CHAMBER ACTION

Senate House

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1 Representative Adkins offered the following:

2

3 **Amendment**

4 Remove lines 1275-1552 and insert:

5 treatment and not in excess of the patient's needs, except for
6 services provided under s. 394.4574(2)(c) and (3). The agency
7 shall conduct reviews of provider exceptions to peer group norms
8 and shall, using statistical methodologies, provider profiling,
9 and analysis of billing patterns, detect and investigate
10 abnormal or unusual increases in billing or payment of claims
11 for Medicaid services and medically unnecessary provision of
12 services. Providers that demonstrate a pattern of submitting
13 claims for medically unnecessary services shall be referred to
14 the Medicaid program integrity unit for investigation. In its
15 annual report, required in s. 409.913, the agency shall report
16 on its efforts to control overutilization as described in this

17 paragraph.
18 (b) The agency shall develop a procedure for determining
19 whether health care providers and service vendors can provide
20 the Medicaid program using a business case that demonstrates
21 whether a particular good or service can offset the cost of
22 providing the good or service in an alternative setting or
23 through other means and therefore should receive a higher
24 reimbursement. The business case must include, but need not be
25 limited to:
26 1. A detailed description of the good or service to be
27 provided, a description and analysis of the agency's current
28 performance of the service, and a rationale documenting how
29 providing the service in an alternative setting would be in the
30 best interest of the state, the agency, and its clients.
31 2. A cost-benefit analysis documenting the estimated
32 specific direct and indirect costs, savings, performance
33 improvements, risks, and qualitative and quantitative benefits
34 involved in or resulting from providing the service. The cost-
35 benefit analysis must include a detailed plan and timeline
36 identifying all actions that must be implemented to realize
37 expected benefits. The Secretary of Health Care Administration
38 shall verify that all costs, savings, and benefits are valid and
39 achievable.
40 (c) If the agency determines that the increased
41 reimbursement is cost-effective, the agency shall recommend a
42 change in the reimbursement schedule for that particular good or
43 service. If, within 12 months after implementing any rate change
44 under this procedure, the agency determines that costs were not

45 offset by the increased reimbursement schedule, the agency may
46 revert to the former reimbursement schedule for the particular
47 good or service.

48 (17) An entity contracting on a prepaid or fixed-sum basis
49 shall meet the~~, in addition to meeting any applicable statutory~~
50 surplus requirements of s. 641.225~~, also maintain at all times~~
51 ~~in the form of cash, investments that mature in less than 180~~
52 ~~days allowable as admitted assets by the Office of Insurance~~
53 ~~Regulation, and restricted funds or deposits controlled by the~~
54 ~~agency or the Office of Insurance Regulation, a surplus amount~~
55 ~~equal to one-and-one-half times the entity's monthly Medicaid~~
56 ~~prepaid revenues~~. ~~As used in this subsection, the term "surplus"~~
57 ~~means the entity's total assets minus total liabilities.~~ If an
58 entity's surplus falls below an amount equal to the surplus
59 requirements of s. 641.225 ~~one-and-one-half times the entity's~~
60 ~~monthly Medicaid prepaid revenues~~, the agency shall prohibit the
61 entity from engaging in marketing and preenrollment activities,
62 shall cease to process new enrollments, and may ~~shall~~ not renew
63 the entity's contract until the required balance is achieved.
64 The requirements of this subsection do not apply:

65 (a) Where a public entity agrees to fund any deficit
66 incurred by the contracting entity; or

67 (b) Where the entity's performance and obligations are
68 guaranteed in writing by a guaranteeing organization which:

69 1. Has been in operation for at least 5 years and has
70 assets in excess of $50 million; or

71 2. Submits a written guarantee acceptable to the agency
72 which is irrevocable during the term of the contracting entity's

73 contract with the agency and, upon termination of the contract,
74 until the agency receives proof of satisfaction of all
75 outstanding obligations incurred under the contract.
76 Section 17. Section 409.91207, Florida Statutes, is
77 created to read:
78 409.91207 Medical Home Pilot Project.--
79 (1) The agency shall develop a plan to implement a medical
80 home pilot project that utilizes primary care case management
81 enhanced by medical home networks to provide coordinated and
82 cost-effective care that is reimbursed on a fee-for-service
83 basis and to compare the performance of the medical home
84 networks with other existing Medicaid managed care models. The
85 agency is authorized to seek a federal Medicaid waiver or an
86 amendment to any existing Medicaid waiver, except for the
87 current 1115 Medicaid waiver authorized in s. 409.91211, as
88 needed, to develop the pilot project created in this section but
89 must obtain approval of the Legislature prior to implementing
90 the pilot project.
91 (2) Each medical home network shall:
92 (a) Provide Medicaid recipients primary care, coordinated
93 services to control chronic illness, pharmacy services,
94 specialty physician services, and hospital outpatient and
95 inpatient services.
96 (b) Coordinate with other health care providers, as
97 necessary, to ensure that Medicaid recipients receive efficient
98 and effective access to other needed medical services,
99 consistent with the scope of services provided to Medipass
100 recipients.

