1 A bill to be entitled
2 An act relating to Medicaid; amending s.
3 409.911, F.S.; adding a duty to the Medicaid
4 Disproportionate Share Council; providing a
5 future repeal of the Disproportionate Share
6 Council; creating the Medicaid Low-Income Pool
7 Council; providing for membership and duties;
8 amending s. 409.912, F.S.; authorizing the
9 Agency for Health Care Administration to
10 contract with comprehensive behavioral health
11 plans in separate counties within or adjacent
12 to an AHCA area; providing that specified
13 federally qualified health centers or entities
14 that are owned by one or more federally
15 qualified health centers are exempt from the
16 requirements imposed by law on health
17 maintenance organizations and health care
18 services; providing exceptions; conforming
19 provisions to the solvency requirements in s.
20 641.2261, F.S.; deleting the
21 competitive-procurement requirement for
22 provider service networks; updating a reference
23 to the provider service network; amending s.
24 409.91211, F.S.; specifying the process for
25 statewide expansion of the Medicaid managed
26 care demonstration program; requiring that
27 matching funds for the Medicaid managed care
28 pilot program be provided by local governmental
29 entities; providing for distribution of funds
30 by the agency; providing legislative intent
31 with respect to the low-income pool plan

1 required under the Medicaid reform waiver;
2 specifying the agency's powers, duties, and
3 responsibilities with respect to implementing
4 the Medicaid managed care pilot program;
5 revising the guidelines for allowing a provider
6 service network to receive fee-for-service
7 payments in the demonstration areas;
8 authorizing the agency to make direct payments
9 to hospitals and physicians for the costs
10 associated with graduate medical education
11 under Medicaid reform; including the Children's
12 Medical Services Network in the Department of
13 Health within those programs intended by the
14 Legislature to participate in the pilot program
15 to the extent possible; requiring that the
16 agency implement standards of quality assurance
17 and performance improvement in the
18 demonstration areas of the pilot program;
19 requiring the agency to establish an encounter
20 database to compile data from managed care
21 plans; requiring the agency to implement
22 procedures to minimize the risk of Medicaid
23 fraud and abuse in all managed care plans in
24 the demonstration areas; clarifying that the
25 assignment process for the pilot program is
26 exempt from certain mandatory procedures for
27 Medicaid managed care enrollment specified in
28 s. 409.9122, F.S.; revising the automatic
29 assignment process in the demonstration areas;
30 requiring that the agency report any
31 modifications to the approved waiver and

1 special terms and conditions to the Legislature
2 within specified time periods; authorizing the
3 agency to implement the provisions of the
4 waiver approved by federal Centers for Medicare
5 and Medicaid Services; requiring the Secretary
6 of Health Care Administration to convene a
7 technical advisory panel to advise the agency
8 in matters relating to rate setting, benefit
9 design, and choice counseling; providing for
10 panel members; providing certain requirements
11 for managed care plans providing benefits to
12 TANF and SSI recipients; providing for
13 capitation rates to be phased in; providing an
14 exception for high-risk, specialty populations;
15 requiring the certification of rates by an
16 actuary and federal approval; providing that,
17 if any conflict exists between the provisions
18 contained in s. 409.91211, F.S., and ch. 409,
19 F.S., concerning the implementation of the
20 pilot program, the provisions contained in s.
21 409.91211, F.S., control; creating s.
22 409.91213, F.S.; requiring the agency to submit
23 quarterly and annual progress reports to the
24 Legislature; providing requirements for the
25 reports; amending s. 641.2261, F.S.; revising
26 the application of solvency requirements to
27 include Medicaid provider service networks;
28 updating a reference; requiring that the agency
29 report to the Legislature the
30 pre-implementation milestones concerning the
31 low-income pool which have been approved by the

1 Federal Government and the status of those
2 remaining to be approved; amending s. 216.346,
3 F.S.; revising provisions relating to contracts
4 between state agencies; providing an effective
5 date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Subsection (9) of section 409.911, Florida
10 Statutes, is amended, and subsection (10) is added to that
11 section, to read:
12 409.911 Disproportionate share program.--Subject to
13 specific allocations established within the General
14 Appropriations Act and any limitations established pursuant to
15 chapter 216, the agency shall distribute, pursuant to this
16 section, moneys to hospitals providing a disproportionate
17 share of Medicaid or charity care services by making quarterly
18 Medicaid payments as required. Notwithstanding the provisions
19 of s. 409.915, counties are exempt from contributing toward
20 the cost of this special reimbursement for hospitals serving a
21 disproportionate share of low-income patients.
22 (9) The Agency for Health Care Administration shall
23 create a Medicaid Disproportionate Share Council.
24 (a) The purpose of the council is to study and make
25 recommendations regarding:
26 1. The formula for the regular disproportionate share
27 program and alternative financing options.
28 2. Enhanced Medicaid funding through the Special
29 Medicaid Payment program.
30 3. The federal status of the upper-payment-limit
31 funding option and how this option may be used to promote

1 health care initiatives determined by the council to be state
2 health care priorities.
3 4. The development of the low-income pool plan as
4 required by the federal Centers for Medicare and Medicaid
5 Services using the objectives established in s.
6 409.91211(1)(c).
7 (b) The council shall include representatives of the
8 Executive Office of the Governor and of the agency;
9 representatives from teaching, public, private nonprofit,
10 private for-profit, and family practice teaching hospitals;
11 and representatives from other groups as needed. The agency
12 must ensure that there is fair representation of each group
13 specified in this paragraph.
14 (c) The council shall submit its findings and
15 recommendations to the Governor and the Legislature no later
16 than March ~~February~~ 1 of each year.
17 (d) This subsection shall stand repealed June 30,
18 2006, unless reviewed and saved from repeal through
19 reenactment by the Legislature.
20 (10) The Agency for Health Care Administration shall
21 create a Medicaid Low-Income Pool Council by July 1, 2006. The
22 Low-Income Pool Council shall consist of 17 members, including
23 three representatives of statutory teaching hospitals, three
24 representatives of public hospitals, three representatives of
25 nonprofit hospitals, three representatives of for-profit
26 hospitals, two representatives of rural hospitals, two
27 representatives of units of local government which contribute
28 funding, and one representative of family practice teaching
29 hospitals. The council shall:
30
31

