By Senator Bennett

21-1520-07

A bill to be entitled

An act relating to managed health care entities; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to contract with certified health maintenance organizations if the health maintenance organizations meet certain requirements; providing that provider service networks not operated by a hospital are not exempt from certain financial requirements; requiring such provider service networks to comply with certain financial requirements before a specified date; requiring minority physician networks to comply by a specified date with certain financial requirements based upon when each network was approved for designation or expansion; restricting the agency's ability to contract with certain managed care plans under certain conditions; defining the terms "mandatory Medicaid managed care enrollment," "managed care plan," and "assignment"; providing certain limitations regarding contracts with managed care plans for assignments of Medicaid recipients; amending s. 409.91211, F.S.; requiring certain provider service networks to meet certain financial requirements based upon when the network was approved by the agency for designation; amending s. 641.225, F.S.; requiring health maintenance organizations to maintain a specified minimum surplus; amending s.

641.2261, F.S.; requiring Medicaid provider service networks to meet certain solvency requirements based upon certain criteria; providing an effective date.

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

Section 1. Subsection (3), paragraph (d) of subsection (4), and paragraph (a) of subsection (49) of section 409.912, Florida Statutes, are amended, and subsection (53) is added to that section, 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.

(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients <u>if, for all applications approved after July 1, 2007, the health maintenance organization has demonstrated to the agency that it has a successful record of providing comprehensive health insurance coverage in this state for at least 3 years and has successfully contracted with this state or another state to provide comprehensive Medicaid services on a prepaid capitated basis for at least 3 years, or has successful experience providing comprehensive prepaid services in any state for a state child health insurance program or Medicare members for at least 3 years</u>.

(4) The agency may contract with:

(d) A provider service network<u>, which</u> may be reimbursed on a fee-for-service or prepaid basis. A provider service network <u>that</u> ~~which~~ is reimbursed by the agency on a

prepaid basis is ~~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, except that provider service networks not operated by a hospital which have been approved for such status after July 1, 2007, are not exempt from the surplus and other financial requirements of part I of chapter 641. Provider service networks not operated by a hospital which were approved on or before July 1, 2007, shall be required by the agency to comply with the surplus and other financial requirements of part I of chapter 641 before July 1, 2010. 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 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. 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.

(49) The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules. The agency shall further require that each minority physician network that has been approved for designation or expansion after July 1, 2007, meet the requirements of part I of chapter 641 as a condition of such designation or expansion. Minority physician networks that were approved on or before July 1, 2007, shall be required by the agency to comply with the surplus and other financial requirements of part I of chapter 641 before July 1, 2010.

(53)(a) The agency may not enter into a contract with a managed care plan that is eligible to receive an assignment of Medicaid recipients which is to be effective in any county if such contract would cause the county to contain fewer than

35,000 recipients subject to mandatory Medicaid managed care enrollment per each managed care plan eligible to receive an assignment of Medicaid recipients residing in the county. For purposes of this subsection, the term "mandatory Medicaid managed care enrollment" has the same meaning as in s. 409.9122, and the terms "managed care plan" and "assignment" have the same meaning as in s. 409.9122(2)(f), except that, for purposes of this subsection, the term "managed care plan" does not include a Children's Medical Services Network that is contracted under paragraph (4)(i) or an entity that is contracted to provide integrated long-term care services under subsection (5).

(b) A contract in effect before July 1, 2007, is not rendered invalid by paragraph (a) and may be renewed notwithstanding paragraph (a). However, paragraph (a) applies if such contract terminates or lapses after July 1, 2007.

(c) Paragraph (a) does not apply in a county that does not contain managed care plans that are eligible to receive an assignment of Medicaid recipients residing in the county.

