

1 A bill to be entitled
 2 An act relating to the Medicaid managed care pilot
 3 program; amending ss. 409.912 and 409.91211, F.S.;
 4 deleting provisions relating to the Medicaid managed care
 5 pilot program; conforming provisions; providing an
 6 effective date.

7
 8 Be It Enacted by the Legislature of the State of Florida:

9
 10 Section 1. Paragraphs (b) and (d) of subsection (4) and
 11 subsection (34) of section 409.912, Florida Statutes, are
 12 amended to read:

13 409.912 Cost-effective purchasing of health care.--The
 14 agency shall purchase goods and services for Medicaid recipients
 15 in the most cost-effective manner consistent with the delivery
 16 of quality medical care. To ensure that medical services are
 17 effectively utilized, the agency may, in any case, require a
 18 confirmation or second physician's opinion of the correct
 19 diagnosis for purposes of authorizing future services under the
 20 Medicaid program. This section does not restrict access to
 21 emergency services or poststabilization care services as defined
 22 in 42 C.F.R. part 438.114. Such confirmation or second opinion
 23 shall be rendered in a manner approved by the agency. The agency
 24 shall maximize the use of prepaid per capita and prepaid
 25 aggregate fixed-sum basis services when appropriate and other
 26 alternative service delivery and reimbursement methodologies,
 27 including competitive bidding pursuant to s. 287.057, designed
 28 to facilitate the cost-effective purchase of a case-managed

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29 | continuum of care. The agency shall also require providers to
30 | minimize the exposure of recipients to the need for acute
31 | inpatient, custodial, and other institutional care and the
32 | inappropriate or unnecessary use of high-cost services. The
33 | agency shall contract with a vendor to monitor and evaluate the
34 | clinical practice patterns of providers in order to identify
35 | trends that are outside the normal practice patterns of a
36 | provider's professional peers or the national guidelines of a
37 | provider's professional association. The vendor must be able to
38 | provide information and counseling to a provider whose practice
39 | patterns are outside the norms, in consultation with the agency,
40 | to improve patient care and reduce inappropriate utilization.
41 | The agency may mandate prior authorization, drug therapy
42 | management, or disease management participation for certain
43 | populations of Medicaid beneficiaries, certain drug classes, or
44 | particular drugs to prevent fraud, abuse, overuse, and possible
45 | dangerous drug interactions. The Pharmaceutical and Therapeutics
46 | Committee shall make recommendations to the agency on drugs for
47 | which prior authorization is required. The agency shall inform
48 | the Pharmaceutical and Therapeutics Committee of its decisions
49 | regarding drugs subject to prior authorization. The agency is
50 | authorized to limit the entities it contracts with or enrolls as
51 | Medicaid providers by developing a provider network through
52 | provider credentialing. The agency may competitively bid single-
53 | source-provider contracts if procurement of goods or services
54 | results in demonstrated cost savings to the state without
55 | limiting access to care. The agency may limit its network based
56 | on the assessment of beneficiary access to care, provider

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57 | availability, provider quality standards, time and distance
58 | standards for access to care, the cultural competence of the
59 | provider network, demographic characteristics of Medicaid
60 | beneficiaries, practice and provider-to-beneficiary standards,
61 | appointment wait times, beneficiary use of services, provider
62 | turnover, provider profiling, provider licensure history,
63 | previous program integrity investigations and findings, peer
64 | review, provider Medicaid policy and billing compliance records,
65 | clinical and medical record audits, and other factors. Providers
66 | shall not be entitled to enrollment in the Medicaid provider
67 | network. The agency shall determine instances in which allowing
68 | Medicaid beneficiaries to purchase durable medical equipment and
69 | other goods is less expensive to the Medicaid program than long-
70 | term rental of the equipment or goods. The agency may establish
71 | rules to facilitate purchases in lieu of long-term rentals in
72 | order to protect against fraud and abuse in the Medicaid program
73 | as defined in s. 409.913. The agency may seek federal waivers
74 | necessary to administer these policies.

75 | (4) The agency may contract with:

76 | (b) An entity that is providing comprehensive behavioral
77 | health care services to certain Medicaid recipients through a
78 | capitated, prepaid arrangement pursuant to the federal waiver
79 | provided for by s. 409.905(5). Such an entity must be licensed
80 | under chapter 624, chapter 636, or chapter 641 and must possess
81 | the clinical systems and operational competence to manage risk
82 | and provide comprehensive behavioral health care to Medicaid
83 | recipients. As used in this paragraph, the term "comprehensive
84 | behavioral health care services" means covered mental health and

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85 substance abuse treatment services that are available to
86 Medicaid recipients. The secretary of the Department of Children
87 and Family Services shall approve provisions of procurements
88 related to children in the department's care or custody prior to
89 enrolling such children in a prepaid behavioral health plan. Any
90 contract awarded under this paragraph must be competitively
91 procured. In developing the behavioral health care prepaid plan
92 procurement document, the agency shall ensure that the
93 procurement document requires the contractor to develop and
94 implement a plan to ensure compliance with s. 394.4574 related
95 to services provided to residents of licensed assisted living
96 facilities that hold a limited mental health license. Except as
97 provided in subparagraph 8., ~~and except in counties where the~~
98 ~~Medicaid managed care pilot program is authorized pursuant to s.~~
99 ~~409.91211,~~ the agency shall seek federal approval to contract
100 with a single entity meeting these requirements to provide
101 comprehensive behavioral health care services to all Medicaid
102 recipients not enrolled in a ~~Medicaid managed care plan~~
103 ~~authorized under s. 409.91211~~ or a Medicaid health maintenance
104 organization in an AHCA area. ~~In an AHCA area where the Medicaid~~
105 ~~managed care pilot program is authorized pursuant to s.~~
106 ~~409.91211 in one or more counties, the agency may procure a~~
107 ~~contract with a single entity to serve the remaining counties as~~
108 ~~an AHCA area or the remaining counties may be included with an~~
109 ~~adjacent AHCA area and shall be subject to this paragraph.~~ Each
110 entity must offer sufficient choice of providers in its network
111 to ensure recipient access to care and the opportunity to select
112 a provider with whom they are satisfied. The network shall

