CHAMBER ACTION

Senate		House
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11 Senators Peaden, Carlton, and Atwater moved the following
12 amendment:
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14 **Senate Amendment (with title amendment)**
15 Delete everything after the enacting clause
16
17 and insert:
18 Section 1. Subsection (9) of section 409.911, Florida
19 Statutes, is amended, and subsection (10) is added to that
20 section, to read:
21 409.911 Disproportionate share program.--Subject to
22 specific allocations established within the General
23 Appropriations Act and any limitations established pursuant to
24 chapter 216, the agency shall distribute, pursuant to this
25 section, moneys to hospitals providing a disproportionate
26 share of Medicaid or charity care services by making quarterly
27 Medicaid payments as required. Notwithstanding the provisions
28 of s. 409.915, counties are exempt from contributing toward
29 the cost of this special reimbursement for hospitals serving a
30 disproportionate share of low-income patients.
31 (9) The Agency for Health Care Administration shall

create a Medicaid Disproportionate Share Council.

(a) The purpose of the council is to study and make recommendations regarding:

1. The formula for the regular disproportionate share program and alternative financing options.

2. Enhanced Medicaid funding through the Special Medicaid Payment program.

3. The federal status of the upper-payment-limit funding option and how this option may be used to promote health care initiatives determined by the council to be state health care priorities.

4. The development of the low-income pool plan as required by the federal Centers for Medicare and Medicaid Services using the objectives established in s. 409.91211(1)(c).

(b) The council shall include representatives of the Executive Office of the Governor and of the agency; representatives from teaching, public, private nonprofit, private for-profit, and family practice teaching hospitals; and representatives from other groups as needed. The agency must ensure that there is fair representation of each group specified in this paragraph.

(c) The council shall submit its findings and recommendations to the Governor and the Legislature no later than March ~~February~~ 1 of each year.

(d) This subsection shall stand repealed June 30, 2006, unless reviewed and saved from repeal through reenactment by the Legislature.

(10) The Agency for Health Care Administration shall create a Medicaid Low-Income Pool Council by July 1, 2006. The Low-Income Pool Council shall consist of 17 members, including

1 three representatives of statutory teaching hospitals, three
2 representatives of public hospitals, three representatives of
3 nonprofit hospitals, three representatives of for-profit
4 hospitals, two representatives of rural hospitals, two
5 representatives of units of local government which contribute
6 funding, and one representative of family practice teaching
7 hospitals. The council shall:
8 (a) Make recommendations on the financing of the
9 low-income pool and the disproportionate share hospital
10 program and the distribution of their funds.
11 (b) Advise the Agency for Health Care Administration
12 on the development of the low-income pool plan required by the
13 federal Centers for Medicare and Medicaid Services pursuant to
14 the Medicaid reform waiver.
15 (c) Advise the Agency for Health Care Administration
16 on the distribution of hospital funds used to adjust inpatient
17 hospital rates, rebase rates, or otherwise exempt hospitals
18 from reimbursement limits as financed by intergovernmental
19 transfers.
20 (d) Submit its findings and recommendations to the
21 Governor and the Legislature no later than February 1 of each
22 year.
23 Section 2. Paragraphs (b), (c), and (d) of subsection
24 (4) of section 409.912, Florida Statutes, are amended to read:
25 409.912 Cost-effective purchasing of health care.--The
26 agency shall purchase goods and services for Medicaid
27 recipients in the most cost-effective manner consistent with
28 the delivery of quality medical care. To ensure that medical
29 services are effectively utilized, the agency may, in any
30 case, require a confirmation or second physician's opinion of
31 the correct diagnosis for purposes of authorizing future

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

1 authorization. The agency is authorized to limit the entities
2 it contracts with or enrolls as Medicaid providers by
3 developing a provider network through provider credentialing.
4 The agency may competitively bid single-source-provider
5 contracts if procurement of goods or services results in
6 demonstrated cost savings to the state without limiting access
7 to care. The agency may limit its network based on the
8 assessment of beneficiary access to care, provider
9 availability, provider quality standards, time and distance
10 standards for access to care, the cultural competence of the
11 provider network, demographic characteristics of Medicaid
12 beneficiaries, practice and provider-to-beneficiary standards,
13 appointment wait times, beneficiary use of services, provider
14 turnover, provider profiling, provider licensure history,
15 previous program integrity investigations and findings, peer
16 review, provider Medicaid policy and billing compliance
17 records, clinical and medical record audits, and other
18 factors. Providers shall not be entitled to enrollment in the
19 Medicaid provider network. The agency shall determine
20 instances in which allowing Medicaid beneficiaries to purchase
21 durable medical equipment and other goods is less expensive to
22 the Medicaid program than long-term rental of the equipment or
23 goods. The agency may establish rules to facilitate purchases
24 in lieu of long-term rentals in order to protect against fraud
25 and abuse in the Medicaid program as defined in s. 409.913.
26 The agency may seek federal waivers necessary to administer
27 these policies.
28 (4) The agency may contract with:
29 (b) An entity that is providing comprehensive
30 behavioral health care services to certain Medicaid recipients
31 through a capitated, prepaid arrangement pursuant to the

