Two members appointed by the Governor, one of whom shall be a representative of a Florida-licensed insurer or a health maintenance organization and one of whom shall be a representative of Medicaid consumers.

4. The Secretary of Health Care Administration or his or her designee.

(c) Panel members shall serve 4-year terms, except that the initial terms shall be staggered as follows:

1. The Governor shall appoint one member for a term of 2 years and one member for a term of 4 year.

2. The President of the Senate shall appoint one member for a term of 2 years and one member for a term of 4 year.

3. The Speaker of the House of Representatives shall appoint one member for a term of 2 years and one member for a term of 4 year.

(d) A vacancy shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(e) Members of the statewide advisory panel shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(f) The agency shall provide staff support to assist the panel in the performance of its duties.

(g) The statewide advisory panel shall establish a medical advisory group consisting of physicians licensed under chapter 458 or chapter 459 who shall act as ambassadors to their communities for the promotion of and assistance in the establishment of medical home networks and provider service networks certified as medical homes. Members of the medical advisory group shall serve without compensation and may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(6) ENROLLMENT.—Each beneficiary served by a certified Tier One, Tier Two, or Tier Three medical home shall be given a choice to enroll in a medical home network or provider service network certified as a medical home. Enrollment shall be

effective upon the agency's receipt of a participation agreement signed by the beneficiary.

(7) FINANCING.—

(a) Subject to a specific appropriation provided for in the General Appropriations Act, medical home network members shall be eligible to receive a monthly enhanced case management fee as follows:

1. The Tier One medical homes shall receive:

a. $3.58 per child in a panel of enrollees; and

b. $5.02 per adult in a panel of enrollees.

2. The Tier Two medical homes shall receive:

a. $4.65 per child in a panel of enrollees; and

b. $6.52 per adult in a panel of enrollees.

3. The Tier Three medical homes shall receive:

a. $6.12 per child in a panel of enrollees; and

b. $8.69 per adult in a panel of enrollees.

(b) Services provided by a medical home network or a provider service network with a fee-for-service contract with the agency shall be reimbursed based on claims filed for Medicaid fee-for-service payments. Services by a provider service network with a contract with the agency for prepaid services shall be paid pursuant to the contract and shall be eligible to receive the credit provided in this subsection.

(c) Any hospital, as defined in s. 395.002(12), participating in a medical home network or service provider network certified as a medical home and employing case managers for the network shall be eligible to receive a credit against

the assessment imposed under s. 395.701. The credit is compensation for participating in the network by providing case management and other network services.

1. The credit shall be prorated based on the number of full-time equivalent case managers hired but shall not be more than $75,000 for each full-time equivalent case manager. The total credit may not exceed $450,000 for any hospital for any state fiscal year.

2. To qualify for the credit, the hospital must employ each full-time equivalent case manager for the entire hospital fiscal year for which the credit is claimed.

3. The hospital must certify the number of full-time equivalent case managers for whom it is entitled to a credit using the certification process required under s. 395.701(2)(a).

4. The agency shall calculate the amount of the credit and reduce the certified assessment for the hospital by the amount of the credit.

(d) The enhanced payments to primary care providers shall not affect the calculation of capitated rates under this chapter.

(8) AGENCY DUTIES; RULEMAKING AUTHORITY.-

(a) The agency shall:

1. Maintain a record of certified primary care providers and provider service networks by classification as Tier One, Tier Two, or Tier Three medical homes.

2. Develop a standard form to be used by primary care providers and provider service networks to certify to the agency that they meet the necessary principles and service capabilities

for the tier in which they seek to be classified. The form shall have a check box for each of the three tiers, a line to indicate whether a primary care network intends to specialize in a target population, a line to specify the target population, if any, and a line for the signature of the provider or principal of an entity. Checking the appropriate tier box and signing the form shall be deemed certification for the purposes of this section.

3. Develop a process for managed care organizations to certify themselves as Tier One, Tier Two, or Tier Three medical homes based on established policies and procedures consistent with the principles and corresponding service capabilities provided for in subsections (1) and (4).

5. Establish a participation agreement to be executed by Medipass recipients who choose to participate in the medical home pilot project.

6. Track the spending for and utilization of services by all enrolled medical home network patients.

7. Ensure that any provider service network is cost-effective as defined in s. 409.912(44). The evaluation shall be made at least annually.

(9) ACHIEVED SAVINGS.—Each medical home network or provider service network certified as a medical home that participates on a fee-for-service basis and that achieves savings equal to or greater than the spending that would have occurred if its enrollees participated in prepaid health plans is eligible to receive funding based on the identified savings pursuant to a specific appropriation provided for in the General Appropriations Act. The funds must be distributed on a pro rata

basis to the physicians who are members of the medical home network to enable the compensation for their services to be as close as possible to 100 percent of Medicare rates. Subject to a specific appropriation, it is the intent of the Legislature that the savings that result from the implementation of the medical home network model be used to enable Medicaid fees to physicians participating in medical home networks to be equivalent to 100 percent of Medicare rates as soon as possible.

(10) COLLABORATION WITH PRIVATE INSURERS.—To enable the state to participate in federal gainsharing initiatives, the agency shall collaborate with the Office of Insurance Regulation to encourage Florida-licensed insurers to incorporate medical home network principles in the design of their individual and employment-based plans. The Department of Management Services is directed to develop a medical home option in the state group insurance program.

(11) QUALITY ASSURANCE AND ACCOUNTABILITY.—Each primary care provider participating in a medical home network or provider service network certified as a medical home shall maintain medical records and clinical data necessary for the network to assess the use, cost, and outcome of services provided to enrollees.

Section 3. Paragraph (b) of subsection (1) and paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

(1)

(b) This waiver authority is contingent upon federal

approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services. A provider who receives low income pool funds shall serve Medicaid recipients regardless of their Florida county of residence and shall not restrict access to care based on residency in a Florida county other than the one in which the provider is located.

(3) The agency shall have the following powers, duties,

and responsibilities with respect to the pilot program:

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks that, for purposes of this paragraph, include the Children's Medical Services Network, over the longer of a 5-year period or through October 1, 2015. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates must include a savings-settlement mechanism that is consistent with s. 409.912(44). As of October 1, 2015 or, after five years of operation, whichever is the longer period, this model must be converted to a risk-adjusted capitated rate ~~by the beginning of the sixth year of operation,~~ and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

Section 4. Paragraph (f) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(2)

(f) If a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan ~~or MediPass provider~~. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice

shall be assigned to managed care plans until an enrollment is achieved of 65 percent in provider service networks designated as a medical home under s. 409.91207 and 35 percent in other ~~35 percent in MediPass and 65 percent in~~ managed care plans~~, of all those eligible to choose managed care, is achieved~~. Once this enrollment is achieved, the assignments shall be divided in the same manner ~~order~~ to maintain the same ~~an~~ enrollment ratio ~~in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively.~~ Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who would be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations,

provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

Section 5. Paragraph (k) is added to subsection (3) of section 409.907, Florida Statutes, and subsection (13) of that section is created, to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any

other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(k) Fully comply with the agency's medical encounter data system.

(13) By January 1, 2011, and annually thereafter until full compliance is reached, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that summarizes data regarding the agency's medical encounter data system, including the number of participating providers, the level of compliance of each provider, and an analysis of service utilization, service trends, and specific problem areas.

Section 6. Subsection (4) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or

goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of

eligibility. The agency shall calculate capitation rates on a regional basis and~~, beginning September 1, 1995,~~ shall include age-band differentials in such calculations.

(a) Beginning October 1, 2010, the agency shall begin a budget neutral adjustment of capitation rates based on aggregate risk scores for each provider's enrollees. During the first two years of the adjustment, the agency shall ensure that no provider has an aggregate risk score that varies by more than 10 percent from the aggregate weighted average for all providers. The risk adjusted capitation rates shall be phased in as follows:

1. In the first fiscal year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted capitation rate methodology.

2. In the second fiscal year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted rate methodology.

3. In the third fiscal year, the risk-adjusted capitation methodology shall be fully implemented.

(b) The Secretary of the agency shall convene a technical advisory panel to advise the agency in the area of risk adjusted rate setting during the transition to risk adjusted capitation rates described in paragraph (a). The panel shall include representatives of prepaid plans in counties not included in the demonstration sites under s. 409.91211(1). The panel shall advise the agency regarding:

1. The selection of a base year of encounter data to be used to set risk adjusted rates.

2. The completeness and accuracy of the encounter dataset.

3. The effect of risk adjusted rates on prepaid plans based on a review of a simulated rate setting process.

Section 7. This act shall take effect July 1, 2010.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 479 Driver License Records
SPONSOR(S): Health Care Services Policy Committee; Reed
TIED BILLS: **IDEN./SIM. BILLS:** SB 962

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Services Policy Committee	13 Y, 0 N, As CS	Schoonover	Schoolfield
2)	Roads, Bridges & Ports Policy Committee	12 Y, 0 N	Brown	Miller
3)	Health & Family Services Policy Council		Schoonover	Gormley
4)				
5)				

SUMMARY ANALYSIS

CS/HB 479 amends s. 322.142, F.S., to allow the Department of Children and Family Services (DCF) to access Department of Highway Safety and Motor Vehicles (DHSMV) image and signature data to conduct protective investigations pursuant to chapter 415, F.S., relating to adult protective services.

The bill also allows DCF to access DHSMV image and signature data for use in expediting the determination of eligibility for public assistance and for use in public assistance fraud investigations.

The bill takes effect on July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Background

Adult Protective Investigations

The Adult Protective Services Program, authorized by Ch. 415, F.S., and managed by the Department of Children and Family Services (DCF), is a system of social services that protects disabled or elderly persons from occurrences of abuse, neglect, and exploitation. Upon report of alleged abuse, neglect, or exploitation, an assessment of an individual's need for protective services is initiated.

