1 A bill to be entitled
2 An act relating to Medicaid managed care programs;
3 amending s. 409.9122, F.S.; revising criteria that the
4 Agency for Health Care Administration is required to
5 consider when assigning a Medicaid recipient to a managed
6 care plan or MediPass provider; requiring the agency to
7 consider a managed care plan's performance and compliance
8 with network adequacy requirements and whether it meets
9 certain needs; requiring the agency to establish, monitor,
10 and evaluate network adequacy standards for managed care
11 plans; expanding the basis for such standards to include
12 patient access standards for specialty care providers and
13 network adequacy standards established by contract, rule,
14 and statute; requiring the agency to encourage the
15 development of public and private partnerships to foster
16 the growth of managed care plans rather than health
17 maintenance organizations; authorizing the agency to enter
18 into contracts with traditional providers of health care
19 to low-income persons subject to a specific appropriation;
20 requiring managed care plans and MediPass providers to
21 demonstrate and document plans to ensure that Medicaid
22 recipients receive health care service in a timely manner;
23 authorizing the agency to extend eligibility for Medicaid
24 recipients enrolled in contracted managed care plans
25 rather than health maintenance organizations; requiring
26 the agency to verify patient load certifications if the
27 agency determines that access to primary care is being
28 compromised; defining the term "Medicaid rate" or

29 "Medicaid reimbursement rate"; requiring the agency to
30 include exemption payments and low-income pool payments in
31 its calculation of the hospital inpatient component of a
32 Medicaid health maintenance organization's capitation
33 rate; amending s. 409.9124, F.S.; conforming provisions
34 regarding managed care reimbursement to changes made by
35 the act; amending s. 409.9128, F.S.; prohibiting a managed
36 care plan or MediPass provider from withholding payment
37 for emergency services and care; providing an effective
38 date.
39
40 Be It Enacted by the Legislature of the State of Florida:
41
42 Section 1. Paragraphs (f) and (k) of subsection (2),
43 paragraph (a) of subsection (3), subsection (8), paragraph (c)
44 of subsection (9), and subsections (11), (12), and (14) of
45 section 409.9122, Florida Statutes, as amended by chapter 2007-
46 331, Laws of Florida, are amended to read:
47 409.9122 Mandatory Medicaid managed care enrollment;
48 programs and procedures.--
49 (2)
50 (f) When a Medicaid recipient does not choose a managed
51 care plan or MediPass provider, the agency shall assign the
52 Medicaid recipient to a managed care plan or MediPass provider.
53 Medicaid recipients who are subject to mandatory assignment but
54 who fail to make a choice shall be assigned to managed care
55 plans until an enrollment of 35 percent in MediPass and 65
56 percent in managed care plans, of all those eligible to choose

57 managed care, is achieved. Once this enrollment is achieved, the
58 assignments shall be divided in order to maintain an enrollment
59 in MediPass and managed care plans which is in a 35 percent and
60 65 percent proportion, respectively. Thereafter, assignment of
61 Medicaid recipients who fail to make a choice shall be based
62 proportionally on the preferences of recipients who have made a
63 choice in the previous period. Such proportions shall be revised
64 at least quarterly to reflect an update of the preferences of
65 Medicaid recipients. The agency shall disproportionately assign
66 Medicaid-eligible recipients who are required to but have failed
67 to make a choice of managed care plan or MediPass, including
68 children, and who are to be assigned to the MediPass program to
69 children's networks as described in s. 409.912(4)(g), Children's
70 Medical Services Network as defined in s. 391.021, exclusive
71 provider organizations, provider service networks, minority
72 physician networks, and pediatric emergency department diversion
73 programs authorized by this chapter or the General
74 Appropriations Act, in such manner as the agency deems
75 appropriate, until the agency has determined that the networks
76 and programs have sufficient numbers to be economically
77 operated. For purposes of this paragraph, when referring to
78 assignment, the term "managed care plans" includes health
79 maintenance organizations, exclusive provider organizations,
80 provider service networks, minority physician networks,
81 Children's Medical Services Network, and pediatric emergency
82 department diversion programs authorized by this chapter or the
83 General Appropriations Act. When making assignments, the agency
84 shall take into account the following criteria:

