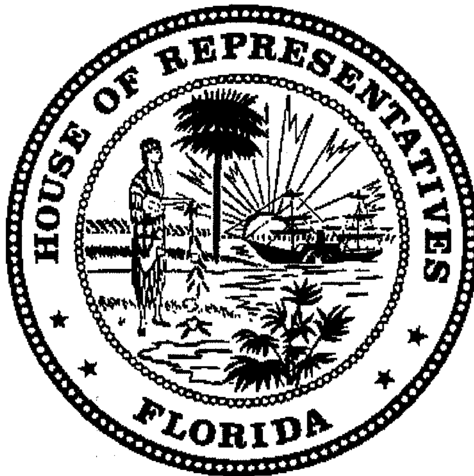

Action Packet

Committee on Health Innovation

Tuesday, March 11, 2008
8:00 AM - 9:30 AM
212 Knott Building

Marco Rubio
Speaker

Rene Garcia
Chair

COMMITTEE MEETING REPORT

Committee on Health Innovation

3/11/2008 8:00:00AM

Location: 212 Knott Building

Attendance:

	Present	*Absent*	*Excused*
Rene Garcia (Chair)	X		
James Frishe	X		
Eduardo Gonzalez	X		
Ed Homan	X		
Jimmy Patronis	X		
Ari Porth	X		
Maria Sachs	X		
Franklin Sands	X		
Will Weatherford	X		
Totals:	**9**	**0**	**0**

Committee meeting was reported out: Tuesday, March 11, 2008 12:19:18PM

COMMITTEE MEETING REPORT

Committee on Health Innovation

3/11/2008 8:00:00AM

Location: 212 Knott Building

HB 525 : Medical Assistance Eligibility of Inmates

[X] *Favorable*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
James Frishe	X				
Eduardo Gonzalez	X				
Ed Homan				X	
Jimmy Patronis	X				
Ari Porth	X				
Maria Sachs	X				
Franklin Sands	X				
Will Weatherford	X				
Rene Garcia (Chair)	X				
	Total Yeas: 8	**Total Nays: 0**			

Appearances:

Waived in Support
Josh Doyle (Lobbyist) - Proponent
Florida Psychiatric Society
521 E. Park Ave.
Tallahassee Florida 32301

Waived in Support
Amanda Ghaffari (Lobbyist) - Proponent
Florida Association of Counties
100 S. Monroe St.
Tallahassee Florida 32301
Phone: (850) 228-7922

Gretchen Harkins (Lobbyist) - Proponent
Senior Legislative Coordinator, Broward County
115 S. Andrews Ave.
Ft. Lauderdale Florida 33312
Phone: (954) 254-7883

Waived in Support
Mario Jardon, CEO (General Public) - Proponent
Citrus Health Network
4175 W 20 Ave.
Hialeah Florida 33012
Phone: (305) 424-3100

Waived in Support
Frank Messersmith (Lobbyist) - Proponent
Florida Sheriffs Association
2901 Lake Bradford
Tallahassee Florida
Phone: (850) 576-5858

Committee meeting was reported out: Tuesday, March 11, 2008 12:19:18PM

Location: 212 Knott Building

Waived in Support
Ellen Pickalkiewicz, Executive Director (State Employee) - Proponent
Florida Substance Abuse & Mental Health Corp.
1317 Winewood Blvd.
Tallahassee Florida 32312
Phone: (850) 410-1576

Brian Pitts (General Public) - Information Only
Justice-2-Jesus
1119 Newton Ave. South
St. Petersburg Florida 33705
Phone: (727) 897-9291

Dr. Sandeep Rahangdale (Lobbyist) (State Employee) - Proponent
Assistant Secretary of Health Services
Department of Corrections 2601 Blairstone Road
Tallahassee Florida 32399
Phone: (850) 528-2491

Waived in Support
Michele Saunders, Executive Director (General Public) - Proponent
Florida Partners in Crisis
4836 Lansdale Circle
Orlando Florida 32817
Phone: (407) 574-7182