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

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

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

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141 3. Except as provided in subparagraph 8., by July 1, 2006,
142 the agency and the Department of Children and Family Services
143 shall contract with managed care entities in each AHCA area
144 except area 6 or arrange to provide comprehensive inpatient and
145 outpatient mental health and substance abuse services through
146 capitated prepaid arrangements to all Medicaid recipients who
147 are eligible to participate in such plans under federal law and
148 regulation. In AHCA areas where eligible individuals number less
149 than 150,000, the agency shall contract with a single managed
150 care plan to provide comprehensive behavioral health services to
151 all recipients who are not enrolled in a Medicaid health
152 maintenance organization ~~or a Medicaid capitated managed care~~
153 ~~plan authorized under s. 409.91211~~. The agency may contract with
154 more than one comprehensive behavioral health provider to
155 provide care to recipients who are not enrolled in a Medicaid
156 ~~capitated managed care plan authorized under s. 409.91211 or a~~
157 Medicaid health maintenance organization in AHCA areas where the
158 eligible population exceeds 150,000. ~~In an AHCA area where the~~
159 ~~Medicaid managed care pilot program is authorized pursuant to s.~~
160 ~~409.91211 in one or more counties, the agency may procure a~~
161 ~~contract with a single entity to serve the remaining counties as~~
162 ~~an AHCA area or the remaining counties may be included with an~~
163 ~~adjacent AHCA area and shall be subject to this paragraph.~~
164 Contracts for comprehensive behavioral health providers awarded
165 pursuant to this section shall be competitively procured. Both
166 for-profit and not-for-profit corporations shall be eligible to
167 compete. Managed care plans contracting with the agency under
168 subsection (3) shall provide and receive payment for the same

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169 comprehensive behavioral health benefits as provided in AHCA
170 rules, including handbooks incorporated by reference. In AHCA
171 area 11, the agency shall contract with at least two
172 comprehensive behavioral health care providers to provide
173 behavioral health care to recipients in that area who are
174 enrolled in, or assigned to, the MediPass program. One of the
175 behavioral health care contracts shall be with the existing
176 provider service network pilot project, as described in
177 paragraph (d), for the purpose of demonstrating the cost-
178 effectiveness of the provision of quality mental health services
179 through a public hospital-operated managed care model. Payment
180 shall be at an agreed-upon capitated rate to ensure cost
181 savings. Of the recipients in area 11 who are assigned to
182 MediPass under the provisions of s. 409.9122(2)(k), a minimum of
183 50,000 of those MediPass-enrolled recipients shall be assigned
184 to the existing provider service network in area 11 for their
185 behavioral care.

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

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

194 b. If the agency determines that the proposed capitation
195 rate in any area is insufficient to provide appropriate
196 services, the agency may adjust the capitation rate to ensure

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197 that care will be available. The agency and the department may
198 use existing general revenue to address any additional required
199 match but may not over-obligate existing funds on an annualized
200 basis.

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

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

211 6. In converting to a prepaid system of delivery, the
212 agency shall in its procurement document require an entity
213 providing only comprehensive behavioral health care services to
214 prevent the displacement of indigent care patients by enrollees
215 in the Medicaid prepaid health plan providing behavioral health
216 care services from facilities receiving state funding to provide
217 indigent behavioral health care, to facilities licensed under
218 chapter 395 which do not receive state funding for indigent
219 behavioral health care, or reimburse the unsubsidized facility
220 for the cost of behavioral health care provided to the displaced
221 indigent care patient.

222 7. Traditional community mental health providers under
223 contract with the Department of Children and Family Services
224 pursuant to part IV of chapter 394, child welfare providers

225 | under contract with the Department of Children and Family
 226 | Services in areas 1 and 6, and inpatient mental health providers
 227 | licensed pursuant to chapter 395 must be offered an opportunity
 228 | to accept or decline a contract to participate in any provider
 229 | network for prepaid behavioral health services.

230 | 8. All Medicaid-eligible children, except children in area
 231 | 1 and children in Highlands County, Hardee County, Polk County,
 232 | or Manatee County of area 6, who are open for child welfare
 233 | services in the HomeSafeNet system, shall receive their
 234 | behavioral health care services through a specialty prepaid plan
 235 | operated by community-based lead agencies either through a
 236 | single agency or formal agreements among several agencies. The
 237 | specialty prepaid plan must result in savings to the state
 238 | comparable to savings achieved in other Medicaid managed care
 239 | and prepaid programs. Such plan must provide mechanisms to
 240 | maximize state and local revenues. The specialty prepaid plan
 241 | shall be developed by the agency and the Department of Children
 242 | and Family Services. The agency is authorized to seek any
 243 | federal waivers to implement this initiative. ~~Medicaid-eligible~~
 244 | ~~children whose cases are open for child welfare services in the~~
 245 | ~~HomeSafeNet system and who reside in AHCA area 10 are exempt~~
 246 | ~~from the specialty prepaid plan upon the development of a~~
 247 | ~~service delivery mechanism for children who reside in area 10 as~~
 248 | ~~specified in s. 409.91211(3)(dd).~~

249 | (d) A provider service network may be reimbursed on a fee-
 250 | for-service or prepaid basis. A provider service network which
 251 | is reimbursed by the agency on a prepaid basis shall be exempt
 252 | from parts I and III of chapter 641, but must comply with the

