1 A bill to be entitled
2 An act relating to Medicaid; providing waiver authority
3 for the Agency for Health Care Administration; providing
4 definitions; requiring managed care plans to provide a
5 wellness and disease management program for certain
6 Medicaid recipients participating in the waiver; requiring
7 managed care plans to provide pharmacy benefits; requiring
8 the agency to establish enhanced benefit coverage and
9 providing procedures therefor; establishing flexible
10 spending accounts and individual development accounts;
11 authorizing the agency to allow recipients to opt out of
12 Medicaid and purchase health care coverage through the
13 private insurance market; authorizing the agency to
14 establish health savings accounts and providing
15 requirements and procedures therefor; requiring the Office
16 of Program Policy Analysis and Government Accountability
17 to study and issue a report on the opt-out program;
18 requiring the agency to apply and enforce certain
19 provisions of law relating to Medicaid fraud and abuse;
20 providing penalties; providing applicability; granting
21 rulemaking authority to the agency; requiring the
22 Legislative Budget Commission to approve the waiver
23 application; requiring legislative authority to implement
24 the waiver; providing for future review and repeal of the
25 act; providing an effective date.
26
27 Be It Enacted by the Legislature of the State of Florida:
28

29 Section 1. Medicaid reform; eligibility determination;
30 services.--
31 (1) WAIVER AUTHORITY.--Notwithstanding any other law to
32 the contrary, the Agency for Health Care Administration is
33 authorized to seek an experimental, pilot, or demonstration
34 project waiver, pursuant to s. 1115 of the Social Security Act,
35 to reform Florida's Medicaid program in urban and rural
36 demonstration sites contingent on federal approval to preserve
37 the upper-payment-limit funding method and the disproportionate
38 share program pursuant to chapter 409, Florida Statutes.
39 (2) DEFINITIONS.--As used in this section, the term:
40 (a) "Agency" means the Agency for Health Care
41 Administration.
42 (b) "Enhanced benefit coverage" means additional health
43 care services or alternative health care coverage which can be
44 purchased by qualified recipients.
45 (c) "Flexible spending account" means an account that
46 encourages consumer ownership and management of resources
47 available for enhanced benefit coverage, wellness activities,
48 preventive services, and other services to improve the health of
49 the recipient.
50 (d) "Health savings account" means an account under which
51 an individual covered by a high-deductible health plan may
52 contribute funds to pay for qualified medical expenses.
53 (e) "Individual development account" means a dedicated
54 savings account that is designed to encourage and enable a
55 recipient to build assets in order to purchase health-related
56 services or health-related products.

57 (f) "Managed care plan" means a health maintenance
58 organization authorized under part I of chapter 641, Florida
59 Statutes; an entity under part II or part III of chapter 641,
60 chapter 627, chapter 636, or s. 409.912, Florida Statutes; a
61 licensed mental health provider under chapter 394, Florida
62 Statutes; a licensed substance abuse provider under chapter 397,
63 Florida Statutes; a certified administrator under chapter 626,
64 Florida Statutes; or a hospital under chapter 395, Florida
65 Statutes, certified by the agency to operate as a managed care
66 plan.
67 (g) "Medicaid opt-out option" means a program that allows
68 a recipient to purchase health care insurance through the
69 private insurance market or an employer-sponsored insurer
70 instead of through a Medicaid-certified plan.
71 (h) "Shall" means the agency must include the provision of
72 a subsection, paragraph, or subparagraph as delineated in this
73 section in the waiver application and implement the provision to
74 the extent allowed in the waiver demonstration sites by the
75 Centers for Medicare and Medicaid Services and as approved by
76 the Legislature pursuant to this section.
77 (3) MANAGED CARE PLANS; WELLNESS AND DISEASE
78 MANAGEMENT.--The agency shall develop a capitated system of care
79 that promotes choice and competition.
80 (a) The agency shall require any plan under this section
81 to establish performance objectives to encourage wellness
82 behaviors or minimize the exposure of recipients to the need for
83 acute inpatient, custodial, and other institutional and long-

