A bill to be entitled

An act relating to Medicaid reform; providing waiver authority to the Agency for Health Care Administration; providing for implementation of demonstration projects; providing definitions; identifying categorical groups for eligibility under the waiver; establishing the choice counseling process; requiring managed care plans to include mandatory Medicaid services and behavioral health and pharmacy services; requiring managed care plans to provide a wellness and disease management program for certain Medicaid recipients participating in the waiver; requiring managed care plans to provide pharmacy benefits; requiring managed care plans to provide behavioral health benefits; requiring a managed care plan to have a certificate of operation from the agency before operating under the waiver; providing for certification requirements; providing for reimbursement of provider service networks; providing an exemption under certain circumstances; providing for continuance of contracts previously awarded; providing for cost sharing by recipients, and requirements; requiring the agency to have accountability and quality assurance standards; requiring the agency to establish a medical care database; providing data collection requirements; requiring certain entities certified to operate a managed care plan to comply with ss. 641.3155 and 641.513, F.S.; providing for the agency to establish and provide for funding of catastrophic coverage; providing for the agency to develop a rate

setting and risk adjustment system; requiring the agency to establish enhanced benefit coverage and providing procedures therefor; establishing flexible spending accounts and individual development accounts; authorizing the agency to allow recipients to opt out of Medicaid and purchase health care coverage through an employer-sponsored insurer; requiring the agency to apply and enforce certain provisions of law relating to Medicaid fraud and abuse; providing penalties; providing for the agency to expand certain demonstration project waivers under certain conditions; providing for integration of state funding to persons who are age 60 and above; requiring the agency to provide a choice of managed care plans to recipients; providing requirements for managed care plans; requiring 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 eligibility determination and choice counseling for persons age 60 and above; providing for imposition of liquidated damages; authorizing the agency to grant 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 system development, contingent upon an appropriation; requiring the agency to establish and

implement a Medicaid buy-in program to assist certain working individuals with disabilities with medical coverage; providing applicability; granting rulemaking authority to the agency; requiring legislative authority to implement the waiver; requiring the Office of Program Policy Analysis and Government Accountability to evaluate the Medicaid reform waiver and issue reports; requiring the agency to submit status reports; requiring the agency to contract for certain evaluation comparisons; 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. Medicaid reform.--

(1) WAIVER AUTHORITY.--Notwithstanding any other law to the contrary, the Agency for Health Care Administration is authorized to seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to reform Florida's Medicaid program pursuant to this section in urban and rural demonstration sites. This waiver authority is contingent on federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized under chapter 409,

Florida Statutes.

(2) IMPLEMENTATION OF DEMONSTRATION PROJECTS.--The agency shall include in the federal waiver request the authority to establish managed care demonstration projects in at least one urban and one rural area, initially in Broward, Baker, Clay, Duval, and Nassau counties.

(3) DEFINITIONS.--As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Catastrophic coverage" means coverage for services provided to a Medicaid recipient after that recipient has received services with an aggregate cost, based on Medicaid reimbursement rates, which exceeds a threshold specified by the agency.

(c) "Enhanced benefit coverage" means additional health care services or alternative health care coverage which can be purchased by qualified recipients.

(d) "Flexible spending account" means an account that encourages consumer ownership and management of resources available for enhanced benefit coverage, wellness activities, preventive services, and other services to improve the health of the recipient.

(e) "Individual development account" means a dedicated savings account that is designed to encourage and enable a recipient to build assets in order to purchase health-related services or health-related products.

(f) "Managed care plan" or "plan" means an entity certified by the agency to accept a capitation payment,

including, but not limited to, a health maintenance organization authorized under part I of chapter 641, Florida Statutes; an entity under part II or part III of chapter 641, chapter 627, chapter 636, or s. 409.912, Florida Statutes; a licensed mental health provider under chapter 394, Florida Statutes; a licensed substance abuse provider under chapter 397, Florida Statutes; a hospital under chapter 395, Florida Statutes; or a provider service network as defined in this section.