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253 solvency requirements in s. 641.2261(2) and meet appropriate
254 financial reserve, quality assurance, and patient rights
255 requirements as established by the agency. Medicaid recipients
256 assigned to a provider service network shall be chosen equally
257 from those who would otherwise have been assigned to prepaid
258 plans and MediPass. The agency is authorized to seek federal
259 Medicaid waivers as necessary to implement the provisions of
260 this section. Any contract previously awarded to a provider
261 service network operated by a hospital pursuant to this
262 subsection shall remain in effect for a period of 3 years
263 following the current contract expiration date, regardless of
264 any contractual provisions to the contrary. A provider service
265 network is a network established or organized and operated by a
266 health care provider, or group of affiliated health care
267 providers, including minority physician networks and emergency
268 room diversion programs ~~that meet the requirements of s.~~
269 ~~409.91211~~, which provides a substantial proportion of the health
270 care items and services under a contract directly through the
271 provider or affiliated group of providers and may make
272 arrangements with physicians or other health care professionals,
273 health care institutions, or any combination of such individuals
274 or institutions to assume all or part of the financial risk on a
275 prospective basis for the provision of basic health services by
276 the physicians, by other health professionals, or through the
277 institutions. The health care providers must have a controlling
278 interest in the governing body of the provider service network
279 organization.

280 (34) The agency and entities that contract with the agency
 281 to provide health care services to Medicaid recipients under
 282 this section or s. ss. 409.91211 and 409.9122 must comply with
 283 the provisions of s. 641.513 in providing emergency services and
 284 care to Medicaid recipients and MediPass recipients. Where
 285 feasible, safe, and cost-effective, the agency shall encourage
 286 hospitals, emergency medical services providers, and other
 287 public and private health care providers to work together in
 288 their local communities to enter into agreements or arrangements
 289 to ensure access to alternatives to emergency services and care
 290 for those Medicaid recipients who need nonemergent care. The
 291 agency shall coordinate with hospitals, emergency medical
 292 services providers, private health plans, ~~capitated managed care~~
 293 ~~networks as established in s. 409.91211,~~ and other public and
 294 private health care providers to implement the provisions of ss.
 295 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop
 296 and implement emergency department diversion programs for
 297 Medicaid recipients.

298 Section 2. Section 409.91211, Florida Statutes, is amended
 299 to read:

300 409.91211 Medicaid managed care ~~pilot program~~.--

301 (1)(a) The agency is authorized to seek and implement
 302 experimental, pilot, or demonstration project waivers, pursuant
 303 to s. 1115 of the Social Security Act, to create a statewide
 304 initiative to provide for a more efficient and effective service
 305 delivery system that enhances quality of care and client
 306 outcomes in the Florida Medicaid program pursuant to this
 307 section. ~~Phase one of the demonstration shall be implemented in~~

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308 ~~two geographic areas. One demonstration site shall include only~~
309 ~~Broward County. A second demonstration site shall initially~~
310 ~~include Duval County and shall be expanded to include Baker,~~
311 ~~Clay, and Nassau Counties within 1 year after the Duval County~~
312 ~~program becomes operational. The agency shall implement~~
313 ~~expansion of the program to include the remaining counties of~~
314 ~~the state and remaining eligibility groups in accordance with~~
315 ~~the process specified in the federally approved special terms~~
316 ~~and conditions numbered 11-W-00206/4, as approved by the federal~~
317 ~~Centers for Medicare and Medicaid Services on October 19, 2005,~~
318 ~~with a goal of full statewide implementation by June 30, 2011.~~

319 (b) This waiver authority is contingent upon federal
320 approval to preserve the upper-payment-limit funding mechanism
321 for hospitals, including a guarantee of a reasonable growth
322 factor, a methodology to allow the use of a portion of these
323 funds to serve as a risk pool for demonstration sites,
324 provisions to preserve the state's ability to use
325 intergovernmental transfers, and provisions to protect the
326 disproportionate share program authorized pursuant to this
327 chapter. Upon completion of the evaluation conducted under s. 3,
328 ch. 2005-133, Laws of Florida, the agency may request statewide
329 expansion of the demonstration projects. Statewide phase-in to
330 additional counties shall be contingent upon review and approval
331 by the Legislature. Under the upper-payment-limit program, or
332 the low-income pool as implemented by the Agency for Health Care
333 Administration pursuant to federal waiver, the state matching
334 funds required for the program shall be provided by local
335 governmental entities through intergovernmental transfers in

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336 accordance with published federal statutes and regulations. The
337 Agency for Health Care Administration shall distribute upper-
338 payment-limit, disproportionate share hospital, and low-income
339 pool funds according to published federal statutes, regulations,
340 and waivers and the low-income pool methodology approved by the
341 federal Centers for Medicare and Medicaid Services.

342 (2)~~(e)~~ It is the intent of the Legislature that the low-
343 income pool plan required by the terms and conditions of the
344 Medicaid reform waiver and submitted to the federal Centers for
345 Medicare and Medicaid Services propose the distribution of the
346 above-mentioned program funds based on the following objectives:

347 (a)~~1.~~ Assure a broad and fair distribution of available
348 funds based on the access provided by Medicaid participating
349 hospitals, regardless of their ownership status, through their
350 delivery of inpatient or outpatient care for Medicaid
351 beneficiaries and uninsured and underinsured individuals;

352 (b)~~2.~~ Assure accessible emergency inpatient and outpatient
353 care for Medicaid beneficiaries and uninsured and underinsured
354 individuals;

355 (c)~~3.~~ Enhance primary, preventive, and other ambulatory
356 care coverages for uninsured individuals;

357 (d)~~4.~~ Promote teaching and specialty hospital programs;

358 (e)~~5.~~ Promote the stability and viability of statutorily
359 defined rural hospitals and hospitals that serve as sole
360 community hospitals;

361 (f)~~6.~~ Recognize the extent of hospital uncompensated care
362 costs;

363 (g)~~7~~. Maintain and enhance essential community hospital
 364 care;

365 (h)~~8~~. Maintain incentives for local governmental entities
 366 to contribute to the cost of uncompensated care;

367 (i)~~9~~. Promote measures to avoid preventable
 368 hospitalizations;

369 (j)~~10~~. Account for hospital efficiency; and

370 (k)~~11~~. Contribute to a community's overall health system.

