By the Committees on Health Care, Banking and Insurance and Senator Brown-Waite

317-2057-98

A bill to be entitled

An act relating to the delivery of health care services; amending s. 409.912, F.S.; directing the Agency for Health Care Administration to establish an outpatient specialty services pilot project; providing definitions; providing criteria for participation; requiring an evaluation and a report to the Governor and Legislature; creating s. 624.1291, F.S.; providing an exemption from the Insurance Code for certain health care services; creating part IV of ch. 641, F.S., the "Provider-Sponsored-Organization Act"; providing legislative findings and purposes with respect to certain federal requirements for authorizing provider-sponsored organizations in this state to provide health care coverage to Medicare beneficiaries under the Medicare Choice plan; providing definitions; prohibiting a provider-sponsored organization from transacting insurance business other than the offering of Medicare Choice plans; providing applicability of parts I and III of ch. 641, F.S., to provider-sponsored organizations; providing exceptions; amending s. 641.227, F.S.; providing for deposits into the Rehabilitation Administrative Expense Fund by a provider-sponsored organization; providing for reimbursements; amending s. 641.316, F.S., relating to fiscal intermediary services;

providing for an exemption from s. 455.654, F.S., to provider-sponsored organizations, relating to financial arrangements; providing an effective date.

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

Section 1. Subsection (34) is added to section 409.912, Florida Statutes, 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. 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.

(34) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Department of Insurance under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality-assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

(f) Nothing in this subsection is intended to conflict with the provision of the 1997-1998 General Appropriations Act which authorizes competitive bidding for Medicaid home health, clinical laboratory, or x-ray services.

Section 2. Section 624.1291, Florida Statutes, is created to read:

624.1291 Certain health care services; exemption from code.--Any person who enters into a contract or agreement with an authorized insurer, or with a health maintenance organization or provider sponsored organization that has obtained a certificate of authority pursuant to chapter 641, to provide health care services to persons insured under a health insurance policy, health maintenance organization contract, or provider-sponsored-organization contract shall not be deemed to be an insurer and shall not be subject to the provisions of this code, regardless of any risk assumed under the contract or agreement, provided that:

(1) The authorized insurer, health maintenance organization, or provider-sponsored organization remains contractually liable to the insured to the full extent provided in the policy or contract with the insured;

(2) The person does not receive any premium payment or per-capita fee from the insured other than fees for services not covered under the insured's policy or contract, such as deductible amounts, co-payments, or charges in excess of policy or contract limits which are otherwise allowed to be collected; and

(3) Any person who is an administrator as defined in s. 626.88 must meet the requirements of part VII of chapter 626, and any person who is performing fiscal intermediary services as defined in s. 641.316 must meet the requirements of that section.

Section 3. Part IV of chapter 641, Florida Statutes, consisting of sections 641.801, 641.802, 641.803, 641.804, 641.805, and 641.806, Florida Statutes, is created to read:

641.801 Short title.--This part may be cited as the "Provider-Sponsored-Organization Act."

641.802 Declaration of legislative findings and purposes.--

(1) The Legislature finds that a major restructuring of health care has taken place which has changed the way in which health care services are paid for and delivered and that today the emphasis is on providing cost-conscious health care services through managed care. The Legislature recognizes that alternative methods for the delivery of health care are needed to promote competition and increase patients' choices.

(2) The Legislature finds that the United States Congress has enacted legislation that allows provider-sponsored organizations to provide coordinated-care plans to Medicare enrollees through the Medicare Choice program. The federal legislation requires any organization that offers a Medicare Choice plan to be organized and licensed under state law as a risk-bearing entity eligible to offer health-benefit coverage in the state in which it offers a Medicare Choice plan.

(3) The Legislature finds that these plans, when properly operated, emphasize cost and quality controls while ensuring that the provider has control over medical decisions.

(4) The Legislature declares that it is the policy of this state:

(a) To eliminate legal barriers to the organization, promotion, and expansion of provider-sponsored organizations that offer Medicare Choice plans in order to encourage the development of valuable options for the Medicare beneficiaries of this state.

(b) To recognize that comprehensive provider-sponsored organizations are exempt from the insurance laws of this state except in the manner and to the extent set forth in this part.

641.803 Definitions.--As used in this part, the term:

(1) "Affiliation" means a relationship between providers in which, through contract, ownership, or otherwise:

(a) One provider directly or indirectly controls, is controlled by, or is under common control with the other;

(b) Both providers are part of a controlled group of corporations under s. 1563 of the Internal Revenue Code of 1986;

(c) Each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations; or

(d) Both providers are part of an affiliated service group under s. 414 of the Internal Revenue Code of 1986.

