By Senator Peaden

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A bill to be entitled

An act relating to a medical home pilot project; amending s. 409.91207, F.S.; requiring the Agency for Health Care Administration to establish a medical home pilot project; providing definitions; providing for the organization of medical home networks; requiring each medical home network to provide specified services; requiring the Secretary of Health Care Administration to appoint a task force to develop and implement the project; providing for the establishment of a statewide advisory panel; providing for membership and duties of the task force and the panel; providing for travel expenses and per diem for members of the task force, 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 home networks; providing for enrollment of Medipass beneficiaries in the pilot project; authorizing the agency to designate priority areas in the state for the development of medical home networks; 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; providing for an appropriation; 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; directing the Department of Management Services to develop a medical home option in the state group insurance program; requiring medical home network providers to maintain certain records and data; providing an effective date.

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

Section 1. 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 home pilot project.—

(1) PURPOSE AND PRINCIPLES.—The agency shall develop and implement a medical home pilot project. The purpose of the project is to establish an enhanced primary care case management program to test a medical home network model for coordinated and cost-effective care in a fee-for-service environment and to compare the performance of the medical home network model with other forms of managed care. The agency may test alternative payment rates and methods for designated medical homes that meet the quality and efficiency guidelines established by the agency. The medical home is intended to modify 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 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 federally qualified health center or 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 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) "Tier One medical home" means a primary care provider designated by the agency as meeting the service capabilities established in paragraph (4)(a).

(f) "Tier Two medical home" means a primary care provider designated by the agency as meeting the service capabilities established in paragraph (4)(b).

(g) "Tier Three medical home" means a primary care provider designated by the agency as meeting the service capabilities established in paragraph (4)(c).

(3) ORGANIZATION.—

(a) Each participating primary care provider shall be a member of a medical home network and shall be designated 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.

(b) The members of each medical home 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.

(4) SERVICE CAPABILITIES.—A 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) 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 documents 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 the agency on the development and implementation of the medical home pilot project and to promote communication among medical home networks. 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) 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.

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

(e) 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. Members of the medical advisory group shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061.

(6) ENROLLMENT.—Each Medipass beneficiary served by a designated Tier One, Tier Two, or Tier Three medical home shall be given a choice to enroll in a medical home network. Enrollment shall be effective upon the agency's receipt of a participation agreement signed by the beneficiary.

(7) PRIORITY AREAS.—The agency may designate primary care providers in any area of the state in which Medipass operates and shall identify priority areas for the development of medical home networks based on an analysis of emergency department use and rates of hospitalization for ambulatory care-sensitive

conditions. In these priority areas, the agency shall conduct outreach to Medicaid primary care providers to explain the medical home network model and encourage participation in the pilot project. At least one medical home shall be designated in each priority area by October 1, 2010.

(8) FINANCING.—

(a) Subject to a specific appropriation provided for in the General Appropriations Act, medical home network members shall be eligible to receive an enhanced case management fee. The Tier One medical homes shall receive a base fee equal to 110 percent of the standard Medipass case management fee. Tier Two medical homes shall receive a base fee equal to 130 percent of the enhanced fee for Tier One medical homes. Tier Three medical homes shall receive a base fee equal to 200 percent of the enhanced fee for Tier One medical homes. The base fee for each tier shall be adjusted based on the age, gender, and eligibility of the enrollees.

(b) Services provided by a medical home network shall be reimbursed based on claims filed for Medicaid fee-for-service payments.

(c) Any hospital, as defined in s. 395.002(12), participating in a medical home network 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 medical home network by providing case management and other medical home network services.

1. The credit shall be prorated based on the number of full-time equivalent case managers hired but shall not be less

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.

(9) AGENCY DUTIES; RULEMAKING AUTHORITY.-

(a) The agency shall:

1. Designate primary care providers as Tier One, Tier Two, or Tier Three medical homes consistent with the principles and applicable service capabilities of each primary care provider as provided in subsections (1) and (4).

2. Develop a standard form to assess the implementation of the principles and service capabilities of each medical home tier as provided in subsections (1) and (4) to be executed by primary care providers in certifying to the agency that they meet the necessary principles and service capabilities for the tier in which they seek to be designated.

3. Base any alternative payment rates and methods that may be established for medical homes on quality indicators that

demonstrate improved patient outcomes compared to the Medicaid fee-for-service system, such as reductions in hospitalizations due to preventable causes, readmission rates, or emergency department use rates and efficiencies in the form of savings associated with these and other quality indicators.

4. Develop a process for designating as Tier One, Tier Two, or Tier Three medical home managed care organizations that establish policies and procedures consistent with the principles and corresponding service capabilities provided for in subsections (1) and (4) and provide documentation that such policies and procedures have been implemented.

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

6. Analyze spending for enrolled medical home network patients compared to capitation rates that would have been paid for these medical home patients if they had been assigned to a prepaid health plan. The agency shall report the aggregated results of this comparison to the Social Services Estimating Conference.

7. Report and publish medical home network financial performance on a quarterly basis. Annual assessments of spending pursuant to subparagraph 6. shall be submitted to the President of the Senate and the Speaker of the House of Representatives by March 1, 2011, February 1, 2012, and February 1, 2013.

8. Report community network utilization performance. The agency shall contract with the University of South Florida to evaluate the use and determine any change in the use of emergency departments, in-hospital care, and pharmaceuticals by

patients in the medical home pilot project. An initial assessment of the utilization performance shall be submitted to the President of the Senate and the Speaker of the House of Representatives by March 1, 2011.

(b) The agency shall adopt any rules necessary for the implementation and administration of this section.

(10) ACHIEVED SAVINGS.—Each medical home network 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 savings shall be distributed as a multiplier to Medicaid fees paid to primary care and principal network providers during the period of the earned savings. 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.

(11) 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.

(12) QUALITY ASSURANCE AND ACCOUNTABILITY.—Each primary

care and principal network provider participating in a medical home network shall maintain medical records and clinical data necessary to assess the use, cost, and outcome of services provided to enrollees.

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