

**THIS LEGISLATIVE SUMMARY WAS ISSUED BY THE FL HOUSE OF  
REPRESENTATIVES ON MAY 13, 2005**

Committee Substitute for Committee Substitute for Senate Bill 838 contains short-term and long-term Medicaid reform activities, pilot projects, and studies designed to improve efficiency, enhance quality of care and client outcomes, and achieve sustainable growth in Florida's Medicaid program. Specifically, the bill:

- Requires the Agency for Health Care Administration (AHCA) to contract with a vendor to identify and counsel providers whose clinical practice patterns are outside normal practice patterns.
- Authorizes AHCA to competitively bid single source provider contracts if less costly.
- Requires AHCA to determine if purchasing medical equipment is less expensive than long-term rental and authorizes AHCA to facilitate purchases in lieu of long-term rentals to protect against fraud and abuse.
- Requires that provider service network contracts currently in effect be extended for a period of three years and provides a definition for a provider service network.
- Directs that AHCA by 12/01/05 design and implement an integrated, fixed-payment delivery system for persons 60 years of age and older:
  - requires pilots initially in two areas of the state – enrollment is voluntary in one pilot;
  - requires combining all funds, excluding nursing home services unless AHCA demonstrates care can be improved in a less costly manner;
  - excludes persons 60 years of age and older who are being served in certain waiver programs, and individuals who are residents of institutional facilities for the developmentally disabled;
  - requires competitive bid process for selecting entities to operate;
  - requires evaluation by OPPAGA in consultation with Auditor General and report by 6/30/08; and
  - requires legislative approval prior to implementation.
- Requires AHCA to develop a business case process to determine whether increased reimbursement for certain services is cost-effective.
- Requires the Comprehensive Assessment Review and Evaluation for Long-term Care Services (CARES) staff to identify Medicare patients in nursing homes who are being inappropriately disqualified from coverage under Medicare and assist with appeal of the disqualification if such activities are federally reimbursable.
- Requires AHCA by 4/01/06 to contract with an entity to develop a real-time, web-based utilization tracking system or electronic medical record for Medicaid recipients.
- Requires AHCA to provide emergency department diversion programs.
- Directs AHCA to allow credentialed dispensing practitioners to participate in the Medicaid program regardless of the proximity of other dispensing entities.

- Requires AHCA to implement a Medicaid prescription drug management program to reduce costs, waste, and fraud, while improving recipient safety.
- Requires AHCA to address the issue of destruction of Medicaid prescription drugs and report to Legislature by 12/01/05.
- Allows reimbursement for mental health crisis care provided in a non-hospital setting, if less costly.
- Creates s. 409.91211, Florida Statutes, to authorize AHCA to seek a federal waiver to create a statewide initiative to deliver Medicaid services in a capitated managed care system designed to replace the fee-for-service system:
  - phase one to be implemented in two geographic areas: one in Broward County only; one initially in Duval County to be expanded to Baker, Clay, and Nassau Counties within one year after Duval is operational.
  - contingent upon a mechanism that provides a reasonable growth factor for the upper-payment-level funding and other intergovernmental transfers.
  - allows statewide expansion of demonstration projects upon completion of evaluation and upon legislative approval.
- Provides a framework within which AHCA is to develop a pilot program by developing, determining, or recommending:
  - a system to deliver all mandatory and optional services pursuant to ss. 409.905 and 409.906, F.S., including emergency services under s. 409.9128, F.S.;
  - Medicaid eligibility categories to be included in a pilot;
  - maximization of all state and federal funds;
  - actuarially sound, risk-adjusted capitation rates that can be separated into comprehensive, enhanced services, and catastrophic care;
  - phase in of financial risk for existing provider service networks and opportunity for federally qualified health centers to participate;
  - stop-loss requirements and transfer of excess cost to catastrophic coverage;
  - process to determine and validate rate of growth of per-member costs;
  - program standards and credentialing requirements for networks to participate in pilot program, including financial solvency, network adequacy, and infrastructure capacity;
  - choice counseling system, including marketing safeguards, promotion of health literacy, reduction of minority health disparities, and opportunity to change plans;
  - system to monitor provision of health services, including utilization and quality, and development of an encounter data-information system;
  - grievance resolution processes for recipients and for providers;
  - criteria for participation in the managed care networks;
  - system to prevent fraud and abuse;
  - actuarial and benefit design analysis over 5-year period;
  - mechanism to reimburse qualified emergency services providers, including continuation of fee-for-service payments;

- system for school districts to participate in the certified school match program; and
- system of primary care for the following:
  1. children with chronic medical conditions;
  2. persons with developmental disabilities; and
  3. Medicaid-eligible children in foster care.
- Provides for automatic assignment to a capitated managed care plan if Medicaid recipient has not enrolled in a plan within 30 days after eligibility; 90 days to disenroll and enroll in another plan; and lock-in for 12 months after an open enrollment period.
- Provides a Medicaid opt-out option to allow recipients to purchase health care coverage through an employer-sponsored plan rather than a Medicaid-certified plan.
- Requires AHCA to post any waiver applications on its Internet website 30-days before submission to the federal government and to submit the waiver applications to appropriate committees of the Senate and the House for review and comment at least 10 working days prior to submission. Recommendation as to whether to approve implementation of federally approved waivers must be made by appropriate legislative committees to the Legislature as a whole.
- Requires AHCA to develop an implementation plan, including a recommended timeline for implementation and specified budgetary projections, and to submit the plan to the President of the Senate and the Speaker of the House of Representatives at the same time waivers are submitted for consideration by the Legislature.
- Provides rulemaking authority to AHCA after legislative approval.
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Auditor General to conduct an evaluation of the pilot to be provided to the Governor and the Legislature no later than June 30, 2008, to consider statewide expansion.
- Provides for global fee reimbursement for Medicaid lung transplant services and provides an appropriation to implement it during 2005-2006 fiscal year.
- Updates federal agency name to Centers for Medicare and Medicaid Services.
- Requires that at least 5 percent of Medicaid audits to detect Medicaid funds lost to fraud and abuse be conducted on a random basis.
- Requires Medicaid recipients to be provided explanations of benefits.
- Requires AHCA by 12/15/05 to study the legal and administrative barriers to enforcing copayments in the Medicaid program.
- Requires AHCA by 1/15/06 to develop recommendations to improve third-party liability recoveries.
- Requires OPPAGA by 1/15/06 to confirm the value of long-term care community diversion programs.
- Requires AHCA by 12/01/05 to study mechanisms for collecting patient-responsibility payments from persons in the long-term care diversion programs.
- Requires OPPAGA by 1/01/06 to conduct a study of Medicaid buy-in programs in other states.

- Requires OPPAGA, in consultation with the Office of Attorney General Medicaid Fraud Control Unit and the Auditor General, by 1/01/06 to study dollars lost to fraud and abuse in the Medicaid prescription drug program, including examination of manufacturers' pricing practices.
- Appropriates \$15.7 million in recurring funds, \$18.2 million in non-recurring funds and 11 FTEs to AHCA for the purpose of implementing the act.
- Repeals the Medicaid rate setting provisions in Conference Committee Report on Committee Substitute for Committee Substitute for Senate Bill 404.
- Requires AHCA to make additional adjustment in calculating payment to prepaid health plans for 2005-2006 fiscal year only with a specified increase required.
- Requires Senate Select Committee on Medicaid Reform to study the provider rate setting process and report recommendations by 3/01/06 to the Governor, the President of the Senate, and the Speaker of the House of Representatives.
- Provides effective date of July 1, 2005.