The program consists of four components:

- The on-site investigation;
- Emergency services, if determined necessary;
- Referral to the local law enforcement, if appropriate; and
- Referral to local social service agencies for any identified needs.[1]

The Florida Abuse Hotline accepts reports related to vulnerable adults who are residents of Florida or currently located in Florida, and are:

- Believed to have been neglected or abused by a caregiver in Florida;
- Suffering from the ill effects of neglect and in need of services; or
- Being exploited by any person who stands in a position of trust or confidence, or any person who knows or should know that a vulnerable adult lacks capacity to consent and who obtains or uses, or endeavors to obtain or use their funds, assets or property.[2]

When a report is determined by a hotline counselor to require an immediate onsite protective investigation, the hotline counselor must immediately notify the DCF's designated district staff responsible for protective investigations. A non-emergency report that is received by the hotline

[1] Department of Children and Families, CF Operating Procedure 140-2, see http://www.dcf.state.fl.us/publications/policies.shtml#adult (last visited February 2, 2010).
[2] Department of Children and Families, *Reporting Abuse of Children and Vulnerable Adults*, see www.dcf.state.fl.us/abuse/publications/mandatedreporters.pdf (2007) (last visited February 2, 2010).

counselor is forwarded to the appropriate district staff in sufficient time so that an investigation occurs within 24 hours.[3]

When a report is called into the Florida Abuse hotline, a protective investigation is initiated, which includes observation, interviews with the victim and witnesses, evidence gathering and collateral contacts.[4] Sometimes during an investigation, abused, neglected, or exploited adults are identified, but lack the capacity to consent to protective services. Additionally DCF reports that during some adult protective investigations, the subject of the investigation denies his or her identity, eluding the investigators.[5]

Public Assistance

Public assistance includes benefits paid to individuals through temporary cash assistance, food stamps, Medicaid or optional state supplemental programs.[6]

Driver's Licenses and Identification Cards

Applicants for driver's licenses are required by the Department of Highway Safety and Motor Vehicles (DHSMV) to provide proof of a social security card and proof of identity by showing documents including proof of citizenship and lawful non-citizenship status.[7] Identical requirements exist in law for state issued identification cards.[8] Upon receipt of the required fee, DHSMV issues to driver's license and identification card applicants, a color photographic or digital imaged driver's license bearing a full-face photograph or digital image of the licensee.[9]

Temporary Cash Assistance

Under state law, temporary cash assistance applicants must be United States citizens, qualified noncitizens, legal residents of the state, and be able to provide a social security number for each member of the family or show proof of application for one.[10] The Department of Children and Family Services (DCF) conducts eligibility for, and administers the temporary cash assistance program under, Title IV-A of the Social Security Act.[11,12]

Medicaid

Both federal and state law require applicants for Medicaid services to show proof of identity and be United States citizens, or qualified non-citizens and legal residents of Florida.[13,14] Additionally, federal law classifies a valid state-issued driver's license as satisfactory documentary evidence of both identity and citizenship, as long as the state issuing the license requires proof of U.S. citizenship or obtains a social security number from the applicant.[15] Since the applications require proof of a social security card, a valid Florida driver's license or state-issued identification card is permitted to receive Medicaid

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[3] s. 415.103(2), F.S.
[4] Department of Children and Families, *Adult Abuse, Neglect, and Exploitation*, see http://www.dcf.state.fl.us/as/ (last visited February 2, 2010).
[5] Department of Children and Families, Staff Analysis HB 91 (2010), on file with the Health Care Services Policy Committee.
[6] s. 414.0252(10), F.S.
[7] s. 322.08, F.S.
[8] s. 322.051, F.S.
[9] s. 322.142(1) and s. 322.051(8), F.S.
[10] s. 414.095(2)(a), F.S.
[11] s. 414.0252(12), F.S.
[12] s. 414.045, F.S.
[13] s. 414.095(2), F.S.
[14] 42 U.S.C. § 1396b(i)(22); 42 C.F.R. § 435.406
[15] 42 U.S.C. § 1396b(x)(3)(b); 42 C.F.R. § 435.407(4)

benefits in Florida. Once Medicaid eligibility has been determined by DCF, then the Agency for Health Care Administration will administer and supervise the Medicaid benefits for the qualified applicant.[16]

Supplemental Nutrition Assistance Program (SNAP)

Under state law, food stamps, or SNAP applicants must be United States citizens, qualified noncitizens, legal residents of the state, and be able to provide a social security number for each member of the family or show proof of application for one.[17] Federal law permits both United States citizens and lawful aliens to receive benefits of SNAP.[18] Specifically, the Code of Federal Regulations requires verification of an applicant's identity by any document which reasonably establishes identity. Driver's licenses or state issued identification cards are reasonable documents under the Code.[19] DCF is the designated department responsible for administering and operating the federally authorized SNAP program.[20]

Fraud

Section 414.39(10), F.S., requires DCF to screen applicants for public assistance, including Medicaid, food stamps, and temporary cash assistance, against a fraud-prone case profile to identify cases for fraud. Additionally the Attorney General conducts a statewide program of Medicaid fraud control, which investigates both Medicaid provider and user fraud.[21]

Department of Highway and Safety Motor Vehicles (DHSMV) Database

The DHSMV is permitted, pursuant to interagency agreements, to share information from its database, including digital images and signatures, in the following circumstances:[22]

- In response to law enforcement agency requests;
- With the Department of State to determine voter registration eligibility;
- With the Department of Revenue for use in establishing paternity and establishing, modifying, or enforcing support obligations;
- With the Department of Children and Families to conduct protective investigations under part III of chapter 39, and
- With the Department of Financial Services relating to unclaimed property.

Under current law, DCF is not permitted to access the DHSMV database relating to protective investigations regarding vulnerable adults. Additionally, DCF is not permitted access to verify identification and citizenship of Medicaid and SNAP applicants, resulting in a delay or lack of receipt of services.[23]

Effect of Proposed Changes

The bill will permit a specified number of DCF employees to access the DHSMV database to conduct protective investigations under chapter 415, F.S., relating to adult protective services. Access to this system should assist investigators in the positive identification of victims and responsible persons who are subjects in investigations of abuse, neglect, or exploitation and provide quick access to the location of such persons, including vulnerable adults.

The bill will also permit, pursuant to an interagency agreement, a specified number of DCF employees to access the DHSMV database for use as verification of identity to expedite the determination of

[16] s. 409.901, F.S.
[17] s. 414.095, F.S.
[18] 7 U.S.C. §2015(f); 7 C.F.R. § 273.2(f)
[19] 7 C.F.R. § 273.2(f)(vii)
[20] s. 414.31, F.S.
[21] s. 409.920 and s. 409.9201, F.S.
[22] s. 322.142(4), F.S.
[23] Department of Children and Families, Staff Analysis HB 479 (2010), on file with the Health Care Services Policy Committee.

eligibility for public assistance and for use in public assistance fraud investigations. The effect of the proposed changes will lessen the time it takes to determine eligibility and reduce benefit errors as a result of incorrect or fraudulent applicant identification.

B. SECTION DIRECTORY:

Section 1. Amends s. 322.142, relating to color photographic or digital imaged licenses.

Section 2. Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On February 2, 2010, the Health Care Services Policy Committee adopted 2 amendments. The first amendment adopted was an amendment to the amendment. It amended s. 322.142, F.S., to allow DCF to access image and signature data of the DHSMV to conduct protective investigations pursuant to chapter 415, F.S., relating to adult protective services.

The second amendment adopted was an amendment to the bill. Not only did it contain the language in the amendment to the amendment, it also contained language that permits a specified number of DCF employees to access the DHSMV database for use as verification of identity to expedite the determination of eligibility for public assistance and for use in public assistance fraud investigations. This amendment provides sufficient access control over digital images and allows implementation without a fiscal impact.

A bill to be entitled

An act relating to driver license records; amending s. 322.142, F.S.; revising the authorized uses of license identification information maintained by the Department of Highway Safety and Motor Vehicles and released to the Department of Children and Family Services; authorizing use for certain adult protective services investigations; providing conditions for such information to be used for verification of identity in determination of eligibility for public assistance and for certain fraud investigations; providing an effective date.

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

Section 1. Subsection (4) of section 322.142, Florida Statutes, is amended to read:

322.142 Color photographic or digital imaged licenses.—

(4) The department may maintain a film negative or print file. The department shall maintain a record of the digital image and signature of the licensees, together with other data required by the department for identification and retrieval. Reproductions from the file or digital record are exempt from the provisions of s. 119.07(1) and shall be made and issued only for departmental administrative purposes; for the issuance of duplicate licenses; in response to law enforcement agency requests; to the Department of State pursuant to an interagency agreement to facilitate determinations of eligibility of voter registration applicants and registered voters in accordance with

ss. 98.045 and 98.075; to the Department of Revenue pursuant to an interagency agreement for use in establishing paternity and establishing, modifying, or enforcing support obligations in Title IV-D cases; to the Department of Children and Family Services pursuant to an interagency agreement to conduct protective investigations under part III of chapter 39 and chapter 415; to the Department of Children and Family Services pursuant to an interagency agreement specifying the number of employees in each of that department's regions to be granted access to the records for use as verification of identity to expedite the determination of eligibility for public assistance and for use in public assistance fraud investigations; or to the Department of Financial Services pursuant to an interagency agreement to facilitate the location of owners of unclaimed property, the validation of unclaimed property claims, and the identification of fraudulent or false claims.

Section 2. This act shall take effect July 1, 2010.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 573 Physician Assistants
SPONSOR(S): Health Care Regulation Policy Committee; Kreegel
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee	11 Y, 0 N, As CS	Guy	Calamas
2)	Health & Family Services Policy Council		Guy	Gormley
3)				
4)				
5)				

SUMMARY ANALYSIS

Committee Substitute for House Bill 573 deletes the requirement that a physician assistant have at least three months of clinical experience in the specialty of the supervising physician. A licensed physician assistant will be allowed to practice and prescribe medication immediately upon the establishment of a supervisory relationship with a physician.

The bill authorizes the Florida Department of Health (DOH) to accept physician assistant licensure applications and supporting documentation electronically.

The bill appears to have no fiscal impact to state or local government.

CS/HB 573 provides an effective date of July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Sections 458.347(7), and 459.022(7), F.S., govern the licensure of physician assistants (PAs) in Florida. Physician assistants are licensed by the Department of Health (DOH) and are regulated by the Florida Council on Physician Assistants (Council) and either the Florida Board of Medicine (Board of Medicine) for PAs licensed under Chapter 458, F.S., or the Florida Board of Osteopathic Medicine (Osteopathic Board) for PAs licensed under Chapter 459, F.S. Currently there are a total of 4,966 licensed PAs in Florida: 3,656 with prescribing authority and 1,310 without prescribing authority.[1]

Physician assistants may only practice under the direct or indirect supervision of a medical doctor or doctor of osteopathic medicine with whom they have a clinical relationship. A supervising physician may only delegate tasks and procedures to the physician assistant that are within the supervising physician's scope of practice.[2] The supervising physician is responsible and liable for any and all acts of the PA and may only supervise up to four PAs at any time.[3]

PAs are regulated through the respective physician practice acts.[4] Each of the medical practice acts has a corresponding board (i.e., the Board of Medicine and Osteopathic Board). The duty of the Boards and its members is to make disciplinary decisions concerning whether a doctor or PA was practicing medicine within the confines of their practice act.[5]

The Florida Council on Physician Assistants (Council) was created in 1995 to recommend the licensure requirements (including educational and training requirements) for PAs, establish a list of formulary drugs that a PA may not prescribe, and develop rules for the use of PAs by doctors to ensure that the continuity of supervision is maintained in each practice setting throughout the state.[6] The Council is composed of five members: three physicians who are members of the Board of Medicine; one physician who is a member of the Board of Osteopathic Medicine; and one licensed PA.[7] Two physician members of the Council must supervise physician assistants.[8] The Council and the medical

[1] Teleconference with Department of Health staff, February 24, 2010 (notes on file with the Committee).
[2] Rule 64B8-30.012(1), F.A.C., and Rule 64B15-6.010(1), F.A.C.
[3] s. 458.347(3), F.S., and s. 459.022(3),F.S.
[4] Chs. 458 and 459, F.S.
[5] s. 458.347(12), F.S., and s. 459.022(12), F.S.
[6] s. 458.347(9), F.S., and s. 459.002(9), F.S
[7] *Id.*
[8] *Id.*

boards both have regulatory functions related to PAs: The Council is responsible for licensing PAs; and the boards are responsible for disciplining PA licensees.