Waived in Support
Bob Sharpe, CEO (Lobbyist) - Proponent
Florida Council for Community Mental Health
316 E. Park Ave.
Tallahassee Florida 32301
Phone: (850) 224-6048

COMMITTEE MEETING REPORT

Committee on Health Innovation

3/11/2008 8:00:00AM

Location: 212 Knott Building

HB 691 : Medicaid Recipients with Psychiatric Disabilities

[X] *Favorable With Amendments (1)*

	Yea	*Nay*	*No Vote*	*Absentee Yea*	*Absentee Nay*
James Frishe	X				
Eduardo Gonzalez	X				
Ed Homan				X	
Jimmy Patronis	X				
Ari Porth	X				
Maria Sachs	X				
Franklin Sands	X				
Will Weatherford	X				
Rene Garcia (Chair)	X				
	Total Yeas: 8	**Total Nays: 0**			

Appearances:

Mario Jardon, CEO (General Public) - Proponent
Citrus Health Network
4175 W 20 Ave.
Hialeah Florida 33012
Phone: (305) 424-3100

Waived in Support
Michele Saunders, Executive Director (General Public) - Proponent
Florida Partners in Crisis
4836 Lansdale Circle
Orlando Florida 32817
Phone: (407) 574-7182

Bob Sharpe, CEO (Lobbyist) - Proponent
Florida Council for Community Mental Health
316 E. Park Ave.
Tallahassee Florida 32301
Phone: (850) 224-6048

Committee meeting was reported out: Tuesday, March 11, 2008 12:19:18PM

COMMITTEE MEETING REPORT

Committee on Health Innovation

3/11/2008 8:00:00AM

Location: 212 Knott Building

Workshop

Medicaid Durable Medical Equipment Fraud

[X] *Workshopped* - Moved to recommend to the Healthcare Council language for a Proposed Council Bill.

Appearances:

Beth Kidder (State Employee) - Information Only
Medicaid Durable Medical Equipment Fraud
Bureau Chief for Medicaid Services
Agency for Health Care Administration 2727 Mahan Drive MS-20
Tallahassee Florida 32308
Phone:(850) 487-2958

Committee meeting was reported out: Tuesday, March 11, 2008 12:19:18PM

COMMITTEE MEETING REPORT

Committee on Health Innovation

3/11/2008 8:00:00AM

Location: 212 Knott Building

Summary:

Committee on Health Innovation

Tuesday March 11, 2008 08:00 am

HB 525	Favorable	Yeas: 8 Nays: 0
HB 691	Favorable With Amendments (1)	Yeas: 8 Nays: 0

Medicaid Durable Medical Equipment Fraud Workshopped

Committee meeting was reported out: Tuesday, March 11, 2008 12:19:18PM

House of Representatives
COMMITTEE BILL ACTION WORKSHEET

Committee/Subcommittee on HEALTH INNOVATION Bill No. HB 525

Meeting Date 3-11-08 Time 8:00 Am Place 212 Knott

COMMITTEE ACTION:

✓ Favorable
____ Favorable with Amendments ____
____ Favorable with Committee Substitute
____ Unfavorable
____ Temporarily Deferred
____ Reconsidered

Other Action: ____

Final Vote on Bill		Members								
Yeas	Nays		Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
✓		Rep. Jim Frishe								
✓		Rep. Eduardo Gonzalez								
		Rep. Ed Homan								
✓		Rep. Jimmy Patronis								
✓		Rep. Ari Porth								
✓		Rep. Maria Lorts Sachs								
✓		Rep. Franklin Sands								
✓		Rep. Will Weatherford								
✓		Rep. Rene Garcia, Chair								
Yeas	Nays		Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
8	0	TOTALS								

House of Representatives
COMMITTEE BILL ACTION WORKSHEET

Committee/Subcommittee on HEALTH INNOVATION Bill No. HB 691

Meeting Date 3-11-08 Time 8:10 Am Place 212 Knott

COMMITTEE ACTION:

_____ Favorable
✓ Favorable with Amendments 1
_____ Favorable with Committee Substitute
_____ Unfavorable
_____ Temporarily Deferred
_____ Reconsidered

Other Action: ____________

Final Vote on Bill		Members	#1							
Yeas	Nays		Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
✓		Rep. Jim Frishe								
✓		Rep. Eduardo Gonzalez								
		Rep. Ed Homan								
✓		Rep. Jimmy Patronis								
✓		Rep. Ari Porth								
✓		Rep. Maria Lorts Sachs								
✓		Rep. Franklin Sands								
✓		Rep. Will Weatherford								
✓		Rep. Rene Garcia, Chair								
Yeas	Nays		Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
8	0	TOTALS	(A)							

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 ______

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1 Council/Committee hearing bill: Health Innovation
2 Representative(s) Zapata offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Paragraph (d) of subsection (4) of section
7 409.912, Florida Statutes, is amended to read:
8 409.912 Cost-effective purchasing of health care.--The
9 agency shall purchase goods and services for Medicaid recipients
10 in the most cost-effective manner consistent with the delivery
11 of quality medical care. To ensure that medical services are
12 effectively utilized, the agency may, in any case, require a
13 confirmation or second physician's opinion of the correct
14 diagnosis for purposes of authorizing future services under the
15 Medicaid program. This section does not restrict access to
16 emergency services or poststabilization care services as defined
17 in 42 C.F.R. part 438.114. Such confirmation or second opinion
18 shall be rendered in a manner approved by the agency. The agency
19 shall maximize the use of prepaid per capita and prepaid
20 aggregate fixed-sum basis services when appropriate and other
21 alternative service delivery and reimbursement methodologies,
22 including competitive bidding pursuant to s. 287.057, designed

23 to facilitate the cost-effective purchase of a case-managed
24 continuum of care. The agency shall also require providers to
25 minimize the exposure of recipients to the need for acute
26 inpatient, custodial, and other institutional care and the
27 inappropriate or unnecessary use of high-cost services. The
28 agency shall contract with a vendor to monitor and evaluate the
29 clinical practice patterns of providers in order to identify
30 trends that are outside the normal practice patterns of a
31 provider's professional peers or the national guidelines of a
32 provider's professional association. The vendor must be able to
33 provide information and counseling to a provider whose practice
34 patterns are outside the norms, in consultation with the agency,
35 to improve patient care and reduce inappropriate utilization.
36 The agency may mandate prior authorization, drug therapy
37 management, or disease management participation for certain
38 populations of Medicaid beneficiaries, certain drug classes, or
39 particular drugs to prevent fraud, abuse, overuse, and possible
40 dangerous drug interactions. The Pharmaceutical and Therapeutics
41 Committee shall make recommendations to the agency on drugs for
42 which prior authorization is required. The agency shall inform
43 the Pharmaceutical and Therapeutics Committee of its decisions
44 regarding drugs subject to prior authorization. The agency is
45 authorized to limit the entities it contracts with or enrolls as
46 Medicaid providers by developing a provider network through
47 provider credentialing. The agency may competitively bid single-
48 source-provider contracts if procurement of goods or services
49 results in demonstrated cost savings to the state without
50 limiting access to care. The agency may limit its network based
51 on the assessment of beneficiary access to care, provider
52 availability, provider quality standards, time and distance
53 standards for access to care, the cultural competence of the

54 provider network, demographic characteristics of Medicaid
55 beneficiaries, practice and provider-to-beneficiary standards,
56 appointment wait times, beneficiary use of services, provider
57 turnover, provider profiling, provider licensure history,
58 previous program integrity investigations and findings, peer
59 review, provider Medicaid policy and billing compliance records,
60 clinical and medical record audits, and other factors. Providers
61 shall not be entitled to enrollment in the Medicaid provider
62 network. The agency shall determine instances in which allowing
63 Medicaid beneficiaries to purchase durable medical equipment and
64 other goods is less expensive to the Medicaid program than long-
65 term rental of the equipment or goods. The agency may establish
66 rules to facilitate purchases in lieu of long-term rentals in
67 order to protect against fraud and abuse in the Medicaid program
68 as defined in s. 409.913. The agency may seek federal waivers
69 necessary to administer these policies.

