1 A bill to be entitled
2 An act relating to the nursing home diversion program;
3 amending s. 409.912, F.S.; directing the Agency for Health
4 Care Administration to expand the nursing home diversion
5 program to include Medicaid recipients who meet certain
6 criteria; specifying locations for phased-in
7 implementation of the program; revising conditions for
8 enrollment in the program; providing for Medicaid
9 recipient choice with regard to contractors; requiring the
10 nursing home diversion contractor to provide an enrollee
11 with information regarding alternative service providers;
12 requiring certain enrollees to participate in the program;
13 requiring the program to combine funding for Medicaid
14 services provided to specified individuals; removing an
15 exception; excluding specified individuals from
16 participation in the program; revising provisions relating
17 to entities eligible to participate in the program;
18 requiring the Department of Elderly Affairs and the agency
19 to seek federal waivers to limit the number of nursing
20 home diversion contractors in additional locations;
21 directing the agency to impose certain requirements on
22 contractors in the program; requiring the Office of
23 Program Policy Analysis and Government Accountability, in
24 consultation with the Auditor General, to evaluate the
25 nursing home diversion contractors in the program;
26 removing an obsolete provision relating to an
27 appropriation for implementation of a pilot program;

28 amending s. 408.040, F.S.; removing a reporting
29 requirement, to conform; providing an effective date.
30
31 Be It Enacted by the Legislature of the State of Florida:
32
33 Section 1. Subsection (5) of section 409.912, Florida
34 Statutes, is amended to read:
35 409.912 Cost-effective purchasing of health care.—The
36 agency shall purchase goods and services for Medicaid recipients
37 in the most cost-effective manner consistent with the delivery
38 of quality medical care. To ensure that medical services are
39 effectively utilized, the agency may, in any case, require a
40 confirmation or second physician's opinion of the correct
41 diagnosis for purposes of authorizing future services under the
42 Medicaid program. This section does not restrict access to
43 emergency services or poststabilization care services as defined
44 in 42 C.F.R. part 438.114. Such confirmation or second opinion
45 shall be rendered in a manner approved by the agency. The agency
46 shall maximize the use of prepaid per capita and prepaid
47 aggregate fixed-sum basis services when appropriate and other
48 alternative service delivery and reimbursement methodologies,
49 including competitive bidding pursuant to s. 287.057, designed
50 to facilitate the cost-effective purchase of a case-managed
51 continuum of care. The agency shall also require providers to
52 minimize the exposure of recipients to the need for acute
53 inpatient, custodial, and other institutional care and the
54 inappropriate or unnecessary use of high-cost services. The
55 agency shall contract with a vendor to monitor and evaluate the

56 clinical practice patterns of providers in order to identify
57 trends that are outside the normal practice patterns of a
58 provider's professional peers or the national guidelines of a
59 provider's professional association. The vendor must be able to
60 provide information and counseling to a provider whose practice
61 patterns are outside the norms, in consultation with the agency,
62 to improve patient care and reduce inappropriate utilization.
63 The agency may mandate prior authorization, drug therapy
64 management, or disease management participation for certain
65 populations of Medicaid beneficiaries, certain drug classes, or
66 particular drugs to prevent fraud, abuse, overuse, and possible
67 dangerous drug interactions. The Pharmaceutical and Therapeutics
68 Committee shall make recommendations to the agency on drugs for
69 which prior authorization is required. The agency shall inform
70 the Pharmaceutical and Therapeutics Committee of its decisions
71 regarding drugs subject to prior authorization. The agency is
72 authorized to limit the entities it contracts with or enrolls as
73 Medicaid providers by developing a provider network through
74 provider credentialing. The agency may competitively bid single-
75 source-provider contracts if procurement of goods or services
76 results in demonstrated cost savings to the state without
77 limiting access to care. The agency may limit its network based
78 on the assessment of beneficiary access to care, provider
79 availability, provider quality standards, time and distance
80 standards for access to care, the cultural competence of the
81 provider network, demographic characteristics of Medicaid
82 beneficiaries, practice and provider-to-beneficiary standards,
83 appointment wait times, beneficiary use of services, provider