Licensure

To become licensed as a PA in Florida, an applicant must demonstrate to the Council:[9]

- Passage of the National Commission on Certification of Physician Assistant exam;
- Completion of the application, the format of which is approved by the Council and includes:
  - certificate of completion of a PA training program;
  - sworn, notarized statement of felony convictions; and
  - sworn statement of denial or revocation of licensure in any state.
- Two letters of recommendation from physicians;[10]
- Payment of a licensure fee; and
- Completion of a two hour course on the prevention of medical errors, error reduction and prevention, and patient safety.[11]

The Council does not currently accept initial licensure and renewal applications electronically. However, DOH is implementing the infrastructure to do so and the Council is scheduled to have this capability by the end of 2010.[12]

Licensure renewal occurs biennially.[13] At the time of renewal, a PA must submit a sworn statement that he or she has had no felony convictions in the previous two years.[14] Furthermore, all PAs are required to complete 100 hours of continuing medical education (CME) biennially.[15] Renewal is subject to specific CME subject matter requirements prescribed in Rules 64B8-30.005, and 64B15-6.0035, F.A.C.

Supervision

A supervising doctor may only delegate tasks and procedures to PA that are within the supervising doctor's scope of practice.[16] The physician may provide direct or indirect supervision. All tasks and procedures performed by the PA must be documented in the appropriate medical record. It is the responsibility of the supervising doctor to ensure that the PA is knowledgeable and skilled in performing the tasks and procedures assigned. The supervising physician is responsible and liable for any and all acts of the PA.

Prescribing and Non-prescribing Physician Assistants

The Council licenses two types of PAs: non-prescribing and prescribing. Prescribing PAs have the authority to prescribe and dispense medications used in the supervising physician's practice, subject to exclusion by the PA formulary.[17] A prescribing PA is not allowed to prescribe controlled substances.[18] Prescribing PAs are required to demonstrate three months of clinical experience in the specialty area of their supervising physician prior to being authorized to prescribe or dispense medication.[19] Prior to licensure, prescribing PAs must complete a Board-approved three hour prescriptive practice course[20]

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[9] s. 458.347(7), F.S., and s. 459.022(7), F.S.
[10] Rule 64B8-30.003(1), F.A.C., and Rule 64B15-6.003(1), F.A.C.
[11] Rule 64B8-30.003(3), F.A.C., and Rule 64B-15-6.003(4), F.A.C.
[12] Teleconference with Department of Health staff, February 24, 2010 (notes on file with the Committee).
[13] s. 458.347(7)(c), F.S. Rule 64B8-30.019, F.A.C., establishes the initial licensure and renewal fee schedule. s. 459.022(7)(b), F.s. Rule 64B15-6.013, F.A.C., establishes the initial licensure and renewal fee schedule.
[14] s. 458.347(7)(c)2, F.S., and s. 459.022(7)(b)2, F.S.
[15] s. 458.347(7)(d), F.S., and s. 459.022(7)(c), F.S.
[16] Rule 64B8-30.012(1), F.A.C., and Rule 64B15-6.010(1), F.A.C.
[17] s. 458.347(4)(e), F.S., and s. 459.022(4)(e), F.S.
[18] s. 458.347(4)(f)1, F.S.
[19] s. 458.347(4)(e)4, F.S., and s. 459.022(4)(e)4, F.S. Generally, Rule 64B8-30.003(5), F.A.C., and Rule 64B15-6.003(5), F.A.C, direct the licensure of prescribing physician assistants.
[20] Rule 64B8-30.003(5)(b), F.A.C., and Rule 64B15-6.033(5)(b), F.A.C.

and they must file for licensure jointly with their supervising physician.[21] For licensure renewal, prescribing PAs must complete an additional 10 hours in the specialty area in which the PA practices.[22]

Each supervising doctor and prescribing PA must keep a written agreement (or protocol) that outlines the intent to delegate prescribing authority and which non-controlled substances the PA is authorized to prescribe. The agreement must be signed and dated by all parties and maintained on file for at least five years; and a copy must be provided to the respective board or council upon request. The PA is restricted to prescribing drugs that are used in the supervising doctor's practice.[23]

Effect of Proposed Changes

Committee Substitute for House Bill 573 deletes the requirement that a physician assistant have at least three months of clinical experience in the specialty of the supervising physician. The practical effect of this provision is to allow a prescribing PA to prescribe medication immediately upon the establishment of a supervisory relationship with a physician.

The bill gives DOH the authority to accept physician assistant licensure applications and supporting documentation electronically.

B. SECTION DIRECTORY:

Section 1: Amending s. 458.347, F.S., relating to physician assistants.
Section 2: Amending s. 458.348, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 3: Amending s. 459.022, F.S., relating to physician assistants.
Section 4: Amending s. 459.025, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 5: Providing an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

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[21] Rule 64B8-30.003(5)(a), F.A.C., and Rule 64B15-6.003(5)(a), F.A.C.
[22] s. 458.347(4)(e)5, F.S., and s. 459.022, (4)(e)5, F.S.
[23] s. 458.347(4)(e), F.S., and s. 459.022(4)(e), F.S.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rule-making authority to implement provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On March 1, 2010, the Health Care Regulation Policy Committee adopted one strike-all amendment to House Bill 573.

The strike-all amendment removes the bill requirement that physician assistant applicants undergo state and federal criminal background checks prior to initial licensure by the Department of Health.

The bill was reported favorably as a Committee Substitute. This analysis reflects the committee substitute.

A bill to be entitled

An act relating to physician assistants; amending ss. 458.347 and 459.022, F.S.; deleting requirements that physician assistants file evidence of certain clinical experience before prescribing or dispensing medication; authorizing the electronic submission of physician assistant license applications and other required documentation; amending ss. 458.348 and 459.025, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Paragraph (e) of subsection (4) of section 458.347, Florida Statutes, is amended, and paragraph (h) is added to subsection (7) of that section, to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription

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

being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department, before commencing to prescribe or dispense, evidence that he or she has completed a continuing medical education course of at least 3 classroom hours in prescriptive practice, conducted by an accredited program approved by the boards, which course covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs, or evidence that he or she has received education comparable to the continuing education course as part of an accredited physician assistant training program.

~~4. The physician assistant must file with the department, before commencing to prescribe or dispense, evidence that the physician assistant has a minimum of 3 months of clinical experience in the specialty area of the supervising physician.~~

4.~~5.~~ The physician assistant must file with the department a signed affidavit that he or she has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application.

5.~~6.~~ The department shall issue a license and a prescriber

number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant shall not be required to independently register pursuant to s. 465.0276.

6.~~7.~~ The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician's name, address, and telephone number, the physician assistant's prescriber number. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

7.~~8.~~ The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

8.~~9.~~ This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.

This paragraph does not apply to facilities licensed pursuant to chapter 395.

(7) PHYSICIAN ASSISTANT LICENSURE.—

(h) An application or other documentation required to be submitted to the department under this subsection may be

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submitted electronically.

Section 2. Paragraph (c) of subsection (4) of section 458.348, Florida Statutes, is amended to read:

458.348 Formal supervisory relationships, standing orders, and established protocols; notice; standards.—

(4) SUPERVISORY RELATIONSHIPS IN MEDICAL OFFICE SETTINGS.—A physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising physician, must comply with the standards set forth in this subsection. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(c) A physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising physician and the services offered at the office are primarily dermatologic or skin care services, which include aesthetic skin care services other than plastic surgery, must comply with the standards listed in subparagraphs 1.-4. Notwithstanding s. 458.347(4)(e)7.~~8.~~, a physician supervising a physician assistant pursuant to this paragraph may not be required to review and cosign charts or medical records prepared by such physician assistant.

1. The physician shall submit to the board the addresses of all offices where he or she is supervising an advanced registered nurse practitioner or a physician's assistant which are not the physician's primary practice location.

2. The physician must be board certified or board eligible in dermatology or plastic surgery as recognized by the board pursuant to s. 458.3312.

3. All such offices that are not the physician's primary place of practice must be within 25 miles of the physician's primary place of practice or in a county that is contiguous to the county of the physician's primary place of practice. However, the distance between any of the offices may not exceed 75 miles.

4. The physician may supervise only one office other than the physician's primary place of practice except that until July 1, 2011, the physician may supervise up to two medical offices other than the physician's primary place of practice if the addresses of the offices are submitted to the board before July 1, 2006. Effective July 1, 2011, the physician may supervise only one office other than the physician's primary place of practice, regardless of when the addresses of the offices were submitted to the board.

Section 3. Paragraph (e) of subsection (4) of section 459.022, Florida Statutes, is amended, and paragraph (g) is added to subsection (7) of that section, to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervisory physician may delegate to a fully

licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervisory physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department, before commencing to prescribe or dispense, evidence that she or he has completed a continuing medical education course of at least 3 classroom hours in prescriptive practice, conducted by an accredited program approved by the boards, which course covers the limitations, responsibilities, and privileges involved in prescribing medicinal drugs, or evidence that she or he has received education comparable to the continuing education course as part of an accredited physician assistant training program.

~~4. The physician assistant must file with the department, before commencing to prescribe or dispense, evidence that the physician assistant has a minimum of 3 months of clinical experience in the specialty area of the supervising physician.~~

4.~~5.~~ The physician assistant must file with the department a signed affidavit that she or he has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application.

5.~~6.~~ The department shall issue a license and a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant shall not be required to independently register pursuant to s. 465.0276.

6.~~7.~~ The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician's name, address, and telephone number, the physician assistant's prescriber number. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

7.~~8.~~ The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

8.~~9.~~ This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.

This paragraph does not apply to facilities licensed pursuant to chapter 395.

(7) PHYSICIAN ASSISTANT LICENSURE.—

(g) An application or other documentation required to be submitted to the department under this subsection may be submitted electronically.

Section 4. Paragraph (c) of subsection (3) of section 459.025, Florida Statutes, is amended to read:

459.025 Formal supervisory relationships, standing orders, and established protocols; notice; standards.—

(3) SUPERVISORY RELATIONSHIPS IN MEDICAL OFFICE SETTINGS.—An osteopathic physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the osteopathic physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising osteopathic physician, must comply with the standards set forth in this subsection. For the purpose of this subsection, an osteopathic physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(c) An osteopathic physician who supervises an advanced registered nurse practitioner or physician assistant at a

medical office other than the osteopathic physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising osteopathic physician and the services offered at the office are primarily dermatologic or skin care services, which include aesthetic skin care services other than plastic surgery, must comply with the standards listed in subparagraphs 1.-4. Notwithstanding s. 459.022(4)(e)7.~~8.~~, an osteopathic physician supervising a physician assistant pursuant to this paragraph may not be required to review and cosign charts or medical records prepared by such physician assistant.

1. The osteopathic physician shall submit to the Board of Osteopathic Medicine the addresses of all offices where he or she is supervising or has a protocol with an advanced registered nurse practitioner or a physician's assistant which are not the osteopathic physician's primary practice location.