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

373 ~~(a) Provide recipients in Medicaid fee-for-service or the~~
 374 ~~MediPass program a comprehensive and coordinated capitated~~
 375 ~~managed care system for all health care services specified in~~
 376 ~~ss. 409.905 and 409.906.~~

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

381 ~~1. Consumer education and choice.~~

382 ~~2. Access to medically necessary services.~~

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

385 ~~4. Reductions in unnecessary service utilization.~~

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

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

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

398 ~~(b) To implement a pilot program, including Medicaid~~
 399 ~~eligibility categories specified in ss. 409.903 and 409.904, as~~
 400 ~~authorized in an approved federal waiver.~~

401 ~~(c) To implement the managed care pilot program that~~
 402 ~~maximizes all available state and federal funds, including those~~
 403 ~~obtained through intergovernmental transfers, the low-income~~
 404 ~~pool, supplemental Medicaid payments, and the disproportionate~~
 405 ~~share program. Within the parameters allowed by federal statute~~
 406 ~~and rule, the agency may seek options for making direct payments~~
 407 ~~to hospitals and physicians employed by or under contract with~~
 408 ~~the state's medical schools for the costs associated with~~
 409 ~~graduate medical education under Medicaid reform.~~

410 ~~(d) To implement actuarially sound, risk-adjusted~~
 411 ~~capitation rates for Medicaid recipients in the pilot program~~
 412 ~~which cover comprehensive care, enhanced services, and~~
 413 ~~catastrophic care.~~

414 ~~(e) To implement policies and guidelines for phasing in~~
 415 ~~financial risk for approved provider service networks over a 3-~~
 416 ~~year period. These policies and guidelines must include an~~
 417 ~~option for a provider service network to be paid fee-for-service~~

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418 ~~rates. For any provider service network established in a managed~~
419 ~~care pilot area, the option to be paid fee-for-service rates~~
420 ~~shall include a savings-settlement mechanism that is consistent~~
421 ~~with s. 409.912(44). This model shall be converted to a risk-~~
422 ~~adjusted capitated rate no later than the beginning of the~~
423 ~~fourth year of operation, and may be converted earlier at the~~
424 ~~option of the provider service network. Federally qualified~~
425 ~~health centers may be offered an opportunity to accept or~~
426 ~~decline a contract to participate in any provider network for~~
427 ~~prepaid primary care services.~~

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

431 ~~(g) To recommend a process to be used by the Social~~
432 ~~Services Estimating Conference to determine and validate the~~
433 ~~rate of growth of the per-member costs of providing Medicaid~~
434 ~~services under the managed care pilot program.~~

435 ~~(h) To implement program standards and credentialing~~
436 ~~requirements for capitated managed care networks to participate~~
437 ~~in the pilot program, including those related to fiscal~~
438 ~~solvency, quality of care, and adequacy of access to health care~~
439 ~~providers. It is the intent of the Legislature that, to the~~
440 ~~extent possible, any pilot program authorized by the state under~~
441 ~~this section include any federally qualified health center,~~
442 ~~federally qualified rural health clinic, county health~~
443 ~~department, the Children's Medical Services Network within the~~
444 ~~Department of Health, or other federally, state, or locally~~
445 ~~funded entity that serves the geographic areas within the~~

446 ~~boundaries of the pilot program that requests to participate.~~
447 ~~This paragraph does not relieve an entity that qualifies as a~~
448 ~~capitated managed care network under this section from any other~~
449 ~~licensure or regulatory requirements contained in state or~~
450 ~~federal law which would otherwise apply to the entity. The~~
451 ~~standards and credentialing requirements shall be based upon,~~
452 ~~but are not limited to:~~

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

455 ~~2. Compliance with early and periodic screening,~~
456 ~~diagnosis, and treatment screening requirements under federal~~
457 ~~law.~~

458 ~~3. The percentage of voluntary disenrollments.~~

459 ~~4. Immunization rates.~~

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

462 ~~6. Recommendations of other authoritative bodies.~~

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

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

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

473 ~~10. The network's ability to submit any financial,~~
 474 ~~programmatic, or patient-encounter data or other information~~
 475 ~~required by the agency to determine the actual services provided~~
 476 ~~and the cost of administering the plan.~~

477 ~~(i) To implement a mechanism for providing information to~~
 478 ~~Medicaid recipients for the purpose of selecting a capitated~~
 479 ~~managed care plan. For each plan available to a recipient, the~~
 480 ~~agency, at a minimum, shall ensure that the recipient is~~
 481 ~~provided with:~~

482 ~~1. A list and description of the benefits provided.~~

483 ~~2. Information about cost sharing.~~

484 ~~3. Plan performance data, if available.~~

485 ~~4. An explanation of benefit limitations.~~

486 ~~5. Contact information, including identification of~~
 487 ~~providers participating in the network, geographic locations,~~
 488 ~~and transportation limitations.~~

489 ~~6. Any other information the agency determines would~~
 490 ~~facilitate a recipient's understanding of the plan or insurance~~
 491 ~~that would best meet his or her needs.~~

492 ~~(j) To implement a system to ensure that there is a record~~
 493 ~~of recipient acknowledgment that choice counseling has been~~
 494 ~~provided.~~

495 ~~(k) To implement a choice counseling system to ensure that~~
 496 ~~the choice counseling process and related material are designed~~
 497 ~~to provide counseling through face-to-face interaction, by~~
 498 ~~telephone, and in writing and through other forms of relevant~~
 499 ~~media. Materials shall be written at the fourth-grade reading~~
 500 ~~level and available in a language other than English when 5~~