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1 (a) Make recommendations on the financing of the
2 low-income pool and the disproportionate share hospital
3 program and the distribution of their funds.
4 (b) Advise the Agency for Health Care Administration
5 on the development of the low-income pool plan required by the
6 federal Centers for Medicare and Medicaid Services pursuant to
7 the Medicaid reform waiver.
8 (c) Advise the Agency for Health Care Administration
9 on the distribution of hospital funds used to adjust inpatient
10 hospital rates, rebase rates, or otherwise exempt hospitals
11 from reimbursement limits as financed by intergovernmental
12 transfers.
13 (d) Submit its findings and recommendations to the
14 Governor and the Legislature no later than February 1 of each
15 year.
16 Section 2. Paragraphs (b), (c), and (d) of subsection
17 (4) of section 409.912, Florida Statutes, are amended to read:
18 409.912 Cost-effective purchasing of health care.--The
19 agency shall purchase goods and services for Medicaid
20 recipients in the most cost-effective manner consistent with
21 the delivery of quality medical care. To ensure that medical
22 services are effectively utilized, the agency may, in any
23 case, require a confirmation or second physician's opinion of
24 the correct diagnosis for purposes of authorizing future
25 services under the Medicaid program. This section does not
26 restrict access to emergency services or poststabilization
27 care services as defined in 42 C.F.R. part 438.114. Such
28 confirmation or second opinion shall be rendered in a manner
29 approved by the agency. The agency shall maximize the use of
30 prepaid per capita and prepaid aggregate fixed-sum basis
31 services when appropriate and other alternative service

1 delivery and reimbursement methodologies, including
2 competitive bidding pursuant to s. 287.057, designed to
3 facilitate the cost-effective purchase of a case-managed
4 continuum of care. The agency shall also require providers to
5 minimize the exposure of recipients to the need for acute
6 inpatient, custodial, and other institutional care and the
7 inappropriate or unnecessary use of high-cost services. The
8 agency shall contract with a vendor to monitor and evaluate
9 the clinical practice patterns of providers in order to
10 identify trends that are outside the normal practice patterns
11 of a provider's professional peers or the national guidelines
12 of a provider's professional association. The vendor must be
13 able to provide information and counseling to a provider whose
14 practice patterns are outside the norms, in consultation with
15 the agency, to improve patient care and reduce inappropriate
16 utilization. The agency may mandate prior authorization, drug
17 therapy management, or disease management participation for
18 certain populations of Medicaid beneficiaries, certain drug
19 classes, or particular drugs to prevent fraud, abuse, overuse,
20 and possible dangerous drug interactions. The Pharmaceutical
21 and Therapeutics Committee shall make recommendations to the
22 agency on drugs for which prior authorization is required. The
23 agency shall inform the Pharmaceutical and Therapeutics
24 Committee of its decisions regarding drugs subject to prior
25 authorization. The agency is authorized to limit the entities
26 it contracts with or enrolls as Medicaid providers by
27 developing a provider network through provider credentialing.
28 The agency may competitively bid single-source-provider
29 contracts if procurement of goods or services results in
30 demonstrated cost savings to the state without limiting access
31 to care. The agency may limit its network based on the

1 assessment of beneficiary access to care, provider
2 availability, provider quality standards, time and distance
3 standards for access to care, the cultural competence of the
4 provider network, demographic characteristics of Medicaid
5 beneficiaries, practice and provider-to-beneficiary standards,
6 appointment wait times, beneficiary use of services, provider
7 turnover, provider profiling, provider licensure history,
8 previous program integrity investigations and findings, peer
9 review, provider Medicaid policy and billing compliance
10 records, clinical and medical record audits, and other
11 factors. Providers shall not be entitled to enrollment in the
12 Medicaid provider network. The agency shall determine
13 instances in which allowing Medicaid beneficiaries to purchase
14 durable medical equipment and other goods is less expensive to
15 the Medicaid program than long-term rental of the equipment or
16 goods. The agency may establish rules to facilitate purchases
17 in lieu of long-term rentals in order to protect against fraud
18 and abuse in the Medicaid program as defined in s. 409.913.
19 The agency may seek federal waivers necessary to administer
20 these policies.
21 (4) The agency may contract with:
22 (b) An entity that is providing comprehensive
23 behavioral health care services to certain Medicaid recipients
24 through a capitated, prepaid arrangement pursuant to the
25 federal waiver provided for by s. 409.905(5). Such an entity
26 must be licensed under chapter 624, chapter 636, or chapter
27 641 and must possess the clinical systems and operational
28 competence to manage risk and provide comprehensive behavioral
29 health care to Medicaid recipients. As used in this paragraph,
30 the term "comprehensive behavioral health care services" means
31 covered mental health and substance abuse treatment services

1 that are available to Medicaid recipients. The secretary of
2 the Department of Children and Family Services shall approve
3 provisions of procurements related to children in the
4 department's care or custody prior to enrolling such children
5 in a prepaid behavioral health plan. Any contract awarded
6 under this paragraph must be competitively procured. In
7 developing the behavioral health care prepaid plan procurement
8 document, the agency shall ensure that the procurement
9 document requires the contractor to develop and implement a
10 plan to ensure compliance with s. 394.4574 related to services
11 provided to residents of licensed assisted living facilities
12 that hold a limited mental health license. Except as provided
13 in subparagraph 8., and except in counties where the Medicaid
14 managed care pilot program is authorized pursuant s.
15 409.91211, the agency shall seek federal approval to contract
16 with a single entity meeting these requirements to provide
17 comprehensive behavioral health care services to all Medicaid
18 recipients not enrolled in a Medicaid managed care plan
19 authorized under s. 409.91211 or a Medicaid health maintenance
20 organization in an AHCA area. In an AHCA area where the
21 Medicaid managed care pilot program is authorized pursuant to
22 s. 409.91211 in one or more counties, the agency may procure a
23 contract with a single entity to serve the remaining counties
24 as an AHCA area or the remaining counties may be included with
25 an adjacent AHCA area and shall be subject to this paragraph.
26 Each entity must offer sufficient choice of providers in its
27 network to ensure recipient access to care and the opportunity
28 to select a provider with whom they are satisfied. The network
29 shall include all public mental health hospitals. To ensure
30 unimpaired access to behavioral health care services by
31 Medicaid recipients, all contracts issued pursuant to this

1 paragraph shall require 80 percent of the capitation paid to
2 the managed care plan, including health maintenance
3 organizations, to be expended for the provision of behavioral
4 health care services. In the event the managed care plan
5 expends less than 80 percent of the capitation paid pursuant
6 to this paragraph for the provision of behavioral health care
7 services, the difference shall be returned to the agency. The
8 agency shall provide the managed care plan with a
9 certification letter indicating the amount of capitation paid
10 during each calendar year for the provision of behavioral
11 health care services pursuant to this section. The agency may
12 reimburse for substance abuse treatment services on a
13 fee-for-service basis until the agency finds that adequate
14 funds are available for capitated, prepaid arrangements.
15 1. By January 1, 2001, the agency shall modify the
16 contracts with the entities providing comprehensive inpatient
17 and outpatient mental health care services to Medicaid
18 recipients in Hillsborough, Highlands, Hardee, Manatee, and
19 Polk Counties, to include substance abuse treatment services.
20 2. By July 1, 2003, the agency and the Department of
21 Children and Family Services shall execute a written agreement
22 that requires collaboration and joint development of all
23 policy, budgets, procurement documents, contracts, and
24 monitoring plans that have an impact on the state and Medicaid
25 community mental health and targeted case management programs.
26 3. Except as provided in subparagraph 8., by July 1,
27 2006, the agency and the Department of Children and Family
28 Services shall contract with managed care entities in each
29 AHCA area except area 6 or arrange to provide comprehensive
30 inpatient and outpatient mental health and substance abuse
31 services through capitated prepaid arrangements to all