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84 term care placement and the inappropriate or unnecessary
85 utilization of high-cost services.
86 (b) The agency shall require plans to provide a wellness
87 or disease management program for certain Medicaid recipients
88 participating in the waiver. At a minimum, the agency shall
89 require plans to develop at least four disease management
90 programs for recipients from the following list of diseases and
91 conditions:
92 1. Diabetes.
93 2. Asthma.
94 3. HIV/AIDS.
95 4. Hemophilia.
96 5. End-stage renal disease.
97 6. Congestive heart failure.
98 7. Chronic obstructive pulmonary disease.
99 8. Autoimmune disorders.
100 9. Obesity.
101 10. Smoking.
102 11. Hypertension.
103 12. Coronary artery disease.
104 13. Chronic kidney disease.
105 14. Chronic pain.
106 (c) The agency shall require a plan to develop appropriate
107 disease management protocols and develop procedures for
108 implementing those protocols, and determine the procedure for
109 providing disease management services to plan enrollees. The
110 agency is authorized to allow a plan to contract separately with

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111 another entity for disease management services or provide
112 disease management services directly through the plan.
113 (d) The agency shall provide oversight to ensure that the
114 service network provides the contractually agreed upon level of
115 service.
116 (e) The agency may establish performance contracts that
117 reward a plan when measurable operational targets in both
118 participation and clinical outcomes are reached or exceeded by
119 the plan.
120 (f) The agency shall establish performance contracts that
121 penalize a plan when measurable operational targets for both
122 participation and clinical outcomes are not reached by the plan.
123 (g) The agency shall develop oversight requirements and
124 procedures to ensure that plans utilize standardized methods and
125 clinical protocols for determining compliance with a wellness or
126 disease management plan.
127 (4) PHARMACY BENEFITS.--
128 (a) The agency shall require plans to provide pharmacy
129 benefits and include pharmacy benefits as part of the capitation
130 risk structure to enable a plan to coordinate and fully manage
131 all aspects of patient care as part of the plan or through a
132 pharmacy benefits manager.
133 (b) The agency may set standards for pharmacy benefits for
134 managed care plans and health insurance plans participating in
135 the Medicaid opt-out option.
136 (c) The agency may set appropriate medication guidelines,
137 including guidelines for copayments.

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138 (d) The agency shall facilitate the establishment of a
139 Florida managed care plan purchasing alliance. The purpose of
140 the alliance is to form agreements among participating plans to
141 purchase pharmaceuticals at a discount, to achieve rebates, or
142 to receive best market price adjustments. Participation in the
143 Florida managed care plan purchasing alliance shall be
144 voluntary.
145 (e) Each plan shall implement a pharmacy fraud, waste, and
146 abuse initiative that may include a surety bond or letter of
147 credit requirement for participating pharmacies, enhanced
148 provider auditing practices, the use of additional fraud and
149 abuse software, recipient management programs for recipients
150 inappropriately using their benefits, and other measures to
151 reduce provider and recipient fraud, waste, and abuse. The
152 initiative shall address enforcement efforts to reduce the
153 number and use of counterfeit prescriptions.
154 (f) The agency shall require plans to report incidences of
155 pharmacy fraud and abuse and establish procedures for receiving
156 and investigating fraud and abuse reports from plans in the
157 demonstration sites. Plans must report instances of fraud and
158 abuse pursuant to chapter 641, Florida Statutes.
159 (5) ENHANCED BENEFIT COVERAGE.--
160 (a) The agency shall establish enhanced benefit coverage
161 and a methodology to fund the enhanced benefit coverage.
162 (b) A recipient who complies with the objectives of a
163 wellness or disease management plan, as determined by the plan,
164 shall have access to the enhanced benefit coverage for the

165 purpose of purchasing or securing health-care services or
166 health-care products.
167 (c) The agency shall establish flexible spending accounts
168 or similar accounts for recipients as approved in the waiver to
169 be administered by the agency or by a managed care plan. The
170 agency shall make deposits to a recipient's flexible spending
171 account contingent on compliance with a wellness plan or a
172 disease management plan.
173 (d) The purpose of the flexible spending accounts is to
174 allow waiver recipients to accumulate funds up to a maximum of
175 $1,000 for purposes of activities allowed by federal regulations
176 or as approved in the waiver.
177 (e) The agency may allow a plan to establish other
178 additional reward systems for compliance with a wellness or
179 disease management objective that are supplemental to the
180 enhanced benefit coverage.
181 (f) The agency shall establish individual development
182 accounts or similar account for recipients as approved in the
183 waiver. The agency shall make deposits into a recipient's
184 individual development account contingent upon compliance with a
185 wellness or a disease management plan.
186 (g) The purpose of an individual development account is to
187 allow waiver recipients to accumulate funds up to a maximum of
188 $1,000 for purposes of activities allowed by federal regulations
189 or as approved in the waiver.
190 (h) A recipient shall choose to participate in a flexible
191 spending account or an individual development account to
192 accumulate funds pursuant to the provisions of this section.