84 turnover, provider profiling, provider licensure history,
85 previous program integrity investigations and findings, peer
86 review, provider Medicaid policy and billing compliance records,
87 clinical and medical record audits, and other factors. Providers
88 shall not be entitled to enrollment in the Medicaid provider
89 network. The agency shall determine instances in which allowing
90 Medicaid beneficiaries to purchase durable medical equipment and
91 other goods is less expensive to the Medicaid program than long-
92 term rental of the equipment or goods. The agency may establish
93 rules to facilitate purchases in lieu of long-term rentals in
94 order to protect against fraud and abuse in the Medicaid program
95 as defined in s. 409.913. The agency may seek federal waivers
96 necessary to administer these policies.
97 (5) The Agency for Health Care Administration, in
98 partnership with the Department of Elderly Affairs, shall expand
99 the nursing home diversion program into ~~create~~ an integrated,
100 fixed-payment delivery program for all Medicaid recipients who
101 meet nursing home admission criteria and are 60 years of age or
102 older and ~~or~~ dually eligible for Medicare and Medicaid. The
103 Agency for Health Care Administration shall implement the
104 integrated program initially in ~~on a pilot basis in two~~ Areas 5,
105 6, and 7 ~~of the state~~. The program shall be implemented in Areas
106 8, 9, 10, and 11 in 2013 and in Areas 1, 2, 3, and 4 in 2014.
107 All Medicaid recipients shall be given a choice of nursing home
108 diversion contractors in each area. In order to ensure enrollee
109 choice, when an enrollee is determined to be likely to require
110 the level of care provided in a hospital or nursing home, the
111 enrollee shall be informed by the nursing home diversion

112 contractor of any feasible alternatives available and given the
113 choice of either institutional or home and community-based
114 services ~~pilot areas shall be Area 7 and Area 11 of the Agency~~
115 ~~for Health Care Administration~~. Enrollment ~~in the pilot areas~~
116 shall be ~~on a voluntary basis and~~ in accordance with approved
117 federal waivers and this section. ~~The agency and its program~~
118 ~~contractors and providers shall not enroll any individual in the~~
119 ~~integrated program because the individual or the person legally~~
120 ~~responsible for the individual fails to choose to enroll in the~~
121 ~~integrated program. Enrollment in the integrated program shall~~
122 ~~be exclusively by affirmative choice of the eligible individual~~
123 ~~or by the person legally responsible for the individual. The~~
124 ~~integrated program must transfer all Medicaid services for~~
125 ~~eligible elderly individuals who choose to participate into an~~
126 ~~integrated-care management model designed to serve Medicaid~~
127 ~~recipients in the community.~~ The integrated program must combine
128 all funding for Medicaid services provided to individuals who
129 are 60 years of age or older and ~~or~~ dually eligible for Medicare
130 and Medicaid into the integrated program, including funds for
131 Medicaid home and community-based waiver services; all Medicaid
132 services authorized in ss. 409.905 and 409.906, including
133 ~~excluding~~ funds for Medicaid nursing home services ~~unless the~~
134 ~~agency is able to demonstrate how the integration of the funds~~
135 ~~will improve coordinated care for these services in a less~~
136 ~~costly manner~~; and Medicare coinsurance and deductibles for
137 persons dually eligible for Medicaid and Medicare as prescribed
138 in s. 409.908(13).
139 (a) Individuals who are 60 years of age or older, ~~or~~

140 dually eligible for Medicare and Medicaid, and enrolled in the
141 developmental disabilities waiver program, the family and
142 supported-living waiver program, the project AIDS care waiver
143 program, the traumatic brain injury and spinal cord injury
144 waiver program, the consumer-directed care waiver program, and
145 the program of all-inclusive care for the elderly program, and
146 residents of institutional care facilities for the
147 developmentally disabled, must be excluded from the integrated
148 program.
149 (b) Managed care entities who meet or exceed the agency's
150 minimum standards are eligible to operate the integrated
151 program. Entities eligible to participate include managed care
152 organizations licensed under chapter 641, including entities
153 eligible to participate in the nursing home diversion program
154 contractors, other qualified providers as defined in s.
155 430.703(6) and (7). The Department of Elderly Affairs and the
156 agency shall comply with s. 430.705(3) prior to approval of any
157 additional contractors, community care for the elderly lead
158 agencies, and other state-certified community service networks
159 that meet comparable standards as defined by the agency, in
160 consultation with the Department of Elderly Affairs and the
161 Office of Insurance Regulation, to be financially solvent and
162 able to take on financial risk for managed care. Community
163 service networks that are certified pursuant to the comparable
164 standards defined by the agency are not required to be licensed
165 under chapter 641. Managed care entities who operate the
166 integrated program shall be subject to s. 408.7056. Eligible
167 entities shall choose to serve enrollees who are dually eligible