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501 ~~percent of the county speaks a language other than English.~~
502 ~~Choice counseling shall also use language lines and other~~
503 ~~services for impaired recipients, such as TTD/TTY.~~

504 ~~(l) To implement a system that prohibits capitated managed~~
505 ~~care plans, their representatives, and providers employed by or~~
506 ~~contracted with the capitated managed care plans from recruiting~~
507 ~~persons eligible for or enrolled in Medicaid, from providing~~
508 ~~inducements to Medicaid recipients to select a particular~~
509 ~~capitated managed care plan, and from prejudicing Medicaid~~
510 ~~recipients against other capitated managed care plans. The~~
511 ~~system shall require the entity performing choice counseling to~~
512 ~~determine if the recipient has made a choice of a plan or has~~
513 ~~opted out because of duress, threats, payment to the recipient,~~
514 ~~or incentives promised to the recipient by a third party. If the~~
515 ~~choice counseling entity determines that the decision to choose~~
516 ~~a plan was unlawfully influenced or a plan violated any of the~~
517 ~~provisions of s. 409.912(21), the choice counseling entity shall~~
518 ~~immediately report the violation to the agency's program~~
519 ~~integrity section for investigation. Verification of choice~~
520 ~~counseling by the recipient shall include a stipulation that the~~
521 ~~recipient acknowledges the provisions of this subsection.~~

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

526 ~~(n) To contract with entities to perform choice~~
527 ~~counseling. The agency may establish standards and performance~~
528 ~~contracts, including standards requiring the contractor to hire~~

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529 ~~choice counselors who are representative of the state's diverse~~
530 ~~population and to train choice counselors in working with~~
531 ~~culturally diverse populations.~~

532 ~~(o) To implement eligibility assignment processes to~~
533 ~~facilitate client choice while ensuring pilot programs of~~
534 ~~adequate enrollment levels. These processes shall ensure that~~
535 ~~pilot sites have sufficient levels of enrollment to conduct a~~
536 ~~valid test of the managed care pilot program within a 2-year~~
537 ~~timeframe.~~

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

546 ~~1. In performing the duties required under this section,~~
547 ~~the agency shall work with managed care plans to establish a~~
548 ~~uniform system to measure and monitor outcomes for a recipient~~
549 ~~of Medicaid services.~~

550 ~~2. The system shall use financial, clinical, and other~~
551 ~~criteria based on pharmacy, medical services, and other data~~
552 ~~that is related to the provision of Medicaid services,~~
553 ~~including, but not limited to:~~

554 ~~a. The Health Plan Employer Data and Information Set~~
555 ~~(HEDIS) or measures that are similar to HEDIS.~~

556 ~~b. Member satisfaction.~~

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- 557 ~~e. Provider satisfaction.~~
- 558 ~~d. Report cards on plan performance and best practices.~~
- 559 ~~e. Compliance with the requirements for prompt payment of~~
560 ~~claims under ss. 627.613, 641.3155, and 641.513.~~
- 561 ~~f. Utilization and quality data for the purpose of~~
562 ~~ensuring access to medically necessary services, including~~
563 ~~underutilization or inappropriate denial of services.~~
- 564 ~~3. The agency shall require the managed care plans that~~
565 ~~have contracted with the agency to establish a quality assurance~~
566 ~~system that incorporates the provisions of s. 409.912(27) and~~
567 ~~any standards, rules, and guidelines developed by the agency.~~
- 568 ~~4. The agency shall establish an encounter database in~~
569 ~~order to compile data on health services rendered by health care~~
570 ~~practitioners who provide services to patients enrolled in~~
571 ~~managed care plans in the demonstration sites. The encounter~~
572 ~~database shall:~~
- 573 ~~a. Collect the following for each type of patient~~
574 ~~encounter with a health care practitioner or facility,~~
575 ~~including:~~
- 576 ~~(I) The demographic characteristics of the patient.~~
- 577 ~~(II) The principal, secondary, and tertiary diagnosis.~~
- 578 ~~(III) The procedure performed.~~
- 579 ~~(IV) The date and location where the procedure was~~
580 ~~performed.~~
- 581 ~~(V) The payment for the procedure, if any.~~
- 582 ~~(VI) If applicable, the health care practitioner's~~
583 ~~universal identification number.~~

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

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

590 ~~e. Collect appropriate information related to health care~~
 591 ~~costs and utilization from managed care plans participating in~~
 592 ~~the demonstration sites.~~

593 ~~5. To the extent practicable, when collecting the data the~~
 594 ~~agency shall use a standardized claim form or electronic~~
 595 ~~transfer system that is used by health care practitioners,~~
 596 ~~facilities, and payors.~~

597 ~~6. Health care practitioners and facilities in the~~
 598 ~~demonstration sites shall electronically submit, and managed~~
 599 ~~care plans participating in the demonstration sites shall~~
 600 ~~electronically receive, information concerning claims payments~~
 601 ~~and any other information reasonably related to the encounter~~
 602 ~~database using a standard format as required by the agency.~~

603 ~~7. The agency shall establish reasonable deadlines for~~
 604 ~~phasing in the electronic transmittal of full encounter data.~~

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

607 ~~(g) To implement a grievance resolution process for~~
 608 ~~Medicaid recipients enrolled in a capitated managed care network~~
 609 ~~under the pilot program modeled after the subscriber assistance~~
 610 ~~panel, as created in s. 408.7056. This process shall include a~~
 611 ~~mechanism for an expedited review of no greater than 24 hours~~

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612 ~~after notification of a grievance if the life of a Medicaid~~
613 ~~recipient is in imminent and emergent jeopardy.~~

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

619 ~~(s) To implement criteria in an approved federal waiver to~~
620 ~~designate health care providers as eligible to participate in~~
621 ~~the pilot program. These criteria must include at a minimum~~
622 ~~those criteria specified in s. 409.907.~~

623 ~~(t) To use health care provider agreements for~~
624 ~~participation in the pilot program.~~