1 federal waiver provided for by s. 409.905(5). Such an entity
2 must be licensed under chapter 624, chapter 636, or chapter
3 641 and must possess the clinical systems and operational
4 competence to manage risk and provide comprehensive behavioral
5 health care to Medicaid recipients. As used in this paragraph,
6 the term "comprehensive behavioral health care services" means
7 covered mental health and substance abuse treatment services
8 that are available to Medicaid recipients. The secretary of
9 the Department of Children and Family Services shall approve
10 provisions of procurements related to children in the
11 department's care or custody prior to enrolling such children
12 in a prepaid behavioral health plan. Any contract awarded
13 under this paragraph must be competitively procured. In
14 developing the behavioral health care prepaid plan procurement
15 document, the agency shall ensure that the procurement
16 document requires the contractor to develop and implement a
17 plan to ensure compliance with s. 394.4574 related to services
18 provided to residents of licensed assisted living facilities
19 that hold a limited mental health license. Except as provided
20 in subparagraph 8., <u>and except in counties where the Medicaid</u>
21 <u>managed care pilot program is authorized pursuant s.</u>
22 <u>409.91211,</u> the agency shall seek federal approval to contract
23 with a single entity meeting these requirements to provide
24 comprehensive behavioral health care services to all Medicaid
25 recipients not enrolled in a <u>Medicaid</u> managed care plan
26 <u>authorized under s. 409.91211 or a Medicaid health maintenance</u>
27 <u>organization</u> in an AHCA area. <u>In an AHCA area where the</u>
28 <u>Medicaid managed care pilot program is authorized pursuant to</u>
29 <u>s. 409.91211 in one or more counties, the agency may procure a</u>
30 <u>contract with a single entity to serve the remaining counties</u>
31 <u>as an AHCA area or the remaining counties may be included with</u>

1 an adjacent AHCA area and shall be subject to this paragraph.
2 Each entity must offer sufficient choice of providers in its
3 network to ensure recipient access to care and the opportunity
4 to select a provider with whom they are satisfied. The network
5 shall include all public mental health hospitals. To ensure
6 unimpaired access to behavioral health care services by
7 Medicaid recipients, all contracts issued pursuant to this
8 paragraph shall require 80 percent of the capitation paid to
9 the managed care plan, including health maintenance
10 organizations, to be expended for the provision of behavioral
11 health care services. In the event the managed care plan
12 expends less than 80 percent of the capitation paid pursuant
13 to this paragraph for the provision of behavioral health care
14 services, the difference shall be returned to the agency. The
15 agency shall provide the managed care plan with a
16 certification letter indicating the amount of capitation paid
17 during each calendar year for the provision of behavioral
18 health care services pursuant to this section. The agency may
19 reimburse for substance abuse treatment services on a
20 fee-for-service basis until the agency finds that adequate
21 funds are available for capitated, prepaid arrangements.
22 1. By January 1, 2001, the agency shall modify the
23 contracts with the entities providing comprehensive inpatient
24 and outpatient mental health care services to Medicaid
25 recipients in Hillsborough, Highlands, Hardee, Manatee, and
26 Polk Counties, to include substance abuse treatment services.
27 2. By July 1, 2003, the agency and the Department of
28 Children and Family Services shall execute a written agreement
29 that requires collaboration and joint development of all
30 policy, budgets, procurement documents, contracts, and
31 monitoring plans that have an impact on the state and Medicaid

1 community mental health and targeted case management programs.
2 3. Except as provided in subparagraph 8., by July 1,
3 2006, the agency and the Department of Children and Family
4 Services shall contract with managed care entities in each
5 AHCA area except area 6 or arrange to provide comprehensive
6 inpatient and outpatient mental health and substance abuse
7 services through capitated prepaid arrangements to all
8 Medicaid recipients who are eligible to participate in such
9 plans under federal law and regulation. In AHCA areas where
10 eligible individuals number less than 150,000, the agency
11 shall contract with a single managed care plan to provide
12 comprehensive behavioral health services to all recipients who
13 are not enrolled in a Medicaid health maintenance organization
14 or a Medicaid capitated managed care plan authorized under s.
15 409.91211. The agency may contract with more than one
16 comprehensive behavioral health provider to provide care to
17 recipients who are not enrolled in a Medicaid capitated
18 managed care plan authorized under s. 409.91211 or a Medicaid
19 health maintenance organization in AHCA areas where the
20 eligible population exceeds 150,000. 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 Contracts for comprehensive behavioral health providers
27 awarded pursuant to this section shall be competitively
28 procured. Both for-profit and not-for-profit corporations
29 shall be eligible to compete. Managed care plans contracting
30 with the agency under subsection (3) shall provide and receive
31 payment for the same comprehensive behavioral health benefits