2. The osteopathic physician must be board certified or board eligible in dermatology or plastic surgery as recognized by the Board of Osteopathic Medicine pursuant to s. 459.0152.

3. All such offices that are not the osteopathic physician's primary place of practice must be within 25 miles of the osteopathic physician's primary place of practice or in a county that is contiguous to the county of the osteopathic physician's primary place of practice. However, the distance between any of the offices may not exceed 75 miles.

4. The osteopathic physician may supervise only one office other than the osteopathic physician's primary place of practice

except that until July 1, 2011, the osteopathic physician may supervise up to two medical offices other than the osteopathic physician's primary place of practice if the addresses of the offices are submitted to the Board of Osteopathic Medicine before July 1, 2006. Effective July 1, 2011, the osteopathic physician may supervise only one office other than the osteopathic physician's primary place of practice, regardless of when the addresses of the offices were submitted to the Board of Osteopathic Medicine.

Section 5. This act shall take effect July 1, 2010.

Health & Family Services Policy Council

Tuesday, March 16, 2010
8:00 AM - 10:00 AM
Webster Hall (212 Knott)

Amendments

Larry Cretul
Speaker

Ed Homan
Chair

COUNCIL/COMMITTEE AMENDMENT

PCB Name: PCB HFPC 10-01 (2010)

Amendment No. 1

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing PCB: Health & Family Services Policy Council

Representative(s) Homan offered the following:

Amendment

Remove lines 307-311 and insert:

this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect through June 30, 2015 ~~for a period of 3 years following the current contract expiration date~~, regardless of any contractual provisions to the contrary. Any contract awarded or renewed on or after July 1, 2010

Amendment No. 2

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing PCB: Health & Family Services Policy Council

Representative Schwartz offered the following:

Amendment (with title amendment)

Between lines 350 and 351, insert:

Section 1. Short title.—This act may be cited as the "Independence at Home Act of 2010."

Section 2. Legislative findings.—The Legislature finds that:

(1) Unless changes are made to the way health care is delivered, growing demand for resources caused by rising health care costs and to a lesser extent the nation's expanding elderly and chronically ill population will confront Floridians with increasingly difficult choices between health care and other priorities. However, opportunities exist to constrain health care costs without adverse health care consequences.

(2) Medicaid beneficiaries with multiple chronic conditions account for a disproportionate share of Medicaid

spending compared to their representation in the overall Medicaid population, and evidence suggests that such patients often receive poorly coordinated care, including conflicting information from health providers and different diagnoses of the same symptoms.

(3) People with chronic conditions account for 76 percent of all hospital admissions, 88 percent of all prescriptions filled, and 72 percent of physician visits.

(4) Studies show that hospital utilization and emergency room visits for patients with multiple chronic conditions can be reduced and significant savings can be achieved through the use of interdisciplinary teams of health care professionals caring for patients in their places of residence.

(5) The Independence at Home Act creates a chronic care coordination pilot project to bring primary care medical services to the highest cost Medicaid beneficiaries with multiple chronic conditions in their home or place of residence so that they may be as independent as possible for as long as possible in a comfortable setting.

(6) The Independence at Home Act generates savings by providing better, more coordinated care across all treatment settings to the highest cost Medicaid beneficiaries with multiple chronic conditions, reducing duplicative and unnecessary services, and avoiding unnecessary hospitalizations, nursing home admissions, and emergency room visits.

(7) The Independence at Home Act holds providers accountable for improving beneficiary outcomes, ensuring patient

and caregiver satisfaction, and achieving cost savings to Medicaid on an annual basis.

(8) The Independence at Home Act creates incentives for practitioners and providers to develop methods and technologies for providing better and lower cost health care to the highest cost Medicaid beneficiaries with the greatest incentives provided in the case of highest cost beneficiaries.

(9) The Independence at Home Act contains the central elements of proven home-based primary care delivery models that have been utilized for years by the United States Department of Veterans Affairs and their "house calls" programs across the country to deliver coordinated care for chronic conditions in the comfort of a patient's home or place of residence.

Section 3. Independence at Home Chronic Care Coordination Pilot Project.—

(1) The Agency for Health Care Administration shall provide for the phased in development, implementation, and evaluation of Independence at Home programs described in this section to meet the following objectives:

(a) To improve patient outcomes, compared to comparable beneficiaries who do not participate in such a program, through reduced hospitalizations, nursing home admissions, or emergency room visits, increased symptom self-management, and similar results.

(b) To improve satisfaction of patients and caregivers, as demonstrated through a quantitative pretest and posttest survey developed by the agency that measures patient and caregiver

satisfaction of care coordination, educational information, timeliness of response, and similar care features.

(c) To achieve a minimum of 5 percent in cost savings in the care of beneficiaries under this section who suffer from multiple high-cost chronic diseases.

(2) INITIAL IMPLEMENTATION; PHASE I.—

(a) IN GENERAL.—In carrying out this section and to the extent possible, the Agency for health Care Administration shall enter into agreements with at least two unaffiliated Independence-at-Home organizations in each of the counties in the state to provide chronic care coordination services for a period of 3 years or until those agreements are terminated by the agency. Agreements under this paragraph shall continue in effect until the agency makes a determination pursuant to subsection (3) or until those agreements are supplanted by new agreements entered into under that section. The phase of implementation under this paragraph shall be known as the initial implementation phase or phase I.

(b) PREFERENCE.—In selecting Independence at Home organizations under this paragraph, the agency shall give a preference, to the extent practicable, to organizations that:

1. Have documented experience in furnishing the types of services covered under this section to eligible beneficiaries in their home or place of residence using qualified teams of health care professionals who are under the direction of a qualified Independence at Home physician or, in a case when such direction is provided by an Independence at Home physician to a physician assistant who has at least 1 year of experience providing

medical and related services for chronically ill individuals in their homes, or other similar qualification as determined by the agency to be appropriate for the Independence at Home program, by the physician assistant acting under the supervision of an Independence at Home physician and as permitted under state law, or by an Independence at Home nurse practitioner;

2. Have the capacity to provide services covered by this section to at least 150 eligible beneficiaries; and

3. Use electronic medical records, health information technology, and individualized plans of care.

(3) EXPANDED IMPLEMENTATION PHASE; PHASE II.—

(a) IN GENERAL.—For periods beginning after the end of the 3-year initial implementation period under subsection (2), and subject to paragraph (b), the Agency For Health Care Administration shall renew agreements described in subsection (2) with an Independence at Home organization that has met all the objectives specified in subsection (1) and enter into agreements described in subsection (2) with any other organization that is located in the state that was not an Independence at Home organization during the initial implementation period and that meets the qualifications of an Independence at Home organization under this section. The agency may terminate and not renew such an agreement with an organization that has not met such objectives during the initial implementation period. The phase of implementation under this paragraph shall be known as the expanded implementation phase or phase II.

(b) CONTINGENCY.—The expanded implementation under paragraph (a) may not occur if the agency finds, not later than 60 days after the date of issuance of the independent evaluation under subsection (5) that continuation of the Independence at Home project is not in the best interest of beneficiaries under this section.

(4) ELIGIBILITY.—An organization is not prohibited from participating under this section during expanded implementation phase under subsection (3) and, to the extent practicable, during initial implementation phase under subsection (2) because of its small size as long as it meets the eligibility requirements of this section.

(5) INDEPENDENT EVALUATIONS.—

(a) IN GENERAL.—The agency shall contract for an independent evaluation of the initial implementation phase under subsection (2) with an interim report to the Legislature to be provided on such evaluation as soon as practicable after the first year of such phase and a final report to be provided to the Legislature as soon as practicable following the conclusion of the initial implementation phase, but not later than 6 months following the end of such phase. Such an evaluation shall be conducted by individuals with knowledge of chronic care coordination programs for the targeted patient population and demonstrated experience in the evaluation of such programs.

(b) INFORMATION TO BE INCLUDED.—Each report shall include an assessment of the following factors and shall identify the characteristics of individual Independence at Home programs that are the most effective in producing improvements in:

1. Beneficiary, caregiver, and provider satisfaction;

2. Health outcomes appropriate for patients with multiple chronic diseases; and

3. Cost savings to the program under this title, such as in reducing:

a. Hospital and skilled nursing facility admission rates and lengths of stay;

b. Hospital readmission rates; and

c. Emergency department visits.

(c) BREAKDOWN BY CONDITION.—Each such report shall include data on performance of Independence-at-Home organizations in responding to the needs of eligible beneficiaries with specific chronic conditions and combinations of conditions, as well as the overall eligible beneficiary population.

(6) AGREEMENTS.—

(a) IN GENERAL.—The agency shall enter into agreements, beginning not later than one year after the date of the enactment of this section, with Independence at Home organizations that meet the participation requirements of this section, including minimum performance standards developed under subsection (e)(3), in order to provide access by eligible beneficiaries to Independence at Home programs under this section.

(b) AUTHORITY.—If the agency deems it necessary to serve the best interest of the beneficiaries under this title the agency may:

1. Require screening of all potential Independence at Home organizations, including owners, (such as through

fingerprinting, licensure checks, site-visits, and other database checks) before entering into an agreement;

2. Require a provisional period during which a new Independence at Home organization would be subject to enhanced oversight (such as prepayment review, unannounced site visits, and payment caps); and

3. Require applicants to disclose previous affiliation with entities that have uncollected Medicaid debt, and authorize the denial of enrollment if the agency determines that these affiliations pose undue risk to the program.

(7) REGULATIONS.—At least three months before entering into the first agreement under this section, the agency shall publish in the Florida Code the specifications for implementing this section. Such specifications shall describe the implementation process from initial to final implementation phases, including how the agency will identify and notify potential enrollees and how and when beneficiaries may enroll and disenroll from Independence at Home programs and change the programs in which they are enrolled.

(8) PERIODIC PROGRESS REPORTS.—Semi-annually during the first year in which this section is implemented and annually thereafter during the period of implementation of this section, the agency shall submit to the appropriate Committees of the House and Senate a report that describes the progress of implementation of this section and explaining any variation from the Independence at Home program as described in this section.

(9) ANNUAL BEST PRACTICES CONFERENCE.—During the initial implementation phase and to the extent practicable at intervals

thereafter, the agency shall provide for an annual Independence at Home teleconference for Independence at Home organizations to share best practices and review treatment interventions and protocols that were successful in meeting all 3 objectives specified in paragraph (1).

(b) Definitions.—For purposes of this section:

(1) ACTIVITIES OF DAILY LIVING.—The term `activities of daily living' means bathing, dressing, grooming, transferring, feeding, or toileting.

(2) CAREGIVER.—The term "caregiver" means, with respect to an individual with a qualifying functional impairment, a family member, friend, or neighbor who provides assistance to the individual.

(3) ELIGIBLE BENEFICIARY.—

(a) IN GENERAL.—The term `eligible beneficiary' means, with respect to an Independence at Home program, an individual who:

1. Is entitled to benefits under Florida's Medicaid program;

2. Has a qualifying functional impairment and has been diagnosed with two or more of the chronic conditions described in subparagraph (C); and

3. Within the 12 months prior to the individual first enrolling with an Independence at Home program under this section, has received benefits under part A for the following services:

(I) Non-elective inpatient hospital services.