(g) "Medicaid buy-in" means a program under s. 4733 of the federal Balanced Budget Act of 1997 to provide Medicaid coverage to certain working individuals with disabilities and pursuant to the provisions of this section.

(h) "Medicaid opt-out option" means a program that allows a recipient to purchase health care insurance through an employer-sponsored insurer instead of through a Medicaid-certified plan.

(i) "Plan benefits" means the mandatory services required of the state by Title XIX of the Social Security Act; behavioral health services specified in s. 409.906(8), Florida Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk adjusted capitation rate. Optional benefits may include any supplemental coverage offered to attract recipients and provide needed care. In all instances, the agency shall ensure that plan benefits include those services that are medically necessary, based on historical Medicaid utilization.

(j) "Provider service network" means an incorporated network:

1. Established or organized, and operated, by a health care provider or group of affiliated health care providers;

2. That provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group;

3. That may make arrangements with physicians, other health care professionals, and health care institutions, to assume all or part of the financial risk on a prospective basis for the provision of basic health services; and

4. Within which health care providers have a controlling interest in the governing body of the provider service network organization, as authorized by s. 409.912, Florida Statutes.

(k) "Shall" means the agency must include the provision of a subsection as delineated in this section in the waiver application and implement the provision to the extent allowed in the demonstration project sites by the Centers for Medicare and Medicaid Services and as approved by the Legislature pursuant to this section.

(4) ELIGIBILITY.--

(a) The agency shall pursue waivers to reform Medicaid for the following categorical groups:

1. Temporary Assistance for Needy Families consistent with ss. 402 and 1931 of the Social Security Act and chapter 409, chapter 414, or chapter 445, Florida Statutes.

2. Supplemental Security Income recipients as defined in Title XVI of the Social Security Act, except for persons who are

dually eligible for Medicaid and Medicare, individuals 60 years of age or older, individuals who have developmental disabilities, and residents of institutions or nursing homes.

3. All children covered pursuant to Title XIX and Title XXI of the Social Security Act.

(b) The agency may pursue any appropriate federal waiver to reform Medicaid for the populations excluded by this subsection.

(5) CHOICE COUNSELING.--

(a) At the time of eligibility determination, the agency shall provide the recipient with all the Medicaid health care options available in that community to assist the recipient in choosing health care coverage.

(b) A recipient shall either choose or be placed in a managed care plan at the time of eligibility determination. Within 30 days after the time of eligibility determination, a recipient may choose to receive health care coverage through another managed care plan or an employer-sponsored insurer.

(c) The agency shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Cost data.

3. Plan performance data, if available.

4. Explanation of benefit limitations.

5. Contact information, including geographic locations and phone numbers of all plan providers and transportation limitations.

6. Any other information the agency determines would

facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(d) The agency shall ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(e) The agency shall ensure that the choice counseling process and material provided are designed to allow recipients with limited education, mental impairment, physical impairment, sensory impairment, cultural differences, and language barriers to understand the choices they must make and the consequences of their choices.

(f) The agency shall require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan violated any of the provisions of s. 409.912(21), Florida Statutes, the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(g) It is the intent of the Legislature, within the authority of the waiver and within available resources, that the agency promote health literacy through outreach activities for Medicaid recipients.

(h) The agency is authorized to contract with entities to perform choice counseling and may establish standards and performance contracts.

(6) PLANS.--

(a) Plan benefits.--The agency shall develop a capitated system of care that promotes choice and competition. Plan benefits shall include the mandatory services required of the state by Title XIX of the Social Security Act; behavioral health services specified in s. 409.906(8), Florida Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk adjusted capitation rate. Optional benefits may include any supplemental coverage offered to attract recipients and provide needed care. In all instances, the agency shall ensure that plan benefits include those services that are medically necessary, based on historical Medicaid utilization.

(b) Wellness and disease management.--

1. The agency shall require any plan under this section to establish performance objectives to encourage wellness behaviors or minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional and long-term care placement and the inappropriate or unnecessary utilization of high-cost services.

2. The agency shall require plans to provide a wellness or disease management program for certain Medicaid recipients participating in the waiver. At a minimum, the agency shall

require plans to develop at least four disease management programs for recipients from the following list of diseases and conditions:

a. Diabetes.

b. Asthma.

c. HIV/AIDS.

d. Hemophilia.

e. End-stage renal disease.

f. Congestive heart failure.

g. Chronic obstructive pulmonary disease.

h. Autoimmune disorders.

i. Obesity.

j. Smoking.

k. Hypertension.

l. Coronary artery disease.

m. Chronic kidney disease.

n. Chronic pain.

o. Oral disease.

3. The agency shall require a plan to develop appropriate disease management protocols and develop procedures for implementing those protocols, and determine the procedure for providing disease management services to plan enrollees. The agency is authorized to allow a plan to contract separately with another entity for disease management services or provide disease management services directly through the plan.

4. The agency shall provide oversight to ensure that the service network provides the contractually agreed upon level of service.

5. The agency may establish performance contracts that reward a plan when measurable operational targets in both participation and clinical outcomes are reached or exceeded by the plan.

6. The agency may establish performance contracts that penalize a plan when measurable operational targets for both participation and clinical outcomes are not reached by the plan.

7. The agency shall develop oversight requirements and procedures to ensure that plans utilize standardized methods and clinical protocols for determining compliance with a wellness or disease management plan.

(c) Pharmacy benefits.--

1. The agency shall require plans to provide pharmacy benefits and include pharmacy benefits as part of the capitation risk structure to enable a plan to coordinate and fully manage all aspects of patient care as part of the plan or through a pharmacy benefits manager.

2. The agency may set standards for pharmacy benefits for managed care plans and specify the therapeutic classes of pharmacy benefits to be included as part of the capitation structure to enable a plan to coordinate and fully manage all aspects of patient care as part of the plan or through a pharmacy benefits manager.

3. Each plan shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for recipients

inappropriately using their benefits, and other measures to reduce provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. The agency shall require plans to report incidences of pharmacy fraud and abuse and establish procedures for receiving and investigating fraud and abuse reports from plans in the demonstration project sites. Plans must report instances of fraud and abuse pursuant to chapter 641, Florida Statutes.

5. The agency shall facilitate the establishment of a Florida managed care plan purchasing alliance. The purpose of the alliance is to form agreements among participating plans to purchase pharmaceuticals at a discount, to achieve rebates, or to receive best market price adjustments. Participation in the Florida managed care plan purchasing alliance shall be voluntary.

6. The agency shall allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

(d) Behavioral health benefits.--

1. The agency shall include behavioral health care benefits as part of the capitation structure to enable a plan to coordinate and fully manage all aspects of patient care.

2. The agency may set standards for behavioral health care benefits for managed care plans and health insurance plans participating in the Medicaid opt-out option pursuant to this section.

3. The agency may set appropriate medication guidelines, including copayments.

(7) CERTIFICATION.--Before any entity may operate a managed care plan under the waiver, it shall obtain a certificate of operation from the agency.

(a) Any entity operating under part I of chapter 641, Florida Statutes, shall be deemed to be a Medicaid-certified plan.

(b) Any entity operating under part II or part III of chapter 641, chapter 627, chapter 636, or s. 409.912, Florida Statutes; a licensed mental health provider under chapter 394, Florida Statutes; a licensed substance abuse provider under chapter 397, Florida Statutes; a hospital under chapter 395, Florida Statutes; or a provider service network as defined in this section shall be in compliance with the requirements and standards developed by the agency. The agency, in consultation with the Office of Insurance Regulation, shall establish certification requirements. It is the intent of the Legislature, to the extent possible, that any project authorized by the state under this section include any federally qualified health center, county health department, or other federal, state, or locally funded entity that serves the geographic area within the boundaries of that project. The certification process shall, at a minimum, take into account the following requirements:

1. The entity has sufficient financial solvency to be placed at risk for the basic plan benefits under ss. 409.905, 409.906(8), and 409.906(20), Florida Statutes, and other covered services.

2. The entity has sufficient service network capacity to meet the need of members under ss. 409.905, 409.906(8), and 409.906(20), Florida Statutes, and other covered services.

3. The entity's primary care providers are geographically accessible to the recipient.

4. The entity has the capacity to provide a wellness or disease management program.

5. The entity shall provide for ambulance service in accordance with ss. 409.908(13)(d) and 409.9128, Florida Statutes.

6. The entity has the infrastructure to manage financial transactions, recordkeeping, data collection, and other administrative functions.

7. The entity, if not a fully indemnified insurance program under chapter 624, chapter 627, chapter 636, or chapter 641, Florida Statues, meets the financial solvency requirements specified in chapter 641, Florida Statutes, as determined by the agency in consultation with the Office of Insurance Regulation.

(c) The agency has the authority to contract with entities not otherwise licensed as an insurer or risk-bearing entity under chapter 627 or chapter 641, Florida Statutes, as long as these entities meet the certification standards of this section and any additional standards as defined by the agency to qualify as managed care plans under this section.

(d) Each entity certified by the agency shall submit to the agency any financial, programmatic, encounter data, or other information required by the agency to determine the actual services provided and cost of administering the plan.

(e) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network that is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans or MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect, regardless of any contractual provisions to the contrary. This paragraph applies only to waivers under this section.

(8) COST SHARING.--

(a) For recipients enrolled in a Medicaid managed care plan, the agency may continue cost-sharing requirements as currently defined in s. 409.9081, Florida Statutes, or as approved under a waiver granted from the federal Centers for Medicare and Medicaid Services. Such approved cost-sharing requirements may include provisions requiring recipients to pay:

1. An enrollment fee;

2. A deductible;

3. Coinsurance or a portion of the plan premium; or

4. Progressively higher percentages of the cost of the medical assistance by families with higher levels of income.

(b) For recipients who opt out of Medicaid, cost sharing shall be governed by the policy of the plan in which the individual enrolls.

(c) If the employer-sponsored coverage requires that the cost-sharing provisions imposed under paragraph (a) include requirements that recipients pay a portion of the plan premium, the agency shall specify the manner in which the premium is paid. The agency may require that the premium be paid to the agency, an organization operating part of the medical assistance program, or the managed care plan.

(d) Cost-sharing provisions adopted under this section may be determined based on the maximum level authorized under an approved federal waiver.

(9) ACCOUNTABILITY AND QUALITY ASSURANCE.--The agency shall establish standards for plan compliance including, but not limited to, quality assurance and performance improvement standards, peer or professional review standards, grievance policies, and program integrity policies. The agency shall develop a data reporting system, work with managed care plans to establish reasonable encounter reporting requirements, and ensure that the data reported is accurate and complete.

(a) In performing the duties required under this section, the agency shall work with managed care plans to establish a

uniform system to measure, improve, and monitor the clinical and functional outcomes of a recipient of Medicaid services. The system may use financial, clinical, and other criteria based on pharmacy, medical services, and other data related to the provision of Medicaid services, including, but not limited to:

1. Health Plan Employer Data and Information Set.

2. Member satisfaction.

3. Provider satisfaction.

4. Report cards on plan performance and best practices.

5. Quarterly reports on compliance with the prompt pay requirements in ss. 627.613, 641.3155, and 641.513, Florida Statutes.

(b) The agency shall require the managed care plans contracted with the agency to establish a quality assurance system incorporating the provisions of s. 409.912(27), Florida Statutes, and any standards, rules, and guidelines developed by the agency.

(c)1. The agency shall establish a medical care database to compile data on health services rendered by health care practitioners providing services to patients enrolled in managed care plans in the demonstration sites. The medical care database shall:

a. Collect for each type of patient encounter with a health care practitioner or facility:

(I) The demographic characteristics of the patient.

(II) The principal, secondary, and tertiary diagnosis.

(III) The procedure performed.

(IV) The date and location where the procedure was

performed.

(V) The charge for the procedure, if any.

(VI) If applicable, the health care practitioner's universal identification number.

(VII) If the health care practitioner rendering the service is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

b. Collect appropriate information relating to prescription drugs for each type of patient encounter.

c. Collect appropriate information related to health care costs, utilization, or resources from managed care plans participating in the demonstration sites.

2. To the extent practicable, when collecting the data required under sub-subparagraph a., the agency shall utilize any standardized claim form or electronic transfer system being used by health care practitioners, facilities, and payers.

3. Health care practitioners and facilities in the demonstration sites shall submit, and managed care plans participating in the demonstration sites shall receive, claims for payment and any other information reasonably related to the medical care database electronically in a standard format as required by the agency.

4. The agency shall establish reasonable deadlines for phasing in of electronic transmittal of claims.

5. The agency shall ensure that the data reported is accurate and complete.

(d) The agency shall describe the evaluation methodology

and standards that will be used to assess the success of the demonstration projects.

(10) STATUTORY COMPLIANCE.--Any entity certified under this section shall comply with ss. 627.613, 641.3155, and 641.513, Florida Statutes.

(11) CATASTROPHIC COVERAGE.--

(a) A plan shall provide catastrophic coverage to the extent required by the agency or up to a monetary threshold determined by the agency and within the capitation rate set by the agency.

(b) The agency shall establish a fund for purposes of covering services under catastrophic coverage. The catastrophic coverage fund shall provide for payment of medically necessary care for recipients who are enrolled in a plan and whose care has exceeded a predetermined monetary threshold. The agency may establish an aggregate maximum level of coverage in the catastrophic fund.

(c) The agency shall develop policies and procedures to allow a plan to utilize the catastrophic coverage for a Medicaid recipient in the plan who has reached the catastrophic coverage threshold.

(d) A recipient participating in a plan may be included in catastrophic coverage at a cost threshold determined by the agency based on actuarial analysis.

(e) If a plan does not cover the catastrophic component, placement of the recipient in the catastrophic coverage shall not release the plan from providing other plan benefits or from the case management of the recipient's care, except when the

agency determines it is in the best interest of the recipient to release the managed care plan from these obligations.

(f) The agency shall establish or contract for an administrative structure to manage the catastrophic coverage function.

(12) RATE SETTING AND RISK ADJUSTMENT.--The agency shall develop a rate setting and risk adjustment system to include:

(a) Rate setting and risk adjustment mechanisms that may be based on:

1. A clinical diagnostic classification system that is established in consultation with plans, providers, and the federal Centers for Medicare and Medicaid Services.

2. Categorical groups that have separate risks or capitation rates based on actuarially sound methodologies.

3. Funding established by the General Appropriations Act as well as eligibility group, geography, gender, age, and health status.

(b) A reimbursement methodology that recognizes risk factors from both a client perspective and a provider perspective.

(c) Provisions related to stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates risks associated with the development of the demonstration projects.

(d) Descriptions of a process to be used by the Social Service Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the managed care initiative.

(e) Descriptions of the eligibility assignment processes that will be used to facilitate client choice and ensure that demonstration projects have adequate enrollment levels. These processes shall ensure that demonstration project sites have sufficient levels of enrollment to conduct a valid test of the managed care demonstration project model within a 2-year timeframe.

(f) Any such rate setting and risk adjustment systems shall include:

1. Criteria to adjust risk.

2. Validation of the rates and risk adjustments.

3. Minimum medical loss ratios which must be determined by an actuarial study. Medical loss ratios are subject to an annual audit. Failure to comply with the minimum medical loss ratios shall be grounds for fines, reductions in capitated payments in the current fiscal year, or contract termination.

(g) Rates shall be established in consultation with an actuary and the federal Centers for Medicare and Medicaid Services and supported by actuarial analysis.

(13) ENHANCED BENEFIT COVERAGE.--

(a) The agency shall establish enhanced benefit coverage and a methodology to fund the enhanced benefit coverage.

(b) A recipient who complies with the objectives of a wellness or disease management plan, as determined by the plan, shall have access to the enhanced benefit coverage for the purpose of purchasing or securing health-care services or health-care products.

(c) The agency shall establish flexible spending accounts or similar accounts for recipients as approved in the waiver to be administered by the agency or by a managed care plan. The agency shall make deposits to a recipient's flexible spending account contingent on compliance with a wellness plan or a disease management plan.

(d) The purpose of the flexible spending accounts is to allow waiver recipients to accumulate funds up to a maximum of $1,000 for purposes of activities allowed by federal regulations or as approved in the waiver.

(e) The agency may allow a plan to establish other additional reward systems for compliance with a wellness or disease management objective that are supplemental to the enhanced benefit coverage.

(f) The agency shall establish individual development accounts or similar accounts for recipients as approved in the waiver. The agency shall make deposits into a recipient's individual development account contingent upon compliance with a wellness or a disease management plan.

(g) The purpose of an individual development account is to allow waiver recipients to accumulate funds up to a maximum of $1,000 for purposes of activities allowed by federal regulations or as approved in the waiver.

(h) A recipient shall choose to participate in a flexible spending account or an individual development account to accumulate funds pursuant to the provisions of this section.

(i) It is the intent of the Legislature that flexible spending accounts and individual development accounts encourage

consumer ownership and management of resources for wellness activities, preventive services, and other services to improve the health of the recipient.

(j) The agency shall develop standards and oversight procedures to monitor access to enhanced services, the use of flexible spending accounts, and the use of individual development accounts as approved by the waiver.

(k) It is the intent of the Legislature that the agency develop an electronic benefit transfer system for the distribution of enhanced benefit funds earned by the recipient.

(14) MEDICAID OPT-OUT OPTION.--

(a) The agency shall allow recipients to purchase health care coverage through an employer-sponsored insurer instead of through a Medicaid-certified plan for recipients who are enrolled in a plan that meets requirements established by the agency in consultation with the Office of Insurance Regulation.

(b) A recipient who chooses the Medicaid opt-out option shall have an opportunity for a specified period of time, as authorized under a waiver granted by the Centers for Medicare and Medicaid Services, to select and enroll in a Medicaid certified plan. If the recipient remains in the employer-sponsored plan after the specified period, the recipient shall remain in the opt-out program for at least 1 year or until the recipient no longer has access to employer-sponsored insurance, until the employer's open enrollment period for a person who opts out in order to participate in employer-sponsored coverage, or until the person is no longer eligible for Medicaid, whichever time period is shorter.

(c) Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

(d) The agency, in consultation with the Office of Insurance Regulation, shall:

1. Determine which Medicaid recipients may participate in the opt-out option on a voluntary basis.

2. Determine the type of plans currently licensed under state law that are suitable to serve the Medicaid opt-out population.

3. Establish oversight, fraud and abuse, administrative, and accounting procedures as recommended by the Office of Insurance Regulation for the operation of the opt-out option.

(15) FRAUD AND ABUSE.--

(a) To minimize the risk of Medicaid fraud and abuse, the agency shall ensure that applicable provisions of chapters 409, 414, 626, 641, and 932, Florida Statutes, relating to Medicaid fraud and abuse, are applied and enforced at the demonstration project sites.

(b) Providers shall have the necessary certification, license, and credentials as required by law and waiver requirements.

(c) The agency shall ensure that the plan is in compliance with the provisions of s. 409.912(21) and (22), Florida Statutes.

(d) The agency shall require each plan to establish program integrity functions and activities to reduce the

incidence of fraud and abuse. Plans must report instances of fraud and abuse pursuant to chapter 641, Florida Statutes.

(e) The plan shall have written administrative and management arrangements or procedures, including a mandatory compliance plan that are designed to guard against fraud and abuse. The plan shall designate a compliance officer with sufficient experience in health care.

(f)1. The agency shall require all contractors in the managed care plan to report all instances of suspected fraud and abuse. A failure to report instances of suspected fraud and abuse is a violation of law and subject to the penalties provided by law.

2. An instance of fraud and abuse in the managed care plan, including, but not limited to, defrauding the state health care benefit program by misrepresentation of fact in reports, claims, certifications, enrollment claims, demographic statistics, and encounter data; the misrepresentation of the qualifications of persons rendering health care and ancillary services; bribery and false statements relating to the delivery of health care; unfair and deceptive marketing practices; and managed care false claims actions, is a violation of law and subject to the penalties provided by law.

3. The agency shall require that all contractors make all files and relevant billing and claims data accessible to state regulators and investigators and that all such data be linked onto a unified system for seamless reviews and investigations.

(16) INTEGRATED MANAGED LONG-TERM CARE SERVICES.--

(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 experimental, pilot, or demonstration project waivers 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 60 years of age or older. 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 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 recipients 60 years of age or older into a managed care delivery system under paragraph (a) in any area of the state, the agency shall provide to recipients a choice of plans which shall include:

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

2. Any other entity certified by the agency to accept a capitation payment which may include 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.

(c) The agency may begin the integration of Medicaid services for the elderly into a managed care delivery system in Pinellas, Hillsborough, Orange, Osceola, and Seminole counties.

(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 certification 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.

5. Makes a good faith effort to develop 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 enrolled in a managed care 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 level of care and financial eligibility standards continue to receive Medicaid.

8. Demonstrates a quality assurance system and a performance 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 plan 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 ss. 627.613, 641.3155, and 641.513, 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 recipients 60 years of age or older 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 recipients age 60 years of age or older 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 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 plan

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) Except as otherwise provided in this section, the Aging Resource Center, if available, shall be the entry point for eligibility determination for persons 60 years of age or older, and shall provide choice counseling to assist recipients in choosing a plan. If an Aging Resource Center is not operating

in an area, the agency may, in consultation with the Department of Elderly Affairs, designate other entities to perform these functions until an Aging Resource Center is established and has the capacity to perform these functions.

(l) 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.

(m) In any area of the state in which the agency has implemented a demonstration project pursuant to this section, the agency may 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.

(n) 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 may choose to enroll in a Medicare managed health care plan operated by the same entity that is placed at risk for

Medicaid services.

(o) 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.

(17) 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.

(18) MEDICAID BUY-IN.--Subject to specific appropriations, the agency shall establish and implement within the waiver demonstration sites a Medicaid buy-in program to assist certain working individuals with disabilities with medical coverage.

(a) The purpose of the Medicaid buy-in program is to allow persons ineligible for Medicaid because of income and categorical restrictions to participate in Medicaid under certain conditions.

(b) Participation in the buy-in program shall be limited to individuals who meet the following criteria:

1. The individual is at least 16 years of age and less than 65 years of age.

2. Net family income must be below 250 percent of the federal poverty level for a family of the size involved.

3. Except for earned income which is completely disregarded, the individual must meet all Supplemental Security Income eligibility criteria, including:

a. Unearned income does not exceed the Supplemental Security Income program income standard.

b. Resources do not exceed the Supplemental Security Income resource standard.

4. The individual is employed and has a monthly earning that is not less than $492 a month.

Supplemental Security Income resource and income methodologies shall be used to determine eligibility pursuant to this paragraph.

(c) Individuals determined eligible for the Medicaid buy-in program may choose to receive health care coverage through a managed care plan or through the Medicaid opt-out option pursuant to this section.

(d) The agency shall require payment of premiums or other cost-sharing charges on a sliding scale based on income, as determined by the agency or as provided in the General Appropriations Act or implementing legislation.

(e) Notwithstanding any other provision to the contrary,

continued eligibility for the Medicaid buy-in program is contingent on the individual payment of any premiums or other cost sharing required under this subsection and continued eligibility.

(f) An individual who is enrolled in the buy-in program and who is unable to maintain employment for involuntary reasons, including temporary leave due to a health problem or involuntary termination, continues to be eligible for Medicaid coverage under the buy-in program if the individual meets the following requirements:

1. Within 30 days after the date on which the individual becomes unemployed, the individual, or an authorized representative of the individual, submits to the agency a written request to continue the individual's Medicaid coverage.

2. The individual has paid any premium or other cost sharing required under this subsection.

3. The individual agrees to continue to pay any premium or other cost sharing during unemployment.

(g) The agency may continue Medicaid coverage under the buy-in program for an individual described in paragraph (f) for up to 6 months after the date of the individual's involuntary loss of employment for just cause as determined by the agency. A 6-month extension under the provision of this paragraph is limited to no more than two extensions in a 5-year period.

(19) APPLICABILITY.--

(a) The provisions of this section apply only to the demonstration project sites approved by the Legislature.

(b) The Legislature authorizes the Agency for Health Care Administration to apply and enforce any provision of law not referenced in this section to ensure the safety, quality, and integrity of the waiver.

(c) In any circumstance when the provisions of chapter 409, Florida Statutes, conflict with this section, this section shall prevail.

(20) 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.

(21) IMPLEMENTATION.--

(a) This section does not authorize the agency to implement any provision of s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program.

(b) Upon approval of a waiver by the Centers for Medicare and Medicaid Services, the agency 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.

(22) EVALUATION.--

(a) Two years after the implementation of the waiver and again at 5 years after the implementation of the waiver, the Office of Program Policy Analysis and Government Accountability, in consultation with appropriate legislative committees, shall conduct an evaluation study and analyze the impact of the

Medicaid reform waiver pursuant to this section, including, at a minimum, analysis of the following provisions of the waiver to the extent allowed in the waiver demonstration sites by the Centers for Medicare and Medicaid Services and implemented as approved by the Legislature pursuant to this section. This evaluation study and analysis shall include at a minimum:

1. Demographic and characteristics of the recipient in the waiver.

2. Plan types and service networks.

3. Health benefit coverage.

4. Choice counseling.

5. Disease management.

6. Pharmacy benefits.

7. Behavioral health benefits.

8. Service utilization.

9. Catastrophic coverage.

10. Enhanced benefits.

11. Medicaid opt-out option.

12. Quality assurance and accountability.

13. Fraud and abuse.

14. Cost and cost benefit of the waiver.

15. Impact of the waiver on the agency.

(b) The Office of Program Policy Analysis and Government Accountability shall submit the evaluation study report to the agency and shall submit quarterly reports to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the appropriate committees or councils of the Senate and the House of Representatives.

(c) The agency shall submit, every 6 months after the date of waiver implementation, a status report describing the progress made on the implementation of the waiver and identification of any issues or problems to the Governor's Office of Planning and Budgeting and the appropriate committees or councils of the Senate and the House of Representatives.

(d) The agency shall provide to the appropriate committees or councils of the Senate and House of Representatives copies of any report or evaluation regarding the waiver that is submitted to the Center for Medicare and Medicaid Services.

(e) The agency shall contract for an evaluation comparison of the waiver demonstration projects with the Medipass fee-for-service program including, at a minimum:

1. Administrative or organizational structure of the service delivery system.

2. Covered services and service utilization patterns of mandatory, optional, and other services.

3. Clinical or health outcomes.

4. Cost analysis, cost avoidance, and cost benefit.

(23) 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.