1 as provided in AHCA rules, including handbooks incorporated by
2 reference. In AHCA area 11, the agency shall contract with at
3 least two comprehensive behavioral health care providers to
4 provide behavioral health care to recipients in that area who
5 are enrolled in, or assigned to, the MediPass program. One of
6 the behavioral health care contracts shall be with the
7 existing provider service network pilot project, as described
8 in paragraph (d), for the purpose of demonstrating the
9 cost-effectiveness of the provision of quality mental health
10 services through a public hospital-operated managed care
11 model. Payment shall be at an agreed-upon capitated rate to
12 ensure cost savings. Of the recipients in area 11 who are
13 assigned to MediPass under the provisions of s.
14 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled
15 recipients shall be assigned to the existing provider service
16 network in area 11 for their behavioral care.
17 4. By October 1, 2003, the agency and the department
18 shall submit a plan to the Governor, the President of the
19 Senate, and the Speaker of the House of Representatives which
20 provides for the full implementation of capitated prepaid
21 behavioral health care in all areas of the state.
22 a. Implementation shall begin in 2003 in those AHCA
23 areas of the state where the agency is able to establish
24 sufficient capitation rates.
25 b. If the agency determines that the proposed
26 capitation rate in any area is insufficient to provide
27 appropriate services, the agency may adjust the capitation
28 rate to ensure that care will be available. The agency and the
29 department may use existing general revenue to address any
30 additional required match but may not over-obligate existing
31 funds on an annualized basis.

1 c. Subject to any limitations provided for in the
2 General Appropriations Act, the agency, in compliance with
3 appropriate federal authorization, shall develop policies and
4 procedures that allow for certification of local and state
5 funds.
6 5. Children residing in a statewide inpatient
7 psychiatric program, or in a Department of Juvenile Justice or
8 a Department of Children and Family Services residential
9 program approved as a Medicaid behavioral health overlay
10 services provider shall not be included in a behavioral health
11 care prepaid health plan or any other Medicaid managed care
12 plan pursuant to this paragraph.
13 6. In converting to a prepaid system of delivery, the
14 agency shall in its procurement document require an entity
15 providing only comprehensive behavioral health care services
16 to prevent the displacement of indigent care patients by
17 enrollees in the Medicaid prepaid health plan providing
18 behavioral health care services from facilities receiving
19 state funding to provide indigent behavioral health care, to
20 facilities licensed under chapter 395 which do not receive
21 state funding for indigent behavioral health care, or
22 reimburse the unsubsidized facility for the cost of behavioral
23 health care provided to the displaced indigent care patient.
24 7. Traditional community mental health providers under
25 contract with the Department of Children and Family Services
26 pursuant to part IV of chapter 394, child welfare providers
27 under contract with the Department of Children and Family
28 Services in areas 1 and 6, and inpatient mental health
29 providers licensed pursuant to chapter 395 must be offered an
30 opportunity to accept or decline a contract to participate in
31 any provider network for prepaid behavioral health services.

1 8. For fiscal year 2004-2005, all Medicaid eligible
2 children, except children in areas 1 and 6, whose cases are
3 open for child welfare services in the HomeSafeNet system,
4 shall be enrolled in MediPass or in Medicaid fee-for-service
5 and all their behavioral health care services including
6 inpatient, outpatient psychiatric, community mental health,
7 and case management shall be reimbursed on a fee-for-service
8 basis. Beginning July 1, 2005, such children, who are open for
9 child welfare services in the HomeSafeNet system, shall
10 receive their behavioral health care services through a
11 specialty prepaid plan operated by community-based lead
12 agencies either through a single agency or formal agreements
13 among several agencies. The specialty prepaid plan must result
14 in savings to the state comparable to savings achieved in
15 other Medicaid managed care and prepaid programs. Such plan
16 must provide mechanisms to maximize state and local revenues.
17 The specialty prepaid plan shall be developed by the agency
18 and the Department of Children and Family Services. The agency
19 is authorized to seek any federal waivers to implement this
20 initiative.
21 (c) A federally qualified health center or an entity
22 owned by one or more federally qualified health centers or an
23 entity owned by other migrant and community health centers
24 receiving non-Medicaid financial support from the Federal
25 Government to provide health care services on a prepaid or
26 fixed-sum basis to recipients. A federally qualified health
27 center or an entity that is owned by one or more federally
28 qualified health centers and is reimbursed by the agency on a
29 prepaid basis is exempt from parts I and III of chapter 641,
30 but must comply with the solvency requirements in s.
31 641.2261(2) and meet the appropriate requirements governing

