A bill to be entitled

An act relating to Medicaid reform; providing a popular name; providing legislative findings and intent; 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; providing for disenrollment in a plan during a specified period of time; providing conditions for changes; requiring managed care plans to include mandatory Medicaid services; requiring managed care plans to provide a wellness and disease management program, pharmacy benefits, behavioral health care benefits, and a grievance resolution process; authorizing the agency to establish enhanced benefit coverage and providing procedures therefor; establishing flexible spending accounts; providing for cost sharing by recipients, and requirements; requiring the agency to submit a report to the Legislature relating to enforcement of Medicaid copayment requirements and other measures; providing for the agency to establish a catastrophic coverage fund or purchase stop-loss coverage to cover certain services; requiring a managed care plan to have a certificate of operation from the agency before operating under the waiver; providing certification requirements; providing for reimbursement of provider service networks; providing an exemption from competitive bid requirements for provider service networks under certain circumstances;

providing for continuance of contracts previously awarded for a specified period of time; 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 develop a rate setting and risk adjustment system; 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; requiring the agency to develop a reimbursement system for school districts participating in the certified school match program; providing for integrated fixed payment delivery system for Medicaid recipients who are a certain age; authorizing the agency to implement the system in certain counties; providing exceptions; 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 who are a certain age; requiring the agency to evaluate the medical loss ratios

of certain managed care plans; authorizing the agency to adopt rules for minimum loss ratios; 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 Office of Program Policy Analysis and Government Accountability conduct a study of the feasibility of establishing a Medicaid buy-in program for certain non-Medicaid eligible persons; requiring the office to submit a report to the Legislature; 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; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to contract with a vendor to monitor and evaluate the clinical practice patterns of providers; authorizing the agency to competitively bid for single-source providers for certain services; authorizing the agency to examine whether purchasing certain durable medical equipment is more cost-effective than long-term rental of such

equipment; providing that a contract awarded to a provider service network remains in effect for a certain period; defining a provider service network; providing health care providers with a controlling interest in the governing body of the provider service network organization; requiring that the agency, in partnership with the Department of Elderly Affairs, develop an integrated, fixed-payment delivery system for Medicaid recipients age 60 and older; deleting an obsolete provision requiring the agency to develop a plan for implementing emergency and crisis care; requiring the agency to develop a system where health care vendors may provide data demonstrating that higher reimbursement for a good or service will be offset by cost savings in other goods or services; requiring the Comprehensive Assessment and Review for Long-Term Care Services (CARES) teams to consult with any person making a determination that a nursing home resident funded by Medicare is not making progress toward rehabilitation and assist in any appeals of the decision; requiring the agency to contract with an entity to design a clinical-utilization information database or electronic medical record for Medicaid providers; requiring that the agency develop a plan to expand disease-management programs; requiring the agency to coordinate with other entities to create emergency room diversion programs for Medicaid recipients; revising the Medicaid prescription drug spending control program to reduce costs and improve Medicaid recipient safety; requiring that the agency

implement a Medicaid prescription drug management system; allowing the agency to require age-related prior authorizations for certain prescription drugs; requiring the agency to determine the extent that prescription drugs are returned and reused in institutional settings and whether this program could be expanded; requiring the agency to develop an in-home, all-inclusive program of services for Medicaid children with life-threatening illnesses; authorizing the agency to pay for emergency mental health services provided through licensed crisis stabilization centers; creating s. 409.91211, F.S.; requiring that the agency develop a pilot program for capitated managed care networks to deliver Medicaid health care services for all eligible Medicaid recipients in Medicaid fee-for-service or the MediPass program; authorizing the agency to include an alternative methodology for making additional Medicaid payments to hospitals; providing legislative intent; providing powers, duties, and responsibilities of the agency under the pilot program; requiring that the agency provide a plan to the Legislature for implementing the pilot program; requiring that the Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, evaluate the pilot program and report to the Governor and the Legislature on whether it should be expanded statewide; amending s. 409.9122, F.S.; revising a reference; amending s. 409.913, F.S.; requiring 5 percent of all program integrity audits to be conducted on a

random basis; requiring that Medicaid recipients be provided with an explanation of benefits; requiring that the agency report to the Legislature on the legal and administrative barriers to enforcing the copayment requirements of s. 409.9081, F.S.; requiring the agency to recommend ways to ensure that Medicaid is the payer of last resort; requiring the agency to conduct a study of provider pay-for-performance systems; requiring the Office of Program Policy Analysis and Government Accountability to conduct a study of the long-term care diversion programs; requiring the agency to evaluate the cost-saving potential of contracting with a multistate prescription drug purchasing pool; requiring the agency to determine how many individuals in long-term care diversion programs have a patient payment responsibility that is not being collected and to recommend how to collect such payments; requiring the Office of Program Policy Analysis and Government Accountability to conduct a study of Medicaid buy-in programs to determine if these programs can be created in this state without expanding the overall Medicaid program budget or if the Medically Needy program can be changed into a Medicaid buy-in program; providing an appropriation for the purpose of contracting to monitor and evaluate clinical practice patterns; providing an appropriation for the purpose of contracting for the database to review real-time utilization of Medicaid services; providing an appropriation for the purpose of developing infrastructure and administrative resources

necessary to implement the pilot project as created in s. 409.91211, F.S.; providing an appropriation for developing an encounter data system for Medicaid managed care plans; providing an effective date.

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

Section 1. Popular name.--This act shall be known as the "Medicaid Reform Act of 2005."

Section 2. Medicaid reform.--

(1) WAIVER AUTHORITY.-- 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 the Florida Medicaid program pursuant to this section. The initial phase shall be in two geographic areas. One pilot program shall include only Broward County. A second pilot program shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within the timeframes approved in the implementation plan. This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanisms for hospitals and contingent upon protection of the disproportionate share program authorized pursuant to chapter 409, Florida Statutes. The agency is directed to negotiate with the Centers for Medicare and Medicaid Services to include in the approved waiver a methodology whereby savings from the demonstration waiver shall be used to increase total upper-payment-limit and disproportionate share payments. Any increased funds shall be

reinvested in programs that provide direct services to uninsured individuals in a cost-effective manner and reduce reliance on hospital emergency care.

(3) IMPLEMENTATION OF DEMONSTRATION PROJECTS.--The agency shall include in the federal waiver request the authority to establish managed care demonstration projects as provided in this section and as approved by the Legislature in the waiver. It is the intent of the Legislature that the agency shall design a demonstration project to initiate a statewide phase-in of reform of the Medicaid program pursuant to this act. Implementation of each phase of reform shall be contingent upon approval of the Legislature or the Legislative Budget Commission if the Legislature is not in session.

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

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

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

(c) "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.

(d) "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, Florida Statutes, or under chapter 627, chapter 636, chapter 391, 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; a provider service network as defined in this section; or a state-certified contractor as defined in this section.

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

(f) "Plan benefits" means the mandatory services specified in s. 409.905, Florida Statutes; 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. Plans shall provide all mandatory services and may cover optional services to attract recipients and provide needed care. Services to recipients under plan benefits shall include emergency services pursuant to s. 409.9128, Florida Statutes.

1. Mandatory and optional services as delineated in s. 409.905, and s. 409.906, Florida Statutes may vary in amount, duration and scope based on actuarial analysis and determination of service utilization among a categorical or predetermined risk group served by the plan.

2. A plan shall provide all mandatory and optional services as delineated in ss. 409.905, and 409.906, Florida Statutes, to a level of amount, duration and scope based on the actuarial analysis and corresponding capitation rate. Contractual stipulations for each risk or categorical group shall not vary among plans.

3. A plan shall be at risk for all services as defined in this section needed by a recipient up to a monetary catastrophic threshold pursuant to this section.

4. Catastrophic coverage pursuant to this section shall not release the plan from continued care management of the recipient and providing other services as stipulated in the contract with the agency.

(g) "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.

(h) "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.

(i) "State-certified contractor" means an entity not authorized under part I, part II, or part III of chapter 641, Florida Statutes, or under chapter 624, chapter 627, or chapter 636, Florida Statutes, qualified by the agency to be certified as a managed care plan. The agency shall develop the standards necessary to authorize an entity to become a state-certified contractor.

(5) 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 of the Social Security Act.

(b) The agency may pursue any appropriate federal waiver to reform Medicaid for the populations not identified by this

subsection, including Title XXI children, if authorized by the Legislature.

(6) 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. The recipient shall choose a plan within 30 days after the recipient is eligible unless the recipient loses eligibility. Failure to choose a plan within 30 days will result in the recipient being assigned to a managed care plan.

(b) After a recipient has chosen a plan or has been assigned to a plan, the recipient shall have 90 days in which to voluntarily disenroll and select another managed care plan. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the managed care plan's grievance process prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the capitated managed

care network, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(c) In the managed care demonstration projects, the Medicaid recipients who are already enrolled in a managed care plan shall remain with that plan until their next eligibility determination. The agency shall develop a method whereby newly eligible Medicaid recipients, Medicaid recipients with renewed eligibility, and Medipass enrollees shall enroll in managed care plans certified pursuant to this section.

(d) A Medicaid recipient receiving services under this section is eligible for only emergency services until the recipient enrolls in a managed care plan. Emergency services provided under this paragraph shall be reimbursed on a fee-for-service basis.

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

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data, if available.

4. An explanation of benefit limitations.

5. Contact information, including identification of providers participating in the network, geographic locations, 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.

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

(g) To accommodate the needs of recipients, the agency shall ensure that the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also utilize language lines and other services for impaired recipients, such as TTD/TTY.

(h) 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.

(i) It is the intent of the Legislature, within the authority of the waiver and within available resources, that the agency promote health literacy and partner with the Department of Health to provide information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(j) The agency is authorized to contract with entities to perform choice counseling and may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(k) The agency shall develop processes to ensure that demonstration sites have sufficient levels of enrollment to conduct a valid test of the managed care demonstration project model within a 2-year timeframe.

(7) 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 delineated in federal law and specified in s. 409.905, Florida Statutes; 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. Plans shall provide all mandatory services and may cover optional services to attract recipients and provide needed care. Mandatory and optional services may vary in amount, duration, and scope of benefits. Services to recipients under plan benefits shall include emergency services pursuant to s. 409.9128, Florida Statutes.

1. Mandatory and optional services as delineated in ss. 409.905 and 409.906, Florida Statutes, may vary in amount, duration, and scope based on actuarial analysis and determination of service utilization among a categorical or predetermined risk group served by the plan.

2. A plan shall provide all mandatory and optional services as delineated in ss. 409.905 and 409.906, Florida Statutes, to a level of amount, duration, and scope based on the actuarial analysis and corresponding capitation rate. Contractual stipulations for each risk or categorical group shall not vary among plans.

3. A plan shall be at risk for all services as defined in this section needed by a recipient up to a monetary catastrophic threshold pursuant to this section.

4. Catastrophic coverage pursuant to this section shall not release the plan from continued care management of the recipient and providing other services as stipulated in the contract with the agency.

(b) Wellness and disease management.--

1. The agency shall require plans to provide a wellness disease management program for certain Medicaid recipients participating in the waiver. The agency shall require plans to develop disease management programs necessary to meet the needs of the population they serve.

2. 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.

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

4. 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.

5. 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.

6. 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 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 may 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.

(d) Behavioral health care 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. Managed care plans shall require their contracted behavioral health providers to have a member's behavioral treatment plan on file in the provider's medical record.

3. Managed care plans are encouraged to contract with specialty mental health providers.

(e) Grievance resolution process.--A grievance resolution process shall be established that uses the subscriber assistance panel, as created in s. 408.7056, Florida Statutes, and the Medicaid fair hearing process to address grievances.

(8) ENHANCED BENEFIT COVERAGE.--

(a) The agency may establish enhanced benefit coverage and a methodology to fund the enhanced benefit coverage within funds provided in the General Appropriations Act.

(b) A recipient who complies with the objectives of a wellness or disease management plan, as determined by the agency, 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 upon compliance with a wellness plan or a disease management plan.

(d) It is the intent of the Legislature that enhanced benefits encourage consumer participation in wellness activities, preventive services, and other services to improve the health of the recipient.

(e) The agency shall develop standards and oversight procedures to monitor access to enhanced benefits during the eligibility period and up to 3 years after loss of eligibility as approved by the waiver.

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

(9) COST SHARING; REPORT.--The Agency for Health Care Administration shall submit to the President of the Senate and the Speaker of the House of Representatives by December 15, 2005, a report on the legal and administrative barriers to enforcing s. 409.9081, Florida Statutes. The report must describe how many services require copayments, which providers collect copayments, and the total amount of copayments collected from recipients for all services required under s. 409.9081, Florida Statutes, by provider type for the fiscal years 2001-2002 through 2004-2005. The agency shall recommend a mechanism to enforce the requirement for Medicaid recipients to make copayments which does not shift the copayment amount to the provider. The agency shall also identify the federal or state laws or regulations that permit Medicaid recipients to declare

impoverishment in order to avoid paying the copayment and extent to which these statements of impoverishment are verified. If claims of impoverishment are not currently verified, the agency shall recommend a system for such verification. The report must also identify any other cost-sharing measures that could be imposed on Medicaid recipients.

(10) CATASTROPHIC COVERAGE.--

(a) To the extent of available appropriations contained in the annual General Appropriations Act for such purposes, all managed care plans shall provide coverage to the extent required by the agency up to a monetary threshold determined by the agency and within the capitation rate set by the agency. This limitation threshold may vary by eligibility group or other appropriate factors, including, but not limited to, recipients with special needs and recipients with certain disease states.

(b) The agency shall establish a fund or purchase stop-loss coverage from a plan under part I of chapter 641, Florida Statutes, or a health insurer authorized under chapter 624, Florida Statutes, for purposes of covering services in excess of those covered by the managed care plan. The catastrophic coverage fund or stop-loss coverage shall provide for payment of medically necessary care for recipients who are enrolled in a plan and whose care has exceeded the predetermined service threshold. The agency may establish an aggregate maximum level of coverage in the catastrophic fund or for the stop-loss coverage.

(c) The agency shall develop policies and procedures to allow all plans to utilize the catastrophic coverage fund or

stop-loss coverage for a Medicaid recipient in the plan who has reached the catastrophic coverage threshold.

(d) The agency shall contract for an administrative structure to manage the catastrophic coverage fund.

(11) 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, part II, or part III of chapter 641, Florida Statutes, or under chapter 627, chapter 636, chapter 391, 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; a provider service network as defined in this section; or a state-certified contractor as defined in this section shall be in compliance with the requirements and standards developed by the agency. For purposes of the waiver established under this section, provider service networks shall be exempt from the competitive bid requirements in s. 409.912, Florida Statutes. The agency, in consultation with the Office of Insurance Regulation, shall establish certification requirements. It is the intent of the Legislature that, to the extent possible, any project authorized by the state under this section include any federally qualified health center, federally qualified rural health clinic, county health department, or any other federally, state, or locally funded entity that serves the geographic area within the boundaries of that project. The certification process shall, at a minimum, include all requirements in the current

Medicaid prepaid health plan contract and 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. Any plan benefit package shall be actuarially equivalent to the premium calculated by the agency to ensure that competing plan benefits are equivalent in value. In all instances, the benefit package must provide services sufficient to meet the needs of the target population based on historical Medicaid utilization.

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

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

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

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

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

8. The entity, if not a fully indemnified insurance program under chapter 624, chapter 627, chapter 636, or chapter

641, Florida Statutes, must meet the financial solvency requirements under this section.

(b) 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.

(c) In certifying a risk-bearing entity and determining the financial solvency of such an entity as a provider service network, the following shall apply:

1. The entity shall maintain a minimum surplus in an amount that is the greater of $1 million or 1.5 percent of projected annual premiums.

2. In lieu of the requirements in subparagraph 1., the agency may consider the following:

a. If the organization is a public entity, the agency may take under advisement a statement from the public entity that a county supports the managed care plan with the county's full faith and credit. In order to qualify for the agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;

b. The state guarantees the solvency of the organization;

c. The organization is a federally qualified health center or is controlled by one or more federally qualified health centers and meets the solvency standards established by the state for such organization pursuant to s. 409.912(4)(c),

Florida Statute; or

d. The entity meets the solvency requirements for federally approved provider-sponsored organizations as defined in 42 C.F.R. ss. 422.380-422.390. However, if the provider service network does not meet the solvency requirements of either chapter 627 or chapter 641, Florida Statutes, the provider service network is limited to the issuance of Medicaid plans.

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

(e) Notwithstanding the provisions of s. 409.912, Florida Statutes, the agency shall extend the existing contract with a hospital-based provider service network for a period not to exceed 3 years.

(12) 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 patient-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 payment of claims requirements of ss. 627.613, 641.3155, and 641.513, Florida Statutes.

(b) The agency shall require the managed care plans that have contracted with the agency to establish a quality assurance system that incorporates 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 that provide 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 payment 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 1.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 plan shall ensure that the data reported is accurate and complete.

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

(14) RATE SETTING AND RISK ADJUSTMENT.--The agency shall develop an actuarially sound rate setting and risk adjustment system for payment to managed care plans that:

(a) Adjusts payment for differences in risk assumed by managed care plans, based on a widely recognized clinical diagnostic classification system or on categorical groups that are established in consultation with the federal Centers for Medicare and Medicaid Services.

(b) Includes a phase-in of patient-encounter level data reporting.

(c) Includes criteria to adjust risk and validation of the rates and risk adjustments.

(d) Establishes rates in consultation with an actuary and the federal Centers for Medicare and Medicaid Services and supported by actuarial analysis.

(e) Reimburses managed care demonstration projects on a capitated basis, except for the first year of operation of a provider service network. The agency shall develop contractual arrangements with the provider service network for a fee-for-service reimbursement methodology that does not exceed total payments under the risk-adjusted capitation during the first year of operation of a managed care demonstration project. Contracts must, at a minimum, require provider service networks to report patient-encounter data, reconcile costs to established risk-adjusted capitation rates at specified periods, and specify

the method and process for settlement of cost differences at the end of the contract period.

(f) Provides actuarial benefit design analyses that indicate the effect on capitation rates and benefits offered in the demonstration program over a prospective 5-year period based on the following assumptions:

1. Growth in capitation rates which is limited to the estimated growth rate in general revenue.

2. Growth in capitation rates which is limited to the average growth rate over the last 3 years in per-recipient Medicaid expenditures.

3. Growth in capitation rates which is limited to the growth rate of aggregate Medicaid expenditures between the 2003-2004 fiscal year and the 2004-2005 fiscal year.

(15) MEDICAID OPT-OUT OPTION.--

(a) The agency shall allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid certified plan.

(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 coverage, 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.

(16) 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 patient-encounter data; 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 into a unified system for seamless reviews and investigations.

(17) CERTIFIED SCHOOL MATCH PROGRAM.—The agency shall develop a system whereby school districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good-faith effort to execute

agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 must be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good-faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's capitated managed care network provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

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

(a) By December 1, 2005, the Agency for Health Care Administration may revise or apply for waivers 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 create an integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older. The Agency for Health Care Administration shall create the integrated, fixed-payment delivery system in partnership with the Department of Elderly Affairs. Rates shall be developed in accordance with 42 C.F.R. s. 438.60, certified by an actuary, and submitted for approval to the Centers for Medicare and

Medicaid Services. Rates must reflect the intent to provide quality care in the least-restrictive setting. The funds to be integrated shall include:

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

2. All funds for all Medicaid services, including Medicaid nursing home services. Inclusion of funds for nursing home services shall be upon certification by the agency that the integration of nursing home funds will improve coordinated care for these services in a less costly manner.

3. All 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 the federal limits of liability specified in the state plan.

(b) The Agency for Health Care Administration shall implement the integrated system initially on a pilot basis in two areas of the state. In one of the areas enrollment shall be on a voluntary basis. In counties where the integrated system is implemented on a voluntary basis, Medicaid recipients 60 years of age and older shall initially enroll in a managed long-term care delivery system, but may, within 30 days, choose to receive services through the traditional fee-for-service delivery system.

(c) The Agency for Health Care Administration and the Department of Elderly Affairs shall evaluate the feasibility of expanding managed long-term care into additional counties using a combined global budgeting system in which funding for Medicaid services which would be available to provide Medicaid services

for an elderly person is combined into a single payment amount that can be used flexibly to provide services required by a participant. Under such a system, a participant is to be assisted in choosing appropriate Medicaid services and providers by means of choice counseling, case management, and other mechanisms designed to assist recipients to choose cost-efficient services in their own homes and communities rather than rely on institutional placement. In evaluating the feasibility of a global budgeting system, the agency and the department shall ensure that such a system is cost-neutral to the state and, to the extent possible, includes services funded by Medicaid, state general revenue programs, and programs funded under the federal Older American's Act.

(d) 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. Entities licensed under chapter 627 or chapter 641, Florida Statutes.

2. Any other entity certified by the agency to accept a capitation payment, 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. Entities not licensed under chapters 627 or 641 must meet comparable standards as defined by the agency, in consultation with the Department of Elderly Affairs and the Office of Insurance Regulation, to be

financially solvent and able to take on financial risk for managed care. Community service networks that are certified pursuant to the comparable standards defined by the agency are not required to be licensed under chapter 641, Florida Statutes.

(e) Individuals who are 60 years of age or older who have developmental disabilities or who are participants in the family and supported-living waiver program, the project AIDS care waiver program, the traumatic brain injury and spinal cord injury waiver program, the consumer-directed care waiver program, or the program of all-inclusive care for the elderly program, and residents of intermediate-care facilities for the developmentally disabled must be excluded from the integrated system.

(f) When the agency implements an integrated system and includes funding for Medicaid nursing home and community-based care services into a managed care delivery system in any area of the state, 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.

(g) 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 and home and community-based services that are provided to recipients 60 years of age or older by managed care plans pursuant to this section. The agency in consultation with the Department of Elderly Affairs shall contract with area agencies on aging to perform initial and ongoing measurement of the appropriateness, effectiveness, and quality of care management and home and community-based services that are provided to recipients 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.

(h) 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.

(i) 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.

(j) 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.

(k) The agency shall evaluate the medical loss ratios of managed care plans providing services to individuals 60 years of

age or older in the Medicaid program and shall annually report such medical loss ratios to the Legislature. Medical loss ratios are subject to an annual audit. The agency may, by rule, adopt minimum medical loss ratios for such managed care plans. Failure to comply with the minimum medical loss ratios shall be grounds for imposition of fines, reductions in capitated payments in the current fiscal year, or contract termination.

(l) 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 or community-based waiver program.

(m) 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 or if the Aging Resource Center or area agency on aging has a contractual relationship with or has any ownership interest in a managed care plan, 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.

(n) 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.

(o) 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.

(p) 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.

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

(19) FUNDING DEVELOPMENT COSTS OF ESSENTIAL COMMUNITY PROVIDERS.--It is the intent of the Legislature to facilitate the development of managed care delivery systems by networks of essential community providers comprised of current community

care for the elderly lead agencies. 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, in consultation with the Department of Elderly Affairs shall establish a grant application process for awards.

(20) MEDICAID BUY-IN.--The Office of Program Policy Analysis and Government Accountability shall conduct a study of state programs that allow non-Medicaid eligible persons under a certain income level to buy into the Medicaid program as if it was private insurance. The study shall examine Medicaid buy-in programs in other states to determine if there are any models that can be implemented in Florida which would provide access to uninsured Floridians and what effect this program would have on Medicaid expenditures based on the experience of similar states. The study must also examine whether the Medically Needy program could be redesigned to be a Medicaid buy-in program. The study must be submitted to the President of the Senate and the Speaker of the House of representatives by January 1, 2006.

(21) 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.

(22) 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.

(23) 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 unless approved by the Legislature.

(b) The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care demonstration project as defined in this section. The agency shall post all waiver applications under this section on its Internet website 30 days before submitting the applications to the United States Centers for Medicare and Medicaid Services. All waiver applications shall be provided for review and comment to the appropriate committees of the Senate and House of Representatives for at least 10 working days prior to submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be submitted to the appropriate committees of the Senate and the House of Representatives in order to obtain authority for implementation as required by s. 409.912(11),

Florida Statutes, before program implementation. The appropriate committees shall recommend whether to approve the implementation of the waivers to the Legislature or to the Legislative Budget Commission if the Legislature is not in session. The agency shall submit a plan containing a detailed timeline for implementation and budgetary projections of the effect of the pilot program on the total Medicaid budget for the 2006-2007 through 2009-2010 fiscal years

(24) EVALUATION.--

(a) Two years after the implementation of the waiver and again 5 years after the implementation of the waiver, the Office of Program Policy Analysis and Government Accountability, shall conduct an evaluation study and analyze the impact of the Medicaid reform waiver pursuant to this section 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. The Office of Program Policy Analysis and Government Accountability shall consult with appropriate legislative committees to select provisions of the waiver to evaluate from among the following:

1. Demographic characteristics of the recipient of 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.

16. Positive impact of plans on health disparities among minorities.

17. Administrative or legal barriers to the implementation and operation of each pilot program.

(b) The Office of Program Policy Analysis and Government Accountability shall submit the evaluation study report to the agency and 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) One year after implementation of the integrated managed long-term care plan, the agency shall contract with an entity experienced in evaluating managed long-term care plans in another state to evaluate, at a minimum, demonstrated cost savings realized and expected, consumer satisfaction, the range of services being provided under the program, and rate-setting methodology.

(d) 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.

(e) 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.

(f) 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.

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

Section 3. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the

Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform

the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may ~~is authorized to~~ seek federal waivers necessary to administer these policies ~~implement this policy~~.

(1) The agency shall work with the Department of Children and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services.

(2) The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(4) The agency may contract with:

(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III by January 1, 1998, and until then are exempt from the provisions of part I of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Office of Insurance Regulation of the Financial Services Commission that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225.

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a managed care plan in an AHCA area. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are

satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent

behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children

and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (16) ~~(17)~~ and (17) ~~(18)~~.

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network which 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 and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section.

(e) An entity that provides only comprehensive behavioral health care services to certain Medicaid recipients through an

administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services.

(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department services. The agency shall contract with vendors on a risk-sharing basis.

(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18 and pediatric emergency departments' diversion programs. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.

(h) An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Office of Insurance Regulation that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225.

(i) A Children's Medical Services Network, as defined in s. 391.021.

~~(5) By October 1, 2003, the agency and the department shall, to the extent feasible, develop a plan for implementing new Medicaid procedure codes for emergency and crisis care, supportive residential services, and other services designed to maximize the use of Medicaid funds for Medicaid-eligible recipients. The agency shall include in the agreement developed pursuant to subsection (4) a provision that ensures that the match requirements for these new procedure codes are met by certifying eligible general revenue or local funds that are currently expended on these services by the department with contracted alcohol, drug abuse, and mental health providers. The plan must describe specific procedure codes to be implemented, a projection of the number of procedures to be delivered during fiscal year 2003-2004, and a financial analysis that describes the certified match procedures, and accountability mechanisms, projects the earnings associated with these procedures, and~~

~~describes the sources of state match. This plan may not be implemented in any part until approved by the Legislative Budget Commission. If such approval has not occurred by December 31, 2003, the plan shall be submitted for consideration by the 2004 Legislature.~~

(5)~~(6)~~ The agency may contract with any public or private entity otherwise authorized by this section on a prepaid or fixed-sum basis for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

(a) Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

(b) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;

(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

(e) Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of

self-insurance to respond to claims for injuries arising out of the furnishing of health care;

(f) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency; and

(g) Provides organizational, operational, financial, and other information required by the agency.

(6) ~~(7)~~ The agency may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the agency;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Office of Insurance Regulation.

(7) ~~(8)~~ The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law.

(8) ~~(9)~~ The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and

prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization.

(9) ~~(10)~~ The agency shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those proscribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(10) ~~(11)~~ The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable

period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.

(a) Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action.

(b) Notwithstanding s. 216.292, funds that are appropriated to the Department of Elderly Affairs for the Assisted Living for the Elderly Medicaid waiver and are not expended shall be transferred to the agency to fund Medicaid-reimbursed nursing home care.

(11) ~~(12)~~ The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.

(12) ~~(13)~~ The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.

(13) ~~(14)~~ (a) The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.

(b) The agency shall develop a procedure for determining whether health care providers and service vendors can provide the Medicaid program with a business case that demonstrates whether a particular good or service can offset the cost of providing the good or service in an alternative setting or through other means and therefore should receive a higher reimbursement. The business case must include, but need not be limited to:

1. A detailed description of the good or service to be provided, a description and analysis of the agency's current performance of the service, and a rationale documenting how providing the service in an alternative setting would be in the best interest of the state, the agency, and its clients.

2. A cost-benefit analysis documenting the estimated specific direct and indirect costs, savings, performance improvements, risks, and qualitative and quantitative benefits involved in or resulting from providing the service. The cost-benefit analysis must include a detailed plan and timeline identifying all actions that must be implemented to realize expected benefits. The Secretary of the Agency for Health Care Administration shall verify that all costs, savings, and benefits are valid and achievable.

(14) ~~(15)~~ (a) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) nursing facility preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most

appropriate to the needs of the person and in the most economical manner possible. The CARES program shall also ensure that individuals participating in Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and resident review.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program. (d) For the purpose of initiating immediate prescreening and diversion assistance for individuals residing in nursing homes and in order to make families aware of alternative long-term care resources so that they may choose a more cost-effective setting for long-term placement, CARES staff shall conduct an assessment and review of a sample of individuals whose nursing home stay is expected to exceed 20 days, regardless of the initial funding

source for the nursing home placement. CARES staff shall provide counseling and referral services to these individuals regarding choosing appropriate long-term care alternatives. This paragraph does not apply to continuing care facilities licensed under chapter 651 or to retirement communities that provide a combination of nursing home, independent living, and other long-term care services.

(e) By January 15 of each year, the agency shall submit a report to the Legislature and the Office of Long-Term-Care Policy describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

3. Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;

4. Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and

5. Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.

(f) The Department of Elderly Affairs shall track individuals over time who are assessed under the CARES program and who are diverted from nursing home placement. By January 15 of each year, the department shall submit to the Legislature and the Office of Long-Term-Care Policy a longitudinal study of the

individuals who are diverted from nursing home placement. The study must include:

1. The demographic characteristics of the individuals assessed and diverted from nursing home placement, including, but not limited to, age, race, gender, frailty, caregiver status, living arrangements, and geographic location;

2. A summary of community services provided to individuals for 1 year after assessment and diversion;

3. A summary of inpatient hospital admissions for individuals who have been diverted; and

4. A summary of the length of time between diversion and subsequent entry into a nursing home or death.

(g) By July 1, 2005, the department and the Agency for Health Care Administration shall report to the President of the Senate and the Speaker of the House of Representatives regarding the impact to the state of modifying level-of-care criteria to eliminate the Intermediate II level of care.

(15) ~~(16)~~ (a) The agency shall identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information

technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with the Department of Health and a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The panel shall begin its work by August 1, 1999, regardless of the number of appointments made by that date. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization or

may be terminated from all participation in the Medicaid program.

2. The agency shall also develop educational interventions designed to promote the proper use of medications by providers and beneficiaries.

3. The agency 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 beneficiaries inappropriately using their benefits, and other steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. By September 30, 2002, the agency shall contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The initiative shall be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program and to otherwise further the intent of this paragraph.

5. The agency may apply for any federal waivers needed to implement this paragraph.

(16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Office of Insurance Regulation, and restricted funds or deposits controlled by the agency or the

Office of Insurance Regulation, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities. If an entity's surplus falls below an amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.

(17) ~~(18)~~ (a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a

maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

(18) ~~(19)~~ An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated with the hospital or physician for the provision of services or according to the lesser of the following:

(a) The usual and customary charges made to the general public by the hospital or physician; or

(b) The Florida Medicaid reimbursement rate established for the hospital or physician.

(19) ~~(20)~~ When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Office of Insurance Regulation pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase.

(20) ~~(21)~~ Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(a) Practices that are discriminatory, including, but not limited to, attempts to discourage participation on the basis of actual or perceived health status.

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing representatives, or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

2. False or misleading claims that the entity is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the entity.

3. False or misleading claims that the state or county recommends that a Medicaid recipient enroll with an entity.

4. Claims that a Medicaid recipient will lose benefits under the Medicaid program, or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the entity.

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (24).

(d) Door-to-door solicitation of recipients who have not contacted the entity or who have not invited the entity to make a presentation.

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated

areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

(21) ~~(22)~~ The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.

(22) ~~(23)~~ A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients.

(23) ~~(24)~~ Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted

within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the recipient, and are provided at no additional cost to the state.

(24) ~~(25)~~ The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients.

(25) ~~(26)~~ The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient.

(26) ~~(27)~~ The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

(a) Guidelines for internal quality assurance programs, including standards for:

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental disabilities; and to adults who have chronic, high-cost medical conditions.

(b) Guidelines which require the entities to conduct quality-of-care studies which:

1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

1. Delineating the role of the external quality review organization.

2. Length of the external quality review organization contract with the state.

3. Participation of the contracting entities in designing external quality review organization review activities.

4. Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

5. Determining the number of focused pattern-of-care studies to be conducted for each plan.

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

(27)~~(28)~~ In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each entity it has contracted with on a prepaid basis to serve Medicaid recipients.

(28)~~(29)~~ The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (20)~~(21)~~(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include

actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract.

(29) ~~(30)~~ Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the provider's name and specialty and, separately, by specialty in alphabetical order.

(30) ~~(31)~~ The agency shall establish an enhanced managed care quality assurance oversight function, to include at least the following components:

(a) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant utilization of services.

(b) At least quarterly analysis and followup, including sanctions as appropriate, of quality findings of the Medicaid

peer review organization and other external quality assurance programs.

(c) At least quarterly analysis and followup, including sanctions as appropriate, of the fiscal viability of managed care plans.

(d) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant satisfaction and disenrollment surveys.

(e) The agency shall conduct regular and ongoing Medicaid recipient satisfaction surveys.

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers.

(31) ~~(32)~~ Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Florida Department of Law Enforcement of all persons with ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03.

(32) ~~(33)~~ The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to

enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs.

(33) ~~(34)~~ The agency and entities that ~~which~~ contract with the agency to provide health care services to Medicaid recipients under this section or ss. 409.91211 and ~~s.~~ 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients. Where feasible, safe, and cost-effective, the agency shall encourage hospitals, emergency medical services providers, and other public and private health care providers to work together in their local communities to enter into agreements or arrangements to ensure access to alternatives to emergency services and care for those Medicaid recipients who need nonemergent care. The agency shall coordinate with hospitals, emergency medical services providers, private health plans, capitated managed care networks as established in s. 409.91211, and other public and private health care providers to implement the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop and implement emergency department diversion programs for Medicaid recipients.

(38) ~~(39)~~(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

11.a. The agency shall implement a Medicaid prescription-drug-management system. The agency may contract with a vendor that has experience in operating prescription-drug-management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug-management system must be designed to improve the quality of care and prescribing practices based on best-practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the development and adoption of best-practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best-practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best-practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best-practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

(V) Track spending trends for prescription drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement disease-management programs in cooperation with physicians and pharmacists, along with a model quality-based medication component for individuals having chronic medical conditions.

12. The agency is authorized to contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the

General Appropriations Act and ensuring cost-effective prescribing practices.

14. The agency may require prior authorization for the off-label use of Medicaid-covered prescribed drugs as specified in the General Appropriations Act. The agency may, but is not required to, preauthorize the use of a product for an indication not in the approved labeling. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the off-label use of a drug.

17.~~15.~~ The agency shall implement a return and reuse program for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid

prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.

(39) ~~(40)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(40) ~~(41)~~ The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. The agency shall report its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

(41) ~~(42)~~ The agency shall develop and implement a utilization management program for Medicaid-eligible recipients for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may also competitively procure these services from an outside vendor on a regional or statewide basis.

(42) ~~(43)~~ The agency may contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

(43) ~~(44)~~ The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(h), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit

results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(44) ~~(45)~~ Subject to the availability of funds, the agency shall mandate a recipient's participation in a provider lock-in program, when appropriate, if a recipient is found by the agency to have used Medicaid goods or services at a frequency or amount not medically necessary, limiting the receipt of goods or services to medically necessary providers after the 21-day appeal process has ended, for a period of not less than 1 year. The lock-in programs shall include, but are not limited to, pharmacies, medical doctors, and infusion clinics. The limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department. The agency shall seek any federal waivers necessary to implement this subsection. The agency shall adopt any rules necessary to comply with or administer this subsection.

(45) ~~(46)~~ The agency shall seek a federal waiver for permission to terminate the eligibility of a Medicaid recipient who has been found to have committed fraud, through judicial or administrative determination, two times in a period of 5 years.

(46) ~~(47)~~ The agency shall conduct a study of available electronic systems for the purpose of verifying the identity and eligibility of a Medicaid recipient. The agency shall recommend to the Legislature a plan to implement an electronic verification system for Medicaid recipients by January 31, 2005.

(47) ~~(48)~~ A provider is not entitled to enrollment in the Medicaid provider network. The agency may implement a Medicaid fee-for-service provider network controls, including, but not limited to, competitive procurement and provider credentialing. If a credentialing process is used, the agency may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural competency, demographic characteristics of beneficiaries, practice standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

(48) ~~(49)~~ The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care, or as a capitated rate provider for Medicaid services. Any savings shall be shared with the minority physician networks pursuant to the contract.

(c) For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(d) The agency may apply for any federal waivers needed to implement this subsection.

(50) To the extent permitted by federal law and as allowed under s. 409.906, the agency shall provide reimbursement for emergency mental health care services for Medicaid recipients in crisis-stabilization facilities licensed under s. 394.875 as long as those services are less expensive than the same services provided in a hospital setting.

Section 4. Paragraphs (a) and (j) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. Upon enrollment, individuals will be able to change their managed care option during the 90-day opt out period required by federal Medicaid regulations. The agency is authorized to seek the necessary Medicaid state plan amendment to implement this policy. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Centers for Medicare and Medicaid Services ~~Health Care Financing Administration~~.

The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement

may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass. School districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(j) The agency shall apply for a federal waiver from the Centers for Medicare and Medicaid Services ~~Health Care Financing~~

~~Administration~~ to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.

Section 5. Subsection (2) of section 409.913, Florida Statutes, is amended, and subsection (36) is added to that section, to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means;

the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments.

(2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis.

(36) The agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and

Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation.

Section 6. The Agency for Health Care Administration shall submit to the Legislature by January 15, 2006, recommendations to ensure that Medicaid is the payer of last resort as required by section 409.910, Florida Statutes. The report must identify the public and private entities that are liable for primary payment of health care services and recommend methods to improve enforcement of third-party liability responsibility and repayment of benefits to the state Medicaid program. The report must estimate the potential recoveries that may be achieved through third-party liability efforts if administrative and legal barriers are removed. The report must recommend whether modifications to the agency's contingency-fee contract for third-party liability could enhance third-party liability for benefits provided to Medicaid recipients.

Section 7. By January 15, 2006, the Office of Program Policy Analysis and Government Accountability shall submit to the Legislature a study of the long-term care community diversion pilot project authorized under ss. 430.701-430.709. The study may be conducted by Office of Program Policy Analysis and Government Accountability staff or by a consultant obtained

through a competitive bid. The study must use a statistically-valid methodology to assess the percent of persons served in the project over a 2-year period who would have required Medicaid nursing home services without the diversion services, which services are most frequently used, and which services are least frequently used. The study must determine whether the project is cost-effective or is an expansion of the Medicaid program because a preponderance of the project enrollees would not have required Medicaid nursing home services within a 2-year period regardless of the availability of the project or that the enrollees could have been safely served through another Medicaid program at a lower cost to the state.

Section 8. The Agency for Health Care Administration shall identify how many individuals in the long-term care diversion programs who receive care at home have a patient-responsibility payment associated with their participation in the diversion program. If no system is available to assess this information, the agency shall determine the cost of creating a system to identify and collect these payments and whether the cost of developing a system for this purpose is offset by the amount of patient-responsibility payments which could be collected with the system. The agency shall report this information to the Legislature by December 1, 2005.

Section 9. This act shall take effect July 1, 2005.