A bill to be entitled

An act relating to Medicaid; providing for the Agency for Health Care Administration to expand certain pilot and demonstration project waivers under certain conditions; providing for integration of state funding to persons who are dually eligible for Medicare and Medicaid; requiring the agency to provide a choice of managed care plans to recipients; providing requirements for managed care plans; permitting the agency to withhold certain funding contingent upon the performance of a plan; requiring the plan to rebate certain profits to the agency; authorizing the agency to limit the number of enrollees in a plan under certain circumstances; providing for certain services in demonstration areas; providing for imposition of liquidated damages; permitting a modification of certificate-of-need conditions to nursing homes under certain circumstances; requiring integration of Medicare and Medicaid services; providing legislative intent; providing for awarding of funds for managed care delivery, contingent upon an appropriation; granting rulemaking authority to the agency; requiring legislative authority to implement the waiver; providing for future review and repeal of the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Managed care delivery systems.--

(1) INCLUSION OF MANAGED CARE FOR DUALLY ELIGIBLE

PERSONS.--

(a) Contingent upon federal approval, the Agency for Health Care Administration may revise or apply for a waiver pursuant to s. 1915 of the Social Security Act or apply for a demonstration project waiver pursuant to s. 1115 of the Social Security Act to reform Florida's Medicaid program in order to integrate all state funding for Medicaid services to persons who are dually eligible for Medicare and Medicaid. Rates shall be developed in accordance with 42 C.F.R. s. 438.6, certified by an actuary, and submitted for approval to the Centers for Medicare and Medicaid Services. The funds to be integrated shall include:

1. All Medicaid home-based and community-based waiver services funds.

2. All funds for all Medicaid services, including Medicaid nursing home services.

3. Funds paid for Medicare premiums, coinsurance, and deductibles for persons dually eligible for Medicaid and Medicare, for which the state is responsible, but not to exceed federal limits of liability specified in the state plan.

(b) When the agency integrates the funding for Medicaid services for dually eligible recipients into a managed care delivery system under paragraph (a) in any area of the state, the agency shall provide to dually eligible recipients a choice of plans which shall include:

1. An entity licensed under chapter 627 or chapter 641, Florida Statutes; or

2. A state-certified provider, including entities eligible to participate in the nursing home diversion program, other

qualified providers as defined in s. 430.703(7), Florida Statutes, and community care for the elderly lead agencies that meet the requirements set forth in s. 430.705(2)(a) and (b), Florida Statutes, as determined by the Department of Financial Services.

(c) The agency shall select managed care plans through competitive procurements in order to ensure a choice of no more than three plans for Medicaid eligible recipients in each of the 11 agency areas in the state.

(d) When the agency integrates the funding for Medicaid nursing home and community-based care services into a managed care delivery system, the agency shall ensure that a plan, in addition to other requirements:

1. Allows an enrollee to select any provider with whom the plan has a contract.

2. Makes a good faith effort to develop contracts with qualified providers currently under contract with the Department of Elderly Affairs, area agencies on aging, or community care for the elderly lead agencies.

3. Secures subcontracts with providers of nursing home and community-based long-term care services sufficient to ensure access to and choice of providers.

4. Develops and uses a service provider qualification system that describes the quality-of-care standards that providers of medical, health, and long-term care services must meet in order to obtain a contract from the plan and that do not duplicate other requirements of federal or state law.

5. Contracts with all qualified nursing homes located in

the area that are served by the plan, including those designated as Gold Seal.

6. Ensures that a Medicaid recipient integrated into a plan who is a resident of a facility licensed under chapter 400, Florida Statutes, and who does not choose to move to another setting is allowed to remain in the facility in which he or she is currently receiving care.

7. Includes persons who are in nursing homes and who convert from non-Medicaid payment sources to Medicaid. Plans shall be at risk for serving persons who convert to Medicaid. The agency shall ensure that persons who choose community alternatives instead of nursing home care and who meet the level of care and financial eligibility standards continue to receive Medicaid.

8. Demonstrates a quality assurance and quality improvement system that is satisfactory to the agency.

9. Develops a system to identify recipients who have special health care needs such as polypharmacy, mental health and substance abuse problems, falls, chronic pain, nutritional deficits, or cognitive deficits or who are ventilator-dependent in order to respond to and meet these needs.

10. Ensures a multidisciplinary team approach to recipient management that facilitates the sharing of information among providers responsible for delivering care to a recipient.

11. Ensures medical oversight of care plans and service delivery, regular medical evaluation of care plans, and the availability of medical consultation for care managers and service coordinators.

12. Develops, monitors, and enforces quality-of-care requirements using existing Agency for Health Care Administration survey and certification data, whenever possible, to avoid duplication of survey or certification activities between the plans and the agency.

13. Ensures a system of care coordination that includes educational and training standards for care managers and service coordinators.

14. Develops a business plan that demonstrates the ability of the contractor to organize and operate a risk-bearing entity.

15. Furnishes evidence of liability insurance coverage or a self-insurance plan that is determined by the Office of Insurance Regulation to be adequate to respond to claims for injuries arising out of the furnishing of health care.

16. Complies with the prompt payment of claims requirements of s. 641.3155, Florida Statutes.

17. Provides for a periodic review of its facilities as required by the agency, which does not duplicate other requirements of federal or state law. The agency shall provide provider survey results to the plan.

18. Provides enrollees the ability, to the extent possible, to choose care providers, including nursing home, assisted living, and adult day care service providers affiliated with a person's religious faith or denomination, nursing home and assisted living facility providers that are part of a retirement community in which an enrollee resides, and nursing homes and assisted living facilities that are geographically located as close as possible to an enrollee's family, friends,

and social support system.