(2) "Comprehensive health care services" means services, medical equipment, and supplies required under the Medicare Choice program.

(3) "Copayment" means a specific dollar amount that the subscriber must pay upon receipt of covered health care services as required or authorized under the Medicare Choice program.

(4) "Medicare Choice" means the Medicare+Choice plan established under the federal Balanced Budget Act of 1997, and as provided for under part IV of chapter 641, the Provider Sponsored Organization Act.

(5) "Provider-sponsored contract" means any contract entered into by a provider-sponsored organization that serves Medicare Choice beneficiaries.

(6) "Provider-sponsored organization" means any organization authorized under this part which:

(a) Is established, organized, and operated by a health care provider or group of affiliated health care providers;

(b) Provides a substantial proportion of the health care items and services specified in the Medicare Choice contract, as defined by the Secretary of the United States Department of Health and Human Services, directly through the provider or affiliated group of providers; and

(c) Shares, with respect to its affiliated providers, directly or indirectly, substantial financial risk in the provision of such items and services and has at least a majority financial interest in the entity.

As used in this subsection, the term "substantial proportion" has the meaning ascribed by the Secretary of the United States Department of Health and Human Services after having taken into account the need for such an organization to assume responsibility for providing significantly more than the majority of the items and services under the Medicare Choice contract through its own affiliated providers and the remainder of the items and services under such contract through providers with which the organization has an agreement

to provide such items and services. Consideration will also be given to the need for the organization to provide a limited proportion of the items and services under the contract through entities that are neither affiliated with nor have an agreement with the organization.

(7) "Subscriber" means a Medicare Choice enrollee who is eligible for coverage as a Medicare beneficiary.

(8) "Surplus" means total assets in excess of total liabilities as determined by the federal rules on solvency standards established by the Secretary of the United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget of 1997, for provider-sponsored organizations that offer the Medicare Choice plan.

641.804 Applicability of other laws.--Except as provided in this part, provider-sponsored organizations shall be governed by this part and are exempt from all other provisions of the Florida Insurance Code.

641.805 Insurance business not authorized.--Neither the Florida Insurance Code nor this part authorize any provider-sponsored organization to transact any insurance business other than to offer Medicare Choice plans pursuant to s. 1855 of the Balanced Budget Act of 1997.

641.806 Applicability of parts I and III; exceptions.--The provisions of parts I and III of this chapter apply to provider-sponsored organizations to the same extent that such sections apply to health maintenance organizations, except that:

(1) The definitions used in this part control to the extent of any conflict with the definitions used in s. 641.19.

(2) The certificate of authority, application for certificate, and all other forms issued or prescribed by the

department pursuant to this part shall refer to a "provider-sponsored organization" rather than a "health maintenance organization."

(3) Such provisions do not apply to the extent of any conflict with ss. 1855 and 1856 of the Balanced Budget Act of 1997 and rules and regulations adopted by the Secretary of the United States Department of Health and Human Services including, but not limited to, requirements related to surplus, net worth, assets, liabilities, investments, provider-sponsored-organization contracts, payment of benefits, and procedures for grievances and appeals.

(4) Such provisions do not apply to the extent of any waiver granted by the Secretary of the United States Department of Health and Human Services under s. 1856(a)(2) of the Balanced Budget Act of 1997.

(5) Such provisions do not apply to the extent that they are unrelated to, or inconsistent with, the limited authority of provider-sponsored organizations to offer only Medicare Choice plans.

(6) Section 641.228, related to the Florida Health Maintenance Organization Consumer Assistance Plan, does not apply.

(7) Such provisions do not preclude a provider-sponsored organization from contracting with one or more companies to provide all necessary administrative and management services.

Section 4. Section 641.227, Florida Statutes, is amended to read:

641.227 Rehabilitation Administrative Expense Fund.--

(1) The department may ~~shall~~ not issue or permit to exist a certificate of authority to operate a health

maintenance organization or provider-sponsored organization in this state unless the organization has deposited with the department $10,000 in cash for use in the Rehabilitation Administrative Expense Fund as established in subsection (2).

(2) The department shall maintain all deposits received under this section and all income from such deposits in trust in an account titled "Rehabilitation Administrative Expense Fund." The fund shall be administered by the department and shall be used for the purpose of payment of the administrative expenses of the department during any rehabilitation of a health maintenance organization or provider-sponsored organization, when rehabilitation is ordered by a court of competent jurisdiction.