1 financial reserve, quality assurance, and patients' rights
2 established by the agency. ~~Such prepaid health care services~~
3 ~~entity must be licensed under parts I and III of chapter 641,~~
4 ~~but shall be prohibited from serving Medicaid recipients on a~~
5 ~~prepaid basis, until such licensure has been obtained.~~
6 ~~However, such an entity is exempt from s. 641.225 if the~~
7 ~~entity meets the requirements specified in subsections (17)~~
8 ~~and (18).~~
9 (d) A provider service network may be reimbursed on a
10 fee-for-service or prepaid basis. A provider service network
11 which is reimbursed by the agency on a prepaid basis shall be
12 exempt from parts I and III of chapter 641, but must comply
13 with the solvency requirements in s. 641.2261(2) and meet
14 appropriate financial reserve, quality assurance, and patient
15 rights requirements as established by the agency. ~~The agency~~
16 ~~shall award contracts on a competitive bid basis and shall~~
17 ~~select bidders based upon price and quality of care.~~ Medicaid
18 recipients assigned to a provider service network
19 ~~demonstration project~~ shall be chosen equally from those who
20 would otherwise have been assigned to prepaid plans and
21 MediPass. The agency is authorized to seek federal Medicaid
22 waivers as necessary to implement the provisions of this
23 section. Any contract previously awarded to a provider service
24 network operated by a hospital pursuant to this subsection
25 shall remain in effect for a period of 3 years following the
26 current contract expiration date, regardless of any
27 contractual provisions to the contrary. A provider service
28 network is a network established or organized and operated by
29 a health care provider, or group of affiliated health care
30 providers, including minority physician networks and emergency
31 room diversion programs that meet the requirements of s.

1 409.91211, which provides a substantial proportion of the
2 health care items and services under a contract directly
3 through the provider or affiliated group of providers and may
4 make arrangements with physicians or other health care
5 professionals, health care institutions, or any combination of
6 such individuals or institutions to assume all or part of the
7 financial risk on a prospective basis for the provision of
8 basic health services by the physicians, by other health
9 professionals, or through the institutions. The health care
10 providers must have a controlling interest in the governing
11 body of the provider service network organization.
12 Section 3. Section 409.91211, Florida Statutes, is
13 amended to read:
14 409.91211 Medicaid managed care pilot program.--
15 (1)(a) The agency is authorized to seek and implement
16 experimental, pilot, or demonstration project waivers,
17 pursuant to s. 1115 of the Social Security Act, to create a
18 statewide initiative to provide for a more efficient and
19 effective service delivery system that enhances quality of
20 care and client outcomes in the Florida Medicaid program
21 pursuant to this section. Phase one of the demonstration shall
22 be implemented in two geographic areas. One demonstration site
23 shall include only Broward County. A second demonstration site
24 shall initially include Duval County and shall be expanded to
25 include Baker, Clay, and Nassau Counties within 1 year after
26 the Duval County program becomes operational. The agency shall
27 implement expansion of the program to include the remaining
28 counties of the state and remaining eligibility groups in
29 accordance with the process specified in the
30 federally-approved special terms and conditions numbered
31 11-W-00206/4, as approved by the federal Centers for Medicare

1 and Medicaid Services on October 19, 2005, with a goal of full
2 statewide implementation by June 30, 2011.
3 (b) This waiver authority is contingent upon federal
4 approval to preserve the upper-payment-limit funding mechanism
5 for hospitals, including a guarantee of a reasonable growth
6 factor, a methodology to allow the use of a portion of these
7 funds to serve as a risk pool for demonstration sites,
8 provisions to preserve the state's ability to use
9 intergovernmental transfers, and provisions to protect the
10 disproportionate share program authorized pursuant to this
11 chapter. Upon completion of the evaluation conducted under s.
12 3, ch. 2005-133, Laws of Florida, the agency may request
13 statewide expansion of the demonstration projects. Statewide
14 phase-in to additional counties shall be contingent upon
15 review and approval by the Legislature. Under the
16 upper-payment-limit program, or the low-income pool as
17 implemented by the Agency for Health Care Administration
18 pursuant to federal waiver, the state matching funds required
19 for the program shall be provided by local governmental
20 entities through intergovernmental transfers in accordance
21 with published federal statutes and regulations. The Agency
22 for Health Care Administration shall distribute
23 upper-payment-limit, disproportionate share hospital, and
24 low-income pool funds according to published federal statutes,
25 regulations, and waivers and the low-income pool methodology
26 approved by the federal Centers for Medicare and Medicaid
27 Services.
28 (c) It is the intent of the Legislature that the
29 low-income pool plan required by the terms and conditions of
30 the Medicaid reform waiver and submitted to the federal
31 Centers for Medicare and Medicaid Services propose the