1 Medicaid recipients who are eligible to participate in such
2 plans under federal law and regulation. In AHCA areas where
3 eligible individuals number less than 150,000, the agency
4 shall contract with a single managed care plan to provide
5 comprehensive behavioral health services to all recipients who
6 are not enrolled in a Medicaid health maintenance organization
7 or a Medicaid capitated managed care plan authorized under s.
8 409.91211. The agency may contract with more than one
9 comprehensive behavioral health provider to provide care to
10 recipients who are not enrolled in a Medicaid capitated
11 managed care plan authorized under s. 409.91211 or a Medicaid
12 health maintenance organization in AHCA areas where the
13 eligible population exceeds 150,000. In an AHCA area where the
14 Medicaid managed care pilot program is authorized pursuant to
15 s. 409.91211 in one or more counties, the agency may procure a
16 contract with a single entity to serve the remaining counties
17 as an AHCA area or the remaining counties may be included with
18 an adjacent AHCA area and shall be subject to this paragraph.
19 Contracts for comprehensive behavioral health providers
20 awarded pursuant to this section shall be competitively
21 procured. Both for-profit and not-for-profit corporations
22 shall be eligible to compete. Managed care plans contracting
23 with the agency under subsection (3) shall provide and receive
24 payment for the same comprehensive behavioral health benefits
25 as provided in AHCA rules, including handbooks incorporated by
26 reference. In AHCA area 11, the agency shall contract with at
27 least two comprehensive behavioral health care providers to
28 provide behavioral health care to recipients in that area who
29 are enrolled in, or assigned to, the MediPass program. One of
30 the behavioral health care contracts shall be with the
31 existing provider service network pilot project, as described

1 in paragraph (d), for the purpose of demonstrating the
2 cost-effectiveness of the provision of quality mental health
3 services through a public hospital-operated managed care
4 model. Payment shall be at an agreed-upon capitated rate to
5 ensure cost savings. Of the recipients in area 11 who are
6 assigned to MediPass under the provisions of s.
7 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled
8 recipients shall be assigned to the existing provider service
9 network in area 11 for their behavioral care.
10 4. By October 1, 2003, the agency and the department
11 shall submit a plan to the Governor, the President of the
12 Senate, and the Speaker of the House of Representatives which
13 provides for the full implementation of capitated prepaid
14 behavioral health care in all areas of the state.
15 a. Implementation shall begin in 2003 in those AHCA
16 areas of the state where the agency is able to establish
17 sufficient capitation rates.
18 b. If the agency determines that the proposed
19 capitation rate in any area is insufficient to provide
20 appropriate services, the agency may adjust the capitation
21 rate to ensure that care will be available. The agency and the
22 department may use existing general revenue to address any
23 additional required match but may not over-obligate existing
24 funds on an annualized basis.
25 c. Subject to any limitations provided for in the
26 General Appropriations Act, the agency, in compliance with
27 appropriate federal authorization, shall develop policies and
28 procedures that allow for certification of local and state
29 funds.
30 5. Children residing in a statewide inpatient
31 psychiatric program, or in a Department of Juvenile Justice or

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1 a Department of Children and Family Services residential
2 program approved as a Medicaid behavioral health overlay
3 services provider shall not be included in a behavioral health
4 care prepaid health plan or any other Medicaid managed care
5 plan pursuant to this paragraph.
6 6. In converting to a prepaid system of delivery, the
7 agency shall in its procurement document require an entity
8 providing only comprehensive behavioral health care services
9 to prevent the displacement of indigent care patients by
10 enrollees in the Medicaid prepaid health plan providing
11 behavioral health care services from facilities receiving
12 state funding to provide indigent behavioral health care, to
13 facilities licensed under chapter 395 which do not receive
14 state funding for indigent behavioral health care, or
15 reimburse the unsubsidized facility for the cost of behavioral
16 health care provided to the displaced indigent care patient.
17 7. Traditional community mental health providers under
18 contract with the Department of Children and Family Services
19 pursuant to part IV of chapter 394, child welfare providers
20 under contract with the Department of Children and Family
21 Services in areas 1 and 6, and inpatient mental health
22 providers licensed pursuant to chapter 395 must be offered an
23 opportunity to accept or decline a contract to participate in
24 any provider network for prepaid behavioral health services.
25 8. For fiscal year 2004-2005, all Medicaid eligible
26 children, except children in areas 1 and 6, whose cases are
27 open for child welfare services in the HomeSafeNet system,
28 shall be enrolled in MediPass or in Medicaid fee-for-service
29 and all their behavioral health care services including
30 inpatient, outpatient psychiatric, community mental health,
31 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. A federally qualified health center or an entity that is owned by one or more federally qualified health centers and is reimbursed by the agency on a prepaid basis is exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet the appropriate requirements governing financial reserve, quality assurance, and patients' rights established by the agency. ~~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~~

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~~entity meets the requirements specified in subsections (17) and (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 comply with the solvency requirements in s. 641.2261(2) and 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 provider service network ~~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. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the

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1 financial risk on a prospective basis for the provision of
2 basic health services by the physicians, by other health
3 professionals, or through the institutions. The health care
4 providers must have a controlling interest in the governing
5 body of the provider service network organization.
6 Section 3. Section 409.91211, Florida Statutes, is
7 amended to read:
8 409.91211 Medicaid managed care pilot program.--
9 (1)(a) The agency is authorized to seek and implement
10 experimental, pilot, or demonstration project waivers,
11 pursuant to s. 1115 of the Social Security Act, to create a
12 statewide initiative to provide for a more efficient and
13 effective service delivery system that enhances quality of
14 care and client outcomes in the Florida Medicaid program
15 pursuant to this section. Phase one of the demonstration shall
16 be implemented in two geographic areas. One demonstration site
17 shall include only Broward County. A second demonstration site
18 shall initially include Duval County and shall be expanded to
19 include Baker, Clay, and Nassau Counties within 1 year after
20 the Duval County program becomes operational. The agency shall
21 implement expansion of the program to include the remaining
22 counties of the state and remaining eligibility groups in
23 accordance with the process specified in the
24 federally-approved special terms and conditions numbered
25 11-W-00206/4, as approved by the federal Centers for Medicare
26 and Medicaid Services on October 19, 2005, with a goal of full
27 statewide implementation by June 30, 2011.
28 (b) This waiver authority is contingent upon federal
29 approval to preserve the upper-payment-limit funding mechanism
30 for hospitals, including a guarantee of a reasonable growth
31 factor, a methodology to allow the use of a portion of these