101 (c) Consist of primary care physicians, federally
102 qualified health centers, clinics affiliated with Florida
103 medical schools or teaching hospitals, programs serving children
104 with special health care needs, medical school faculty,
105 statutory teaching hospitals, and other hospitals that agree to
106 participate in the network. A managed care organization is
107 eligible to be designated as a medical home network if it
108 documents policies and procedures consistent with subsection
109 (3).
110 (3) The medical home pilot project developed by the agency
111 must be designed to modify the processes and patterns of health
112 care service delivery in the Medicaid program by requiring a
113 medical home network to:
114 (a) Assign a personal medical provider to lead an
115 interdisciplinary team of professionals who share the
116 responsibility for ongoing care to a specific panel of patients.
117 (b) Require the personal medical provider to identify the
118 patient's health care needs and respond to those needs either
119 directly or through arrangements with other qualified providers.
120 (c) Coordinate or integrate care across all parts of the
121 health care delivery system.
122 (d) Integrate information technology into the health care
123 delivery system to enhance clinical performance and monitor
124 patient outcomes.
125 (4) The agency shall have the following duties, and
126 responsibilities with respect to the development of the medical
127 home pilot project:
128 (a) To develop and recommend a medical home pilot project

129 in at least two geographic regions in the state that will
130 facilitate access to specialty services in the state's medical
131 schools and teaching hospitals.
132 (b) To develop and recommend funding strategies that
133 maximize available state and federal funds, including:
134 1. Enhanced primary care case management fees to
135 participating federally qualified health centers and primary
136 care clinics owned or operated by a medical school or teaching
137 hospital.
138 2. Enhanced payments to participating medical schools
139 through the supplemental physician payment program using
140 certified funds.
141 3. Reimbursement for facility costs, in addition to
142 medical services, for participating outpatient primary or
143 specialty clinics.
144 4. Supplemental Medicaid payments through the low-income
145 pool and exempt fee-for-service rates for participating
146 hospitals.
147 5. Enhanced capitation rates for managed care
148 organizations designated as medical home networks to reflect
149 enhanced fee-for-service payments to medical home network
150 providers.
151 (c) To develop and recommend criteria to designate medical
152 home networks as eligible to participate in the pilot program
153 and recommend incentives for medical home networks to
154 participate in the medical home pilot project, including bonus
155 payments and shared saving arrangements.
156 (d) To develop a comprehensive fiscal estimate of the

157 medical home pilot project that includes, but is not limited to,
158 anticipated savings to the Medicaid program and any anticipated
159 administrative costs.
160 (e) To develop and recommend which medical services the
161 medical home network would be responsible for providing to
162 enrolled Medicaid recipients.
163 (f) To develop and recommend methodologies to measure the
164 performance of the medical home pilot project including patient
165 outcomes, cost-effectiveness, provider participation, recipient
166 satisfaction, and accountability to ensure the quality of the
167 medical care provided to Medicaid recipients enrolled in the
168 pilot.
169 (g) To recommend policies and procedures for the medical
170 home pilot project administration including, but not limited to:
171 an implementation timeline, the Medicaid recipient enrollment
172 process, recruitment and enrollment of Medicaid providers, and
173 the reimbursement methodologies for participating Medicaid
174 providers.
175 (h) To determine and recommend methods to evaluate the
176 medical home pilot project including but not limited to the
177 comparison of the Medicaid fee-for service system, Medipass
178 system, and other Medicaid managed care programs.
179 (i) To develop and recommend standards and designation
180 requirements for a medical home network that include, but are
181 not limited to: medical care provided by the network, referral
182 arrangements, medical record requirements, health information
183 technology standards, follow-up care processes, and data
184 collection requirements.

185 (5) The Secretary of Health Care Administration shall
186 appoint a task force by August 1, 2009, to assist the agency in
187 the development and implementation of the medical home pilot
188 project. The task force must include, but is not limited to,
189 representatives of providers who could potentially participate
190 in a medical home network, Medicaid recipients, and existing
191 Medipass and managed care providers. Members of the task force
192 shall serve without compensation but are entitled to
193 reimbursement for per diem and travel expenses as provided in s.
194 112.061.
195 (6) The agency shall submit an implementation plan for the
196 medical home pilot project authorized in this section to the
197 Speaker of the House of Representatives, the President of the
198 Senate, and the Governor by February 1, 2010. The implementation
199 plan must include any approved waivers, waiver applications, or
200 state plan amendments necessary to implement the medical home
201 pilot project.
202 (a) The agency shall post any waiver applications, or
203 waiver amendments, authorized under this section on its Internet
204 website 15 days before submitting the applications to the United
205 States Centers for Medicare and Medicaid Services.
206 (b) The implementation of the medical home pilot project,
207 including any Medicaid waivers authorized in this section, is
208 contingent upon review and approval by the Legislature.
209 (c) Upon legislative approval to implement the medical
210 home pilot project, the agency may initiate the adoption of
211 administrative rules to implement and administer the medical
212 home pilot project created in this section.