(II) Services in the emergency department of a hospital.

(III) Any one of the following:

(aa) Skilled nursing or sub-acute rehabilitation services in a Medicaid-certified nursing facility.

(bb) Comprehensive acute rehabilitation facility or Comprehensive outpatient rehabilitation facility services.

(cc) Skilled nursing or rehabilitation services through a Medicaid-certified home health agency.

(b) DISQUALIFICATIONS.—Such term does not include an individual:

1. Who resides in a setting that presents a danger to the safety of in-home health care providers and primary caregivers; or

2. Whose enrollment in an Independence at Home program the agency determines would be inappropriate.

(C) CHRONIC CONDITIONS DESCRIBED.—The chronic conditions described in this subparagraph are the following:

1. Congestive heart failure.

2. Diabetes.

3. Chronic obstructive pulmonary disease.

4. Ischemic heart disease.

5. Peripheral arterial disease.

6. Stroke.

7. Alzheimer's Disease and other dementias designated by the agency.

8. Pressure ulcers.

9. Hypertension.

10 Myasthenia Graves

11. Neurodegenerative diseases designated by the agency which result in high costs under this title, including amyotropic lateral sclerosis (ALS), multiple sclerosis, and Parkinson's disease.

12. Any other chronic condition that the agency identifies as likely to result in high costs to the program under this title when such condition is present in combination with one or more of the chronic conditions specified in the preceding clauses.

(4) INDEPENDENCE AT HOME ASSESSMENT.—The term "Independence-at-Home assessment" means a determination of eligibility of an individual for an Independence at Home program as an eligible beneficiary as defined in paragraph (3), a comprehensive medical history, physical examination, and assessment of the beneficiary's clinical and functional status that:

(a) Is conducted in person by an individual—

1. Who—

a. is an Independence at Home physician or an Independence at Home nurse practitioner; or

b. A physician assistant, nurse practitioner, or clinical nurse specialist who is employed by an Independence at Home organization and is supervised by an Independence at Home physician or Independence at Home nurse practitioner; and

(ii) Does not have an ownership interest in the Independence at Home organization unless the agency determines that it is impracticable to preclude such individual's involvement; and

(b) Includes an assessment of—

1. Activities of daily living and other co-morbidities;

2. Medications and medication adherence;

3. Affect, cognition, executive function, and presence of mental disorders;

4. Functional status, including mobility, balance, gait, risk of falling, and sensory function;

5. social functioning and social integration;

6. Environmental needs and a safety assessment;

7. The ability of the beneficiary's primary caregiver to assist with the beneficiary's care as well as the caregiver's own physical and emotional capacity, education, and training;

8. Whether, in the professional judgment of the individual conducting the assessment, the beneficiary is likely to benefit from an Independence at Home program;

9. Whether the conditions in the beneficiary's home or place of residence would permit the safe provision of services in the home or residence, respectively, under an Independence at Home program;

10. Whether the beneficiary has a designated primary care physician whom the beneficiary has seen in an office-based setting within the previous 12 months; and

11. Other factors determined appropriate by the agency.

(5) INDEPENDENCE AT HOME CARE TEAM.—The term "Independence-at-Home care team".—

(a) Means, with respect to a participant, a team of qualified individuals that provides services to the participant as part of an Independence at Home program; and

(b) Includes an Independence at Home physician and/or an Independence at Home nurse practitioner and an Independence at Home coordinator (who may also be an Independence at Home physician or an Independence at Home nurse practitioner).

(6) INDEPENDENCE AT HOME COORDINATOR.—The term "Independence-at-Home coordinator" means, with respect to a participant, an individual who—

(a) Is employed by an Independence at Home organization and is responsible for coordinating all of the services of the participant's Independence at Home plan;

(b) Is a licensed health professional, such as a physician, registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, or other health care professional as the agency determines appropriate, who has at least one year of experience providing and coordinating medical and related services for individuals in their homes; and

(c) Serves as the primary point of contact responsible for communications with the participant and for facilitating communications with other health care providers under the plan.

(7) INDEPENDENCE AT HOME ORGANIZATION.—The term "Independence-at-Home organization" means a provider of services, a physician or physician group practice which receives payment for services furnished under this title (other than only under this section) and which—

(a) Has entered into an agreement under subsection (a)(2) to provide an Independence at Home program under this section;

(b)1. Provides all of the services of the Independence at Home plan in a participant's home or place of residence, or

2. If the organization is not able to provide all such services in such home or residence, has adequate mechanisms for ensuring the provision of such services by one or more qualified entities;

(c) Has Independence at Home physicians, clinical nurse specialists, nurse practitioners, or physician assistants available to respond to patient emergencies 24 hours a day, seven days a week;

(d) Accepts all eligible beneficiaries from the organization's service area, as determined under the agreement with the agency under this section, except to the extent that qualified staff are not available; and

(e) Meets other requirements for such an organization under this section.

(8) INDEPENDENCE AT HOME PHYSICIAN.—The term "Independence-at-Home physician" means a physician who:

(a) Is employed by or affiliated with an Independence at Home organization, as required under paragraph (7)(C), or has another contractual relationship with the Independence at Home organization that requires the physician to make in-home visits and to be responsible for the plans of care for the physician's patients;

(b) Is certified—

1. By the American Board of Family Physicians, the American Board of Internal Medicine, the American Osteopathic Board of Family Physicians, the American Osteopathic Board of Internal Medicine, the American Board of Emergency Medicine, or the American Board of Physical Medicine and Rehabilitation; or

2. By a Board recognized by the American Board of Medical Specialties and determined by the agency to be appropriate for the Independence at Home program;

(c) Has—

1. A certification in geriatric medicine as provided by American Board of Medical Specialties; or

2. Passed the clinical competency examination of the American Academy of Home Care Physicians and has substantial experience in the delivery of medical care in the home, including at least two years of experience in the management of Medicare or Medicaid patients and one year of experience in home-based medical care including at least 200 house calls; and

(d) Has furnished services during the previous 12 months for which payment is made under this title.

(9) INDEPENDENCE AT HOME NURSE PRACTITIONER.—The term "Independence-at-Home nurse practitioner" means a nurse practitioner who:

(a) Is employed by or affiliated with an Independence at Home organization, as required under paragraph (7)(C), or has another contractual relationship with the Independence at Home organization that requires the nurse practitioner to make in-home visits and to be responsible for the plans of care for the nurse practitioner's patients;

(b) Practices in accordance with State law regarding scope of practice for nurse practitioners;

(c) Is certified—

1. As a Gerontologic Nurse Practitioner by the American Academy of Nurse Practitioners Certification Program or the American Nurses Credentialing Center; or

2. As a family nurse practitioner or adult nurse practitioner by the American Academy of Nurse Practitioners Certification Board or the American Nurses Credentialing Center and holds a certificate of Added Qualification in gerontology, elder care or care of the older adult provided by the American Academy of Nurse Practitioners, the American Nurses Credentialing Center or a national nurse practitioner certification board deemed by the agency to be appropriate for an Independence at Home program; and

(d) has furnished services during the previous 12 months for which payment is made under this title.

(10) INDEPENDENCE-AT-HOME PLAN-The term "Independence at Home plan" means a plan established under subsection (d)(2) for a specific participant in an Independence at Home program.

(11) INDEPENDENCE-AT-HOME PROGRAM-The term "Independence-at-Home program" means a program described in subsection (d) that is operated by an Independence at Home organization.

(12) PARTICIPANT.—The term "participant" means an eligible beneficiary who has voluntarily enrolled in an Independence at Home program.

(13) QUALIFIED ENTITY.—The term "qualified entity" means a person or organization that is licensed or otherwise legally permitted to provide the specific service (or services) provided under an Independence at Home plan that the entity has agreed to provide.

(14) QUALIFYING FUNCTIONAL IMPAIRMENT.—The term "qualifying functional impairment" means an inability to perform, without the assistance of another person, three (3) or more activities of daily living.

(15) QUALIFIED INDIVIDUAL.—The term "qualified individual" means a individual that is licensed or otherwise legally permitted to provide the specific service (or services) under an Independence at Home plan that the individual has agreed to provide.

(c) Identification and Enrollment of Prospective Program Participants.—

(1) NOTICE TO ELIGIBLE INDEPENDENCE AT HOME BENEFICIARIES- the agency shall develop a model notice to be made available to Medicaid beneficiaries (and to their caregivers) who are potentially eligible for an Independence at Home program by participating providers and by Independence at Home programs. Such notice shall include the following information:

(a) A description of the potential advantages to the beneficiary participating in an Independence at Home program.

(b) A description of the eligibility requirements to participate.

(c) Notice that participation is voluntary.

(d) A statement that all other Medicaid benefits remain available to beneficiaries who enroll in an Independence at Home program.

(e) Notice that those who enroll in an Independence at Home program will be responsible for copayments for house calls made by Independence at Home physicians, physician assistants,

or by Independence at Home nurse practitioners, except that such copayments may be reduced or eliminated at the discretion of the Independence at Home physician, physician assistant, or Independence at Home nurse practitioner involved in accordance with paragrraph (f).

(f) A description of the services that could be provided.

(g) A description of the method for participating, or withdrawing from participation, in an Independence at Home program or becoming no longer eligible to so participate.

(2) VOLUNTARY PARTICIPATION AND CHOICE- An eligible beneficiary may participate in an Independence at Home program through enrollment in such program on a voluntary basis and may terminate such participation at any time. Such a beneficiary may also receive Independence at Home services from the Independence at Home organization of the beneficiary's choice but may not receive Independence at Home services from more than one Independence at Home organization at a time.

(d) Independence at Home Program Requirements-

(1) IN GENERAL- Each Independence at Home program shall, for each participant enrolled in the program—

(a) Designate—

1. An Independence at Home physician or an Independence at Home nurse practitioner; and

2. An Independence at Home coordinator;

(b) Have a process to ensure that the participant received an Independence at Home assessment before enrollment in the program;

(c) With the participation of the participant (or the participant's representative or caregiver), an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, or an Independence at Home nurse practitioner, and the Independence at Home coordinator, develop an Independence at Home plan for the participant in accordance with paragraph (2);

(d) Ensure that the participant receives an Independence at Home assessment at least every 6 months after the original assessment to ensure that the Independence at Home plan for the participant remains current and appropriate;

(e) Implement all of the services under the participant's Independence at Home plan and in instances in which the Independence at Home organization does not provide specific services within the Independence at Home plan, ensure that qualified entities successfully provide those specific services; and

(f) Provide for an electronic medical record and electronic health information technology to coordinate the participant's care and to exchange information with the Medicaid program and electronic monitoring and communication technologies and mobile diagnostic and therapeutic technologies as appropriate and accepted by the participant.