85 1. A managed care plan maintains ~~has~~ sufficient network
86 capacity to meet the need of members.
87 2. The managed care plan or MediPass has previously
88 enrolled the recipient as a member, or one of the managed care
89 plan's primary care providers or MediPass providers has
90 previously provided health care to the recipient.
91 3. The agency has knowledge that the member has previously
92 expressed a preference for a particular managed care plan or
93 MediPass provider as indicated by Medicaid fee-for-service
94 claims data, but has failed to make a choice.
95 4. The managed care plan's or MediPass primary care
96 providers are geographically accessible to the recipient's
97 residence.
98 5. The managed care plan's performance and compliance with
99 the network adequacy requirements, which the agency shall
100 validate annually.
101 (k) When a Medicaid recipient does not choose a managed
102 care plan or MediPass provider, the agency shall assign the
103 Medicaid recipient to a managed care plan, except in those
104 counties in which there are fewer than two managed care plans
105 accepting Medicaid enrollees, in which case assignment shall be
106 to a managed care plan or a MediPass provider. Medicaid
107 recipients in counties with fewer than two managed care plans
108 accepting Medicaid enrollees who are subject to mandatory
109 assignment but who fail to make a choice shall be assigned to
110 managed care plans until an enrollment of 35 percent in MediPass
111 and 65 percent in managed care plans, of all those eligible to
112 choose managed care, is achieved. Once that enrollment is

113 achieved, the assignments shall be divided in order to maintain
114 an enrollment in MediPass and managed care plans which is in a
115 35 percent and 65 percent proportion, respectively. For purposes
116 of this paragraph, when referring to assignment, the term
117 "managed care plans" includes exclusive provider organizations,
118 provider service networks, Children's Medical Services Network,
119 minority physician networks, and pediatric emergency department
120 diversion programs authorized by this chapter or the General
121 Appropriations Act. When making assignments, the agency shall
122 take into account the following criteria:

123 1. A managed care plan has sufficient network capacity to
124 meet the urgent, emergency, acute, and chronic needs ~~need~~ of its
125 members and has consistently maintained compliance with the
126 network adequacy requirements over the previous 12-month period.

127 2. The managed care plan or MediPass has previously
128 enrolled the recipient as a member, or one of the managed care
129 plan's primary care providers or MediPass providers has
130 previously provided health care to the recipient.

131 3. The agency has knowledge that the member has previously
132 expressed a preference for a particular managed care plan or
133 MediPass provider as indicated by Medicaid fee-for-service
134 claims data, but has failed to make a choice.

135 4. The managed care plan's or MediPass primary care
136 providers are geographically accessible to the recipient's
137 residence.

138 5. The agency shall ~~has authority to~~ make mandatory
139 assignments based on quality of service and performance of
140 managed care plans.

141 (3)(a) The agency shall establish quality-of-care and
142 network adequacy standards for managed care plans, which the
143 agency shall monitor quarterly and evaluate annually. These
144 standards shall be based upon, but are not limited to:
145 1. Compliance with the accreditation requirements as
146 provided in s. 641.512.
147 2. Compliance with Early and Periodic Screening,
148 Diagnosis, and Treatment screening requirements.
149 3. The percentage of voluntary disenrollments.
150 4. Immunization rates.
151 5. Standards of the National Committee for Quality
152 Assurance and other approved accrediting bodies.
153 6. Recommendations of other authoritative bodies.
154 7. Specific requirements of the Medicaid program and
155 network adequacy, or standards designed to specifically meet
156 assist the unique needs of Medicaid recipients, including
157 patient access standards for specialty care providers.
158 8. Compliance with the health quality improvement system
159 as established by the agency, which incorporates standards and
160 guidelines developed by the Medicaid Bureau of the Health Care
161 Financing Administration as part of the quality assurance reform
162 initiative.
163 9. Network adequacy as established by contract, rule, and
164 statute for urgent, emergency, acute, and chronic care.
165 (8)(a) The agency shall encourage the development of
166 public and private partnerships to foster the growth of managed
167 care plans health maintenance organizations and prepaid health

CODING: Words stricken are deletions; words underlined are additions.