(3) Upon successful rehabilitation of a health maintenance organization or provider-sponsored organization, the organization shall reimburse the fund for the amount of expenses incurred by the department during the court-ordered rehabilitation period.

(4) If a court of competent jurisdiction orders liquidation of a health maintenance organization or provider-sponsored organization, the fund shall be reimbursed for expenses incurred by the department as provided for in chapter 631.

(5) Each deposit made under this section shall be allowed as an asset for purposes of determination of the financial condition of the health maintenance organization or provider-sponsored organization. The deposit shall be refunded to the organization only when the organization both ceases operation as a health maintenance organization or provider-sponsored organization and no longer holds a subsisting certificate of authority.

Section 5. Paragraph (b) of subsection (2) and subsection (5) of section 641.316, Florida Statutes, are amended to read:

641.316 Fiscal intermediary services.--

(1) It is the intent of the Legislature, through the adoption of this section, to ensure the financial soundness of fiscal intermediary services organizations established to develop, manage, and administer the business affairs of health care professional providers such as medical doctors, doctors of osteopathy, doctors of chiropractic, doctors of podiatric medicine, doctors of dentistry, or other health professionals regulated by the Department of Health.

(2)(a) The term "fiduciary" or "fiscal intermediary services" means reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations.

(b) The term "fiscal intermediary services organization" means a person or entity <u>that</u> ~~which~~ performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations <u>or provider-sponsored organizations</u> other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization licensed under this chapter, <u>a</u>

provider-sponsored organization licensed under this chapter, or physician group practices as defined in s. 455.236(3)(f).

(3) A fiscal intermediary services organization which is operated for the purpose of acquiring and administering provider contracts with managed care plans for professional health care services, including, but not limited to, medical, surgical, chiropractic, dental, and podiatric care, and which performs fiduciary or fiscal intermediary services shall be required to secure and maintain a fidelity bond in the minimum amount of $10 million. This requirement shall apply to all persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted provider or provider panel. The fidelity bond shall provide coverage against misappropriation of funds by the fiscal intermediary or its officers, agents, or employees; must be posted with the department for the benefit of managed care plans, subscribers, and providers; and must be on a form approved by the department. The fidelity bond must be maintained and remain unimpaired as long as the fiscal intermediary services organization continues in business in this state and until the termination of its registration.

(4) A fiscal intermediary services organization may not collect from the subscriber any payment other than the copayment or deductible specified in the subscriber agreement.

(5) Any fiscal intermediary services organization, other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization licensed under this chapter, a

provider-sponsored organization licensed under this chapter, or physician group practices as defined in s. 455.236(3)(f), must register with the department and meet the requirements of this section. In order to register as a fiscal intermediary services organization, the organization must comply with ss. 641.21(1)(c) and (d) and 641.22(6). Should the department determine that the fiscal intermediary services organization does not meet the requirements of this section, the registration shall be denied. In the event that the registrant fails to maintain compliance with the provisions of this section, the department may revoke or suspend the registration. In lieu of revocation or suspension of the registration, the department may levy an administrative penalty in accordance with s. 641.25.

(6) The department shall promulgate rules necessary to implement the provisions of this section.

Section 6. A provider-sponsored organization is exempt from section 455.654, Florida Statutes, for the provision of health care services to enrollees of a Medicare Choice plan.

Section 7. This act shall take effect October 1, 1998.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS for SB 1432

A new provision is added to s. 409.912, F.S., to direct the Agency for Health Care Administration to issue a request for proposal or intent to negotiate for a three-year outpatient specialty services pilot project in a rural and urban county in the state on a demonstration basis. Specification of certain requirements for the entity that is ultimately awarded the contract as well as an objective for the project is provided. The Agency for Health Care Administration is required to conduct a quality-assurance review each year of the project and the project contractor is required to submit data to the Agency relating to services provided to Medicaid recipients. The Agency must evaluate the project and report its findings to the Governor and the Legislature by January 1, 2001. Language clarifies that this provision is not intended to conflict with existing law providing for competitive bidding for Medicaid home health, clinical laboratory, or x-ray services.

Language is deleted that explicitly excluded from state insurance regulation certain contracts or agreements with employers that have established self-funded employee-benefit plans, as specified, under the federal Employee Retirement Income Security Act (ERISA) of 1974. Language is added clarifying that provider-sponsored organizations are not precluded by provisions of the bill from contracting with more than one company for administrative and management services.

The term "Medicare Choice" is define to reflect the name adopted in federal legislation that created the program.