A bill to be entitled

An act relating to Medicaid; providing waiver authority to the Agency for Health Care Administration; specifying demonstration pilot project sites; providing requirements for managed care pilot projects; providing for implementation of demonstration pilot projects; providing definitions; requiring the agency to develop a capitated system of care; requiring managed care plans to include mandatory Medicaid services and behavioral health and pharmacy services; requiring a managed care plan to have a certificate of authority from the agency before operating under the waiver; providing for certification requirements, including financial solvency, infrastructure, network capacity, and recipient access to be established in consultation with Office of Insurance Regulation; providing for contracts for administrative functions, and requirements; providing for cost sharing by recipients, and requirements; providing for continuance of the MediPass program, under certain circumstances; requiring the agency to develop an encounter data system; requiring plans and providers to report data; requiring the agency to have an accountability system; requiring plans to have quality assurance systems; requiring plans to have quality improvement systems; requiring certain entities certified to operate a managed care plan to comply with ss. 641.3155 and 641.513, F.S.; providing for agency to establish and provide for funding of catastrophic coverage for recipients who exceed a plan's

risk capacity; providing for a threshold to access to catastrophic coverage; requiring plans to continue to provide services to recipients receiving catastrophic coverage; providing for agency to develop a rate setting and risk adjustment system based on set premiums, health status, and other factors and actuarial analysis and requirements for the system; providing for applicability and enforcement; granting rulemaking authority to the agency; requiring legislative authority to implement the waiver; providing for future review and repeal of the act; amending s. 409.912, F.S.; deleting requirement for competitive bidding for provider service networks and preserving hospital networks; providing an effective date.

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

Section 1. Medicaid reform; pilot projects.--

(1) WAIVER AUTHORITY.--Notwithstanding any other law to the contrary, the Agency for Health Care Administration is authorized to seek an experimental, pilot, or demonstration project waiver, pursuant to s. 1115 of the Social Security Act, to reform Florida's Medicaid program pursuant to this section in the urban and rural demonstration sites of Broward, Baker, Clay, Duval, and Nassau counties. This waiver authority is contingent on 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 pilot project sites,

provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized under chapter 409, Florida Statutes.

(2) MANAGED CARE PILOT PROJECTS.--The agency shall include in the federal waiver request the authority to establish managed care pilot projects in at least one urban and one rural area. The waiver request shall include:

(a) Standards related to minimum network provider qualifications.

(b) A reimbursement methodology that recognizes risk factors from both a client perspective and a provider perspective.

(c) Policies and guidelines for phasing financial risk for approved pilots over a 3-year period. The policies and guidelines shall include an option to pay fee-for-service rates, which may include a savings settlement option, for at least 2 years. This model may be converted to a risk-adjusted capitated rate in the third year of operation.

(d) Provisions related to stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates risks associated with the development of the pilot projects.

(e) Descriptions of a process to be used by the Social Service Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the managed care initiative.

(f) Requirements for an encounter data system that

provides data related to patient services from the beginning of the pilot projects.

(g) The location and justification for the pilot project sites.

(h) Descriptions of target populations to be served which shall be limited to the Temporary Assistance for Needy Families and the Supplemental Security Income eligibility groups.

(i) Descriptions of the eligibility assignment processes that will be used to facilitate client choice and ensure that pilot projects have adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot project model within a 2-year timeframe.

(j) Descriptions of the evaluation methodology and standards that will be used to assess the success of the pilot projects.

(3) IMPLEMENTATION OF PILOT PROJECTS.--For the purpose of implementing the demonstration pilot projects, individuals enrolled from the Temporary Assistance for Needy Families and Supplemental Security Income eligibility groups shall only be from the MediPass and Medicaid fee-for-service programs.

(4) DEFINITIONS.--As used in this section, the term:

(a) "Administrator" means an administrator as defined in s. 626.88, Florida Statutes.

(b) "Agency" means the Agency for Health Care Administration.

(c) "Catastrophic coverage" means coverage for services provided to a Medicaid recipient after that recipient has

received services with an aggregate cost, based on Medicaid reimbursement rates, which exceeds a threshold specified by the agency.

(d) "Managed care plan" means a health maintenance organization authorized under part I of chapter 641, Florida Statutes; an entity under part II or part III of chapter 641, chapter 627, chapter 636, or s. 409.912, Florida Statutes; a licensed mental health provider under chapter 394, Florida Statutes; a licensed substance abuse provider under chapter 397, Florida Statutes; a certified administrator under chapter 626, Florida Statutes; or a hospital under chapter 395, Florida Statutes, certified by the agency to operate as a managed care plan; a local government provider of services to the elderly under chapter 410 or chapter 430, Florida Statutes; a provider of developmental disabilities services under chapter 393, Florida Statutes; the Children's Medical Services network under chapter 391, Florida Statutes; a network of licensed health care providers under a board of county commissioners; or a certified state contractor approved by the agency.