1 distribution of the abovementioned program funds based on the
2 following objectives:
3 1. Assure a broad and fair distribution of available
4 funds based on the access provided by Medicaid participating
5 hospitals, regardless of their ownership status, through their
6 delivery of inpatient or outpatient care for Medicaid
7 beneficiaries and uninsured and underinsured individuals;
8 2. Assure accessible emergency inpatient and
9 outpatient care for Medicaid beneficiaries and uninsured and
10 underinsured individuals;
11 3. Enhance primary, preventive, and other ambulatory
12 care coverages for uninsured individuals;
13 4. Promote teaching and specialty hospital programs;
14 5. Promote the stability and viability of statutorily
15 defined rural hospitals and hospitals that serve as sole
16 community hospitals;
17 6. Recognize the extent of hospital uncompensated care
18 costs;
19 7. Maintain and enhance essential community hospital
20 care;
21 8. Maintain incentives for local governmental entities
22 to contribute to the cost of uncompensated care;
23 9. Promote measures to avoid preventable
24 hospitalizations;
25 10. Account for hospital efficiency; and
26 11. Contribute to a community's overall health system.
27 (2) The Legislature intends for the capitated managed
28 care pilot program to:
29 (a) Provide recipients in Medicaid fee-for-service or
30 the MediPass program a comprehensive and coordinated capitated
31 managed care system for all health care services specified in

ss. 409.905 and 409.906.

(b) Stabilize Medicaid expenditures under the pilot program compared to Medicaid expenditures in the pilot area for the 3 years before implementation of the pilot program, while ensuring:

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 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

1 cost to catastrophic coverage that accommodates the risks
2 associated with the development of the pilot program.
3 (g) To ~~determine and~~ recommend a process to be used by
4 the Social Services Estimating Conference to determine and
5 validate the rate of growth of the per-member costs of
6 providing Medicaid services under the managed care pilot
7 program.
8 (h) To <u>implement</u> ~~determine and recommend~~ program
9 standards and credentialing requirements for capitated managed
10 care networks to participate in the pilot program, including
11 those related to fiscal solvency, quality of care, and
12 adequacy of access to health care providers. It is the intent
13 of the Legislature that, to the extent possible, any pilot
14 program authorized by the state under this section include any
15 federally qualified health center, federally qualified rural
16 health clinic, county health department, <u>the Children's</u>
17 <u>Medical Services Network within the Department of Health,</u> or
18 other federally, state, or locally funded entity that serves
19 the geographic areas within the boundaries of the pilot
20 program that requests to participate. This paragraph does not
21 relieve an entity that qualifies as a capitated managed care
22 network under this section from any other licensure or
23 regulatory requirements contained in state or federal law
24 which would otherwise apply to the entity. The standards and
25 credentialing requirements shall be based upon, but are not
26 limited to:
27 1. Compliance with the accreditation requirements as
28 provided in s. 641.512.
29 2. Compliance with early and periodic screening,
30 diagnosis, and treatment screening requirements under federal
31 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.

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.

(j) To implement ~~develop and recommend~~ a system to ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(k) To implement ~~develop and recommend~~ a choice counseling system to 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 use language lines and other services for impaired recipients, such as TTD/TTY.

(l) To implement ~~develop and recommend~~ a system that prohibits capitated managed care plans, their representatives, and providers employed by or contracted with the capitated managed care plans from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular capitated managed care plan, and from prejudicing Medicaid recipients against other capitated managed care plans. The system 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), 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.

(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

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

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

8. The system must ensure that the data reported is accurate and complete.

~~(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.

