A bill to be entitled

An act relating to a model fixed-payment service delivery system for people with developmental disabilities; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to implement federal waivers to administer a model fixed-payment service delivery system for Medicaid recipients with developmental disabilities; providing legislative intent; providing for implementation of the system on a pilot basis in certain areas of the state; providing for administration of the system by the Agency for Persons with Disabilities; providing requirements for selection of entities to operate the system; providing for mandatory enrollment in system pilot areas; requiring an evaluation of the system; requiring the agency to submit a report to the Governor and Legislature; authorizing the agency to seek certain waivers and adopt rules; requiring the agency to receive specific authorization prior to expanding the system; providing an effective date.

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

Section 1. Subsection (53) 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. 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.

(53) By December 1, 2007, the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, shall create a model fixed-payment service delivery system for persons with developmental disabilities who receive services under the developmental disabilities waiver program administered by the Agency for Persons with Disabilities. Persons with developmental disabilities who receive services under the family and supported living waiver program or the consumer-directed care plus waiver program administered by the Agency for Persons with Disabilities may also be included in the system if the agency determines that such inclusion is feasible and will improve coordination of care and management of costs. The system must transfer and combine all services funded by Medicaid waiver programs and services funded only by the state, including room and board and supported living payments, for individuals who participate in the system.

(a) The Legislature intends that the system provide recipients in Medicaid waiver programs with a coordinated system of services, increased cost predictability, and a stabilized rate of increase in Medicaid expenditures compared to Medicaid expenditures in the pilot areas specified in paragraph (b) for the 3 years before the system was implemented while ensuring:

1. Consumer choice.

2. Opportunities for consumer-directed services.

3. Access to medically necessary services.

4. Coordination of community-based services.

5. Reductions in the unnecessary use of services.

(b) The agency shall implement the system on a pilot basis in Area 1 of the Agency for Persons with Disabilities and in another area that is determined by the agency, in consultation with the Agency for Persons with Disabilities, to be an appropriate pilot site. After completion of the development phase of the system, attainment of necessary federal approval, procurement of qualified entities, and rate setting, the agency shall delegate administration of the system to the Agency for Persons with Disabilities. The Agency for Persons with Disabilities shall administer contracts with qualified entities and provide quality assurance, monitoring oversight, and other duties necessary for the system. The enrollment of Medicaid waiver recipients in the system in pilot areas shall be mandatory.

(c) The agency shall use a competitive procurement process to select entities to operate the system. Entities eligible to submit bids include community service networks that meet standards of financial solvency, as defined and determined by the agency in consultation with the Agency for Persons with Disabilities and the Office of Insurance Regulation, and that are able to take on financial risk for managed care. The agency shall ensure that bid requirements for entities include, but are not limited to, standards related to:

1. Fiscal solvency.

2. Quality of care.

3. Adequacy of access to provider services.

4. Specific requirements of the Medicaid program designed to meet the needs of the Medicaid recipients.

5. The network's infrastructure capacity to manage financial transactions, recordkeeping, data collection, and other administrative functions.

6. The network's ability to submit any financial, programmatic, or recipient encounter data or other information required by the agency to determine the actual services provided and the cost of administering the plan.

(d) When the agency implements the system in an area of the state, the agency shall endeavor to provide recipients enrolled in the system with a choice of plans from qualified entities. The agency shall ensure that an entity operating a system, in addition to other requirements:

1. Identifies the needs of the recipients using a standardized assessment process approved by the agency.

2. Allows a recipient to select any provider that has a contract with the entity, provided that the service offered by the provider is appropriate to meet the needs of the recipient.

3. Makes a good faith effort to develop contracts with qualified providers currently under contract with the Agency for Persons with Disabilities.

4. Develops and uses a service provider qualification system approved by the agency that describes the quality of care standards that providers of services to persons with developmental disabilities must meet in order to obtain a contract with the plan entity.

5. Excludes, when feasible, chronically poor-performing facilities and providers as determined by the agency.

6. Demonstrates a quality assurance system and a performance improvement system that are satisfactory to the agency.

(e) The agency must ensure that the capitation-rate-setting methodology for the system is actuarially sound and reflects the intent to provide quality care in the least restrictive setting. The agency may choose to limit financial risk for entities operating the system to cover high-cost recipients or to address the catastrophic care needs of recipients enrolled in the system.

(f) The system must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 393 or chapter 429 at the time of enrollment in the system, the recipient must be permitted to continue to reside in the noncontracted facility. The system must also provide that, in the absence of a contract between the system provider and the residential facility licensed under chapter 393 or chapter 429, the current Medicaid waiver rates must prevail.

(g) Within 24 months after implementation, the agency shall contract for a comprehensive evaluation of the system. The evaluation must include assessments of cost savings, cost-effectiveness, recipient outcomes, consumer choice, 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 system and include recommendations regarding statewide expansion of the system. The

agency shall submit its evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2010.

(h) The agency may seek federal waivers or Medicaid state plan amendments and adopt rules as necessary to administer the system on a pilot basis. The agency must receive specific authorization from the Legislature prior to expanding beyond the pilot areas designated for the implementation of the system.

Section 2. This act shall take effect July 1, 2007.