By Senator Peaden

2-1705A-07

A bill to be entitled

An act relating to health care; amending s. 409.912, F.S.; authorizing the Agency for Health Care Administration to implement an integrated, fixed-payment delivery system for certain Medicaid recipients; providing that enrollment in areas within which a pilot program is conducted is voluntary; authorizing the agency to implement federal waivers without prior authorization from the Legislature; providing an effective date.

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

Section 1. Subsection (5) 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 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.

(5) By December 1, 2005, the Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older. The Agency for Health Care Administration shall implement the integrated system initially on a pilot basis in two areas of the state. ~~In one of the areas~~ Enrollment <u>in the pilot areas</u> shall be on a voluntary basis. The program must transfer all Medicaid services for eligible elderly individuals who choose to participate into an integrated-care management model designed to serve Medicaid recipients in the community. The program must combine all funding for Medicaid

services provided to individuals 60 years of age or older into the integrated system, including funds for Medicaid home and community-based waiver services; all Medicaid services authorized in ss. 409.905 and 409.906, excluding funds for Medicaid nursing home services unless the agency is able to demonstrate how the integration of the funds will improve coordinated care for these services in a less costly manner; and Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).

(a) Individuals who are 60 years of age or older and enrolled in the developmental disabilities waiver program, the family and supported-living waiver program, the project AIDS care waiver program, the traumatic brain injury and spinal cord injury waiver program, the consumer-directed care waiver program, and the program of all-inclusive care for the elderly program, and residents of institutional care facilities for the developmentally disabled, must be excluded from the integrated system.

(b) The program must use a competitive procurement process to select entities to operate the integrated system. Entities eligible to submit bids include managed care organizations licensed under chapter 641, including entities eligible to participate in the nursing home diversion program, other qualified providers as defined in s. 430.703(7), community care for the elderly lead agencies, and other state-certified community service networks that meet comparable standards as defined by the agency, in consultation with the Department of Elderly Affairs and the Office of Insurance Regulation, to be financially solvent and able to take on financial risk for managed care. Community service

networks that are certified pursuant to the comparable standards defined by the agency are not required to be licensed under chapter 641.

(c) The agency must ensure that the capitation-rate-setting methodology for the integrated system is actuarially sound and reflects the intent to provide quality care in the least restrictive setting. The agency must also require integrated-system providers to develop a credentialing system for service providers and to contract with all Gold Seal nursing homes, where feasible, and exclude, where feasible, chronically poor-performing facilities and providers as defined by the agency. The integrated system must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 400 or chapter 429 at the time the integrated system is initiated, the recipient must be permitted to continue to reside in the noncontracted facility as long as the recipient desires. The integrated system must also provide that, in the absence of a contract between the integrated-system provider and the residential facility licensed under chapter 400 or chapter 429, current Medicaid rates must prevail. The agency and the Department of Elderly Affairs must jointly develop procedures to manage the services provided through the integrated system in order to ensure quality and recipient choice.

(d) Within 24 months after implementation, the Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the pilot project for the integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older. The evaluation must include assessments of cost savings; consumer education, choice, and access to services;

coordination of care; and quality of care. The evaluation must describe administrative or legal barriers to the implementation and operation of the pilot program and include recommendations regarding statewide expansion of the pilot program. The office shall submit an evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2008.

(e) The agency may seek federal waivers and adopt rules as necessary to administer the integrated system. The agency may implement the approved federal waivers and other provisions as specified in this section. ~~The agency must receive specific authorization from the Legislature prior to implementing the waiver for the integrated system.~~

Section 2. This act shall take effect upon becoming a law.

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SENATE SUMMARY

Authorizes the Agency for Health Care Administration to implement an integrated, fixed-payment delivery system for certain Medicaid recipients. Provides that enrollment in certain pilot areas is voluntary. Authorizes the agency to implement federal waivers without authorization from the Legislature.