70 (4) The agency may contract with:

71 (d) A provider service network, which may be reimbursed on
72 a fee-for-service or prepaid basis. A provider service network
73 that ~~which~~ is reimbursed by the agency on a prepaid basis is
74 ~~shall be~~ exempt from parts I and III of chapter 641, but must
75 comply with the solvency requirements in s. 641.2261(2) and meet
76 appropriate financial reserve, quality assurance, and patient
77 rights requirements as established by the agency.

78 1. Except as provided in subparagraph 2., Medicaid
79 recipients assigned to a provider service network shall be
80 chosen equally from those who would otherwise have been assigned
81 to prepaid plans and MediPass. The agency is authorized to seek
82 federal Medicaid waivers as necessary to implement the
83 provisions of this section. Any contract previously awarded to a
84 provider service network operated by a hospital pursuant to this

85 subsection shall remain in effect for a period of 3 years
86 following the current contract expiration date, regardless of
87 any contractual provisions to the contrary. A provider service
88 network is a network established or organized and operated by a
89 health care provider, or group of affiliated health care
90 providers, including minority physician networks and emergency
91 room diversion programs that meet the requirements of s.
92 409.91211, which provides a substantial proportion of the health
93 care items and services under a contract directly through the
94 provider or affiliated group of providers and may make
95 arrangements with physicians or other health care professionals,
96 health care institutions, or any combination of such individuals
97 or institutions to assume all or part of the financial risk on a
98 prospective basis for the provision of basic health services by
99 the physicians, by other health professionals, or through the
100 institutions. The health care providers must have a controlling
101 interest in the governing body of the provider service network
102 organization.
103 2. The agency shall seek applications for and is
104 authorized to contract with a specialty provider service network
105 that exclusively enrolls Medicaid beneficiaries who have
106 psychiatric disabilities. The Medicaid specialty provider
107 service network shall be responsible for providing the full
108 range of physical and behavioral health services that other
109 Medicaid health maintenance organizations and provider service
110 networks are required to provide. Medicaid beneficiaries having
111 psychiatric disabilities who are required but fail to select a
112 managed care plan shall be assigned to the specialty provider
113 service network in those geographic areas where a specialty
114 provider service network is available. For purposes of
115 enrollment, in addition to those who meet the diagnostic

116 criteria indicating a mental illness or emotional disturbance,
117 beneficiaries served by Medicaid-enrolled community mental
118 health agencies or who voluntarily choose the specialty provider
119 service network shall be presumed to meet the plan enrollment
120 criteria.

121 Section 2. Paragraphs (o) and (aa) of subsection (3) and
122 paragraphs (a), (b), (c), (d), and (e) of subsection (4) of
123 section 409.91211, Florida Statutes, are amended, and paragraph
124 (ee) is added to subsection (3) of that section, to read:

125 409.91211 Medicaid managed care pilot program.--

126 (3) The agency shall have the following powers, duties,
127 and responsibilities with respect to the pilot program:

128 (o) To implement eligibility assignment processes to
129 facilitate client choice while ensuring pilot programs of
130 adequate enrollment levels. These processes shall ensure that
131 pilot sites have sufficient levels of enrollment to conduct a
132 valid test of the managed care pilot program within a 2-year
133 timeframe. The eligibility assignment process shall be modified
134 as specified in paragraph (aa).