1 (t) To use ~~develop and recommend~~ health care provider
2 agreements for participation in the pilot program.
3 (u) To require that all health care providers under
4 contract with the pilot program be duly licensed in the state,
5 if such licensure is available, and meet other criteria as may
6 be established by the agency. These criteria shall include at
7 a minimum those criteria specified in s. 409.907.
8 (v) To ensure that managed care organizations work
9 collaboratively ~~develop and recommend agreements~~ with other
10 state or local governmental programs or institutions for the
11 coordination of health care to eligible individuals receiving
12 services from such programs or institutions.
13 (w) To implement procedures to minimize the risk of
14 Medicaid fraud and abuse in all plans operating in the
15 Medicaid managed care pilot program authorized in this
16 section.
17 1. The agency shall ensure that applicable provisions
18 of this chapter and chapters 414, 626, 641, and 932 which
19 relate to Medicaid fraud and abuse are applied and enforced at
20 the demonstration project sites.
21 2. Providers must have the certification, license, and
22 credentials that are required by law and waiver requirements.
23 3. The agency shall ensure that the plan is in
24 compliance with s. 409.912(21) and (22).
25 4. The agency shall require that each plan establish
26 functions and activities governing program integrity in order
27 to reduce the incidence of fraud and abuse. Plans must report
28 instances of fraud and abuse pursuant to chapter 641.
29 5. The plan shall have written administrative and
30 management arrangements or procedures, including a mandatory
31 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"~~

1 ~~have the meanings as provided in s. 409.913. The agency must~~
2 ~~refer incidents of suspected fraud, abuse, overutilization and~~
3 ~~duplicative utilization, and underutilization or inappropriate~~
4 ~~denial of services to the appropriate regulatory agency.~~
5 (x) To develop and provide actuarial and benefit
6 design analyses that indicate the effect on capitation rates
7 and benefits offered in the pilot program over a prospective
8 5-year period based on the following assumptions:
9 1. Growth in capitation rates which is limited to the
10 estimated growth rate in general revenue.
11 2. Growth in capitation rates which is limited to the
12 average growth rate over the last 3 years in per-recipient
13 Medicaid expenditures.
14 3. Growth in capitation rates which is limited to the
15 growth rate of aggregate Medicaid expenditures between the
16 2003-2004 fiscal year and the 2004-2005 fiscal year.
17 (y) To develop a mechanism to require capitated
18 managed care plans to reimburse qualified emergency service
19 providers, including, but not limited to, ambulance services,
20 in accordance with ss. 409.908 and 409.9128. The pilot program
21 must include a provision for continuing fee-for-service
22 payments for emergency services, including, but not limited
23 to, individuals who access ambulance services or emergency
24 departments and who are subsequently determined to be eligible
25 for Medicaid services.
26 (z) To ensure that ~~develop a system whereby~~ school
27 districts participating in the certified school match program
28 pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by
29 Medicaid, subject to the limitations of s. 1011.70(1), for a
30 Medicaid-eligible child participating in the services as
31 authorized in s. 1011.70, as provided for in s. 409.9071,

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

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

1 be coordinated with community-based care providers as
2 specified in s. 409.1675, where available, and be sufficient
3 to meet the medical, developmental, and emotional needs of
4 these children.
5 (4)(a) A Medicaid recipient in the pilot area who is
6 not currently enrolled in a capitated managed care plan upon
7 implementation is not eligible for services as specified in
8 ss. 409.905 and 409.906, for the amount of time that the
9 recipient does not enroll in a capitated managed care network.
10 If a Medicaid recipient has not enrolled in a capitated
11 managed care plan within 30 days after eligibility, the agency
12 shall assign the Medicaid recipient to a capitated managed
13 care plan based on the assessed needs of the recipient as
14 determined by the agency and the recipient shall be exempt
15 from s. 409.9122. When making assignments, the agency shall
16 take into account the following criteria:
17 1. A capitated managed care network has sufficient
18 network capacity to meet the needs of members.
19 2. The capitated managed care network has previously
20 enrolled the recipient as a member, or one of the capitated
21 managed care network's primary care providers has previously
22 provided health care to the recipient.
23 3. The agency has knowledge that the member has
24 previously expressed a preference for a particular capitated
25 managed care network as indicated by Medicaid fee-for-service
26 claims data, but has failed to make a choice.
27 4. The capitated managed care network's primary care
28 providers are geographically accessible to the recipient's
29 residence.
30 (b) When more than one capitated managed care network
31 provider meets the criteria specified in paragraph (3)(h), the

agency shall make recipient assignments consecutively by 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

1 inappropriate changes of primary care providers, service
2 access impairments due to significant changes in the
3 geographic location of services, or fraudulent enrollment. The
4 agency may require a recipient to use the capitated managed
5 care network's grievance process as specified in paragraph
6 (3)(g) prior to the agency's determination of cause, except in
7 cases in which immediate risk of permanent damage to the
8 recipient's health is alleged. The grievance process, when
9 used, must be completed in time to permit the recipient to
10 disenroll no later than the first day of the second month
11 after the month the disenrollment request was made. If the
12 capitated managed care network, as a result of the grievance
13 process, approves an enrollee's request to disenroll, the
14 agency is not required to make a determination in the case.
15 The agency must make a determination and take final action on
16 a recipient's request so that disenrollment occurs no later
17 than the first day of the second month after the month the
18 request was made. If the agency fails to act within the
19 specified timeframe, the recipient's request to disenroll is
20 deemed to be approved as of the date agency action was
21 required. Recipients who disagree with the agency's finding
22 that cause does not exist for disenrollment shall be advised
23 of their right to pursue a Medicaid fair hearing to dispute
24 the agency's finding.
25 (f)~~(e)~~ The agency shall apply for federal waivers from
26 the Centers for Medicare and Medicaid Services to lock
27 eligible Medicaid recipients into a capitated managed care
28 network for 12 months after an open enrollment period. After
29 12 months of enrollment, a recipient may select another
30 capitated managed care network. However, nothing shall prevent
31 a Medicaid recipient from changing primary care providers

