1 A bill to be entitled
2 An act relating to Medicaid recipients with psychiatric
3 disabilities ; amending s. 409.912, F.S.; authorizing the
4 Agency for Health Care Administration to contract with
5 certain service networks that enroll Medicaid recipients
6 with psychiatric disabilities; providing for recipients
7 with psychiatric disabilities to be assigned to a
8 specified service network under certain circumstances;
9 amending s. 409.91211, F.S.; revising duties of the agency
10 to include contracting with provider service networks
11 specializing in care for Medicaid recipients with
12 psychiatric disabilities; revising criteria for assignment
13 of certain Medicaid recipients; providing an effective
14 date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Paragraph (d) of subsection (4) of section
19 409.912, Florida Statutes, is amended to read:
20 409.912 Cost-effective purchasing of health care.--The
21 agency shall purchase goods and services for Medicaid recipients
22 in the most cost-effective manner consistent with the delivery
23 of quality medical care. To ensure that medical services are
24 effectively utilized, the agency may, in any case, require a
25 confirmation or second physician's opinion of the correct
26 diagnosis for purposes of authorizing future services under the
27 Medicaid program. This section does not restrict access to
28 emergency services or poststabilization care services as defined

29 in 42 C.F.R. part 438.114. Such confirmation or second opinion
30 shall be rendered in a manner approved by the agency. The agency
31 shall maximize the use of prepaid per capita and prepaid
32 aggregate fixed-sum basis services when appropriate and other
33 alternative service delivery and reimbursement methodologies,
34 including competitive bidding pursuant to s. 287.057, designed
35 to facilitate the cost-effective purchase of a case-managed
36 continuum of care. The agency shall also require providers to
37 minimize the exposure of recipients to the need for acute
38 inpatient, custodial, and other institutional care and the
39 inappropriate or unnecessary use of high-cost services. The
40 agency shall contract with a vendor to monitor and evaluate the
41 clinical practice patterns of providers in order to identify
42 trends that are outside the normal practice patterns of a
43 provider's professional peers or the national guidelines of a
44 provider's professional association. The vendor must be able to
45 provide information and counseling to a provider whose practice
46 patterns are outside the norms, in consultation with the agency,
47 to improve patient care and reduce inappropriate utilization.
48 The agency may mandate prior authorization, drug therapy
49 management, or disease management participation for certain
50 populations of Medicaid beneficiaries, certain drug classes, or
51 particular drugs to prevent fraud, abuse, overuse, and possible
52 dangerous drug interactions. The Pharmaceutical and Therapeutics
53 Committee shall make recommendations to the agency on drugs for
54 which prior authorization is required. The agency shall inform
55 the Pharmaceutical and Therapeutics Committee of its decisions
56 regarding drugs subject to prior authorization. The agency is

57 authorized to limit the entities it contracts with or enrolls as
58 Medicaid providers by developing a provider network through
59 provider credentialing. The agency may competitively bid single-
60 source-provider contracts if procurement of goods or services
61 results in demonstrated cost savings to the state without
62 limiting access to care. The agency may limit its network based
63 on the assessment of beneficiary access to care, provider
64 availability, provider quality standards, time and distance
65 standards for access to care, the cultural competence of the
66 provider network, demographic characteristics of Medicaid
67 beneficiaries, practice and provider-to-beneficiary standards,
68 appointment wait times, beneficiary use of services, provider
69 turnover, provider profiling, provider licensure history,
70 previous program integrity investigations and findings, peer
71 review, provider Medicaid policy and billing compliance records,
72 clinical and medical record audits, and other factors. Providers
73 shall not be entitled to enrollment in the Medicaid provider
74 network. The agency shall determine instances in which allowing
75 Medicaid beneficiaries to purchase durable medical equipment and
76 other goods is less expensive to the Medicaid program than long-
77 term rental of the equipment or goods. The agency may establish
78 rules to facilitate purchases in lieu of long-term rentals in
79 order to protect against fraud and abuse in the Medicaid program
80 as defined in s. 409.913. The agency may seek federal waivers
81 necessary to administer these policies.
82 (4) The agency may contract with:
83 (d) A provider service network, which may be reimbursed on
84 a fee-for-service or prepaid basis. A provider service network