135 (aa) To implement a mechanism whereby Medicaid recipients
136 who are already enrolled in a managed care plan or the MediPass
137 program in the pilot areas shall be offered the opportunity to
138 change to capitated managed care plans on a staggered basis, as
139 defined by the agency. All Medicaid recipients shall have 30
140 days in which to make a choice of capitated managed care plans.
141 Those Medicaid recipients who do not make a choice shall be
142 assigned to a capitated managed care plan in accordance with
143 paragraph (4)(a) and shall be exempt from s. 409.9122. To
144 facilitate continuity of care for a Medicaid recipient who is
145 also a recipient of Supplemental Security Income (SSI), prior to
146 assigning the SSI recipient to a capitated managed care plan,

147 the agency shall determine whether the SSI recipient has an
148 ongoing relationship with a provider, including a community
149 mental health provider or capitated managed care plan, and, if
150 so, the agency shall assign the SSI recipient to that provider,
151 provider service network, or capitated managed care plan where
152 feasible. Those SSI recipients who do not have such a provider
153 relationship shall be assigned to a capitated managed care plan
154 provider in accordance with this paragraph and paragraphs (4)(a)
155 through (d) ~~and shall be exempt from s. 409.9122~~.
156 (ee) To develop and implement a service delivery
157 alternative within capitated managed care plans to provide
158 Medicaid services as specified in ss. 409.905 and 409.906 for
159 persons who have psychiatric disabilities which are sufficient
160 to meet the medical, developmental, and emotional needs of those
161 persons.
162 (4)(a) A Medicaid recipient in the pilot area who is not
163 currently enrolled in a capitated managed care plan upon
164 implementation is not eligible for services as specified in ss.
165 409.905 and 409.906, for the amount of time that the recipient
166 does not enroll in a capitated managed care network. If a
167 Medicaid recipient has not enrolled in a capitated managed care
168 plan within 30 days after eligibility, the agency shall assign
169 the Medicaid recipient to a capitated managed care plan based on
170 the assessed needs of the recipient as determined by the agency
171 and the recipient shall be exempt from s. 409.9122. When making
172 assignments, the agency shall take into account the following
173 criteria:
174 1. A capitated managed care network has sufficient network
175 capacity to meet the needs of members.
176 2. The capitated managed care network has previously
177 enrolled the recipient as a member, or one of the capitated

178 managed care network's primary care providers has previously
179 provided health care to the recipient.
180 3. The agency has knowledge that the member has previously
181 expressed a preference for a particular capitated managed care
182 network as indicated by Medicaid fee-for-service claims data,
183 but has failed to make a choice.
184 4. The capitated managed care network's primary care
185 providers are geographically accessible to the recipient's
186 residence.
187 5. The extent of the psychiatric disability of the
188 Medicaid beneficiary.
189 (b) When more than one capitated managed care network
190 provider meets the criteria specified in paragraph (3)(h), the
191 agency shall assess a beneficiary's psychiatric disability
192 before making an assignment and make recipient assignments
193 consecutively by family unit.
194 (c) If a recipient is currently enrolled with a Medicaid
195 managed care organization that also operates an approved reform
196 plan within a demonstration area and the recipient fails to
197 choose a plan during the reform enrollment process or during
198 redetermination of eligibility, the recipient shall be
199 automatically assigned by the agency into the most appropriate
200 reform plan operated by the recipient's current Medicaid managed
201 care plan. If the recipient's current managed care plan does not
202 operate a reform plan in the demonstration area which adequately
203 meets the needs of the Medicaid recipient, the agency shall use
204 the automatic assignment process as prescribed in the special
205 terms and conditions numbered 11-W-00206/4. All enrollment and
206 choice counseling materials provided by the agency must contain
207 an explanation of the provisions of this paragraph for current
208 managed care recipients and an explanation of the choice of any