213 Section 18. Subsections (2), (7), (11), (13), (14), (15),
214 (24), (25), (27), (30), (31), and (36) of section 409.913,
215 Florida Statutes, are amended, and subsections (37) and (38) are
216 added to that section, to read:
217 409.913 Oversight of the integrity of the Medicaid
218 program.--The agency shall operate a program to oversee the
219 activities of Florida Medicaid recipients, and providers and
220 their representatives, to ensure that fraudulent and abusive
221 behavior and neglect of recipients occur to the minimum extent
222 possible, and to recover overpayments and impose sanctions as
223 appropriate. Beginning January 1, 2003, and each year
224 thereafter, the agency and the Medicaid Fraud Control Unit of
225 the Department of Legal Affairs shall submit a joint report to
226 the Legislature documenting the effectiveness of the state's
227 efforts to control Medicaid fraud and abuse and to recover
228 Medicaid overpayments during the previous fiscal year. The
229 report must describe the number of cases opened and investigated
230 each year; the sources of the cases opened; the disposition of
231 the cases closed each year; the amount of overpayments alleged
232 in preliminary and final audit letters; the number and amount of
233 fines or penalties imposed; any reductions in overpayment
234 amounts negotiated in settlement agreements or by other means;
235 the amount of final agency determinations of overpayments; the
236 amount deducted from federal claiming as a result of
237 overpayments; the amount of overpayments recovered each year;
238 the amount of cost of investigation recovered each year; the
239 average length of time to collect from the time the case was
240 opened until the overpayment is paid in full; the amount

241 determined as uncollectible and the portion of the uncollectible
242 amount subsequently reclaimed from the Federal Government; the
243 number of providers, by type, that are terminated from
244 participation in the Medicaid program as a result of fraud and
245 abuse; and all costs associated with discovering and prosecuting
246 cases of Medicaid overpayments and making recoveries in such
247 cases. The report must also document actions taken to prevent
248 overpayments and the number of providers prevented from
249 enrolling in or reenrolling in the Medicaid program as a result
250 of documented Medicaid fraud and abuse and must include policy
251 recommendations ~~recommend changes~~ necessary to prevent or
252 recover overpayments and changes necessary to prevent and detect
253 Medicaid fraud. All policy recommendations in the report must
254 include a detailed fiscal analysis, including, but not limited
255 to, implementation costs, estimated savings to the Medicaid
256 program, and the return on investment. The agency must submit
257 the policy recommendations and fiscal analyses in the report to
258 the appropriate estimating conference, pursuant to s. 216.137,
259 by February 15 of each year. The agency and the Medicaid Fraud
260 Control Unit of the Department of Legal Affairs each must
261 include detailed unit-specific performance standards,
262 benchmarks, and metrics in the report, including projected cost
263 savings to the state Medicaid program during the following
264 fiscal year.
265 (2) The agency shall conduct, or cause to be conducted by
266 contract or otherwise, reviews, investigations, analyses,
267 audits, or any combination thereof, to determine possible fraud,
268 abuse, overpayment, or recipient neglect in the Medicaid program

269 and shall report the findings of any overpayments in audit
270 reports as appropriate. At least 5 percent of all audits shall
271 be conducted on a random basis. As part of its ongoing fraud
272 detection activities, the agency shall identify and monitor, by
273 contract or otherwise, patterns of overutilization of Medicaid
274 services based on state averages. The agency shall track
275 Medicaid provider prescription and billing patterns and evaluate
276 them against Medicaid medical necessity criteria and coverage
277 and limitation guidelines adopted by rule. Medical necessity
278 determination requires that service be consistent with symptoms
279 or confirmed diagnosis of illness or injury under treatment and
280 not in excess of the patient's needs. The agency shall conduct
281 reviews of provider exceptions to peer group norms and shall,
282 using statistical methodologies, provider profiling, and
283 analysis of billing patterns, detect and investigate abnormal or
284 unusual increases in billing or payment of claims for Medicaid
285 services and medically unnecessary provision of services, except
286 for services provided under s. 394.4574(2)(c) and (3).