Section 2. Paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(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 over a 3-year period. 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 shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall be converted to a risk-adjusted capitated rate no later than the beginning of the fourth year of operation, and may be converted earlier at the option of the provider service network. For a provider service network not operated by a hospital which is approved by the agency for designation after July 1, 2007, the applicant shall meet the initial surplus and other financial requirements of chapter 641. Provider service networks not operated by a hospital which were approved on or before July 1, 2007, shall be required by the agency to comply with the surplus and other financial requirements of part I of chapter 641 before July 1, 2010. 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 3. Subsections (1), (2), and (6) of section 641.225, Florida Statutes, are amended to read:

641.225 Surplus requirements.--

(1)(a) Until July 1, 2010, each health maintenance organization receiving a certificate of authority on or before July 1, 2007, shall at all times maintain a minimum surplus in an amount that is the greater of$1.5 million~~$1,500,000~~, ~~or~~ 10 percent of total liabilities, or 2 percent of total annualized premium.

(b) After June 30, 2010, each health maintenance organization receiving a certificate of authority on or before July 1, 2007, shall at all times maintain a minimum surplus in the amount of $5 million, 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greater.

(c) Each health maintenance organization receiving a certificate of authority after July 1, 2007, shall at all times maintain a minimum surplus in the amount of $5 million, 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greater.

(2) The office shall not issue a certificate of authority, except as provided in subsection (3), unless the health maintenance organization has a minimum surplus in an amount that ~~which~~ is the greater of:

(a) Ten percent of their total liabilities based on their startup projection as set forth in this part;

(b) Two percent of their total projected premiums based on their startup projection as set forth in this part; or

(c) Five million dollars~~$1,500,000~~, plus all startup losses, excluding profits, projected to be incurred on their startup projection until the projection reflects statutory net profits for 12 consecutive months.

(6) In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the health maintenance organization, provided that the written guarantee is made by a guaranteeing organization which:

(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of the greater of$5 million~~$2 million~~ or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply,

except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. If the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations.

(b) Submits a guarantee that is approved by the office as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless the guaranteeing organization can demonstrate to the office that the cancellation of the guarantee will not result in the insolvency of the health maintenance organization and the office approves cancellation of the guarantee.

(c) Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.

(d) Submits annually, within 3 months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles. The office may, as it deems necessary, require quarterly financial statements from the guaranteeing organization.

Section 4. Subsection (2) of section 641.2261, Florida Statutes, is amended to read:

641.2261 Application of solvency requirements to provider-sponsored organizations and Medicaid provider service networks.--

(2) The solvency requirements of this part ~~in 42 C.F.R. s. 422.350, subpart H, and the solvency requirements established in approved federal waivers pursuant to chapter 409~~ apply to a Medicaid provider service network not operated by a hospital licensed under chapter 395 if the network was approved for designation as a provider service network under chapter 409 after July 1, 2007. The solvency requirements of this part must be applied on or before July 1, 2010, to provider service networks not operated by a hospital which were approved for designation on or before July 1, 2007. If at any time the solvency requirements of subpart H of 42 C.F.R. 422.350 and the solvency requirements established in approved federal waivers under chapter 409 exceed the requirements of this part, the federal requirements apply to provider service networks not operated by a hospital licensed under chapter 395. The solvency requirements of subpart H of 42 C.F.R. 422.350 and the solvency requirements established in approved federal waivers under chapter 409, rather than the solvency requirements of this part, apply to a Medicaid provider service network operated by a hospital licensed under chapter 395. ~~rather than the solvency requirements of this part.~~

Section 5. This act shall take effect upon becoming a law.

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SENATE SUMMARY

Authorizes the Agency for Health Care Administration to contract with certain health maintenance organizations if the health maintenance organizations meet certain requirements. Provides that certain provider service networks are not exempt from certain financial requirements. Requires such provider service networks to comply with certain financial requirements before a specified date. Requires minority physician networks to comply by a specified date with certain financial requirements based upon certain factors. Restricts the agency's ability to contract with certain managed care plans under certain conditions. Requires certain provider service networks to meet certain financial requirements based upon specific criteria. Requires health maintenance organizations to maintain a specified minimum surplus. Requires Medicaid provider service networks to meet certain solvency requirements based upon certain criteria.