(e) "Plan benefits" means the mandatory services specified in s. 409.905, Florida Statutes; behavioral health services specified in s. 409.906(8), Florida Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk adjusted capitation rate. Optional benefits may include any supplemental coverage offered to attract recipients and provide needed care. Mandatory and

optional services may vary in amount, duration, and scope. In all instances, the agency shall ensure that plan benefits include those services that are medically necessary, based on historical Medicaid utilization.

(f) "Provider service network" means a network established or organized and operated by a health care provider, or a group of affiliated health care providers, that provides a substantial proportion of the health care items and services under a contract directly through the provider or an affiliated group of providers and that 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 or other health care professionals or through the institutions. The health care providers shall have a controlling interest in the governing body of the provider service network organization, as authorized by s. 409.912, Florida Statutes.

(5) PLANS.--

(a) The agency shall develop a capitated system of care that promotes choice and competition.

(b) Plan benefits shall include the mandatory services specified in s. 409.905, Florida Statutes; behavioral health services specified in s. 409.906(8), Florida Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk-adjusted capitation rate. Optional

benefits may include any supplemental coverage offered to attract recipients and provide needed care.

(6) CERTIFICATION.--Before any entity may operate a managed care plan under the waiver, it shall obtain a certificate of operation from the agency.

(a) Any entity operating under part I of chapter 641, Florida Statutes, shall be in compliance with that part in order to obtain a certificate.

(b) Any entity in operation must be in compliance with the requirements and standards developed by the agency. The agency, in consultation with the Office of Insurance Regulation, shall establish certification requirements. Any pilot or demonstration project authorized by the state under this section must include any federally qualified health center that serves the geographic area within the boundaries of that pilot or demonstration project. The certification process shall, at a minimum, take into account the following requirements:

1. The entity has sufficient financial solvency to be placed at risk for the basic plan benefits under ss. 409.905, 409.906(8), and 409.906(20), Florida Statutes, and other covered services.

2. The entity has sufficient service network capacity to meet the need of members under ss. 409.905, 409.906(8), and 409.906(20), Florida Statutes, and other covered services.

3. The entity's primary care providers are geographically accessible to the recipient.

4. The entity has the capacity to provide a wellness or disease management program.

5. The entity shall provide for ambulance service in accordance with ss. 409.908(13)(d) and 409.9128, Florida Statutes.

6. The entity has the infrastructure to manage financial transactions, recordkeeping, data collection, and other administrative functions.

7. The entity, if not a fully indemnified insurance program under chapter 624, chapter 627, chapter 636, or chapter 641, Florida Statues, meets the financial solvency requirements specified in chapter 624, Florida Statutes, as determined by the agency in consultation with the Office of Insurance Regulation.

(c) The agency may contract with administrators to provide plan benefits to recipients using the Medicaid fee-for-service system, the MediPass system, or a network of providers approved by the agency.

1. The agency may develop administrative rates that encourage quality management of benefits.

2. All groups served under contracts with administrators shall be covered by sufficient stop-loss coverage as defined in s. 627.6482, Florida Statutes, to provide recipients with catastrophic coverage as required by this section.

(d) The agency may contract with administrators licensed under s. 626.88, Florida Statutes, to provide enhanced benefits to recipients.

(e) The agency has the authority to contract with entities not otherwise licensed as an insurer or risk-bearing entity under chapter 627 or chapter 641, Florida Statutes, as long as

these entities meet standards defined by the agency to qualify as state certified contractors.

(f) Each entity certified by the agency shall submit to the agency any financial, programmatic, encounter data, or other information required by the agency to determine the actual services provided and cost of administering the plan.

(7) COST SHARING.--

(a) For recipients enrolled in a Medicaid managed care plan, the agency may continue cost-sharing requirements as currently defined in s. 409.9081, Florida Statutes, or as approved under a waiver granted from the federal Centers for Medicare and Medicaid Services. Such approved cost-sharing requirements may include provisions requiring recipients to pay:

1. An enrollment fee;

2. A deductible;

3. Coinsurance or a portion of the plan premium; or

4. Progressively higher percentages of the cost of the medical assistance by families with higher levels of income.

(b) For recipients who opt out of Medicaid, cost sharing shall be governed by the policy of the plan in which the individual enrolls.

(c) If the private insurance or employer-sponsored coverage requires that the cost-sharing provisions imposed under paragraph (a) include requirements that recipients pay a portion of the plan premium, the agency shall specify the manner in which the premium is paid. The agency may require that the premium be paid to the agency, an organization operating part of the medical assistance program, or the managed care plan.

(d) Cost-sharing provisions adopted under this section may be determined based on the maximum level authorized under an approved federal waiver.

(8) MEDIPASS.--The MediPass program shall be continued and improved until such time that the pilot or demonstration waiver proves that the Medicaid reform works statewide in both urban and rural counties.