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

630 ~~(v) To ensure that managed care organizations work~~
631 ~~collaboratively with other state or local governmental programs~~
632 ~~or institutions for the coordination of health care to eligible~~
633 ~~individuals receiving services from such programs or~~
634 ~~institutions.~~

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

638 ~~1. The agency shall ensure that applicable provisions of~~
639 ~~this chapter and chapters 414, 626, 641, and 932 which relate to~~

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640 ~~Medicaid fraud and abuse are applied and enforced at the~~
641 ~~demonstration project sites.~~

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

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

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

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

655 ~~6.a. The agency shall require all managed care plan~~
656 ~~contractors in the pilot program to report all instances of~~
657 ~~suspected fraud and abuse. A failure to report instances of~~
658 ~~suspected fraud and abuse is a violation of law and subject to~~
659 ~~the penalties provided by law.~~

660 ~~b. An instance of fraud and abuse in the managed care~~
661 ~~plan, including, but not limited to, defrauding the state health~~
662 ~~care benefit program by misrepresentation of fact in reports,~~
663 ~~claims, certifications, enrollment claims, demographic~~
664 ~~statistics, or patient-encounter data; misrepresentation of the~~
665 ~~qualifications of persons rendering health care and ancillary~~
666 ~~services; bribery and false statements relating to the delivery~~
667 ~~of health care; unfair and deceptive marketing practices; and~~

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

670 ~~e. The agency shall require that all contractors make all~~
671 ~~files and relevant billing and claims data accessible to state~~
672 ~~regulators and investigators and that all such data is linked~~
673 ~~into a unified system to ensure consistent reviews and~~
674 ~~investigations.~~

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

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

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

684 ~~3. Growth in capitation rates which is limited to the~~
685 ~~growth rate of aggregate Medicaid expenditures between the 2003-~~
686 ~~2004 fiscal year and the 2004-2005 fiscal year.~~

687 ~~(y) To develop a mechanism to require capitated managed~~
688 ~~care plans to reimburse qualified emergency service providers,~~
689 ~~including, but not limited to, ambulance services, in accordance~~
690 ~~with ss. 409.908 and 409.9128. The pilot program must include a~~
691 ~~provision for continuing fee-for-service payments for emergency~~
692 ~~services, including, but not limited to, individuals who access~~
693 ~~ambulance services or emergency departments and who are~~
694 ~~subsequently determined to be eligible for Medicaid services.~~

695 ~~(z) To ensure that school districts participating in the~~
 696 ~~certified school match program pursuant to ss. 409.908(21) and~~
 697 ~~1011.70 shall be reimbursed by Medicaid, subject to the~~
 698 ~~limitations of s. 1011.70(1), for a Medicaid-eligible child~~
 699 ~~participating in the services as authorized in s. 1011.70, as~~
 700 ~~provided for in s. 409.9071, regardless of whether the child is~~
 701 ~~enrolled in a capitated managed care network. Capitated managed~~
 702 ~~care networks must make a good faith effort to execute~~
 703 ~~agreements with school districts regarding the coordinated~~
 704 ~~provision of services authorized under s. 1011.70. County health~~
 705 ~~departments and federally qualified health centers delivering~~
 706 ~~school-based services pursuant to ss. 381.0056 and 381.0057 must~~
 707 ~~be reimbursed by Medicaid for the federal share for a Medicaid-~~
 708 ~~eligible child who receives Medicaid-covered services in a~~
 709 ~~school setting, regardless of whether the child is enrolled in a~~
 710 ~~capitated managed care network. Capitated managed care networks~~
 711 ~~must make a good faith effort to execute agreements with county~~
 712 ~~health departments and federally qualified health centers~~
 713 ~~regarding the coordinated provision of services to a Medicaid-~~
 714 ~~eligible child. To ensure continuity of care for Medicaid~~
 715 ~~patients, the agency, the Department of Health, and the~~
 716 ~~Department of Education shall develop procedures for ensuring~~
 717 ~~that a student's capitated managed care network provider~~
 718 ~~receives information relating to services provided in accordance~~
 719 ~~with ss. 381.0056, 381.0057, 409.9071, and 1011.70.~~

720 ~~(aa) To implement a mechanism whereby Medicaid recipients~~
 721 ~~who are already enrolled in a managed care plan or the MediPass~~
 722 ~~program in the pilot areas shall be offered the opportunity to~~

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723 ~~change to capitated managed care plans on a staggered basis, as~~
724 ~~defined by the agency. All Medicaid recipients shall have 30~~
725 ~~days in which to make a choice of capitated managed care plans.~~
726 ~~Those Medicaid recipients who do not make a choice shall be~~
727 ~~assigned to a capitated managed care plan in accordance with~~
728 ~~paragraph (4) (a) and shall be exempt from s. 409.9122. To~~
729 ~~facilitate continuity of care for a Medicaid recipient who is~~
730 ~~also a recipient of Supplemental Security Income (SSI), prior to~~
731 ~~assigning the SSI recipient to a capitated managed care plan,~~
732 ~~the agency shall determine whether the SSI recipient has an~~
733 ~~ongoing relationship with a provider or capitated managed care~~
734 ~~plan, and, if so, the agency shall assign the SSI recipient to~~
735 ~~that provider or capitated managed care plan where feasible.~~
736 ~~Those SSI recipients who do not have such a provider~~
737 ~~relationship shall be assigned to a capitated managed care plan~~
738 ~~provider in accordance with paragraph (4) (a) and shall be exempt~~
739 ~~from s. 409.9122.~~

740 ~~(bb) To develop and recommend a service delivery~~
741 ~~alternative for children having chronic medical conditions which~~
742 ~~establishes a medical home project to provide primary care~~
743 ~~services to this population. The project shall provide~~
744 ~~community-based primary care services that are integrated with~~
745 ~~other subspecialties to meet the medical, developmental, and~~
746 ~~emotional needs for children and their families. This project~~
747 ~~shall include an evaluation component to determine impacts on~~
748 ~~hospitalizations, length of stays, emergency room visits, costs,~~
749 ~~and access to care, including specialty care and patient and~~
750 ~~family satisfaction.~~