209 specialty provider service network or specialty managed care
210 plan.
211 (d) Except as provided in paragraph (b), the agency may
212 not engage in practices that are designed to favor one capitated
213 managed care plan over another or that are designed to influence
214 Medicaid recipients to enroll in a particular capitated managed
215 care network in order to strengthen its particular fiscal
216 viability.
217 (e) After a recipient has made a selection or has been
218 enrolled in a capitated managed care network, the recipient
219 shall have 90 days in which to voluntarily disenroll and select
220 another capitated managed care network. After 90 days, no
221 further changes may be made except for cause. Cause shall
222 include, but not be limited to, poor quality of care, lack of
223 access to necessary specialty services, an unreasonable delay or
224 denial of service, inordinate or inappropriate changes of
225 primary care providers, service access impairments due to
226 significant changes in the geographic location of services, or
227 fraudulent enrollment. The agency may require a recipient to use
228 the capitated managed care network's grievance process as
229 specified in paragraph (3)(q) prior to the agency's
230 determination of cause, except in cases in which immediate risk
231 of permanent damage to the recipient's health is alleged. The
232 grievance process, when used, must be completed in time to
233 permit the recipient to disenroll no later than the first day of
234 the second month after the month the disenrollment request was
235 made. If the capitated managed care network, as a result of the
236 grievance process, approves an enrollee's request to disenroll,
237 the agency is not required to make a determination in the case.
238 The agency must make a determination and take final action on a
239 recipient's request so that disenrollment occurs no later than

240 the first day of the second month after the month the request
241 was made. If the agency fails to act within the specified
242 timeframe, the recipient's request to disenroll is deemed to be
243 approved as of the date agency action was required. Recipients
244 who disagree with the agency's finding that cause does not exist
245 for disenrollment shall be advised of their right to pursue a
246 Medicaid fair hearing to dispute the agency's finding. When a
247 specialty provider service network or specialty managed care
248 plan first becomes available in a geographic area, beneficiaries
249 meeting diagnostic criteria shall be offered an open enrollment
250 period during which they may choose to reenroll in a specialty
251 provider service network or specialty managed care plan.
252 Section 3. This act shall take effect July 1, 2008.
253
254
255
256 ---
257 **T I T L E A M E N D M E N T**
258 Remove the entire title and insert:
259 An act relating to Medicaid provider service networks;
260 amending s. 409.912, F.S.; authorizing the Agency for
261 Health Care Administration to contract with a specialty
262 provider service network that exclusively enrolls Medicaid
263 beneficiaries who have psychiatric disabilities; requiring
264 the specialty provider to offer the same physical and
265 behavioral health services that are required from other
266 Medicaid health maintenance organizations and provider
267 service networks; requiring that beneficiaries be assigned
268 to a specialty provider service network under certain
269 circumstances; amending s. 409.91211, F.S.; requiring that
270 the agency modify eligibility assignment processes for

271 managed care pilot programs to include specialty plans
272 that specialize in care for beneficiaries who have
273 psychiatric disabilities; requiring the agency to provide
274 a service delivery alternative to provide Medicaid
275 services to persons having psychiatric disabilities;
276 providing an additional criterion for the agency in making
277 assignments; requiring that enrollment and choice
278 counseling materials contain an explanation concerning the
279 choice of a network or plan; providing for an additional
280 open enrollment period following the availability of
281 specialty services; providing an effective date.
282
283

House of Representatives
COMMITTEE BILL ACTION WORKSHEET

Committee/Subcommittee on HEALTH INNOVATION Bill No. Medicaid Durable Medical Equipment Fraud

Meeting Date 3-11-08 Time 8:00 Am Place 212 Knott

COMMITTEE ACTION:

- ________ Favorable
- ________ Favorable with Amendments ________
- ________ Favorable with Committee Substitute
- ________ Unfavorable
- ________ Temporarily Deferred
- ________ Reconsidered

Other Action: move to refer language to Council for PCB

Final Vote on Bill		Members								
Yeas	Nays		Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
		Rep. Jim Frishe								
		Rep. Eduardo Gonzalez								
		Rep. Ed Homan								
		Rep. Jimmy Patronis								
		Rep. Ari Porth								
		Rep. Maria Lorts Sachs								
		Rep. Franklin Sands								
		Rep. Will Weatherford								
		Rep. Rene Garcia, Chair								
Yeas	Nays		Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
		TOTALS	(A)							