1 within the capitated managed care network during the 12-month
2 period.
3 (g)(f) The agency shall apply for federal waivers from
4 the Centers for Medicare and Medicaid Services to allow
5 recipients to purchase health care coverage through an
6 employer-sponsored health insurance plan instead of through a
7 Medicaid-certified plan. This provision shall be known as the
8 opt-out option.
9 1. A recipient who chooses the Medicaid opt-out option
10 shall have an opportunity for a specified period of time, as
11 authorized under a waiver granted by the Centers for Medicare
12 and Medicaid Services, to select and enroll in a
13 Medicaid-certified plan. If the recipient remains in the
14 employer-sponsored plan after the specified period, the
15 recipient shall remain in the opt-out program for at least 1
16 year or until the recipient no longer has access to
17 employer-sponsored coverage, until the employer's open
18 enrollment period for a person who opts out in order to
19 participate in employer-sponsored coverage, or until the
20 person is no longer eligible for Medicaid, whichever time
21 period is shorter.
22 2. Notwithstanding any other provision of this
23 section, coverage, cost sharing, and any other component of
24 employer-sponsored health insurance shall be governed by
25 applicable state and federal laws.
26 (5) This section does not authorize the agency to
27 implement any provision of s. 1115 of the Social Security Act
28 experimental, pilot, or demonstration project waiver to reform
29 the state Medicaid program in any part of the state other than
30 the two geographic areas specified in this section unless
31 approved by the Legislature.

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

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

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

1 risk-adjusted capitation rate methodology.
2 (b) In the second year, the capitation rates shall be
3 weighted so that 50 percent of each capitation rate is based
4 on the current methodology and 50 percent is based on a new
5 risk-adjusted rate methodology.
6 (c) In the following fiscal year, the risk-adjusted
7 capitation methodology may be fully implemented.
8 (10) Subsections (8) and (9) do not apply to managed
9 care plans offering benefits exclusively to high-risk,
10 specialty populations. The agency may set risk-adjusted rates
11 immediately for such plans.
12 (11) Before the implementation of risk-adjusted rates,
13 the rates shall be certified by an actuary and approved by the
14 federal Centers for Medicare and Medicaid Services.
15 (12) For purposes of this section, the term "capitated
16 managed care plan" includes health insurers authorized under
17 chapter 624, exclusive provider organizations authorized under
18 chapter 627, health maintenance organizations authorized under
19 chapter 641, the Children's Medical Services Network under
20 chapter 391, and provider service networks that elect to be
21 paid fee-for-service for up to 3 years as authorized under
22 this section.
23 (13)~~(7)~~ Upon review and approval of the applications
24 for waivers of applicable federal laws and regulations to
25 implement the managed care pilot program by the Legislature,
26 the agency may initiate adoption of rules pursuant to ss.
27 120.536(1) and 120.54 to implement and administer the managed
28 care pilot program as provided in this section.
29 (14) It is the intent of the Legislature that if any
30 conflict exists between the provisions contained in this
31 section and other provisions of this chapter which relate to