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

756 ~~(dd) To implement service delivery mechanisms within~~
757 ~~capitated managed care plans to provide Medicaid services as~~
758 ~~specified in ss. 409.905 and 409.906 to Medicaid-eligible~~
759 ~~children whose cases are open for child welfare services in the~~
760 ~~HomeSafeNet system. These services must be coordinated with~~
761 ~~community-based care providers as specified in s. 409.1671,~~
762 ~~where available, and be sufficient to meet the medical,~~
763 ~~developmental, behavioral, and emotional needs of these~~
764 ~~children. These service delivery mechanisms must be implemented~~
765 ~~no later than July 1, 2008, in AHCA area 10 in order for the~~
766 ~~children in AHCA area 10 to remain exempt from the statewide~~
767 ~~plan under s. 409.912(4)(b)8.~~

768 ~~(4)(a) A Medicaid recipient in the pilot area who is not~~
769 ~~currently enrolled in a capitated managed care plan upon~~
770 ~~implementation is not eligible for services as specified in ss.~~
771 ~~409.905 and 409.906, for the amount of time that the recipient~~
772 ~~does not enroll in a capitated managed care network. If a~~
773 ~~Medicaid recipient has not enrolled in a capitated managed care~~
774 ~~plan within 30 days after eligibility, the agency shall assign~~
775 ~~the Medicaid recipient to a capitated managed care plan based on~~
776 ~~the assessed needs of the recipient as determined by the agency~~
777 ~~and the recipient shall be exempt from s. 409.9122. When making~~

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778 ~~assignments, the agency shall take into account the following~~
779 ~~criteria:~~

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

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

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

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

793 ~~(b) When more than one capitated managed care network~~
794 ~~provider meets the criteria specified in paragraph (3)(h), the~~
795 ~~agency shall make recipient assignments consecutively by family~~
796 ~~unit.~~

797 ~~(c) If a recipient is currently enrolled with a Medicaid~~
798 ~~managed care organization that also operates an approved reform~~
799 ~~plan within a demonstration area and the recipient fails to~~
800 ~~choose a plan during the reform enrollment process or during~~
801 ~~redetermination of eligibility, the recipient shall be~~
802 ~~automatically assigned by the agency into the most appropriate~~
803 ~~reform plan operated by the recipient's current Medicaid managed~~
804 ~~care plan. If the recipient's current managed care plan does not~~
805 ~~operate a reform plan in the demonstration area which adequately~~

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806 ~~meets the needs of the Medicaid recipient, the agency shall use~~
807 ~~the automatic assignment process as prescribed in the special~~
808 ~~terms and conditions numbered 11-W-00206/4. All enrollment and~~
809 ~~choice counseling materials provided by the agency must contain~~
810 ~~an explanation of the provisions of this paragraph for current~~
811 ~~managed care recipients.~~

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

817 ~~(e) After a recipient has made a selection or has been~~
818 ~~enrolled in a capitated managed care network, the recipient~~
819 ~~shall have 90 days in which to voluntarily disenroll and select~~
820 ~~another capitated managed care network. After 90 days, no~~
821 ~~further changes may be made except for cause. Cause shall~~
822 ~~include, but not be limited to, poor quality of care, lack of~~
823 ~~access to necessary specialty services, an unreasonable delay or~~
824 ~~denial of service, inordinate or inappropriate changes of~~
825 ~~primary care providers, service access impairments due to~~
826 ~~significant changes in the geographic location of services, or~~
827 ~~fraudulent enrollment. The agency may require a recipient to use~~
828 ~~the capitated managed care network's grievance process as~~
829 ~~specified in paragraph (3)(g) prior to the agency's~~
830 ~~determination of cause, except in cases in which immediate risk~~
831 ~~of permanent damage to the recipient's health is alleged. The~~
832 ~~grievance process, when used, must be completed in time to~~
833 ~~permit the recipient to disenroll no later than the first day of~~

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

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

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

860 ~~1. A recipient who chooses the Medicaid opt-out option~~
861 ~~shall have an opportunity for a specified period of time, as~~

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862 ~~authorized under a waiver granted by the Centers for Medicare~~
863 ~~and Medicaid Services, to select and enroll in a Medicaid-~~
864 ~~certified plan. If the recipient remains in the employer-~~
865 ~~sponsored plan after the specified period, the recipient shall~~
866 ~~remain in the opt-out program for at least 1 year or until the~~
867 ~~recipient no longer has access to employer-sponsored coverage,~~
868 ~~until the employer's open enrollment period for a person who~~
869 ~~opts out in order to participate in employer-sponsored coverage,~~
870 ~~or until the person is no longer eligible for Medicaid,~~
871 ~~whichever time period is shorter.~~

872 ~~2. Notwithstanding any other provision of this section,~~
873 ~~coverage, cost sharing, and any other component of employer-~~
874 ~~sponsored health insurance shall be governed by applicable state~~
875 ~~and federal laws.~~

876 ~~(5) This section does not authorize the agency to~~
877 ~~implement any provision of s. 1115 of the Social Security Act~~
878 ~~experimental, pilot, or demonstration project waiver to reform~~
879 ~~the state Medicaid program in any part of the state other than~~
880 ~~the two geographic areas specified in this section unless~~
881 ~~approved by the Legislature.~~

882 ~~(6) The agency shall develop and submit for approval~~
883 ~~applications for waivers of applicable federal laws and~~
884 ~~regulations as necessary to implement the managed care pilot~~
885 ~~project as defined in this section. The agency shall post all~~
886 ~~waiver applications under this section on its Internet website~~
887 ~~30 days before submitting the applications to the United States~~
888 ~~Centers for Medicare and Medicaid Services. All waiver~~
889 ~~applications shall be provided for review and comment to the~~