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193 (i) It is the intent of the Legislature that flexible
194 spending accounts and individual development accounts encourage
195 consumer ownership and management of resources for wellness
196 activities, preventive services, and other services to improve
197 the health of the recipient.
198 (j) The agency shall develop standards and oversight
199 procedures to monitor access to enhanced services, the use of
200 flexible spending accounts, and the use of individual
201 development accounts as approved by the waiver.
202 (k) It is the intent of the Legislature that the agency
203 develop an electronic benefit transfer system for the
204 distribution of enhanced benefit funds earned by the recipient.
205 (l) The agency shall establish or contract for an
206 administrative structure to manage the enhanced benefit
207 coverage.
208 (6) MEDICAID OPT-OUT OPTION.--
209 (a) The agency may allow recipients to purchase health
210 care coverage through the private insurance market instead of
211 through a Medicaid-certified plan for recipients who are
212 enrolled in a plan that meets requirements established by the
213 agency in consultation with the Office of Insurance Regulation.
214 (b) A recipient who chooses the Medicaid opt-out option
215 shall remain in the opt-out program for at least 1 year or until
216 the recipient no longer has access to employer-sponsored
217 insurance, until the employer's open enrollment period for a
218 person who opts out in order to participate in employer-
219 sponsored coverage, or until the person is no longer eligible
220 for Medicaid, whichever time period is shorter.

221 (c) The agency may establish other criteria and procedures
222 to allow recipients who are not satisfied with the insurance
223 plan to redirect the defined contribution allocated to the
224 recipient to a managed care plan.
225 (d) The agency may allow recipients to opt out of Medicaid
226 and establish health savings accounts. Recipients who choose to
227 opt out of Medicaid and establish health savings accounts must
228 purchase catastrophic insurance coverage.
229 (e) The agency may allow a recipient who chooses to
230 participate in the opt-out option to direct the defined
231 contribution allocated to the recipient to pay the recipient's
232 portion of the premiums for employer-sponsored or direct health
233 care coverage available to the recipient in his or her place of
234 employment. Notwithstanding any other provision of this section,
235 coverage, cost sharing, and any other component of employer-
236 sponsored health insurance shall be governed by applicable state
237 and federal laws.
238 (f) The agency, in consultation with the Office of
239 Insurance Regulation, shall:
240 1. Determine which Medicaid recipients may participate in
241 the opt-out option on a voluntary basis.
242 2. Determine the comprehensive services and benefits to be
243 included in the opt-out option consistent with the mandatory
244 services specified in s. 409.905, Florida Statutes, the
245 behavioral health services specified in s. 409.906(8), Florida
246 Statutes, and the pharmacy services specified in s. 409.906(20),
247 Florida Statutes, and may develop additional specifications for
248 the insurance coverage.

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249 3. Determine the type of plans currently licensed under
250 state law that are suitable to serve the Medicaid opt-out
251 population.
252 4. Establish oversight, fraud and abuse, administrative,
253 and accounting procedures as recommended by the Office of
254 Insurance Regulation for the operation of the opt-out option.
255 5. Implement oversight and monitoring activities,
256 including, but not limited to, administrative and financial
257 monitoring, which shall be conducted by the Office of Insurance
258 Regulation.
259 6. Include the results of oversight and monitoring
260 activities in the choice counseling process to allow individuals
261 to review the information before making a choice to enroll in a
262 plan.
263 (g) The agency may:
264 1. Enter into contracts with qualified third parties,
265 private or public, for any service necessary to carry out the
266 purposes of the opt-out option.
267 2. Take any legal action on behalf of the recipient
268 against any insurance company to enforce compliance with
269 coverage requirements.
270 (h) Two years after the implementation of the waiver, the
271 Office of Program Policy Analysis and Government Accountability
272 shall conduct studies and analyses related to the opt-out
273 option, including examining the type of health care benefits
274 provided, utilization, costs, quality, and efforts to address
275 occurrences of fraud and abuse. A copy of the report shall be
276 provided to the legislative committees having jurisdiction over