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

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

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

1 641.2261 Application of ~~federal~~ solvency requirements
2 to provider-sponsored organizations and Medicaid provider
3 service networks.--
4 (1) The solvency requirements of ss. 1855 and 1856 of
5 the Balanced Budget Act of 1997 and 42 C.F.R. 422.350, subpart
6 H, ~~rules adopted by the Secretary of the United States~~
7 ~~Department of Health and Human Services~~ apply to a health
8 maintenance organization that is a provider-sponsored
9 organization rather than the solvency requirements of this
10 part. However, if the provider-sponsored organization does not
11 meet the solvency requirements of this part, the organization
12 is limited to the issuance of Medicare+Choice plans to
13 eligible individuals. For the purposes of this section, the
14 terms "Medicare+Choice plans," "provider-sponsored
15 organizations," and "solvency requirements" have the same
16 meaning as defined in the federal act and federal rules and
17 regulations.
18 (2) The solvency requirements in 42 C.F.R. 422.350,
19 subpart H, and the solvency requirements established in
20 approved federal waivers pursuant to chapter 409, apply to a
21 Medicaid provider service network rather than the solvency
22 requirements of this part.
23 Section 6. The Agency for Health Care Administration
24 shall report to the Legislature by April 1, 2006, on the
25 specific pre-implementation milestones required by the special
26 terms and conditions related to the low-income pool which have
27 been approved by the Federal Government and the status of any
28 remaining pre-implementation milestones that have not been
29 approved by the Federal Government.
30 Section 7. Section 216.346, Florida Statutes, is
31 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.
15
16
17 =============== T I T L E A M E N D M E N T ===============
18 And the title is amended as follows:
19 Delete everything before the enacting clause
20
21 and insert:
22 A bill to be entitled
23 An act relating to Medicaid; amending s.
24 409.911, F.S.; adding a duty to the Medicaid
25 Disproportionate Share Council; providing a
26 future repeal of the Disproportionate Share
27 Council; creating the Medicaid Low-Income Pool
28 Council; providing for membership and duties;
29 amending s. 409.912, F.S.; authorizing the
30 Agency for Health Care Administration to
31 contract with comprehensive behavioral health

1 plans in separate counties within or adjacent
2 to an AHCA area; providing that specified
3 federally qualified health centers or entities
4 that are owned by one or more federally
5 qualified health centers are exempt from the
6 requirements imposed by law on health
7 maintenance organizations and health care
8 services; providing exceptions; conforming
9 provisions to the solvency requirements in s.
10 641.2261, F.S.; deleting the
11 competitive-procurement requirement for
12 provider service networks; updating a reference
13 to the provider service network; amending s.
14 409.91211, F.S.; specifying the process for
15 statewide expansion of the Medicaid managed
16 care demonstration program; requiring that
17 matching funds for the Medicaid managed care
18 pilot program be provided by local governmental
19 entities; providing for distribution of funds
20 by the agency; providing legislative intent
21 with respect to the low-income pool plan
22 required under the Medicaid reform waiver;
23 specifying the agency's powers, duties, and
24 responsibilities with respect to implementing
25 the Medicaid managed care pilot program;
26 revising the guidelines for allowing a provider
27 service network to receive fee-for-service
28 payments in the demonstration areas;
29 authorizing the agency to make direct payments
30 to hospitals and physicians for the costs
31 associated with graduate medical education

1 under Medicaid reform; including the Children's
2 Medical Services Network in the Department of
3 Health within those programs intended by the
4 Legislature to participate in the pilot program
5 to the extent possible; requiring that the
6 agency implement standards of quality assurance
7 and performance improvement in the
8 demonstration areas of the pilot program;
9 requiring the agency to establish an encounter
10 database to compile data from managed care
11 plans; requiring the agency to implement
12 procedures to minimize the risk of Medicaid
13 fraud and abuse in all managed care plans in
14 the demonstration areas; clarifying that the
15 assignment process for the pilot program is
16 exempt from certain mandatory procedures for
17 Medicaid managed care enrollment specified in
18 s. 409.9122, F.S.; revising the automatic
19 assignment process in the demonstration areas;
20 requiring that the agency report any
21 modifications to the approved waiver and
22 special terms and conditions to the Legislature
23 within specified time periods; authorizing the
24 agency to implement the provisions of the
25 waiver approved by federal Centers for Medicare
26 and Medicaid Services; requiring the Secretary
27 of Health Care Administration to convene a
28 technical advisory panel to advise the agency
29 in matters relating to rate setting, benefit
30 design, and choice counseling; providing for
31 panel members; providing certain requirements

1 for managed care plans providing benefits to
2 TANF and SSI recipients; providing for
3 capitation rates to be phased in; providing an
4 exception for high-risk, specialty populations;
5 requiring the certification of rates by an
6 actuary and federal approval; providing that,
7 if any conflict exists between the provisions
8 contained in s. 409.91211, F.S., and ch. 409,
9 F.S., concerning the implementation of the
10 pilot program, the provisions contained in s.
11 409.91211, F.S., control; creating s.
12 409.91213, F.S.; requiring the agency to submit
13 quarterly and annual progress reports to the
14 Legislature; providing requirements for the
15 reports; amending s. 641.2261, F.S.; revising
16 the application of solvency requirements to
17 include Medicaid provider service networks;
18 updating a reference; requiring that the agency
19 report to the Legislature the
20 pre-implementation milestones concerning the
21 low-income pool which have been approved by the
22 Federal Government and the status of those
23 remaining to be approved; amending s. 216.346,
24 F.S.; revising provisions relating to contracts
25 between state agencies; providing an effective
26 date.
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