890 ~~appropriate committees of the Senate and House of~~
891 ~~Representatives for at least 10 working days prior to~~
892 ~~submission. All waivers submitted to and approved by the United~~
893 ~~States Centers for Medicare and Medicaid Services under this~~
894 ~~section must be approved by the Legislature. Federally approved~~
895 ~~waivers must be submitted to the President of the Senate and the~~
896 ~~Speaker of the House of Representatives for referral to the~~
897 ~~appropriate legislative committees. The appropriate committees~~
898 ~~shall recommend whether to approve the implementation of any~~
899 ~~waivers to the Legislature as a whole. The agency shall submit a~~
900 ~~plan containing a recommended timeline for implementation of any~~
901 ~~waivers and budgetary projections of the effect of the pilot~~
902 ~~program under this section on the total Medicaid budget for the~~
903 ~~2006-2007 through 2009-2010 state fiscal years. This~~
904 ~~implementation plan shall be submitted to the President of the~~
905 ~~Senate and the Speaker of the House of Representatives at the~~
906 ~~same time any waivers are submitted for consideration by the~~
907 ~~Legislature. The agency may implement the waiver and special~~
908 ~~terms and conditions numbered 11-W-00206/4, as approved by the~~
909 ~~federal Centers for Medicare and Medicaid Services. If the~~
910 ~~agency seeks approval by the Federal Government of any~~
911 ~~modifications to these special terms and conditions, the agency~~
912 ~~must provide written notification of its intent to modify these~~
913 ~~terms and conditions to the President of the Senate and the~~
914 ~~Speaker of the House of Representatives at least 15 days before~~
915 ~~submitting the modifications to the Federal Government for~~
916 ~~consideration. The notification must identify all modifications~~
917 ~~being pursued and the reason the modifications are needed. Upon~~

918 ~~receiving federal approval of any modifications to the special~~
919 ~~terms and conditions, the agency shall provide a report to the~~
920 ~~Legislature describing the federally approved modifications to~~
921 ~~the special terms and conditions within 7 days after approval by~~
922 ~~the Federal Government.~~

923 ~~(7) (a) The Secretary of Health Care Administration shall~~
924 ~~convene a technical advisory panel to advise the agency in the~~
925 ~~areas of risk-adjusted-rate setting, benefit design, and choice~~
926 ~~counseling. The panel shall include representatives from the~~
927 ~~Florida Association of Health Plans, representatives from~~
928 ~~provider sponsored networks, a Medicaid consumer representative,~~
929 ~~and a representative from the Office of Insurance Regulation.~~

930 ~~(b) The technical advisory panel shall advise the agency~~
931 ~~concerning:~~

932 ~~1. The risk-adjusted rate methodology to be used by the~~
933 ~~agency, including recommendations on mechanisms to recognize the~~
934 ~~risk of all Medicaid enrollees and for the transition to a risk-~~
935 ~~adjustment system, including recommendations for phasing in risk~~
936 ~~adjustment and the use of risk corridors.~~

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

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

942 ~~4. Issues of benefit design, including the actuarial~~
943 ~~equivalence and sufficiency standards to be used.~~

944 ~~5. The implementation plan for the proposed choice-~~
945 ~~counseling system, including the information and materials to be~~

946 ~~provided to recipients, the methodologies by which recipients~~
947 ~~will be counseled regarding choice, criteria to be used to~~
948 ~~assess plan quality, the methodology to be used to assign~~
949 ~~recipients into plans if they fail to choose a managed care~~
950 ~~plan, and the standards to be used for responsiveness to~~
951 ~~recipient inquiries.~~

952 ~~(c) The technical advisory panel shall continue in~~
953 ~~existence and advise the agency on matters outlined in this~~
954 ~~subsection.~~

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

964 ~~(9) After any calculations of aggregate risk scores or~~
965 ~~revised aggregate risk scores in subsection (8), the capitation~~
966 ~~rates for plans participating under this section shall be phased~~
967 ~~in as follows:~~

968 ~~(a) In the first year, the capitation rates shall be~~
969 ~~weighted so that 75 percent of each capitation rate is based on~~
970 ~~the current methodology and 25 percent is based on a new risk-~~
971 ~~adjusted capitation rate methodology.~~

972 ~~(b) In the second year, the capitation rates shall be~~
973 ~~weighted so that 50 percent of each capitation rate is based on~~

974 ~~the current methodology and 50 percent is based on a new risk-~~
 975 ~~adjusted rate methodology.~~

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

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

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

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

993 ~~(13) Upon review and approval of the applications for~~
 994 ~~waivers of applicable federal laws and regulations to implement~~
 995 ~~the managed care pilot program by the Legislature, the agency~~
 996 ~~may initiate adoption of rules pursuant to ss. 120.536(1) and~~
 997 ~~120.54 to implement and administer the managed care pilot~~
 998 ~~program as provided in this section.~~

999 ~~(14) It is the intent of the Legislature that if any~~
 1000 ~~conflict exists between the provisions contained in this section~~
 1001 ~~and other provisions of this chapter which relate to the~~

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1002 ~~implementation of the Medicaid managed care pilot program, the~~
1003 ~~provisions contained in this section shall control. The agency~~
1004 ~~shall provide a written report to the Legislature by April 1,~~
1005 ~~2006, identifying any provisions of this chapter which conflict~~
1006 ~~with the implementation of the Medicaid managed care pilot~~
1007 ~~program created in this section. After April 1, 2006, the agency~~
1008 ~~shall provide a written report to the Legislature immediately~~
1009 ~~upon identifying any provisions of this chapter which conflict~~
1010 ~~with the implementation of the Medicaid managed care pilot~~
1011 ~~program created in this section.~~

1012 Section 3. This act shall take effect July 1, 2009.