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

168 ~~for Medicare and Medicaid, enrollees who are 60 years of age or~~
169 ~~older, or both.~~
170 (c) The agency must ensure that the capitation-rate-
171 setting methodology for the integrated program is actuarially
172 sound and reflects the intent to provide quality care in the
173 least restrictive setting. The agency must also require nursing
174 home diversion contractors ~~integrated-program providers~~ to
175 develop a credentialing system for service providers and to
176 contract with all Gold Seal nursing homes, where feasible, and
177 exclude, where feasible, chronically poor-performing facilities
178 and providers as defined by the agency. The integrated program
179 must develop and maintain an informal provider grievance system
180 that addresses provider payment and contract problems. The
181 agency shall also establish a formal grievance system to address
182 those issues that were not resolved through the informal
183 grievance system. The integrated program must provide that if
184 the recipient resides in a noncontracted residential facility
185 licensed under chapter 400 or chapter 429 at the time of
186 enrollment in the integrated program and the recipient's needs
187 cannot be met in a less restrictive environment, the recipient
188 must be permitted to continue to reside in the noncontracted
189 facility as long as the recipient desires. The integrated
190 program must also provide that, in the absence of a contract
191 between the nursing home diversion contractor ~~integrated-program~~
192 ~~provider~~ and the residential facility licensed under chapter 400
193 or chapter 429, current Medicaid rates must prevail. The nursing
194 home diversion contractor ~~integrated-program provider~~ must
195 ensure that electronic nursing home claims that contain

196 sufficient information for processing are paid within 10
197 business days after receipt. Alternately, the <u>nursing home</u>
198 <u>diversion contractor</u> ~~integrated-program provider~~ may establish a
199 capitated payment mechanism to prospectively pay nursing homes
200 at the beginning of each month. The agency and the Department of
201 Elderly Affairs must jointly develop procedures to manage the
202 services provided through the integrated program in order to
203 ensure quality and recipient choice.
204 (d) The Office of Program Policy Analysis and Government
205 Accountability, in consultation with the Auditor General, shall
206 comprehensively evaluate ~~the pilot project for~~ the integrated,
207 fixed-payment delivery program for Medicaid recipients created
208 under this subsection. The evaluation shall begin as soon as
209 Medicaid recipients are enrolled in the managed care ~~pilot~~
210 program plans and shall continue for 24 months thereafter. The
211 evaluation must include assessments of each <u>nursing home</u>
212 <u>diversion contractor</u> ~~managed care plan~~ in the integrated program
213 with regard to cost savings; consumer education, choice, and
214 access to services; coordination of care; and quality of care.
215 The evaluation must describe administrative or legal barriers to
216 the implementation and operation of the ~~pilot~~ program ~~and~~
217 ~~include recommendations regarding statewide expansion of the~~
218 ~~pilot program~~. The office shall submit its evaluation report to
219 the Governor, the President of the Senate, and the Speaker of
220 the House of Representatives no later than December 31, <u>2014</u>
221 ~~2009~~.
222 (e) The agency may seek federal waivers or Medicaid state
223 plan amendments and adopt rules as necessary to administer the

224 integrated program. The agency may implement the approved
225 federal waivers and other provisions as specified in this
226 subsection.
227 ~~(f) The implementation of the integrated, fixed-payment~~
228 ~~delivery program created under this subsection is subject to an~~
229 ~~appropriation in the General Appropriations Act.~~
230 Section 2. Paragraph (e) of subsection (1) of section
231 408.040, Florida Statutes, is redesignated as paragraph (d), and
232 present paragraph (d) of that subsection is amended to read:
233 408.040 Conditions and monitoring.—
234 (1)
235 ~~(d) If a nursing home is located in a county in which a~~
236 ~~long-term care community diversion pilot project has been~~
237 ~~implemented under s. 430.705 or in a county in which an~~
238 ~~integrated, fixed-payment delivery program for Medicaid~~
239 ~~recipients who are 60 years of age or older or dually eligible~~
240 ~~for Medicare and Medicaid has been implemented under s.~~
241 ~~409.912(5), the nursing home may request a reduction in the~~
242 ~~percentage of annual patient days used by residents who are~~
243 ~~eligible for care under Title XIX of the Social Security Act,~~
244 ~~which is a condition of the nursing home's certificate of need.~~
245 ~~The agency shall automatically grant the nursing home's request~~
246 ~~if the reduction is not more than 15 percent of the nursing~~
247 ~~home's annual Medicaid-patient-days condition. A nursing home~~
248 ~~may submit only one request every 2 years for an automatic~~
249 ~~reduction. A requesting nursing home must notify the agency in~~
250 ~~writing at least 60 days in advance of its intent to reduce its~~
251 ~~annual Medicaid-patient-days condition by not more than 15~~

252 ~~percent. The agency must acknowledge the request in writing and~~
253 ~~must change its records to reflect the revised certificate-of-~~
254 ~~need condition. This paragraph expires June 30, 2011.~~
255 Section 3. This act shall take effect July 1, 2011.