(e) In addition to other quality assurance standards required by law or by rule or in an approved federal waiver, and in consultation with the Department of Elderly Affairs and area agencies on aging, the agency shall develop quality assurance standards that are specific to the care needs of elderly individuals and that measure enrollee outcomes and satisfaction with care management, nursing home services, and other services that are provided to dually eligible recipients by managed care plans pursuant to this section. The agency shall contract with area agencies on aging to perform initial and ongoing measurement of the appropriateness, effectiveness, and quality of services that are provided to dually eligible recipients by managed care plans and to collect and report the resolution of enrollee grievances and complaints. The agency and the department shall coordinate the quality measurement activities performed by area agencies on aging with other quality assurance activities required by this section in a manner that promotes efficiency and avoids duplication.

(f) If there is not a contractual relationship between a nursing home provider and a plan in an area in which the demonstration project operates, the nursing home shall cooperate with the efforts of the administrator of a plan to determine if a recipient would be more appropriately served in a community setting, and payments shall be made in accordance with Medicaid nursing home rates as calculated in the Medicaid state plan.

(g) The agency may develop innovative risk-sharing agreements that limit the level of custodial nursing home risk

that the plan assumes, consistent with the intent of the Legislature to reduce the use and cost of nursing home care. Under risk-sharing agreements, the agency may reimburse the administering entity or a nursing home for the cost of providing nursing home care for Medicaid-eligible recipients who have been permanently placed and remain in nursing home care.

(h) The agency shall withhold a percentage of the capitation rate that would otherwise have been paid to a plan in order to create a quality reserve fund, which shall be annually disbursed to those contracted plans that deliver high-quality services, have a low rate of enrollee complaints, have successful enrollee outcomes, are in compliance with quality improvement standards, and demonstrate other indicators determined by the agency to be consistent with high-quality service delivery.

(i) The agency shall implement a system of profit rebates that require a plan to rebate a portion of the plan's profits that exceed 3 percent. The portion of profit above 3 percent that is to be rebated shall be determined by the agency on a sliding scale; however, no profits above 15 percent may be retained by the plan. Rebates shall be paid to the agency.

(j) The agency may limit the number of persons enrolled in a plan who are not nursing home facility residents but who would be Medicaid eligible as defined under s. 409.904(3), Florida Statutes, if served in an approved home-based or community-based waiver program.

(k) In the demonstration areas, the area agency on aging shall serve as the aging resource center, shall be the entry

point for eligibility determination for dually eligible persons, and shall provide choice counseling to assist recipients in choosing a managed care plan.

(l) The agency, in cooperation with the Florida Health Care Association, the Florida Association of Homes for the Aging, and the Department of Elderly Affairs, is directed to create a task force for the purpose of developing a system of monitoring and enforcing quality-of-care requirements and managing and responding to enrollee grievances and complaints, which is specific to long-term care service delivery in a managed care environment.

(m) In the event that a managed care plan does not meet its obligations under its contract with the agency or under the requirements of this section, the agency may impose liquidated damages. Such liquidated damages shall be calculated by the agency as reasonable estimates of the agency's financial loss and are not to be used to penalize the plan. If the agency imposes liquidated damages, the agency may collect those damages by reducing the amount of any monthly premium payments otherwise due to the plan by the amount of the damages. Liquidated damages are forfeited and will not be subsequently paid to a plan upon compliance or cure of default unless a determination is made after appeal that the damages should not have been imposed.

(n) In any area of the state in which the agency has implemented a demonstration project pursuant to this section, the agency shall grant a modification of certificate-of-need conditions related to Medicaid participation to a nursing home that has experienced decreased Medicaid patient day utilization

due to a transition to a managed care delivery system.

(o) Notwithstanding any other law to the contrary, the agency shall ensure that, to the extent possible, Medicare and Medicaid services are integrated. When possible, persons served by the managed care delivery system who are eligible for Medicare shall be enrolled in a Medicare managed health care plan operated by the same entity that is placed at risk for Medicaid services.

(p) It is the intent of the Legislature that the agency begin discussions with the federal Centers for Medicare and Medicaid Services regarding the inclusion of Medicare in an integrated long-term care system.

(2) FUNDING DEVELOPMENT COSTS OF ESSENTIAL COMMUNITY PROVIDERS.--It is the intent of the Legislature to facilitate development of managed care delivery systems by networks of essential community providers, including current community care for the elderly lead agencies and other networks as defined in this section. To allow the assumption of responsibility and financial risk for managing a recipient through the entire continuum of Medicaid services, the agency shall, subject to appropriations included in the General Appropriations Act, award up to $500,000 per applicant for the purpose of funding managed care delivery system development costs. The terms of repayment may not extend beyond 6 years after the date when the funding begins and must include payment in full with a rate of interest equal to or greater than the federal funds rate. The agency shall establish a grant application process for awards.

(3) RULEMAKING.--The Agency for Health Care Administration is authorized to adopt rules in consultation with the appropriate state agencies to implement the provisions of this section.

(4) IMPLEMENTATION.--Upon approval of a waiver by the Centers for Medicare and Medicaid Services, the Agency for Health Care Administration shall report the provisions and structure of the approved waiver and any deviations from this section to the Legislature. The agency shall implement the waiver after authority to implement the waiver is granted by the Legislature.

(5) REVIEW AND REPEAL.--This section shall stand repealed on July 1, 2010, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. This act shall take effect July 1, 2005.