85 which is reimbursed by the agency on a prepaid basis shall be
86 exempt from parts I and III of chapter 641, but must comply with
87 the solvency requirements in s. 641.2261(2) and meet appropriate
88 financial reserve, quality assurance, and patient rights
89 requirements as established by the agency. The agency is
90 authorized to contract with specialty provider service networks
91 that exclusively enroll Medicaid recipients with psychiatric
92 disabilities.
93 1. Except as provided in subparagraph 2., Medicaid
94 recipients assigned to a provider service network shall be
95 chosen equally from those who would otherwise have been assigned
96 to prepaid plans and MediPass. The agency is authorized to seek
97 federal Medicaid waivers as necessary to implement the
98 provisions of this section. Any contract previously awarded to a
99 provider service network operated by a hospital pursuant to this
100 subsection shall remain in effect for a period of 3 years
101 following the current contract expiration date, regardless of
102 any contractual provisions to the contrary. A provider service
103 network is a network established or organized and operated by a
104 health care provider, or group of affiliated health care
105 providers, including minority physician networks and emergency
106 room diversion programs that meet the requirements of s.
107 409.91211, which provides a substantial proportion of the health
108 care items and services under a contract directly through the
109 provider or affiliated group of providers and may make
110 arrangements with physicians or other health care professionals,
111 health care institutions, or any combination of such individuals
112 or institutions to assume all or part of the financial risk on a

113 prospective basis for the provision of basic health services by
114 the physicians, by other health professionals, or through the
115 institutions. The health care providers must have a controlling
116 interest in the governing body of the provider service network
117 organization.
118 2. A Medicaid recipient with psychiatric disabilities who
119 fails to select a managed care plan shall be assigned to a
120 provider service network that exclusively enrolls Medicaid
121 recipients with psychiatric disabilities, if such program is
122 available in the geographic area where the recipient resides.
123 Section 2. Paragraph (a) of subsection (4) of section
124 409.91211, Florida Statutes, is amended, and paragraph (ee) is
125 added to subsection (3) of that section, to read:
126 409.91211 Medicaid managed care pilot program.--
127 (3) The agency shall have the following powers, duties,
128 and responsibilities with respect to the pilot program:
129 (ee) To seek applications for and contract with provider
130 service networks specializing in care for recipients with
131 psychiatric disabilities. The agency shall develop and implement
132 a definition of psychiatric disabilities for membership and
133 assignment purposes and establish assignment processes for
134 recipients with psychiatric disabilities who fail to choose a
135 managed care plan.
136 (4)(a) A Medicaid recipient in the pilot area who is not
137 currently enrolled in a capitated managed care plan upon
138 implementation is not eligible for services as specified in ss.
139 409.905 and 409.906, for the amount of time that the recipient
140 does not enroll in a capitated managed care network. If a

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

141 Medicaid recipient has not enrolled in a capitated managed care
142 plan within 30 days after eligibility, the agency shall assign
143 the Medicaid recipient to a capitated managed care plan based on
144 the assessed needs of the recipient as determined by the agency
145 and the recipient shall be exempt from s. 409.9122. When making
146 assignments, the agency shall take into account the following
147 criteria:
148 1. A capitated managed care network has sufficient network
149 capacity to meet the needs of members.
150 2. The capitated managed care network has previously
151 enrolled the recipient as a member, or one of the capitated
152 managed care network's primary care providers has previously
153 provided health care to the recipient.
154 3. The agency has knowledge that the member has previously
155 expressed a preference for a particular capitated managed care
156 network as indicated by Medicaid fee-for-service claims data,
157 but has failed to make a choice.
158 4. The capitated managed care network's primary care
159 providers are geographically accessible to the recipient's
160 residence.
161 5. The existence of any known diagnoses or disabilities,
162 including psychiatric disabilities.
163 Section 3. This act shall take effect July 1, 2008.