(9) ENCOUNTER DATA SYSTEM.--The agency shall develop an encounter data reporting system and ensure that the data reported is accurate and complete. All providers and plans are required to report to the agency encounter data that includes the diagnosis, services received by recipients, and other information as required by the agency.

(10) ACCOUNTABILITY.--In performing the duties under this section, the agency shall adopt standards for measuring performance and meeting federally required audit standards and require plans to submit data necessary for monitoring performance and ensuring accountability according to these standards. The standards shall consider clinical and functional health outcomes, consumer satisfaction, access to primary care and preventive services, and other critical elements of plan performance identified by the agency including, but not limited to:

(a) Health Plan Employer Data and Information Set.

(b) Member satisfaction.

(c) Provider satisfaction.

(d) Report cards on plan performance and best practices.

(e) Quarterly reports in compliance with the prompt pay

requirements in ss. 627.623 and 641.3155, Florida Statutes.

(11) QUALITY ASSURANCE.--The agency shall require the plans certified by the agency to establish a quality assurance system incorporating the provisions of s. 409.912(27), Florida Statutes, and any standards, rules, and guidelines developed by the agency. The agency shall establish standards for plan compliance including, but not limited to, quality assurance and performance improvement standards, peer or professional review standards, grievance policies, and program integrity policies.

(12) QUALITY IMPROVEMENT.--The agency shall require the plans certified by the agency to establish a quality improvement system to improve the quality and effectiveness of care by identifying causes of system of care problems and improving health outcomes.

(13) STATUTORY COMPLIANCE.--Any entity certified under this section shall comply with ss. 641.3155 and 641.513, Florida Statutes.

(14) CATASTROPHIC COVERAGE.--

(a) The agency may establish a fund for purposes of covering services under catastrophic coverage. The catastrophic coverage fund shall provide for payment of medically necessary care for recipients who are enrolled in a plan that is not responsible for catastrophic care and whose care has exceeded a predetermined monetary threshold. The agency may establish an aggregate maximum level of coverage in the catastrophic fund.

(b) The agency shall develop policies and procedures to allow a plan to utilize the catastrophic coverage for a Medicaid recipient in the plan who has reached the catastrophic coverage

threshold.

(c) A recipient participating in a plan may be included in catastrophic coverage at a cost threshold determined by the agency based on actuarial analysis.

(d) If a plan does not cover the catastrophic component, placement of the recipient in the catastrophic coverage shall not release the plan from providing other plan benefits or from the case management of the recipient's care, except when the agency determines it is in the best interest of the recipient to release the managed care plan from these obligations.

(e) The agency shall establish or contract for an administrative structure to manage the catastrophic coverage function.

(15) RATE SETTING AND RISK ADJUSTMENT.--The agency may develop a rate setting and risk adjustment system to include:

(a) Rate setting and risk adjustment mechanisms that may be based on:

1. A clinical diagnostic classification system that is established in consultation with plans, providers, and the federal Centers for Medicare and Medicaid Services.

2. Categorical groups that have separate risks or capitation rates based on actuarially sound methodologies.

3. Funding established by the General Appropriations Act as well as eligibility group, geography, gender, age, and health status.

4. Minimum premium plans as defined in s. 627.6482, Florida Statutes.

(b) Any such rate setting and risk adjustment systems

shall include:

1. Criteria to adjust risk.

2. Validation of the rates and risk adjustments.

3. Minimum medical loss ratios which must be determined by an actuarial study. Medical loss ratios are subject to an annual audit. Failure to comply with the minimum medical loss ratios shall be grounds for fines, reductions in capitated payments in the current fiscal year, or contract termination.

(c) Rates shall be established in consultation with an actuary and the federal Centers for Medicare and Medicaid Services and supported by actuarial analysis.

(16) APPLICABILITY OF OTHER LAW.--The Legislature authorizes the Agency for Health Care Administration to apply and enforce any provision of law not referenced in this section to ensure the safety, quality, and integrity of the waiver.

(17) RULEMAKING.--The Agency for Health Care Administration is authorized to adopt rules to implement the provisions of this section.

(18) IMPLEMENTATION.--Upon approval of a waiver by the Centers for Medicare and Medicaid Services, the Agency for Health Care Administration shall report the provisions and structure of the approved waiver and any deviations from this section to the Legislature. The agency shall implement the waiver after authority to implement the waiver is granted by the Legislature.

(19) REVIEW AND REPEAL.--This section shall stand repealed on July 1, 2010, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. Paragraph (d) of subsection (4) of section 409.912, Florida Statutes, is amended 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 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 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 is authorized to seek federal waivers necessary to implement this policy.

(4) The agency may contract with:

(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 meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. ~~The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care.~~ Medicaid

recipients assigned to a demonstration project 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, regardless of any contractual provisions to the contrary.

Section 3. This act shall take effect July 1, 2005.