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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/19/2010	.	
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The Committee on Health and Human Services Appropriations (Sobel) recommended the following:

Senate Amendment (with title amendment)

Between lines 811 and 812
insert:

Section 3. Subsection (54) 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.

(54)(a) Beginning January 1, 2011, all new and renewing


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agency contracts with managed care plans shall require that a plan may make a substantial change in operation only during an annual 30-day change period. The agency shall attempt to stagger the change periods of managed care plans uniformly throughout the year.

(b) For purposes of this section, the term "substantial change in operation" means a cessation of operation in or withdrawal from any county or market, plan merger or acquisition, or voluntary action or inaction by the managed care plan that directly or indirectly results in a reduction in plan enrollment of more than 5 percent in any county or market.

(c) A managed care plan that intends to make a substantial change in operation must notify the state at least 120 days before the start of its annual change period as well as develop and implement an individualized transition plan for each enrollee that will be impacted by such change.

(d) A managed care plan that makes a substantial change in operation that does not comply with the requirements of this subsection shall incur a fine or a financial penalty equal to any profit or surplus earned by the plan for the next full calendar quarter following the effective date of the change, whichever is greater.

Section 4. Paragraph (a) of subsection (1) and subsection (5) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

(1)(a) The agency is authorized to seek and implement experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service


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delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One demonstration site shall include only Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. The agency shall implement expansion of the program to include the remaining counties of the state and remaining eligibility groups in accordance with the process specified in the federally approved special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services on October 19, 2005, with a goal of full statewide implementation by June 30, 2011. The agency is authorized to seek amendments to the waiver. By December 31, 2010, the agency shall submit to the Centers for Medicare and Medicaid Services a request for modifications to the special terms and conditions. The requested modifications shall be based on changes that have occurred in the initial waiver assumptions, available evaluation results, and input collected from stakeholders using a public process. Modifications shall be drafted and submitted so as to avoid any risk of disruption to the low-income pool.

(5) This section does not authorize the agency, unless expressly approved by the Legislature:

(a) To implement any provision of s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program in any part of the state other than the ~~two~~ geographic areas specified in this

section ~~unless approved by the Legislature~~;

(b) To require participation in any experimental, pilot, or demonstration project waiver of the state Medicaid program by any recipient who is not a member of an enrollment group for which participation was mandatory as of January 1, 2010; or

(c) To modify any medical sufficiency standard used in plan benefit design.

Section 5. Paragraph (m) is added to subsection (2) of section 409.9122, Florida Statutes, to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(2)

(m)1. Time allotted pursuant to this subsection to any Medicaid recipient for the selection of, enrollment in, or disenrollment from a managed care plan or MediPass shall be tolled throughout any month in which the enrollment broker or choice counseling provider, whichever is applicable, is subject to corrective action or termination for failure to comply with the terms and conditions of its contract with the agency, or has otherwise acted or failed to act in a manner that the agency deems likely to jeopardize its ability to perform its assigned responsibilities as set forth in paragraphs (c) and (d).

2. During any month in which time is tolled for a recipient, he or she must be afforded uninterrupted access to benefits and services identical to those available prior to such tolling.

3. The agency shall incorporate into all pertinent contracts that are executed or renewed on or after July 1, 2010, provisions authorizing and requiring the agency to recoup costs

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incurred pursuant to this paragraph which result from any action or failure to act on the part of the enrollment broker or choice counselor.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 29

and insert:

certain information on its website; amending s. 409.912, F.S.; requiring each new or renewing contract between the Agency for Health Care Administration and a managed care plan to provide that the managed care plan may make a substantial change in the operation of the managed care plan only during the annual 30-day change period; defining the term "substantial change in operation"; requiring a managed care plan that intends to make a substantial change in its operation to notify the state at least 120 days before the start of its annual change period; requiring each managed care plan to develop and implement an individualized transition plan for each affected enrollee; providing that a managed care plan that makes a substantial change in operation without complying with such requirements shall incur a fine or a financial penalty; amending s. 409.91211, F.S.; requiring the agency to submit to the Centers for Medicare and Medicaid Services a request to modify the special

terms and conditions of the present demonstration projects; limiting the authority of the agency to participate in certain specified activities unless expressly approved by the Legislature; amending s. 409.9122, F.S.; providing that time is tolled for a Medicaid recipient throughout any month in which the enrollment broker is subject to corrective action or termination for failure to comply with the terms and conditions of its contract with the agency; authorizing and requiring the agency to recoup costs that result from any action or failure to act on the part of the enrollment broker or choice counselor; providing an