(2) INDEPENDENCE AT HOME PLAN.—

(a) IN GENERAL.—An Independence at Home plan for a participant shall be developed with the participant, an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as

permitted under State law, an Independence at Home nurse practitioner, or an Independence at Home coordinator, and, if appropriate, one or more of the participant's caregivers and shall:

1. Document the chronic conditions, co-morbidities, and other health needs identified in the participant's Independence at Home assessment;

2. Determine which services under an Independence at Home plan described in subparagraph (C) are appropriate for the participant; and

3. Identify the qualified entity responsible for providing each service under such plan.

(b) COMMUNICATION OF INDIVIDUALIZED INDEPENDENCE AT HOME PLAN TO THE INDEPENDENCE AT HOME COORDINATOR.—If the individual responsible for conducting the participant's Independence at Home assessment and developing the Independence at Home plan is not the participant's Independence at Home coordinator, the Independence at Home physician or Independence at Home nurse practitioner is responsible for ensuring that the participant's Independence at Home coordinator has such plan and is familiar with the requirements of the plan and has the appropriate contact information for all of the members of the Independence at Home care team.

(c) SERVICES PROVIDED UNDER AN INDEPENDENCE AT HOME PLAN.—An Independence-at-Home organization shall coordinate and make available through referral to a qualified entity the services described in the following clauses (i) through (iii) to the extent they are needed and covered by under this title and shall

provide the care coordination services described in the following clause (iv) to the extent they are appropriate and accepted by a participant:

1. Primary care services, such as physician visits, diagnosis, treatment, and preventive services.

2. Home health services, such as skilled nursing care and physical and occupational therapy.

3. Phlebotomy and ancillary laboratory and imaging services, including point of care laboratory and imaging diagnostics.

4. Care coordination services, consisting of—

(I) Monitoring and management of medications by a pharmacist who is certified in geriatric pharmacy by the Commission for Certification in Geriatric Pharmacy or possesses other comparable certification demonstrating knowledge and expertise in geriatric or chronic disease pharmacotherapy , as well as assistance to participants and their caregivers with respect to selection of a prescription drug plan that best meets the needs of the participant's chronic conditions.

(II) Coordination of all medical treatment furnished to the participant, regardless of whether such treatment is covered and available to the participant under this title.

(III) Self-care education and preventive care consistent with the participant's condition.

(IV) Education for primary caregivers and family members.

(V) Caregiver counseling services and information about, and referral to, other caregiver support and health care services in the community.

(VI) Referral to social services, such as personal care, meals, volunteers, and individual and family therapy.

(VII) Information about, and access to, hospice care.

(VIII) Pain and palliative care and end-of-life care, including information about developing advanced directives and physicians orders for life sustaining treatment.

(3) PRIMARY TREATMENT ROLE WITHIN AN INDEPENDENCE AT HOME CARE TEAM- An Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, or an Independence at Home nurse practitioner may assume the primary treatment role as permitted under State law.

(4) ADDITIONAL RESPONSIBILITIES-

(a) OUTCOMES REPORT- Each Independence at Home organization offering an Independence at Home program shall monitor and report to the agency, in a manner specified by AHCA, on:

1. Patient outcomes;

2. Beneficiary, caregiver, and provider satisfaction with respect to coordination of the participant's care; and

3. The achievement of mandatory minimum savings described in subsection (e)(6).

(b) ADDITIONAL REQUIREMENTS- Each such organization and program shall provide AHCA with listings of individuals employed by the organization, including contract employees, and individuals with an ownership interest in the organization and comply with such additional requirements as AHCA may specify.

(e) Terms and Conditions.-

(1) IN GENERAL- An agreement under this section with an Independence at Home organization shall contain such terms and conditions as AHCA may specify consistent with this section.

(2) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS-The agency may not enter into an agreement with such an organization under this section for the operation of an Independence at Home program unless—

(a) The program and organization meet the requirements of subsection (d), minimum quality and performance standards developed under paragraph (3), and such clinical, quality improvement, financial, program integrity, and other requirements as the agency deems to be appropriate for participants to be served; and

(b) The organization demonstrates to the satisfaction of the agency that the organization is able to assume financial risk for performance under the agreement with respect to payments made to the organization under such agreement through available reserves, reinsurance, or withholding of funding provided under this title, or such other means as AHCA determines appropriate.

(3) MINIMUM QUALITY AND PERFORMANCE STANDARDS-

(a) IN GENERAL-The agency shall develop mandatory minimum quality and performance standards for Independence at Home organizations and programs which shall be no more stringent that those established by the Federal Center for Medicare/Medicaid Services (CMS).

(b) STANDARDS TO BE INCLUDED- Such standards shall include measures of:

1. Improvement in participant outcomes;

2. Improvement in satisfaction of the beneficiary, caregiver, and provider involved; and

3. Cost savings consistent with paragraph (6).

(c) MINIMUM PARTICIPATION STANDARD.—Such standards shall include a requirement that, for any year after the first year and except as the agency may provide for a program serving a rural area, an Independence at Home program had an average number of participants during the previous year of at least 150 participants.

(4) TERM OF AGREEMENT AND MODIFICATION- The agreement under this subsection shall be, subject to paragraphs (3)(C) and (5), for a period of three years, and the terms and conditions may be modified during the contract period by the agency as necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs or upon the request of the Independence at Home organization.

(5) TERMINATION AND NON-RENEWAL OF AGREEMENT.—

(a) IN GENERAL.—If AHCA determines that an Independence at Home organization has failed to meet the minimum performance standards under paragraph (3) or other requirements under this section, or if AHCA deems it necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs, AHCA may terminate the agreement of the organization at the end of the contract year.

(b) REQUIRED TERMINATION WHERE RISK TO HEALTH OR SAFETY OF A PARTICIPANT.—The agency shall terminate an agreement with an Independence at Home organization at any time the agency

determines that the care being provided by such organization poses a threat to the health and safety of a participant.

(c) TERMINATION BY INDEPENDENCE AT HOME ORGANIZATIONS.—Notwithstanding any other provision of this subsection, an Independence at Home organization may terminate an agreement with the agency under this section to provide an Independence at Home program at the end of a contract year if the organization provides to the agency and to the beneficiaries participating in the program notification of such termination more than 90 days before the end of such year. Paragraphs (6), (8), and (9)(B) shall apply to the organization until the date of termination.

(d) NOTICE OF INVOLUNTARY TERMINATION.—The agency shall notify the participants in an Independence at Home program as soon as practicable if a determination is made to terminate an agreement with the Independence at Home organization involuntarily as provided in paragraphs (a) and (b). Such notice shall inform the beneficiary of any other Independence at Home organizations that might be available to the beneficiary.

(6) MANDATORY MINIMUM SAVINGS-

(a) REQUIRED-

1. IN GENERAL.—Under an agreement under this subsection, each Independence at Home organization shall ensure that during any year of the agreement for its Independence at Home program, there is an aggregate savings in the cost to the program under this title for participating beneficiaries, as calculated under subparagraph (B), that is not less than 5 percent of the product described in clause (ii) for such participating beneficiaries and year.

2. PRODUCT DESCRIBED.—The product described in this clause for participating beneficiaries in an Independence at Home program for a year is the product of—

(I) The estimated average monthly costs that would have been incurred under Florida Medicaid , other than those in the Medicaid Reform Pilot Counties if those beneficiaries had not participated in the Independence at Home program; and

(II) The number of participant-months for that year.

(b) COMPUTATION OF AGGREGATE SAVINGS-

1. MODEL FOR CALCULATING SAVINGS.—The agency shall contract with a nongovernmental organization or academic institution to independently develop an analytical model for determining whether an Independence at Home program achieves at least savings required under paragraph (a) relative to costs that would have been incurred by Medicaid in the absence of Independence at Home programs. The analytical model developed by the independent research organization for making these determinations shall utilize state-of-the-art econometric techniques, such as Heckman's selection correction methodologies, to account for sample selection bias, omitted variable bias, or problems with endogeneity.

2. APPLICATION OF THE MODEL.—Using the model developed under clause (i), the agency shall compare the actual costs to Medicaid of beneficiaries participating in an Independence at Home program to the predicted costs to Medicaid of such beneficiaries to determine whether an Independence at Home program achieves the savings required under subparagraph (A).

3. REVISIONS OF THE MODE.—The agency shall require that the model developed under clause (i) for determining savings shall be designed according to instructions that will control, or adjust for, inflation as well as risk factors including, age, race, gender, disability status, socioeconomic status, region of country (such as State, county, metropolitan statistical area, or zip code), and such other factors as the agency determines to be appropriate, including adjustment for prior health care utilization. the agency may add to, modify, or substitute for such adjustment factors if such changes will improve the sensitivity or specificity of the calculation of costs savings.

4. PARTICIPANT-MONTH.—In making the calculation described in subparagraph (a), each month or part of a month in a program year that a beneficiary participates in an Independence at Home program shall be counted as a "participant-month".

(c) NOTICE OF SAVINGS CALCULATION- No later than 30 days before the beginning of the first year of the pilot project under this section and 120 days before the beginning of any Independence at Home program year after the first such year, the agency shall publish in the Florida Administrative Weekly description of the model developed under subparagraph (B)(i) and information for calculating savings required under subparagraph (A), including any revisions, sufficient to permit Independence at Home organizations to determine the savings they will be required to achieve during the program year to meet the savings requirement under subparagraph (A). In order to facilitate this notice, the agency may designate a single annual date for the beginning of all Independence at Home program years that shall

not be later than one year from the date of enactment of this section.

(7) MANNER OF PAYMENT.—Subject to paragraph (8), payments shall be made by the agency to an Independence at Home organization at a rate negotiated between the agency and the organization under the agreement for:

(a) Independence at Home assessments; and

(b) On a per-participant, per-month basis for the items and services required to be provided or made available under subsection (2).

(8) ENSURING MANDATORY MINIMUM SAVINGS-The agency shall require any Independence at Home organization that fails in any year to achieve the mandatory minimum savings described in subsection (6) to provide those savings by refunding payments made to the organization under paragraph (7) during such year.

(9) BUDGET NEUTRAL PAYMENT CONDITION-

(a) IN GENERAL- Under this section, the agency shall ensure that the cumulative, aggregate sum of Medicaid program benefit expenditures for participants in Independence at Home programs and funds paid to Independence at Home organizations under this section, shall not exceed the Medicaid program benefit expenditures under such parts that the agency estimates would have been made for such participants in the absence of such programs.

(b) TREATMENT OF SAVINGS-

1. INITIAL IMPLEMENTATION PHASE.—If an Independence at Home organization achieves aggregate savings in a year in the initial implementation phase in excess of the mandatory minimum

savings described in paragraph (6)(A)(ii), 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title during the initial implementation phase.

2. EXPANDED IMPLEMENTATION PHASE- If an Independence at Home organization achieves aggregate savings in a year in the expanded implementation phase in excess of 5 percent of the product described in paragraph (6)(A)(ii)—

(I) Insofar as such savings do not exceed 25 percent of such product, 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title; and

(II) Insofar as such savings exceed 25 percent of such product, in the agency's discretion, 50 percent of such excess aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title.

(f) Waiver of Coinsurance for House Calls.—A physician, physician assistant, or nurse practitioner furnishing services related to the Independence at Home program in the home or residence of a participant in an Independence at Home program may waive collection of any coinsurance that might otherwise be payable under section 1833(a) with respect to such services but only if the conditions described in section 1128A(i)(6)(A) are met.