168 plans that will provide high-quality health care to Medicaid
169 recipients.
170 (b) Subject to <u>a specific appropriation</u> ~~the availability~~
171 ~~of moneys~~ and any limitations established by the General
172 Appropriations Act ~~or chapter 216~~, the agency is authorized to
173 enter into contracts with traditional providers of health care
174 to low-income persons to assist such providers with the
175 technical aspects of cooperatively developing Medicaid prepaid
176 health plans.
177 1. The agency may contract with disproportionate share
178 hospitals, county health departments, federally initiated or
179 federally funded community health centers, and counties that
180 operate either a hospital or a community clinic.
181 2. A contract may not be for more than $100,000 per year,
182 and no contract may be extended with any particular provider for
183 more than 2 years. The contract is intended only as seed or
184 development funding and requires a commitment from the
185 interested party.
186 3. A contract must require participation by at least one
187 community health clinic and one disproportionate share hospital.
188 (9)
189 (c) The agency shall require managed care plans and
190 MediPass providers to demonstrate and document plans and
191 activities, as defined by rule, including outreach and followup,
192 undertaken to ensure that Medicaid recipients receive the health
193 care service to which they are entitled <u>in a timely manner</u>.
194 (11) The agency may extend eligibility for Medicaid
195 recipients enrolled in <u>contracted managed care plans</u> ~~licensed~~

196 ~~and accredited health maintenance organizations~~ for the duration
197 of the enrollment period or for 6 months, whichever is earlier,
198 provided the agency certifies that such an offer will not
199 increase state expenditures.
200 (12) A managed care plan that has a Medicaid contract
201 shall at least annually review each primary care physician's
202 active patient load and shall ensure that additional Medicaid
203 recipients are not assigned to physicians who have a total
204 active patient load of more than 3,000 patients. As used in this
205 subsection, the term "active patient" means a patient who is
206 seen by the same primary care physician, or by a physician
207 assistant or advanced registered nurse practitioner under the
208 supervision of the primary care physician, at least three times
209 within a calendar year. Each primary care physician shall
210 annually certify to the managed care plan whether or not his or
211 her patient load exceeds the limits established under this
212 subsection and the managed care plan shall accept such
213 certification on face value as compliance with this subsection.
214 The agency shall accept the managed care plan's representations
215 that it is in compliance with this subsection based on the
216 certification of its primary care physicians, unless the agency
217 has an objective indication that access to primary care is being
218 compromised, such as failure to maintain network adequacy or
219 receiving complaints or grievances relating to access to care.
220 If the agency determines that an objective indication exists
221 that access to primary care is being compromised, it shall ~~may~~
222 verify the patient load certifications submitted by the managed
223 care plan's primary care physicians and that the managed care

224 plan is not assigning Medicaid recipients to primary care
225 physicians who have an active patient load of more than 3,000
226 patients.
227 (14) As used in this section and ss. 409.912(19),
228 409.9128(5)(d), and 641.513(6)(d), the term "Medicaid rate" or
229 "Medicaid reimbursement rate" is equivalent to the amount paid
230 directly to a hospital by the agency for providing inpatient or
231 outpatient services to a Medicaid recipient on a fee-for-service
232 basis. The agency shall include in its calculation of the
233 hospital inpatient component of a Medicaid health maintenance
234 organization's capitation rate any special payments, including,
235 but not limited to, upper payment limit, exemption payments,
236 low-income pool payments, or disproportionate share hospital
237 payments~~,~~ made to qualifying hospitals through the fee-for-
238 service program. The agency may seek federal waiver approval or
239 state plan amendments ~~amendment~~ as needed to implement this
240 adjustment.
241 Section 2. Subsection (6) of section 409.9124, Florida
242 Statutes, is amended to read:
243 409.9124 Managed care reimbursement.--The agency shall
244 develop and adopt by rule a methodology for reimbursing managed
245 care plans.
246 (6) As used in this section and ss. 409.912(19),
247 409.9128(5)(d), and 641.513(6)(d), the term "Medicaid rate" or
248 "Medicaid reimbursement rate" is equivalent to the amount paid
249 directly to a hospital by the agency for providing inpatient or
250 outpatient services to a Medicaid recipient on a fee-for-service
251 basis. The agency shall include in its calculation of the