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277 the opt-out option.
278 (7) FRAUD AND ABUSE.--
279 (a) To minimize the risk of Medicaid fraud and abuse, the
280 agency shall ensure that applicable provisions of chapters 409,
281 414, 626, 641, and 932, Florida Statutes, relating to Medicaid
282 fraud and abuse, are applied and enforced at the waiver
283 demonstration sites.
284 (b) Providers must have the necessary certification,
285 license, and credentials as required by law and waiver
286 requirements.
287 (c) When a plan is not a fully indemnified insurance
288 program under chapter 624, chapter 627, chapter 636, or chapter
289 641, Florida Statutes, the plan must meet financial solvency
290 requirements as specified in chapter 641, Florida Statutes, and
291 as determined by the agency in the certification process, in
292 consultation with the Office of Insurance Regulation.
293 (d) The agency shall ensure that the plan is in compliance
294 with the provisions of s. 409.912(21) and (22), Florida
295 Statutes.
296 (e) The agency shall require each plan to establish
297 program integrity functions and activities to reduce the
298 incidence of fraud and abuse. Plans must report instances of
299 fraud and abuse pursuant to chapter 641, Florida Statutes.
300 (f) The agency shall establish a unit within the Office of
301 Medicaid Program Integrity dedicated to fraud and abuse
302 prevention, mitigation, and intervention in the waiver
303 demonstration sites.
304 (g)1. The agency shall require all contractors in the

305 managed care plan to report all instances of suspected fraud and
306 abuse. A failure to report instances of suspected fraud and
307 abuse is a violation of law and subject to the penalties
308 provided by law.
309 2. An instance of fraud and abuse in the managed care
310 plan, including, but not limited to, defrauding the state health
311 care benefit program by misrepresentation of fact in reports,
312 claims, certifications, enrollment claims, demographic
313 statistics, and encounter data; the misrepresentation of the
314 qualifications of persons rendering health care and ancillary
315 services; bribery and false statements relating to the delivery
316 of health care; unfair and deceptive marketing practices; and
317 managed care false claims actions, is a violation of law and
318 subject to the penalties provided by law.
319 3. The agency shall require that all contractors make all
320 files and relevant billing and claims data accessible to state
321 regulators and investigators and that all such data be linked
322 onto a unified system for seamless reviews and investigations.
323 (8) APPLICABILITY.--
324 (a) The provisions of this section apply only to the
325 waiver demonstration sites approved by the Legislature.
326 (b) The Legislature authorizes the Agency for Health Care
327 Administration to apply and enforce any provision of law not
328 referenced in this section to ensure the safety, quality, and
329 integrity of the waiver.
330 (c) In any circumstance when the provisions of chapter
331 409, Florida Statutes, conflict with this section, this section
332 shall prevail.

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333 (9) RULEMAKING AUTHORITY.--The Agency for Health Care
334 Administration is authorized to adopt rules to implement the
335 provisions of this section.
336 (10) WAIVER APPLICATION.--The agency shall submit the
337 waiver application pursuant to this section to the Legislative
338 Budget Commission for approval prior to submitting the waiver
339 application to the Centers for Medicare and Medicaid Services.
340 (11) IMPLEMENTATION.--
341 (a) This section does not authorize the agency to
342 implement any provision of the s. 1115 of the Social Security
343 Act experimental, pilot, or demonstration program waiver to
344 reform the state Medicaid program.
345 (b) Upon approval of a waiver by the Centers for Medicare
346 and Medicaid Services, the agency shall report the provisions
347 and structure of the approved waiver and any deviations from
348 this section to the Legislature. The agency shall implement the
349 waiver after authority to implement the waiver is granted by the
350 Legislature.
351 (12) REVIEW AND REPEAL.--This section shall stand repealed
352 on July 1, 2010, unless reviewed and saved from repeal through
353 reenactment by the Legislature.
354 Section 2. This act shall take effect July 1, 2005.