(g) Report.—Not later than 3 months after the date of receipt of the independent evaluation provided under subsection (5) and each year thereafter during which this section is being

implemented, the agency shall submit to the Committees of jurisdiction in Congress a report that shall include:

(1) Whether the Independence at Home programs under this section are meeting the minimum quality and performance standards in (e)(3);

(2) A comparative evaluation of Independence at Home organizations in order to identify which programs, and characteristics of those programs, were the most effective in producing the best participant outcomes, patient and caregiver satisfaction, and cost savings; and

(3) An evaluation of whether the participant eligibility criteria identified beneficiaries who were in the top ten percent of the highest cost Medicaid beneficiaries.

T I T L E A M E N D M E N T

Remove line 32 and insert:

maintain certain records and data; creating the "Independence at Home Act"; providing legislative findings; providing for an Independence at Home Chronic Care pilot project; providing for implementation and independent evaluation of the pilot project; requiring a report to the United States Congress; providing an effective

Examples:

- Medical Home Agreement
- Tier One Entry-Level Medical Home Self-Evaluation Form
- Tier Two Advanced Medical Home Self-Evaluation Form
- Tier Three Optimal Medical Home Self-Evaluation Form

Medical Home Agreement

Principles of Medical Home

As identified by the patient centered Medical Home collaborative and adopted by OHCA, the principles of a Medical Home are as follows:

A. **Personal Physician/Provider** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
B. **Physician/Provider Directed Medical Practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
C. **Whole Person Orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
D. **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
E. **Quality and safety** are hallmarks of the medical home.
F. **Enhanced access to care** is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Patient Information and Responsibilities

As a SoonerCare member, there are rules you must follow.
It is your responsibility to:

- Be aware of PCP's office hours so you will know when you can be seen.
- Call for an appointment as early as possible, keep your appointments.
- You may have to wait up to three (3) weeks to be seen for checkups and shots.
- Even if you have an appointment, you may have to wait past that time to see your PCP. You should ask to reschedule if you cannot wait.
- If you cannot keep your appointment, you must call the provider's office at least 24 hours before your appointment. Your provider may ask to dismiss you as a patient if you continually miss appointments.

When you call your PCP you should always:

- Tell the staff why you need an appointment.
- Have your medical ID card available.
- Call your PCP's office if your problem gets worse before your scheduled visit. Ask to speak to the nurse. Tell the nurse what symptoms you have and ask if you should be seen sooner because of them.

Medical Home Agreement

During your PCP visit you should always:

- Give staff the information they need to help you. This includes telling them about your symptoms.
- Tell your PCP your medical history.
- Take shot records to PCP appointment.
- Inform PCP of all prescription drugs, over-the-counter medications, and herbal supplements you are taking.
- Inform PCP of any medical equipment you are using.
- Inform PCP of any other health care appointments.
- Follow the treatment plans and guidelines that your PCP gives you.

Please also keep in mind:

- Your PCP will refer you to a specialist as needed. You will get a referral only if indicated by your PCP. The specialist must be a SoonerCare provider.
- You must get a referral BEFORE you go to a specialist.
- Do not ask your PCP for a referral AFTER you have seen specialist.
- If your PCP gives you a referral for a service that is not covered under SoonerCare, you will have to pay for it.
- If you do not keep your appointment, the specialist may not give you another one.
- Provider will not give a prescription he/she does not determine is needed.
- In most cases provider will not see you in the office the same day you call.
- SoonerCare allows unlimited PCP visits monthly.
- SoonerCare limits specialty visits to 4 times per month.

After-Hours Coverage:

- Provider will arrange for call coverage when unavailable to members and provide all panel members with the information necessary to ensure member access;
- You may call the Patient Advice Line at 1-800-530-3002 after 5 p.m. weekdays or anytime on the weekends and holidays.
- If you think you have a true *medical* emergency, go to the nearest emergency room or call 911 (or your local emergency number).

As a patient you should expect Provider and staff to treat you professionally and respectfully. It is also expected that you and your family members will treat Provider and office staff respectfully and will refrain from using rude, offensive, or threatening behavior. You may call the SoonerCare Helpline to report complaints or concerns regarding provider and staff: 1-877-252-6002

I have read and understand the Patient Rights and Responsibilities. I agree to follow the rules as listed above and as stated in the SC Member Handbook.

Patient Name Printed:_____

Patient Signature:_____ Date: _____

Provider Signature: _____ Date: _____

Tier One Entry-Level Medical Home
Self-Evaluation Form

Provider Name: _____
Provider ID: _____NPI_____
Address: _____
Phone: _____FAX_____
Practice Type: _____
(i.e. FP, Peds, GP, etc)
Medical Home requested panel capacity: _____
Number of hours per week PROVIDER is available for appointments: _____
Approximate percent of PROVIDER's hours stated above that are spent caring for patients that are SoonerCare members: _____

Please describe below how PROVIDER meets the requirements defined below.

1. PROVIDER supplies all medically necessary primary and preventive services for panel members. Yes_____ No_____

2. PROVIDER is a VFC participant (if PROVIDER sees members less than 18 of age for primary care).
   PROVIDER provides all scheduled immunizations to appropriate panel members, records all immunizations in the Oklahoma State Immunization Information System (OSIIS) and adheres to all requirements of the VFC program: Yes_____ No_____.

   VFC ID#_____ OSIIS ID#_____

3. PROVIDER organizes clinical data in a paper or electronic format as a patient specific charting system for individual panel members. A patient-specific charting system is defined as charting tools that organize and document the following clinical information in the medical record:
   a. Problem lists
   b. Lists of over-the-counter medications, supplements and alternative therapies
   c. Lists of prescribed medications including both chronic and short-term
   d. Structured template for age-appropriate risk factors (minimum of 3)
   e. Structured templates for narrative progress notes.
   Yes_____ No_____

4. PROVIDER maintains and updates the member's medication list maintained in the chart and also reviews all other medications a member is taking during each office visit.
   Yes_____ No _____

5. PROVIDER maintains a system to track diagnostic tests and provide follow-up on test results. Provider also uses a tickler system to remind/notify panel members about follow-up test as needed via written logs/paper based documents or electronic reports. PROVIDER has written procedures that outlines diagnostic test tracking procedures, in addition to detailing designated staff that maintain and oversee this process.
Yes _____No_____
If yes, please explain your process:

_____
_____
_____
_____
_____
_____
_____

6. PROVIDER maintains a system to track referrals including self referrals by member. Provider notifies panel members when specialty appointment is made by the PCP. Provider documents attempts to obtain a copy of the specialist provider's consult and findings. Only one documented attempt to obtain records is expected. This requirement can be fulfilled by written request on the referral form, by mail or telephone contact. PROVIDER has written procedures that outline designated staff that maintain and oversee this process.

Yes_____ No_____ if yes, please explain your process:

_____
_____
_____
_____
_____
_____
_____

7. PROVIDER supplies care coordination and continuity of care through proactive contact with panel members and encourages family participation in coordination of care. PROVIDER coordinates the delivery of primary care services with all specialists, case manager, and community-based provider (such as school based clinics, WIC, and Children's First program) involved with the member including, but not limited to consultations and referrals.
Yes_____ No_____ if yes, provide an example:

_____
_____
_____
_____

8. PROVIDER supplies patient/family education and support utilizing varying forms of educational materials, appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided. An example would include patient information handouts, which can be found on the OHCA website.
   Yes_____ No_____
   If yes, what type of educational support is used by PROVIDER? _____

Optional Add–on payments

9. PROVIDER accepts electronic communication from the OHCA in lieu of written notification.
   Yes _____ No_____

   E-Mail address for communications: _____

10. PROVIDER supplies voice-to-voice telephone coverage to panel members, 24 hours a day, seven days a week, where a patient can speak directly with a licensed health care professional. All calls are triaged and forwarded to the PCP or on-call provider when necessary (use of the OHCA Patient Advice Line does not meet this requirement). This coverage includes an after hours and weekend/vacation number to call that connects to a person or message that can be returned within one half hour. PROVIDER maintains a formal professional agreement with the on-call PCP or provider and notification is shared relating to panel members' needs and issues.
    Yes _____ No _____
    Briefly describe how this process is performed in PROVIDER's office:

Tier Two Advanced Medical Home
Self-Evaluation Form

Provider Name: _____
Provider ID: _____ NPI _____
Address: _____
Phone: _____ Fax _____
Practice Type: _____
(i.e. FP, Peds, GP, etc)
Medical Home requested panel capacity: _____
Number of hours per week PROVIDER is available for appointments: _____
Approximate percent of PROVIDER's hours stated above that are spent caring for patients that are SoonerCare members: _____

Please describe below how PROVIDER meets the requirements defined below.

1. PROVIDER supplies all medically necessary primary and preventive services for panel members. Yes_____ No_____

2. PROVIDER is a VFC participant (if PROVIDER sees members less than 18 years of age for primary care).
   PROVIDER provides all scheduled immunizations to appropriate panel members, records all immunizations in the Oklahoma State Immunization Information System (OSIIS) and adheres to all requirements of the VFC program: Yes_____ No_____.

   VFC ID#_____ OSIIS ID#_____

3. PROVIDER organizes clinical data in a paper or electronic format as a patient specific charting system for individual patients. A patient-specific charting system is defined as charting tools that organize and document the following clinical information in the medical record:
   a. Problem lists
   b. Lists of over-the-counter medications, supplements and alternative therapies
   c. Lists of prescribed medications including both chronic and short-term
   d. Structured template for age-appropriate risk factors (minimum of 3)
   e. Structured templates for narrative progress notes.
   Yes_____ No_____

4. PROVIDER maintains and updates the member's medication list maintained in the chart and also reviews all other medications a member is taking during each office visit.
   Yes_____ No _____

5. PROVIDER maintains a system to track diagnostic tests and provide follow-up on test results. Provider also uses a tickler system to remind/notify panel members about follow-up tests as needed via written logs/paper based documents or electronic reports. PROVIDER has written procedures that outlines diagnostic test tracking procedures, in addition to detailing designated staff that maintain and oversee this process.
   Yes _____No_____ if yes, please explain your process:

_____
_____
_____
_____
_____
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6. PROVIDER maintains a system to track referrals including self referrals by member. Provider notifies panel members when specialty appointment is made by the PCP. Provider documents attempts to obtain a copy of the specialist provider's consult and finding. Only one documented attempt to obtain records is expected. This requirement can be fulfilled by written request on the referral form, by mail or telephone contact. PROVIDER has written procedures that outline designated staff that maintain and oversee this process.

   Yes_____ No_____ if yes, please explain your process: _____

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7. PROVIDER supplies care coordination and continuity of care through proactive contact with panel members and encourages family participation in coordination of care. PROVIDER coordinates the delivery of primary care services with all specialists, case manager, and community-based providers (such as school based clinics, WIC, and Children's First program) involved with the patient including but not limited to consultations and referrals.
   Yes_____ No_____
   If yes, provide an example: _____

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8. PROVIDER supplies patient/family education and support, utilizing varying forms of educational materials, appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided. An example would include patient information handouts, which can be found on the OHCA website.