252 hospital inpatient component of a Medicaid health maintenance
253 organization's capitation rate any special payments, including,
254 but not limited to, upper payment limit, exemption payments,
255 low-income pool payments, or disproportionate share hospital
256 payments, made to qualifying hospitals through the fee-for-
257 service program. The agency may seek federal waiver approval or
258 state plan amendments as needed to implement this adjustment.
259 ~~For the 2005-2006 fiscal year only, the agency shall make an~~
260 ~~additional adjustment in calculating the capitation payments to~~
261 ~~prepaid health plans, excluding prepaid mental health plans.~~
262 ~~This adjustment must result in an increase of 2.8 percent in the~~
263 ~~average per member, per month rate paid to prepaid health plans,~~
264 ~~excluding prepaid mental health plans, which are funded from~~
265 ~~Specific Appropriations 225 and 226 in the 2005-2006 General~~
266 ~~Appropriations Act.~~
267 Section 3. Paragraph (d) of subsection (1), paragraph (b)
268 of subsection (3), and subsection (5) of section 409.9128,
269 Florida Statutes, are amended to read:
270 409.9128 Requirements for providing emergency services and
271 care.--
272 (1) In providing for emergency services and care as a
273 covered service, neither a managed care plan nor the MediPass
274 program may:
275 (d) Deny or withhold payment based on the enrollee's or
276 the hospital's failure to notify the managed care plan or
277 MediPass primary care provider in advance or within a certain
278 period of time after the care is given.
279 (3)

280 (b) If a determination has been made that an emergency
281 medical condition exists and the enrollee has notified the
282 hospital, or the hospital emergency personnel otherwise has
283 knowledge that the patient is an enrollee of the managed care
284 plan or the MediPass program, the hospital must make a
285 reasonable attempt to notify the enrollee's primary care
286 physician, if known, or the managed care plan, if the managed
287 care plan had previously requested in writing that the
288 notification be made directly to the managed care plan, of the
289 existence of the emergency medical condition. If the primary
290 care physician is not known, or has not been contacted, the
291 hospital must:
292 1. Notify the managed care plan or the MediPass provider
293 as soon as possible prior to discharge of the enrollee from the
294 emergency care area; or
295 2. Notify the managed care plan or the MediPass provider
296 within 24 hours or on the next business day after admission of
297 the enrollee as an inpatient to the hospital.
298
299 If notification required by this paragraph is not accomplished,
300 the hospital must document its attempts to notify the managed
301 care plan or the MediPass provider or the circumstances that
302 precluded attempts to notify the managed care plan or the
303 MediPass provider. Neither a managed care plan nor the Medicaid
304 program on behalf of MediPass patients may deny or withhold
305 payment for emergency services and care based on a hospital's
306 failure to comply with the notification requirements of this
307 paragraph.

308 (5) Reimbursement for services provided to an enrollee of
309 a managed care plan under this section by a provider who does
310 not have a contract with the managed care plan shall be the
311 lesser of:
312 (a) The provider's billed charges;
313 (b) The usual and customary provider charges for similar
314 services in the community where the services were provided;
315 (c) The charge mutually agreed to by the entity and the
316 provider within 60 days after submittal of the claim; or
317 (d) The Medicaid rate defined as equivalent to the amount
318 paid directly to a hospital by the agency for providing
319 inpatient and outpatient services to a Medicaid recipient on a
320 fee-for-service basis.
321 Section 4. This act shall take effect July 1, 2008.