1 funds to serve as a risk pool for demonstration sites,
2 provisions to preserve the state's ability to use
3 intergovernmental transfers, and provisions to protect the
4 disproportionate share program authorized pursuant to this
5 chapter. Upon completion of the evaluation conducted under s.
6 3, ch. 2005-133, Laws of Florida, the agency may request
7 statewide expansion of the demonstration projects. Statewide
8 phase-in to additional counties shall be contingent upon
9 review and approval by the Legislature. Under the
10 upper-payment-limit program, or the low-income pool as
11 implemented by the Agency for Health Care Administration
12 pursuant to federal waiver, the state matching funds required
13 for the program shall be provided by local governmental
14 entities through intergovernmental transfers in accordance
15 with published federal statutes and regulations. The Agency
16 for Health Care Administration shall distribute
17 upper-payment-limit, disproportionate share hospital, and
18 low-income pool funds according to published federal statutes,
19 regulations, and waivers and the low-income pool methodology
20 approved by the federal Centers for Medicare and Medicaid
21 Services.
22 (c) It is the intent of the Legislature that the
23 low-income pool plan required by the terms and conditions of
24 the Medicaid reform waiver and submitted to the federal
25 Centers for Medicare and Medicaid Services propose the
26 distribution of the abovementioned program funds based on the
27 following objectives:
28 1. Assure a broad and fair distribution of available
29 funds based on the access provided by Medicaid participating
30 hospitals, regardless of their ownership status, through their
31

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1 delivery of inpatient or outpatient care for Medicaid
2 beneficiaries and uninsured and underinsured individuals;
3 2. Assure accessible emergency inpatient and
4 outpatient care for Medicaid beneficiaries and uninsured and
5 underinsured individuals;
6 3. Enhance primary, preventive, and other ambulatory
7 care coverages for uninsured individuals;
8 4. Promote teaching and specialty hospital programs;
9 5. Promote the stability and viability of statutorily
10 defined rural hospitals and hospitals that serve as sole
11 community hospitals;
12 6. Recognize the extent of hospital uncompensated care
13 costs;
14 7. Maintain and enhance essential community hospital
15 care;
16 8. Maintain incentives for local governmental entities
17 to contribute to the cost of uncompensated care;
18 9. Promote measures to avoid preventable
19 hospitalizations;
20 10. Account for hospital efficiency; and
21 11. Contribute to a community's overall health system.
22 (2) The Legislature intends for the capitated managed
23 care pilot program to:
24 (a) Provide recipients in Medicaid fee-for-service or
25 the MediPass program a comprehensive and coordinated capitated
26 managed care system for all health care services specified in
27 ss. 409.905 and 409.906.
28 (b) Stabilize Medicaid expenditures under the pilot
29 program compared to Medicaid expenditures in the pilot area
30 for the 3 years before implementation of the pilot program,
31 while ensuring:

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1. Consumer education and choice.

2. Access to medically necessary services.

3. Coordination of preventative, acute, and long-term care.

4. Reductions in unnecessary service utilization.

(c) Provide an opportunity to evaluate the feasibility of statewide implementation of capitated managed care networks as a replacement for the current Medicaid fee-for-service and MediPass systems.

(3) The agency shall have the following powers, duties, and responsibilities with respect to the ~~development of a~~ pilot program:

(a) To implement ~~develop and recommend~~ a system to deliver all mandatory services specified in s. 409.905 and optional services specified in s. 409.906, as approved by the Centers for Medicare and Medicaid Services and the Legislature in the waiver pursuant to this section. Services to recipients under plan benefits shall include emergency services provided under s. 409.9128.

(b) To implement a pilot program, including ~~recommend~~ Medicaid eligibility categories~~, from those~~ specified in ss. 409.903 and 409.904, as authorized in an approved federal waiver ~~which shall be included in the pilot program~~.

(c) To implement ~~determine and recommend how to design~~ the managed care pilot program that maximizes ~~in order to take maximum advantage of~~ all available state and federal funds, including those obtained through intergovernmental transfers, the low-income pool, supplemental Medicaid payments ~~the upper payment level funding systems~~, and the disproportionate share program. Within the parameters allowed by federal statute and rule, the agency may seek options for making

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direct payments to hospitals and physicians employed by or under contract with the state's medical schools for the costs associated with graduate medical education under Medicaid reform.

(d) To implement ~~determine and recommend~~ actuarially sound, risk-adjusted capitation rates for Medicaid recipients in the pilot program which ~~can be separated to~~ cover comprehensive care, enhanced services, and catastrophic care.

(e) To implement ~~determine and recommend~~ policies and guidelines for phasing in financial risk for approved provider service networks over a 3-year period. These policies and guidelines must ~~shall~~ include an option for a provider service network to be paid ~~to pay~~ fee-for-service rates ~~that may include a savings settlement option for at least 2 years~~. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall ~~may~~ be converted to a risk-adjusted capitated rate no later than the beginning of the fourth ~~in the third~~ year of operation, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

(f) To implement ~~determine and recommend provisions related to~~ stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates the risks associated with the development of the pilot program.

(g) To ~~determine and~~ recommend a process to be used by the Social Services Estimating Conference to determine and validate the rate of growth of the per-member costs of

providing Medicaid services under the managed care pilot program.

(h) To implement ~~determine and recommend~~ program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers. It is the intent of the Legislature that, to the extent possible, any pilot program authorized by the state under this section include any federally qualified health center, federally qualified rural health clinic, county health department, the Children's Medical Services Network within the Department of Health, or other federally, state, or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate. This paragraph does not relieve an entity that qualifies as a capitated managed care network under this section from any other licensure or regulatory requirements contained in state or federal law which would otherwise apply to the entity. The standards and credentialing requirements shall be based upon, but are not limited to:

1. Compliance with the accreditation requirements as provided in s. 641.512.

2. Compliance with early and periodic screening, diagnosis, and treatment screening requirements under federal law.

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

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7. Specific requirements of the Medicaid program, or standards designed to specifically meet the unique needs of Medicaid recipients.

8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and guidelines developed by the Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.

9. The network's infrastructure capacity to manage financial transactions, recordkeeping, data collection, and other administrative functions.

10. The network's ability to submit 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.

(i) To implement ~~develop and recommend~~ a mechanism for providing information to Medicaid recipients for the purpose of selecting a capitated managed care plan. For each plan available to a recipient, the agency, at a minimum, 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.

1 (j) To <u>implement</u> ~~develop and recommend~~ a system to
2 ensure that there is a record of recipient acknowledgment that
3 choice counseling has been provided.
4 (k) To <u>implement</u> ~~develop and recommend~~ a choice
5 counseling system to ensure that the choice counseling process
6 and related material are designed to provide counseling
7 through face-to-face interaction, by telephone, and in writing
8 and through other forms of relevant media. Materials shall be
9 written at the fourth-grade reading level and available in a
10 language other than English when 5 percent of the county
11 speaks a language other than English. Choice counseling shall
12 also use language lines and other services for impaired
13 recipients, such as TTD/TTY.
14 (l) To <u>implement</u> ~~develop and recommend~~ a system that
15 prohibits capitated managed care plans, their representatives,
16 and providers employed by or contracted with the capitated
17 managed care plans from recruiting persons eligible for or
18 enrolled in Medicaid, from providing inducements to Medicaid
19 recipients to select a particular capitated managed care plan,
20 and from prejudicing Medicaid recipients against other
21 capitated managed care plans. The system shall require the
22 entity performing choice counseling to determine if the
23 recipient has made a choice of a plan or has opted out because
24 of duress, threats, payment to the recipient, or incentives
25 promised to the recipient by a third party. If the choice
26 counseling entity determines that the decision to choose a
27 plan was unlawfully influenced or a plan violated any of the
28 provisions of s. 409.912(21), the choice counseling entity
29 shall immediately report the violation to the agency's program
30 integrity section for investigation. Verification of choice
31

counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(m) To implement ~~develop and recommend~~ a choice counseling system that promotes health literacy and provides information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(n) To ~~develop and recommend a system for the agency to~~ contract with entities to perform choice counseling. The agency may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(o) To implement ~~determine and recommend descriptions of the~~ eligibility assignment processes ~~which will be used~~ to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe.

(p) To implement standards for plan compliance, including, but not limited to, standards for quality assurance and performance improvement, standards for peer or professional reviews, grievance policies, and policies for maintaining program integrity. The agency shall develop a data-reporting system, seek input from managed care plans in order to establish requirements for patient-encounter reporting, and ensure that the data reported is accurate and complete.

1. In performing the duties required under this section, the agency shall work with managed care plans to

1 establish a uniform system to measure and monitor outcomes for
2 a recipient of Medicaid services.
3 2. The system shall use financial, clinical, and other
4 criteria based on pharmacy, medical services, and other data
5 that is related to the provision of Medicaid services,
6 including, but not limited to:
7 a. The Health Plan Employer Data and Information Set
8 (HEDIS) or measures that are similar to HEDIS.
9 b. Member satisfaction.
10 c. Provider satisfaction.
11 d. Report cards on plan performance and best
12 practices.
13 e. Compliance with the requirements for prompt payment
14 of claims under ss. 627.613, 641.3155, and 641.513.
15 f. Utilization and quality data for the purpose of
16 ensuring access to medically necessary services, including
17 underutilization or inappropriate denial of services.
18 3. The agency shall require the managed care plans
19 that have contracted with the agency to establish a quality
20 assurance system that incorporates the provisions of s.
21 409.912(27) and any standards, rules, and guidelines developed
22 by the agency.
23 4. The agency shall establish an encounter database in
24 order to compile data on health services rendered by health
25 care practitioners who provide services to patients enrolled
26 in managed care plans in the demonstration sites. The
27 encounter database shall:
28 a. Collect the following for each type of patient
29 encounter with a health care practitioner or facility,
30 including:
31 (I) The demographic characteristics of the patient.

1 (II) The principal, secondary, and tertiary diagnosis.
2 (III) The procedure performed.
3 (IV) The date and location where the procedure was
4 performed.
5 (V) The payment for the procedure, if any.
6 (VI) If applicable, the health care practitioner's
7 universal identification number.
8 (VII) If the health care practitioner rendering the
9 service is a dependent practitioner, the modifiers appropriate
10 to indicate that the service was delivered by the dependent
11 practitioner.
12 b. Collect appropriate information relating to
13 prescription drugs for each type of patient encounter.
14 c. Collect appropriate information related to health
15 care costs and utilization from managed care plans
16 participating in the demonstration sites.
17 5. To the extent practicable, when collecting the data
18 the agency shall use a standardized claim form or electronic
19 transfer system that is used by health care practitioners,
20 facilities, and payors.
21 6. Health care practitioners and facilities in the
22 demonstration sites shall electronically submit, and managed
23 care plans participating in the demonstration sites shall
24 electronically receive, information concerning claims payments
25 and any other information reasonably related to the encounter
26 database using a standard format as required by the agency.
27 7. The agency shall establish reasonable deadlines for
28 phasing in the electronic transmittal of full encounter data.
29 8. The system must ensure that the data reported is
30 accurate and complete.
31

~~(p) To develop and recommend a system to monitor the provision of health care services in the pilot program, including utilization and quality of health care services for the purpose of ensuring access to medically necessary services. This system shall include an encounter data information system that collects and reports utilization information. The system shall include a method for verifying data integrity within the database and within the provider's medical records.~~

(q) To implement ~~recommend~~ a grievance resolution process for Medicaid recipients enrolled in a capitated managed care network under the pilot program modeled after the subscriber assistance panel, as created in s. 408.7056. This process shall include a mechanism for an expedited review of no greater than 24 hours after notification of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

(r) To implement ~~recommend~~ a grievance resolution process for health care providers employed by or contracted with a capitated managed care network under the pilot program in order to settle disputes among the provider and the managed care network or the provider and the agency.

(s) To implement ~~develop and recommend~~ criteria in an approved federal waiver to designate health care providers as eligible to participate in the pilot program. ~~The agency and capitated managed care networks must follow national guidelines for selecting health care providers, whenever available.~~ These criteria must include at a minimum those criteria specified in s. 409.907.

(t) To use ~~develop and recommend~~ health care provider agreements for participation in the pilot program.

(u) To require that all health care providers under contract with the pilot program be duly licensed in the state, if such licensure is available, and meet other criteria as may be established by the agency. These criteria shall include at a minimum those criteria specified in s. 409.907.

(v) To ensure that managed care organizations work collaboratively ~~develop and recommend agreements~~ with other state or local governmental programs or institutions for the coordination of health care to eligible individuals receiving services from such programs or institutions.

(w) To implement procedures to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program authorized in this section.

1. The agency shall ensure that applicable provisions of this chapter and chapters 414, 626, 641, and 932 which relate to Medicaid fraud and abuse are applied and enforced at the demonstration project sites.

2. Providers must have the certification, license, and credentials that are required by law and waiver requirements.

3. The agency shall ensure that the plan is in compliance with s. 409.912(21) and (22).

4. The agency shall require that each plan establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse. Plans must report instances of fraud and abuse pursuant to chapter 641.

5. The plan shall have written administrative and management arrangements or procedures, including a mandatory compliance plan, which are designed to guard against fraud and abuse. The plan shall designate a compliance officer who has sufficient experience in health care.

6.a. The agency shall require all managed care plan contractors in the pilot program 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.

b. 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, or 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 false claims actions in the provision of managed care, is a violation of law and subject to the penalties provided by law.

c. 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 is linked into a unified system to ensure consistent reviews and investigations.

~~(w) To develop and recommend a system to oversee the activities of pilot program participants, health care providers, capitated managed care networks, and their representatives in order to prevent fraud or abuse, overutilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of participants and to recover overpayments as appropriate. For the purposes of this paragraph, the terms "abuse" and "fraud" have the meanings as provided in s. 409.913. The agency must refer incidents of suspected fraud, abuse, overutilization and~~

1 ~~duplicative utilization, and underutilization or inappropriate~~
2 ~~denial of services to the appropriate regulatory agency.~~
3 (x) To develop and provide actuarial and benefit
4 design analyses that indicate the effect on capitation rates
5 and benefits offered in the pilot program over a prospective
6 5-year period based on the following assumptions:
7 1. Growth in capitation rates which is limited to the
8 estimated growth rate in general revenue.
9 2. Growth in capitation rates which is limited to the
10 average growth rate over the last 3 years in per-recipient
11 Medicaid expenditures.
12 3. Growth in capitation rates which is limited to the
13 growth rate of aggregate Medicaid expenditures between the
14 2003-2004 fiscal year and the 2004-2005 fiscal year.
15 (y) To develop a mechanism to require capitated
16 managed care plans to reimburse qualified emergency service
17 providers, including, but not limited to, ambulance services,
18 in accordance with ss. 409.908 and 409.9128. The pilot program
19 must include a provision for continuing fee-for-service
20 payments for emergency services, including, but not limited
21 to, individuals who access ambulance services or emergency
22 departments and who are subsequently determined to be eligible
23 for Medicaid services.
24 (z) To <u>ensure that</u> ~~develop a system whereby~~ school
25 districts participating in the certified school match program
26 pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by
27 Medicaid, subject to the limitations of s. 1011.70(1), for a
28 Medicaid-eligible child participating in the services as
29 authorized in s. 1011.70, as provided for in s. 409.9071,
30 regardless of whether the child is enrolled in a capitated
31 managed care network. Capitated managed care networks must

1 make a good faith effort to execute agreements with school
2 districts regarding the coordinated provision of services
3 authorized under s. 1011.70. County health departments <u>and</u>
4 <u>federally qualified health centers</u> delivering school-based
5 services pursuant to ss. 381.0056 and 381.0057 must be
6 reimbursed by Medicaid for the federal share for a
7 Medicaid-eligible child who receives Medicaid-covered services
8 in a school setting, regardless of whether the child is
9 enrolled in a capitated managed care network. Capitated
10 managed care networks must make a good faith effort to execute
11 agreements with county health departments <u>and federally</u>
12 <u>qualified health centers</u> regarding the coordinated provision
13 of services to a Medicaid-eligible child. To ensure continuity
14 of care for Medicaid patients, the agency, the Department of
15 Health, and the Department of Education shall develop
16 procedures for ensuring that a student's capitated managed
17 care network provider receives information relating to
18 services provided in accordance with ss. 381.0056, 381.0057,
19 409.9071, and 1011.70.
20 (aa) To <u>implement</u> ~~develop and recommend~~ a mechanism
21 whereby Medicaid recipients who are already enrolled in a
22 managed care plan or the MediPass program in the pilot areas
23 shall be offered the opportunity to change to capitated
24 managed care plans on a staggered basis, as defined by the
25 agency. All Medicaid recipients shall have 30 days in which to
26 make a choice of capitated managed care plans. Those Medicaid
27 recipients who do not make a choice shall be assigned to a
28 capitated managed care plan in accordance with paragraph
29 (4)(a) <u>and shall be exempt from s. 409.9122</u>. To facilitate
30 continuity of care for a Medicaid recipient who is also a
31 recipient of Supplemental Security Income (SSI), prior to

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1 assigning the SSI recipient to a capitated managed care plan,
2 the agency shall determine whether the SSI recipient has an
3 ongoing relationship with a provider or capitated managed care
4 plan, and, if so, the agency shall assign the SSI recipient to
5 that provider or capitated managed care plan where feasible.
6 Those SSI recipients who do not have such a provider
7 relationship shall be assigned to a capitated managed care
8 plan provider in accordance with paragraph (4)(a) and shall be
9 exempt from s. 409.9122.
10 (bb) To develop and recommend a service delivery
11 alternative for children having chronic medical conditions
12 which establishes a medical home project to provide primary
13 care services to this population. The project shall provide
14 community-based primary care services that are integrated with
15 other subspecialties to meet the medical, developmental, and
16 emotional needs for children and their families. This project
17 shall include an evaluation component to determine impacts on
18 hospitalizations, length of stays, emergency room visits,
19 costs, and access to care, including specialty care and
20 patient and family satisfaction.
21 (cc) To develop and recommend service delivery
22 mechanisms within capitated managed care plans to provide
23 Medicaid services as specified in ss. 409.905 and 409.906 to
24 persons with developmental disabilities sufficient to meet the
25 medical, developmental, and emotional needs of these persons.
26 (dd) To develop and recommend service delivery
27 mechanisms within capitated managed care plans to provide
28 Medicaid services as specified in ss. 409.905 and 409.906 to
29 Medicaid-eligible children in foster care. These services must
30 be coordinated with community-based care providers as
31 specified in s. 409.1675, where available, and be sufficient

1 to meet the medical, developmental, and emotional needs of
2 these children.
3 (4)(a) A Medicaid recipient in the pilot area who is
4 not currently enrolled in a capitated managed care plan upon
5 implementation is not eligible for services as specified in
6 ss. 409.905 and 409.906, for the amount of time that the
7 recipient does not enroll in a capitated managed care network.
8 If a Medicaid recipient has not enrolled in a capitated
9 managed care plan within 30 days after eligibility, the agency
10 shall assign the Medicaid recipient to a capitated managed
11 care plan based on the assessed needs of the recipient as
12 determined by the agency and the recipient shall be exempt
13 from s. 409.9122. When making assignments, the agency shall
14 take into account the following criteria:
15 1. A capitated managed care network has sufficient
16 network capacity to meet the needs of members.
17 2. The capitated managed care network has previously
18 enrolled the recipient as a member, or one of the capitated
19 managed care network's primary care providers has previously
20 provided health care to the recipient.
21 3. The agency has knowledge that the member has
22 previously expressed a preference for a particular capitated
23 managed care network as indicated by Medicaid fee-for-service
24 claims data, but has failed to make a choice.
25 4. The capitated managed care network's primary care
26 providers are geographically accessible to the recipient's
27 residence.
28 (b) When more than one capitated managed care network
29 provider meets the criteria specified in paragraph (3)(h), the
30 agency shall make recipient assignments consecutively by
31 family unit.

(c) If a recipient is currently enrolled with a Medicaid managed care organization that also operates an approved reform plan within a demonstration area and the recipient fails to choose a plan during the reform enrollment process or during redetermination of eligibility, the recipient shall be automatically assigned by the agency into the most appropriate reform plan operated by the recipient's current Medicaid managed care plan. If the recipient's current managed care plan does not operate a reform plan in the demonstration area which adequately meets the needs of the Medicaid recipient, the agency shall use the automatic assignment process as prescribed in the special terms and conditions numbered 11-W-00206/4. All enrollment and choice counseling materials provided by the agency must contain an explanation of the provisions of this paragraph for current managed care recipients.

(d)~~(c)~~ The agency may not engage in practices that are designed to favor one capitated managed care plan over another or that are designed to influence Medicaid recipients to enroll in a particular capitated managed care network in order to strengthen its particular fiscal viability.

(e)~~(d)~~ After a recipient has made a selection or has been enrolled in a capitated managed care network, the recipient shall have 90 days in which to voluntarily disenroll and select another capitated managed care network. 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 capitated managed care network's grievance process as specified in paragraph (3)(g) 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.

(f)~~(e)~~ The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a capitated managed care network for 12 months after an open enrollment period. After 12 months of enrollment, a recipient may select another capitated managed care network. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the capitated managed care network during the 12-month period.

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(g)~~(f)~~ The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid-certified plan. This provision shall be known as the opt-out option.

1. 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.

2. 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.

(5) 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 in any part of the state other than the two geographic areas specified in this section unless approved by the Legislature.

(6) The agency shall develop and submit for approval applications for waivers of applicable federal laws and

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1 regulations as necessary to implement the managed care pilot
2 project as defined in this section. The agency shall post all
3 waiver applications under this section on its Internet website
4 30 days before submitting the applications to the United
5 States Centers for Medicare and Medicaid Services. All waiver
6 applications shall be provided for review and comment to the
7 appropriate committees of the Senate and House of
8 Representatives for at least 10 working days prior to
9 submission. All waivers submitted to and approved by the
10 United States Centers for Medicare and Medicaid Services under
11 this section must be approved by the Legislature. Federally
12 approved waivers must be submitted to the President of the
13 Senate and the Speaker of the House of Representatives for
14 referral to the appropriate legislative committees. The
15 appropriate committees shall recommend whether to approve the
16 implementation of any waivers to the Legislature as a whole.
17 The agency shall submit a plan containing a recommended
18 timeline for implementation of any waivers and budgetary
19 projections of the effect of the pilot program under this
20 section on the total Medicaid budget for the 2006-2007 through
21 2009-2010 state fiscal years. This implementation plan shall
22 be submitted to the President of the Senate and the Speaker of
23 the House of Representatives at the same time any waivers are
24 submitted for consideration by the Legislature. The agency may
25 implement the waiver and special terms and conditions numbered
26 11-W-00206/4, as approved by the federal Centers for Medicare
27 and Medicaid Services. If the agency seeks approval by the
28 Federal Government of any modifications to these special terms
29 and conditions, the agency must provide written notification
30 of its intent to modify these terms and conditions to the
31 President of the Senate and the Speaker of the House of

1 Representatives at least 15 days before submitting the
2 modifications to the Federal Government for consideration. The
3 notification must identify all modifications being pursued and
4 the reason the modifications are needed. Upon receiving
5 federal approval of any modifications to the special terms and
6 conditions, the agency shall provide a report to the
7 Legislature describing the federally approved modifications to
8 the special terms and conditions within 7 days after approval
9 by the Federal Government.
10 (7)(a) The Secretary of Health Care Administration
11 shall convene a technical advisory panel to advise the agency
12 in the areas of risk-adjusted-rate setting, benefit design,
13 and choice counseling. The panel shall include representatives
14 from the Florida Association of Health Plans, representatives
15 from provider-sponsored networks, a Medicaid consumer
16 representative, and a representative from the Office of
17 Insurance Regulation.
18 (b) The technical advisory panel shall advise the
19 agency concerning:
20 1. The risk-adjusted rate methodology to be used by
21 the agency, including recommendations on mechanisms to
22 recognize the risk of all Medicaid enrollees and for the
23 transition to a risk-adjustment system, including
24 recommendations for phasing in risk adjustment and the use of
25 risk corridors.
26 2. Implementation of an encounter data system to be
27 used for risk-adjusted rates.
28 3. Administrative and implementation issues regarding
29 the use of risk-adjusted rates, including, but not limited to,
30 cost, simplicity, client privacy, data accuracy, and data
31 exchange.

1 4. Issues of benefit design, including the actuarial
2 equivalence and sufficiency standards to be used.
3 5. The implementation plan for the proposed
4 choice-counseling system, including the information and
5 materials to be provided to recipients, the methodologies by
6 which recipients will be counseled regarding choice, criteria
7 to be used to assess plan quality, the methodology to be used
8 to assign recipients into plans if they fail to choose a
9 managed care plan, and the standards to be used for
10 responsiveness to recipient inquiries.
11 (c) The technical advisory panel shall continue in
12 existence and advise the agency on matters outlined in this
13 subsection.
14 (8) The agency must ensure, in the first two state
15 fiscal years in which a risk-adjusted methodology is a
16 component of rate setting, that no managed care plan providing
17 comprehensive benefits to TANF and SSI recipients has an
18 aggregate risk score that varies by more than 10 percent from
19 the aggregate weighted mean of all managed care plans
20 providing comprehensive benefits to TANF and SSI recipients in
21 a reform area. The agency's payment to a managed care plan
22 shall be based on such revised aggregate risk score.
23 (9) After any calculations of aggregate risk scores or
24 revised aggregate risk scores in subsection (8), the
25 capitation rates for plans participating under s. 409.91211
26 shall be phased in as follows:
27 (a) In the first year, the capitation rates shall be
28 weighted so that 75 percent of each capitation rate is based
29 on the current methodology and 25 percent is based on a new
30 risk-adjusted capitation rate methodology.
31

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(b) In the second year, the capitation rates shall be weighted so that 50 percent of each capitation rate is based on the current methodology and 50 percent is based on a new risk-adjusted rate methodology.

(c) In the following fiscal year, the risk-adjusted capitation methodology may be fully implemented.

(10) Subsections (8) and (9) do not apply to managed care plans offering benefits exclusively to high-risk, specialty populations. The agency may set risk-adjusted rates immediately for such plans.

(11) Before the implementation of risk-adjusted rates, the rates shall be certified by an actuary and approved by the federal Centers for Medicare and Medicaid Services.

(12) For purposes of this section, the term "capitated managed care plan" includes health insurers authorized under chapter 624, exclusive provider organizations authorized under chapter 627, health maintenance organizations authorized under chapter 641, the Children's Medical Services Network under chapter 391, and provider service networks that elect to be paid fee-for-service for up to 3 years as authorized under this section.

(13)~~(7)~~ Upon review and approval of the applications for waivers of applicable federal laws and regulations to implement the managed care pilot program by the Legislature, the agency may initiate adoption of rules pursuant to ss. 120.536(1) and 120.54 to implement and administer the managed care pilot program as provided in this section.

(14) It is the intent of the Legislature that if any conflict exists between the provisions contained in this section and other provisions of this chapter which relate to the implementation of the Medicaid managed care pilot program,

1 the provisions contained in this section shall control. The
2 agency shall provide a written report to the Legislature by
3 April 1, 2006, identifying any provisions of this chapter
4 which conflict with the implementation of the Medicaid managed
5 care pilot program created in this section. After April 1,
6 2006, the agency shall provide a written report to the
7 Legislature immediately upon identifying any provisions of
8 this chapter which conflict with the implementation of the
9 Medicaid managed care pilot program created in this section.
10 Section 4. Section 409.91213, Florida Statutes, is
11 created to read:
12 409.91213 Quarterly progress reports and annual
13 reports.--
14 (1) The agency shall submit to the Governor, the
15 President of the Senate, the Speaker of the House of
16 Representatives, the Minority Leader of the Senate, the
17 Minority Leader of the House of Representatives, and the
18 Office of Program Policy Analysis and Government
19 Accountability the following reports:
20 (a) The quarterly progress report submitted to the
21 United States Centers for Medicare and Medicaid Services no
22 later than 60 days following the end of each quarter. The
23 intent of this report is to present the agency's analysis and
24 the status of various operational areas. The quarterly
25 progress report must include, but need not be limited to:
26 1. Events occurring during the quarter or anticipated
27 to occur in the near future which affect health care delivery,
28 including, but not limited to, the approval of and contracts
29 for new plans, which report must specify the coverage area,
30 phase-in period, populations served, and benefits; the
31 enrollment; grievances; and other operational issues.

1 2. Action plans for addressing any policy and
2 administrative issues.
3 3. Agency efforts related to collecting and verifying
4 encounter data and utilization data.
5 4. Enrollment data disaggregated by plan and by
6 eligibility category, such as Temporary Assistance for Needy
7 Families or Supplemental Security Income; the total number of
8 enrollees; market share; and the percentage change in
9 enrollment by plan. In addition, the agency shall provide a
10 summary of voluntary and mandatory selection rates and
11 disenrollment data.
12 5. For purposes of monitoring budget neutrality,
13 enrollment data, member-month data, and expenditures in the
14 format for monitoring budget neutrality which is provided by
15 the federal Centers for Medicare and Medicaid Services.
16 6. Activities and associated expenditures of the
17 low-income pool.
18 7. Activities related to the implementation of choice
19 counseling, including efforts to improve health literacy and
20 the methods used to obtain public input, such as recipient
21 focus groups.
22 8. Participation rates in the enhanced benefit
23 accounts program, including participation levels; a summary of
24 activities and associated expenditures; the number of accounts
25 established, including active participants and individuals who
26 continue to retain access to funds in an account but who no
27 longer actively participate; an estimate of quarterly deposits
28 in the accounts; and expenditures from the accounts.
29 9. Enrollment data concerning employer-sponsored
30 insurance which document the number of individuals selecting
31 to opt out when employer-sponsored insurance is available. The

1 agency shall include data that identify enrollee
2 characteristics, including the eligibility category, type of
3 employer-sponsored insurance, and type of coverage, such as
4 individual or family coverage. The agency shall develop and
5 maintain disenrollment reports specifying the reason for
6 disenrollment in an employer-sponsored insurance program. The
7 agency shall also track and report on those enrollees who
8 elect the option to reenroll in the Medicaid reform
9 demonstration.
10 10. Progress toward meeting the demonstration goals.
11 11. Evaluation activities.
12 (b) An annual report documenting accomplishments,
13 project status, quantitative and case-study findings,
14 utilization data, and policy and administrative difficulties
15 in the operation of the Medicaid waiver demonstration program.
16 The agency shall submit the draft annual report no later than
17 October 1 after the end of each fiscal year.
18 (2) Beginning with the annual report for demonstration
19 year two, the agency shall include a section concerning the
20 administration of enhanced benefit accounts, the participation
21 rates, an assessment of expenditures, and an assessment of
22 potential cost savings.
23 (3) Beginning with the annual report for demonstration
24 year four, the agency shall include a section that provides
25 qualitative and quantitative data describing the impact the
26 low-income pool has had on the rate of uninsured people in
27 this state, beginning with the implementation of the
28 demonstration program.
29 Section 5. Section 641.2261, Florida Statutes, is
30 amended to read:
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CODING: Words ~~stricken~~ are deletions; words underlined are additions.

641.2261 Application of ~~federal~~ solvency requirements to provider-sponsored organizations and Medicaid provider service networks.--

(1) The solvency requirements of ss. 1855 and 1856 of the Balanced Budget Act of 1997 and 42 C.F.R. 422.350, subpart H, ~~rules adopted by the Secretary of the United States Department of Health and Human Services~~ apply to a health maintenance organization that is a provider-sponsored organization rather than the solvency requirements of this part. However, if the provider-sponsored organization does not meet the solvency requirements of this part, the organization is limited to the issuance of Medicare+Choice plans to eligible individuals. For the purposes of this section, the terms "Medicare+Choice plans," "provider-sponsored organizations," and "solvency requirements" have the same meaning as defined in the federal act and federal rules and regulations.

(2) The solvency requirements in 42 C.F.R. 422.350, subpart H, and the solvency requirements established in approved federal waivers pursuant to chapter 409, apply to a Medicaid provider service network rather than the solvency requirements of this part.

Section 6. The Agency for Health Care Administration shall report to the Legislature by April 1, 2006, on the specific pre-implementation milestones required by the special terms and conditions related to the low-income pool which have been approved by the Federal Government and the status of any remaining pre-implementation milestones that have not been approved by the Federal Government.

Section 7. Section 216.346, Florida Statutes, is amended to read:

1 216.346 Contracts between state agencies; restriction
2 on overhead or other indirect costs.--In any contract between
3 state agencies, including any contract involving the State
4 University System or the Florida Community College System, the
5 agency receiving the contract or grant moneys shall charge no
6 more than a reasonable percentage ~~5 percent~~ of the total cost
7 of the contract or grant for overhead or indirect costs or any
8 other costs not required for the payment of direct costs. This
9 provision is not intended to limit an agency's ability to
10 certify matching funds or designate in-kind contributions that
11 will allow the drawdown of federal Medicaid dollars that do
12 not affect state budgeting.
13 Section 8. This act shall take effect upon becoming a
14 law.
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