   Yes_____ No_____

   If yes, what type of educational support is used by your practice? _____
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9. PROVIDER accepts electronic communication from OHCA in lieu of written notification.
   Yes _____ No_____

   E-Mail address for communications: _____

10. PROVIDER supplies voice-to-voice telephone coverage to panel members, 24 hours a day, seven days a week, where a patient can speak directly with a licensed health care professional. All calls are triaged and forwarded to the PCP or on-call provider when necessary (use of the OHCA Patient Advice Line does not meet this requirement). This coverage includes an after hours and weekend/vacation number to call that connects to a person or message that can be returned within one half hour. PROVIDER maintains a formal professional agreement with the on-call PCP or provider and notification is shared relating to panel members' needs and issues.
    Yes _____ No _____
    Briefly describe how this process is performed in PROVIDER's office:
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11. PROVIDER obtains a hard copy of the mutual agreement on the role of medical home between the provider and the patient. The defined roles should be explained within the context of all of the joint principles that reflect a patient centered medical home. The copy signed by the PCP and member is maintained in the patient's record.
    Yes ____ No_____

last dates of EPSDT/mammogram/pap, etc.) to identify and track panel members both inside and outside of the PCP practice.
Yes_____ No _____
Briefly describe how this process is performed in PROVIDER's office:

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16. PROVIDER coordinates care and follow-up for panel members who receive care in inpatient and outpatient facilities. Information can be obtained from the member, OHCA or the facility. This information should be maintained in the medical record. Upon notification of member activity, the provider attempts to contact member and schedule a follow up appointment. Inpatient and outpatient activity should be documented on the problem list.
Yes_____ No_____
Briefly describe how this process is performed in PROVIDER's office: _____

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17. PROVIDER implements processes to promote access to care and provider-member communication. PCP or office staff communicates directly with panel members through a variety of methods (email, scheduled and unscheduled postal mailings, etc.)
Yes_____ No_____
Briefly describe how this process is performed in PROVIDER's office:

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Optional (PROVIDER must choose three additional components)

18. PROVIDER develops a healthcare team that provides ongoing support, oversight and guidance of all medical care received by the member. This requirement includes documentation of contact with specialist and other health care disciplines that provide care for the member outside of the PCP office. The team may include doctors, nurses and other office staff.

Briefly describe how this process will be performed in your office:

12. PROVIDER maintains a full time practice with established office hours to see patients a total of at least thirty (30) hours scheduled hours.
    Yes _____ No _____
    List hours by day offered in PROVIDER'S office: -

13. ROVIDER uses scheduling processes to promote continuity with clinicians including (but not limited to) open scheduling and maintaining open appointment slots to accommodate work-in, routine and urgent appointments. (Open scheduling is defined as the practice of having open appointment slots available in the morning and afternoon for same day/urgent care appointments available to SoonerCare patients. Over booking does not meet this requirement. PROVIDER implements training and written triage procedures for the scheduling staff.
    Yes_____ No _____
    Briefly describe how this process is performed in PROVIDER's office:_____

14. PROVIDER implements and documents behavioral health/substance abuse screening (using State of Oklahoma screening tool or any other appropriate tool) and makes a direct referral to the OHCA behavioral health referral number or other appropriate entity.
    Yes _____ No _____

15. PROVIDER uses data received from OHCA (i.e. rosters, patient utilization profiles, immunization reports, etc.) and/or information obtained from secure website (eligibility,

Yes_____ No_____
Briefly describe how this process will be performed in PROVIDER's office:

19. PROVIDER supplies post-visit follow up for panel members. (Examples may include outreach calls to members for the monitoring of new medications, ongoing weight and blood sugar checks, blood pressure monitoring, etc.)
Yes_____ No _____
Briefly describe how this process will be performed in PROVIDER's office:

20. PROVIDER implements specific evidence-based clinical practice guidelines for preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc. Yes_____ No_____

Briefly describe how this process will be performed and what guidelines will be utilized in PROVIDER's office:

21. PROVIDER implements a medication reconciliation procedure to avoid interactions or duplications. Examples may include using e-Pocrates, e-Prescribing, SoonerScribe Pro-DUR software, screening for drug interactions, etc.
Yes____ No _____
Briefly describe how this process will be performed in PROVIDER's office (please include software program used if applicable):

22. PROVIDER uses personalized screening, brief intervention and referral to treatment (SBIRT) procedures for appropriate members requiring specialty treatment. Through the usage of these procedures the PROVIDER will expedite treatment with the goal of improving outcomes for panel members suffering from mental illness and substance abuse.
    Yes _____ No _____
    Briefly describe how this process will be performed and what guidelines will be utilized in PROVIDER's office:

23. PROVIDER offers at least 4 hours of after hours care to SoonerCare members. (After hours care is defined as appointments, scheduled or work-ins, readily available to SoonerCare members outside the hours of 8 a.m. - 5 p.m. Monday – Friday). Hours can not be earlier then 7:30am or later then 9:00pm. This requirement is per location regardless of number of providers. Solo practitioners can arrange after hours coverage through another approved choice provider location. Multiple locations can submit for a single location to provide after hours coverage. These requests will be reviewed and decided on a case by case basis. PROVIDER maintains vacation coverage in the same manner.
    Yes_____ No_____
    Briefly describe how this process will be performed in PROVIDER's office:

Tier Three Optimal Medical Home
Self-Evaluation Form

Provider Name: _____
Provider ID: _____NPI_____
Address: _____
Phone: _____Fax_____
Practice Type: _____
(i.e. FP, Peds, GP, etc)
Medical Home requested panel capacity: _____
Number of hours per week PROVIDER is available for appointments: _____
Approximate percent of PROVIDER's hours stated above that are spent caring for patients that are SoonerCare members: _____

Please describe below how PROVIDER meets the requirements defined below.

1. PROVIDER supplies all medically necessary primary and preventive services for panel members. Yes_____ No_____

2. PROVIDER is a VFC participant (if PROVIDER sees members less than 18 years of age for primary care).
   PROVIDER provides all scheduled immunizations to appropriate panel members, records all immunizations in the Oklahoma State Immunization Information System (OSIIS), and adheres to all requirements of the VFC program: Yes_____ No_____.

   VFC ID#_____ OSIIS ID#_____

3. PROVIDER organizes clinical data in a paper or electronic format as a patient specific charting system for individual patients. A patient-specific charting system is defined as charting tools that organize and document the following clinical information in the medical record:
   a. Problem lists
   b. Lists of over-the-counter medications, supplements, and alternative therapies
   c. Lists of prescribed medications, including both chronic and short-term
   d. Structured template for age-appropriate risk factors (minimum of three)
   e. Structured templates for narrative progress notes
   Yes_____ No_____

4. PROVIDER maintains and updates the member's medication list maintained in the chart, and also reviews all other medications a member is taking during each office visit.
   Yes_____ No _____

5. PROVIDER maintains a system to track diagnostic tests and provide follow-up on test results. Provider also uses a tickler system to remind/notify panel members about follow-up tests as needed via written logs/paper based documents or electronic reports.
   PROVIDER has written procedures that outlines diagnostic test tracking procedures, in addition to detailing designated staff that maintain and oversee this process.
   Yes _____No_____ if yes, please explain PROVIDER's process:

6. PROVIDER maintains a system to track referrals including self referrals by member. Provider notifies panel members when specialty appointment is made by the PCP. Provider documents attempts to obtain a copy of the specialist provider's consult and findings. Only one documented attempt to obtain records is expected. This requirement can be fulfilled by written request on the referral form, by mail or telephone contact. PROVIDER has written procedures that outline designated staff that maintain and oversee this process.

   Yes_____ No_____ if yes, please explain PROVIDER's process: _____

7. PROVIDER supplies care coordination and continuity of care through proactive contact with panel members and encourages family participation in coordination of care. PROVIDER coordinates the delivery of primary care services with all specialists, case managers, and community-based providers (such as school based clinics, WIC, and Children's First program) involved with the patient including, but not limited to consultations and referrals.
   Yes_____ No_____
   If yes, provide an example: _____

8. PROVIDER supplies patient education and support, utilizing varying forms of educational materials, appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided. An example would include patient information handouts, which can be found on the OHCA website.
   Yes_____ No_____
   If yes, what type of educational support is used by PROVIDER's practice?

9. PROVIDER accepts electronic communication from OHCA in lieu of written notification.
   Yes _____ No_____

   E-Mail address for communications: _____

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    Yes _____ No _____
    Briefly describe how this process is performed in PROVIDER's office:

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Yes_____ No_____
Briefly describe how this process is performed in PROVIDER's office:

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Yes_____ No_____
Briefly describe how this process will be performed in PROVIDER's office:

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Yes_____ No _____
Briefly describe how this process will be performed in PROVIDER's office:

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Briefly describe how this process will be performed and what guidelines will be utilized in PROVIDER's office:

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21. PROVIDER implements a medication reconciliation procedure to avoid interactions or duplications. Examples may include using e-Pocrates, e-Prescribing, SoonerScribe Pro-DUR software, screening for drug interactions, etc.
    Yes____ No _____
    Briefly describe how this process will be performed in PROVIDER's office (please include software program used if applicable):

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22. PROVIDER uses personalized screening, brief intervention, and referral to treatment (SBIRT) procedures for appropriate panel members requiring specialty treatment. Through the usage of these procedures, the PROVIDER will expedite treatment with the goal of improving outcomes for members suffering from mental illness and substance abuse.
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23. PROVIDER offers at least 4 hours of after hours care to SoonerCare members. (After hours care is defined as appointments, scheduled or work-ins, readily available to SoonerCare members outside the hours of 8 a.m. - 5 p.m. Monday – Friday). Hours can not be earlier then 7:30am or later then 9:00pm. This requirement is per location regardless of number of providers. Solo practitioners can arrange after hours coverage through another approved choice provider location. Multiple locations can submit for a single location to provide after hours coverage. These requests will be reviewed and decided on a case by case basis. PROVIDER maintains vacation coverage in the same manner.
    Yes _____ No _____

Briefly describe how this process is performed in PROVIDER's office:

24. PROVIDER uses health assessment tools to characterize patient 'needs and risks' utilizing any OHCA recommended format tool (examples include AAP approved standardized developmental screening tool, SoonerCare Health Assessment form, disease-specific screening tool, etc.). Tools may be publicly available, privately purchased, or available on the OHCA website.
Yes_____ No_____

Briefly describe how this process will be performed in PROVIDER's office:

Tier Three Optional. These are not required but are recommended if applicable

25 PROVIDER uses a secure electronic interactive web site to maximize communication with panel members/families this will allow patients to request appointments, referrals, test results, and prescription refills; as well as allow the practice to contact patients to schedule follow-up appointments, relay test results, inform patients of preventive care needs, instruct on medication, etc.
Yes_____ No _____
Briefly describe how this process is performed in PROVIDER's office:

26. PROVIDER utilizes integrated care plans for panel members who are co-managed with specialist(s)/other healthcare disciplines, and maintains a central record or database that contains all pertinent information.
Yes_____ No_____

Briefly describe how this process will be performed in PROVIDER's office:

27. PROVIDER regularly measures their performance for quality improvement, using national benchmarks for comparison. Provider takes necessary actions to continuously improve services/processes and reports that information to the OHCA regularly.
Yes _____ No _____
Briefly describe how this process is performed in PROVIDER's office: