A bill to be entitled

An act relating to Medicaid; amending s. 641.2261, F.S.; revising the applicability of solvency requirements to include Medicaid provider service networks and updating a reference; amending s. 409.911, F.S.; adding a duty to the Medicaid Disproportionate Share Council; providing a future repeal of the Disproportionate Share Council; creating the Medicaid Low-Income Pool Council; providing for membership and duties; amending s. 409.912, F.S.; providing an exception from certain contract procurement requirements for specified Medicaid managed care pilot programs and Medicaid health maintenance organizations; providing an exemption for federally qualified health centers and entities owned by federally qualified health centers from pts. I and III of ch. 641, F.S., under certain circumstances; deleting the competitive procurement requirement for provider service networks; requiring provider service networks to comply with the solvency requirements in s. 641.2261, F.S.; updating a reference; including certain minority physician networks and emergency room diversion programs in the description of provider service networks; amending s. 409.91211, F.S.; providing for distribution of upper payment limit, hospital disproportionate share program, and low income pool funds; providing legislative intent with respect to distribution of said funds; providing for implementation of the powers, duties, and responsibilities of the Agency for Health Care Administration with respect to the pilot

program; including the Division of Children's Medical Services Network within the Department of Health in a list of state-authorized pilot programs; requiring the agency to develop a data reporting system; requiring the agency to implement procedures to minimize fraud and abuse; providing that certain Medicaid and Supplemental Security Income recipients are exempt from s. 409.9122, F.S.; providing for Medicaid reimbursement of federally qualified health centers that deliver certain school-based services; authorizing the agency to assign certain Medicaid recipients to reform plans; authorizing the agency to implement the provisions of the waiver approved by the Centers for Medicare and Medicaid Services and requiring the agency to notify the Legislature prior to seeking federal approval of modifications to said terms and conditions; requiring the Secretary of Health Care Administration to convene a technical advisory panel; providing for membership and duties; limiting aggregate risk score of certain managed care plans for payment purposes for a specified period of time; providing for phase in of capitation rates; providing applicability; requiring rates to be certified and approved; defining the term "capitated managed care plan"; providing for conflict between specified provisions of ch. 409, F.S., and requiring a report by the agency pertaining thereto; creating s. 409.91212, F.S.; authorizing the agency to expand the Medicaid reform demonstration program; providing readiness criteria; providing for public

meetings; requiring notice of intent to expand the demonstration program; requiring the agency to request a hearing by the Joint Legislative Committee on Medicaid Reform Implementation; authorizing the agency to request certain budget transfers; amending s. 409.9122, F.S.; revising provisions relating to assignment of certain Medicaid recipients to managed care plans; creating s. 11.72, F.S.; creating the Joint Legislative Committee on Medicaid Reform Implementation; providing for membership, powers, and duties; amending s. 216.346, F.S.; revising provisions relating to contracts between state agencies; providing an effective date.

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

Section 1. Section 641.2261, Florida Statutes, is amended to read:

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. s. 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 of 42 C.F.R. s. 422.350 subpart H and the solvency requirements established in the approved federal waiver pursuant to chapter 409 apply to a Medicaid provider service network rather than the solvency requirements of this part.

Section 2. Subsection (9) of section 409.911, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(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 three representatives of statutory teaching hospitals, three

representatives of public hospitals, three representatives of nonprofit hospitals, three representatives of for-profit hospitals, two representatives of rural hospitals, two representatives of units of local government which contribute funding, and one representative of family practice teaching hospitals. The council shall:

(a) Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.

(b) Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.

(c) Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.

(d) Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

Section 3. Paragraphs (b), (c), and (d) of subsection (4) of section 409.912, Florida Statutes, are amended to read:

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

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

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

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8. and except in counties where the Medicaid managed care pilot program is authorized under s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid capitated managed care

plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized under s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

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

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211 in AHCA areas where the

eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized under s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. ~~Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k),~~ A minimum of 50,000 ~~of those~~ MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

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

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

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

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

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

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to

prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

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

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The

specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. A federally qualified health center or an entity owned by one or more federally qualified health centers that 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 entity meets the requirements specified in subsections (17) and (18).~~

(d) A provider service network which 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 financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling

interest in the governing body of the provider service network organization.

Section 4. Section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(1)(a) The agency is authorized to seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One demonstration site shall include only Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Under the upper payment limit program, the hospital disproportionate share program, or the low income pool as implemented by the agency pursuant to federal waiver, the state matching funds required for the program shall be provided by the

state and by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The agency shall distribute funds from the upper payment limit program, the hospital disproportionate share program, and the low income pool in accordance with published federal statutes, regulations, and waivers and the low income pool methodology approved by the Centers for Medicare and Medicaid Services. ~~Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature.~~

(b) It is the intent of the Legislature that the low income pool plan required by the terms and conditions of the Medicaid reform waiver and submitted to the Centers for Medicare and Medicaid Services propose the distribution of the program funds in paragraph (a) based on the following objectives:

1. Ensure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals.

2. Ensure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals.

3. Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals.

4. Promote teaching and specialty hospital programs.

5. Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals.

6. Recognize the extent of hospital uncompensated care costs.

7. Maintain and enhance essential community hospital care.

8. Maintain incentives for local governmental entities to contribute to the cost of uncompensated care.

9. Promote measures to avoid preventable hospitalizations.

10. Account for hospital efficiency.

11. Contribute to a community's overall health system.

(2) The Legislature intends for the capitated managed care pilot program to:

(a) Provide recipients in Medicaid fee-for-service or the MediPass program a comprehensive and coordinated capitated 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 that includes ~~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 ~~upper payment-level funding systems~~, and the disproportionate share program. Within the parameters allowed by federal statute and rule, the agency is authorized to 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 shall include an option for a provider service network to be paid ~~to pay~~ fee-for-service rates. 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) ~~that may include a savings settlement option for at least 2 years~~. 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, any federally qualified rural health clinic, county health department, the Division of Children's Medical Services Network within the Department of Health, or any 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.

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, quality assurance and performance

improvement standards, peer or professional review standards, grievance policies, and program integrity policies.

(q) To develop a data reporting system, seek input from managed care plans to establish patient-encounter reporting requirements, and ensure that the data reported is accurate and complete.

(r) To work with managed care plans to establish a uniform system to measure and monitor outcomes of a recipient of Medicaid services which shall use financial, clinical, and other criteria based on pharmacy services, medical services, and other data related to the provision of Medicaid services, including, but not limited to:

1. Health Plan Employer Data and Information Set (HEDIS) or HEDIS measures specific to Medicaid.

2. Member satisfaction.

3. Provider satisfaction.

4. Report cards on plan performance and best practices.

5. Compliance with the prompt payment of claims requirements provided in ss. 627.613, 641.3155, and 641.513.

6. Utilization and quality data for the purpose of ensuring access to medically necessary services, including underutilization or inappropriate denial of services.

(s) To require managed care plans that have contracted with the agency to establish a quality assurance system that incorporates the provisions of s. 409.912(27) and any standards, rules, and guidelines developed by the agency.

(t) To establish a patient-encounter database to compile data on health care services rendered by health care

practitioners that provide services to patients enrolled in managed care plans in the demonstration sites. Health care practitioners and facilities in the demonstration sites shall submit, and managed care plans participating in the demonstration sites shall receive, claims payment and any other information reasonably related to the patient-encounter database electronically in a standard format as required by the agency. The agency shall establish reasonable deadlines for phasing in the electronic transmittal of full-encounter data. The patient-encounter database shall:

1. Collect the following information, if applicable, for each type of patient encounter with a health care practitioner or facility, including:

a. The demographic characteristics of the patient.

b. The principal, secondary, and tertiary diagnosis.

c. The procedure performed.

d. The date when and the location where the procedure was performed.

e. The amount of the payment for the procedure.

f. The health care practitioner's universal identification number.

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

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

3. Collect appropriate information related to health care costs and utilization from managed care plans participating in the demonstration sites. To the extent practicable, the agency shall utilize a standardized claim form or electronic transfer system that is used by health care practitioners, facilities, and payors. ~~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.~~

(u) ~~(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.

(v) ~~(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.

(w) ~~(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.

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

(y) ~~(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.

(z) ~~(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.

(aa) ~~(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 chapters 409, 414, 626, 641, and 932, relating to Medicaid fraud and abuse, are applied and enforced at the demonstration sites.

2. Providers shall have the necessary certification, license, and credentials required by law and federal waiver.

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

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

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

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, and patient-encounter data; misrepresentation of the qualifications of persons rendering health care and ancillary services; bribery and false statements relating to the delivery of health care; unfair and deceptive marketing practices; and managed care false claims actions, is a violation of law and subject to the penalties provided by law.

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

~~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 duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency.~~

(bb) ~~(x)~~ To develop and provide actuarial and benefit design analyses that indicate the effect on capitation rates and benefits offered in the pilot program over a prospective 5-year period based on the following assumptions:

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

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

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

(cc) ~~(y)~~ To develop a mechanism to require capitated managed care plans to reimburse qualified emergency service providers, including, but not limited to, ambulance services, in accordance with ss. 409.908 and 409.9128. The pilot program must

include a provision for continuing fee-for-service payments for emergency services, including, but not limited to, individuals who access ambulance services or emergency departments and who are subsequently determined to be eligible for Medicaid services.

(dd) ~~(z)~~ To ensure ~~develop a system whereby~~ school districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments and federally qualified health centers delivering school-based services pursuant to ss. 381.0056 and 381.0057 must be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's capitated managed care network provider

receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(ee) ~~(aa)~~ To implement ~~develop and recommend~~ a mechanism whereby Medicaid recipients who are already enrolled in a managed care plan or the MediPass program in the pilot areas shall be offered the opportunity to change to capitated managed care plans on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of capitated managed care plans. Those Medicaid recipients who do not make a choice shall be assigned to a capitated managed care plan in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a capitated managed care plan, the agency shall determine whether the SSI recipient has an ongoing relationship with a provider or capitated managed care plan, and, if so, the agency shall assign the SSI recipient to that provider or capitated managed care plan where feasible. Those SSI recipients who do not have such a provider relationship shall be assigned to a capitated managed care plan provider in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122.

(ff) ~~(bb)~~ To develop and recommend a service delivery alternative for children having chronic medical conditions which establishes a medical home project to provide primary care services to this population. The project shall provide community-based primary care services that are integrated with other subspecialties to meet the medical, developmental, and

emotional needs for children and their families. This project shall include an evaluation component to determine impacts on hospitalizations, length of stays, emergency room visits, costs, and access to care, including specialty care and patient and family satisfaction.

(gg) ~~(cc)~~ To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these persons.

(hh) ~~(dd)~~ To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children in foster care. These services must be coordinated with community-based care providers as specified in s. 409.1675, where available, and be sufficient to meet the medical, developmental, and emotional needs of these children.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency and shall be exempt from s. 409.9122. When making assignments, the agency shall take into account the following criteria:

1. A capitated managed care network has sufficient network capacity to meet the needs of members.

2. The capitated managed care network has previously enrolled the recipient as a member, or one of the capitated managed care network's primary care providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular capitated managed care network as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The capitated managed care network's primary care providers are geographically accessible to the recipient's residence.

(b) When more than one capitated managed care network 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 pilot 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 organization. If the recipient's current managed care organization does not operate a reform plan in the pilot area that adequately meets the needs of the Medicaid recipient, the agency shall use the auto assignment process as prescribed in

the Centers for Medicare and Medicaid Services Special Terms and Conditions number 11-W-00206/4. All agency enrollment and choice counseling materials shall communicate the provisions of this paragraph to 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.

(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.~~

(5)~~(6)~~ The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care pilot project as defined in this section. The agency shall post all waiver applications under this section on its Internet website 30 days before submitting the applications to the United States Centers for Medicare and Medicaid Services. All waiver applications shall be provided for review and comment to the appropriate committees of the Senate and House of Representatives for at least 10 working days prior to

submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be approved by the Legislature. Federally approved waivers must be submitted to the President of the Senate and the Speaker of the House of Representatives for referral to the appropriate legislative committees. The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole. The agency shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the pilot program under this section on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature. The agency is authorized to implement the waiver and Centers for Medicare and Medicaid Services Special Terms and Conditions number 11-W-00206/4. If the agency seeks approval by the Federal Government of any modifications to these special terms and conditions, the agency shall provide written notification of its intent to modify these terms and conditions to the President of the Senate and Speaker of the House of Representatives at least 15 days prior to submitting the modifications to the Federal Government for consideration. The notification shall identify all modifications being pursued and the reason they are needed. Upon receiving federal approval of any modifications to the special terms and conditions, the agency shall report to the Legislature describing the federally

approved modifications to the special terms and conditions within 7 days after their approval by the Federal Government.

(6) ~~(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.

(7)(a) The Secretary of Health Care Administration shall convene a technical advisory panel to advise the agency in the following areas: risk-adjusted rate setting, benefit design, and choice counseling. The panel shall include representatives from the Florida Association of Health Plans, representatives from provider-sponsored networks, and a representative from the Office of Insurance Regulation.

(b) The technical advisory panel shall advise the agency on the following:

1. The risk-adjusted rate methodology to be used by the agency including recommendations on mechanisms to recognize the risk of all Medicaid enrollees and transitioning to a risk-adjustment system, including recommendations for phasing in risk adjustment and the uses of risk corridors.

2. Implementation of an encounter data system to be used for risk-adjusted rates.

3. Administrative and implementation issues regarding the use of risk-adjusted rates, including, but not limited to, cost, simplicity, client privacy, data accuracy, and data exchange.

4. Benefit design issues, including the actuarial equivalence and sufficiency standards to be used.

5. The implementation plan for the proposed choice counseling system, including the information and materials to be provided to recipients, the methodologies by which recipients will be counseled regarding choices, criteria to be used to assess plan quality, the methodology to be used to assign recipients to plans if they fail to choose a managed care plan, and the standards to be used for responsiveness to recipient inquiries.

(c) The technical advisory panel shall continue in existence and advise the secretary on matters outlined in this subsection.

(8) The agency must ensure in the first 2 state fiscal years in which a risk-adjusted methodology is a component of rate setting that no managed care plan providing comprehensive benefits to TANF and SSI recipients has an aggregate risk score that varies by more than 10 percent from the aggregate weighted mean of all managed care plans providing comprehensive benefits to TANF and SSI recipients in a reform area. The agency's payment to a managed care plan shall be based on such revised aggregate risk score.

(9) After any calculations of aggregate risk scores or revised aggregate risk scores pursuant to subsection (8), the capitation rates for plans participating under 409.91211 shall be phased in as follows:

(a) In the first fiscal year, the capitation rates shall be weighted so that 75 percent of each capitation rate is based

on the current methodology and 25 percent is based upon a new risk-adjusted capitation rate methodology.

(b) In the second fiscal 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) shall not apply to managed care plans offering benefits exclusively to high-risk, specialty populations. The agency shall have the discretion to set risk-adjusted rates immediately for said plans.

(11) Prior to the implementation of risk-adjusted rates, 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 authorized 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) It is the intent of the Legislature that if any conflict exists between the provisions contained in this section and other provisions of chapter 409, as they relate to implementation of the Medicaid managed care pilot program, the provisions contained in this section shall control. The agency

shall provide a written report to the President of the Senate and the Speaker of the House of Representatives by April 1, 2006, identifying any provisions of chapter 409 that conflict with the implementation of the Medicaid managed care pilot program as created in this section. After April 1, 2006, the agency shall provide a written report to the President of the Senate and the Speaker of the House of Representatives immediately upon identifying any provisions of chapter 409 that conflict with the implementation of the Medicaid managed care pilot program as created in this section.

Section 5. Section 409.91212, Florida Statutes, is created to read:

409.91212 Medicaid reform demonstration program expansion.--

(1) The agency may expand the Medicaid reform demonstration program pursuant to s. 409.91211 into any county of the state beginning in year two of the demonstration program if readiness criteria are met, the Joint Legislative Committee on Medicaid Reform Implementation has submitted a recommendation pursuant to s. 11.72 regarding the extent to which the criteria have been met, and the agency has secured budget approval from the Legislative Budget Commission pursuant to s. 11.90. For the purpose of this section, the term "readiness" means there is evidence that at least two programs in a county meet the following criteria:

(a) Demonstrate knowledge and understanding of managed care under the framework of Medicaid reform.

(b) Demonstrate financial capability to meet solvency

standards.

(c) Demonstrate adequate controls and process for financial management.

(d) Demonstrate the capability for clinical management of Medicaid recipients.

(e) Demonstrate the adequacy, capacity, and accessibility of the services network.

(f) Demonstrate the capability to operate a management information system and an encounter data system.

(g) Demonstrate capability to implement quality assurance and utilization management activities.

(h) Demonstrate capability to implement fraud control activities.

(2) The agency shall conduct meetings and public hearings in the targeted expansion county with the public and provider community. The agency shall provide notice regarding public hearings. The agency shall maintain records of the proceedings.

(3) The agency shall provide a 30-day notice of intent to expand the demonstration program with supporting documentation that the readiness criteria has been met to the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability.

(4) The agency shall request a hearing and consideration by the Joint Legislative Committee on Medicaid Reform Implementation after the 30-day notice required in subsection (3) has expired in the form of a letter to the chair of the

committee.

(5) Upon receiving a memorandum from the Joint Legislative Committee on Medicaid Reform Implementation regarding the extent to which the expansion criteria pursuant to subsection (1) have been met, the agency may submit a budget amendment, pursuant to chapter 216, to request the necessary budget transfers associated with the expansion of the demonstration program.

Section 6. Paragraphs (f), (k), and (l) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(f) When an eligible ~~a~~ Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider according to the following provisions:

1. Effective January 1, 2006, Medicaid recipients who are subject to mandatory Medicaid managed care enrollment but who fail to make a choice shall be assigned to Medicaid managed care plans until not less than 75 percent of all Medicaid recipients eligible to choose managed care are enrolled in managed care plans. When that percentage is achieved, assignment of Medicaid recipients who fail to make a choice shall be based proportionally each period on the preferences of recipients who made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. Members of managed care

plans operating under the provisions of s. 409.91211 shall not be included in the percentage calculation.

2. Effective July 1, 2007, Medicaid recipients who are subject to mandatory Medicaid managed care enrollment but who fail to make a choice shall be assigned to managed care plans.

3. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act.

4. In counties in which there are no managed care plans that accept Medicaid enrollees, assignment shall be to a MediPass provider.

5. When assigning Medicaid recipients who fail to make a choice, the agency shall take into account the following criteria:

a. Network capacity is sufficient to meet the needs of members.

b. The recipient has an enrollment history with a managed care plan or a treatment history with one of the primary care providers within a managed care plan.

c. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan but has failed to make a choice.

d. Primary care providers and specialists are geographically accessible to the recipient's residence. ~~Medicaid~~

~~recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 percent in MediPass and 60 percent in managed care plans is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 percent and 60 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric~~

~~emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

~~1. A managed care plan has sufficient network capacity to meet the need of members.~~

~~2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.~~

~~3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee for service claims data, but has failed to make a choice.~~

~~4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.~~

~~(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 40 percent in MediPass and 60 percent in managed care plans is achieved. Once that~~

~~enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 40 percent and 60 percent proportion, respectively. In service areas 1 and 6 of the Agency for Health Care Administration where the agency is contracting for the provision of comprehensive behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:~~

~~1. A managed care plan has sufficient network capacity to meet the need of members.~~

~~2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.~~

~~3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.~~

~~4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.~~

~~5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.~~

(k)~~(l)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

Section 7. The Agency for Health Care Administration shall report to the Legislature by April 1, 2006, the specific preimplementation milestones required by the Centers for Medicare and Medicaid Services Special Terms and Conditions related to the low income pool that have been approved by the Federal Government and the status of any remaining preimplementation milestones that have not been approved by the Federal Government.

Section 8. Quarterly progress and annual reports.--The Agency for Health Care Administration shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability the following reports:

(1) Quarterly progress reports submitted to Centers for

Medicare and Medicaid Services no later than 60 days following the end of each quarter. These reports shall present the agency's analysis and the status of various operational areas. The quarterly progress reports shall include, but are not limited to, the following:

(a) Documentation of events that occurred during the quarter or that are anticipated to occur in the near future that affect health care delivery, including, but not limited to, the approval of contracts with new managed care plans, the procedures for designating coverage areas, the process of phasing in managed care, a description of the populations served and the benefits provided, the number of recipients enrolled, a list of grievances submitted by enrollees, and other operational issues.

(b) Action plans for addressing policy and administrative issues.

(c) Documentation of agency efforts related to the collection and verification of encounter and utilization data.

(d) Enrollment data for each managed care plan according to the following specifications: total number of enrollees, eligibility category, number of enrollees receiving Temporary Assistance for Needy Families or Supplemental Security Income, market share, and percentage change in enrollment. In addition, the agency shall provide a summary of voluntary and mandatory selection rates and disenrollment data. Enrollment data, number of members by month, and expenditures shall be submitted in the format for monitoring budget neutrality provided by the Centers for Medicare and Medicaid Services.

(e) Documentation of low income pool activities and associated expenditures.

(f) Documentation of activities related to the implementation of choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups.

(g) Participation rates in the Enhanced Benefit Accounts Program, as established in the Centers for Medicare and Medicaid Services Special Terms and Conditions number 11-W-00206/4, which shall include: participation levels, summary of activities and associated expenditures, number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate, estimated quarterly deposits in accounts, and expenditures from the accounts.

(h) Enrollment data on employer-sponsored insurance that documents the number of individuals selecting to opt out when employer-sponsored insurance is available. The agency shall include data that identifies enrollee characteristics to include eligibility category, type of employer-sponsored insurance, and type of coverage based on whether the coverage is for the individual or the family. The agency shall develop and maintain disenrollment reports specifying the reason for disenrolling in an employer-sponsored insurance program. The agency shall also track and report on those enrollees who elect to reenroll in the Medicaid reform waiver demonstration program.

(i) Documentation of progress toward the demonstration program goals.

(j) Documentation of evaluation activities.

(2) The annual report shall document accomplishments, program status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Medicaid reform waiver demonstration program. The agency shall submit the draft annual report no later than October 1 after the end of each fiscal year.

(a) Beginning with the annual report for demonstration program year two, the agency shall include a section on the administration of enhanced benefit accounts, participation rates, an assessment of expenditures, and potential cost savings.

(b) Beginning with the annual report for demonstration program year four, the agency shall include a section that provides qualitative and quantitative data that describes the impact of the low income pool on the number of uninsured persons in the state from the start of the implementation of the demonstration program.

Section 9. Section 11.72, Florida Statutes, is created to read:

11.72 Joint Legislative Committee on Medicaid Reform Implementation; creation; membership; powers; duties.--

(1) There is created a standing joint committee of the Legislature designated the Joint Legislative Committee on Medicaid Reform Implementation for the purpose of reviewing policy issues related to expansion of the Medicaid managed care pilot program pursuant to s. 409.91211.

(2) The Joint Legislative Committee on Medicaid Reform Implementation shall be composed of eight members appointed as follows: four members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the minority party; and four members of the Senate appointed by the President of the Senate, one of whom shall be a member of the minority party. The President of the Senate shall appoint the chair in even-numbered years and the vice chair in odd-numbered years, and the Speaker of the House of Representatives shall appoint the chair in odd-numbered years and the vice chair in even-numbered years from among the committee membership. Vacancies shall be filled in the same manner as the original appointment. Members shall serve without compensation, except that members are entitled to reimbursement for per diem and travel expenses in accordance with s. 112.061.

(3) The committee shall be governed by joint rules of the Senate and the House of Representatives which shall remain in effect until repealed or amended by concurrent resolution.

(4) The committee shall meet at the call of the chair. The committee may hold hearings on matters within its purview which are in the public interest. A quorum shall consist of a majority of members from each house, plus one additional member from either house. Action by the committee requires a majority vote of the members present of each house.

(5) The committee shall be jointly staffed by the appropriations and substantive committees of the House of Representatives and the Senate. During even-numbered years the

Senate shall serve as lead staff and during odd-numbered years the House of Representatives shall serve as lead staff.

(6) The committee shall:

(a) Review reports, public hearing proceedings, documents, and materials provided by the Agency for Health Care Administration relating to the expansion of the Medicaid managed care pilot program to other counties of the state pursuant to s. 409.91212.

(b) Consult with the substantive and fiscal committees of the House of Representatives and the Senate which have jurisdiction over the Medicaid matters relating to agency action to expand the Medicaid managed care pilot program.

(c) Meet to consider and make a recommendation regarding the extent to which the expansion criteria pursuant to s. 409.91212 have been met.

(7) Within 2 days after meeting, during which the committee reviewed documents, material, and testimony related to the expansion criteria, the committee shall submit a memorandum to the Speaker of the House of Representatives, the President of the Senate, the Legislative Budget Commission, and the agency delineating the extent to which the agency met the expansion criteria.

Section 10. Section 216.346, Florida Statutes, is amended to read:

216.346 Contracts between state agencies; restriction on overhead or other indirect costs.--In any contract between state agencies, including any contract involving the State University System or the Florida Community College System, the agency

receiving the contract or grant moneys shall charge no more than a reasonable percentage ~~5 percent~~ of the total cost of the contract or grant for overhead or indirect costs or any other costs not required for the payment of direct costs. This provision is not intended to limit an agency's ability to certify matching funds or designate in-kind contributions which will allow the drawdown of federal Medicaid dollars that do not affect state budgeting.

Section 11. This act shall take effect upon becoming a law.