603-02764-10

Proposed Committee Substitute by the Committee on Health and Human Services Appropriations

A bill to be entitled

An act relating to Medicaid; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to impose a fine against a person under contract with the agency who violates certain provisions; requiring an entity that contracts with the agency as a managed care plan to post a surety bond with the agency or maintain an account of a specified sum; requiring the agency to pursue the entity if the entity terminates the contract with the agency before the end date of the contract; amending s. 409.91211, F.S.; extending by 3 years the statewide implementation of an enhanced service delivery system for the Florida Medicaid program; providing for the expansion of the pilot project into counties that have two or more plans and the capacity to serve the designated population; requiring that the agency provide certain specified data to the recipient when selecting a capitated managed care plan; revising certain requirements for entities performing choice counseling for recipients; requiring the agency to provide behavioral health care services to Medicaid-eligible children; extending a date by which the behavioral health care services will be delivered to children; authorizing the agency to extend the time to continue operation of the pilot program; requiring that the agency seek public input on extending and

expanding the managed care pilot program and post certain information on its website; providing an effective date.

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

Section 1. Present subsections (23) through (53) of section 409.912, Florida Statutes, are renumbered as subsections (24) through (54), respectively, and a new subsection (23) is added to that section, and present subsections (21) and (22) of that section 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.

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

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

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

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

by whom they are reimbursed.

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

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

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

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (25) ~~(24)~~.

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

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

(22) The agency shall ~~may~~ impose a fine for a violation of this section or the contract with the agency by a person or

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

(23) Any entity that contracts with the agency on a prepaid or fixed-sum basis as a managed care plan as defined in s. 409.9122(2)(f) or s. 409.91211 shall post a surety bond with the agency in an amount that is equivalent to a 1-year guaranteed savings amount as specified in the contract. In lieu of a surety bond, the agency may establish an irrevocable account in which the vendor funds an equivalent amount over a 6-month period. The purpose of the surety bond or account is to protect the agency if the entity terminates its contract with the agency before the scheduled end date for the contract. If the contract is terminated by the vendor for any reason, the agency shall pursue a claim against the surety bond or account for an early termination fee. The early termination fee must be equal to administrative costs incurred by the state due to the early termination and the differential of the guaranteed savings based on the original contract term and the corresponding termination date. The agency shall terminate a vendor who does not reimburse the state within 30 days after any early termination involving administrative costs and requiring reimbursement of lost savings

from the Medicaid program.

Section 2. Subsections (1) through (6) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

(1)(a) The agency is authorized to seek and implement 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. The agency shall implement expansion of the program to include the remaining counties of the state and remaining eligibility groups in accordance with the process specified in the federally approved special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services ~~on October 19, 2005,~~ with a goal of full statewide implementation by June 30, 2014 ~~2011~~.

(b) This waiver extension shall ~~authority is contingent upon federal approval to~~ preserve the low-income pool ~~upper-payment-limit~~ funding mechanism for providers and 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. ~~Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida,~~ The agency shall expand ~~may request statewide expansion of~~ the demonstration to counties that have two or more plans and that have capacity to serve the designated population ~~projects~~. The agency may expand to additional counties as plan capacity is developed. ~~Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature.~~ Under ~~the upper-payment-limit program, or~~ the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute ~~upper-payment-limit,~~ disproportionate share hospital~~,~~ and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services.

(c) 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 federal Centers for Medicare and Medicaid Services propose the distribution of the above-mentioned program funds based on the following objectives:

1. Assure 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. Assure 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; and

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 pilot program:

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

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

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

(d) To implement actuarially sound, risk-adjusted

capitation rates for Medicaid recipients in the pilot program which cover comprehensive care, enhanced services, and catastrophic care.

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks that, for purposes of this paragraph, include the Children's Medical Services Network, over a 5-year period. These policies and guidelines must include an option for a provider service network to be paid 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 must include a savings-settlement mechanism that is consistent with s. 409.912(44). This model must be converted to a risk-adjusted capitated rate by the beginning of the sixth 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 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 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 program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care

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

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

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

3. The percentage of voluntary disenrollments.

4. Immunization rates.

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

6. Recommendations of other authoritative bodies.

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 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. A list of providers participating in the plan networks.

4.~~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 a system to ensure that there is a record of recipient acknowledgment that plan choice ~~counseling~~ has been provided.

(k) To implement 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 or~~, 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 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 a choice counseling system that promotes health literacy, uses technology effectively, and provides information intended ~~aimed~~ to reduce minority health disparities through outreach activities for Medicaid recipients.

(n) 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 eligibility assignment processes to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe.

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

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

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

a. The Health Plan Employer Data and Information Set

(HEDIS) or measures that are similar to HEDIS.

b. Member satisfaction.

c. Provider satisfaction.

d. Report cards on plan performance and best practices.

e. Compliance with the requirements for prompt payment of claims under ss. 627.613, 641.3155, and 641.513.

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

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

4. The agency shall establish an encounter database in order to compile data on health services rendered by health care practitioners who provide services to patients enrolled in managed care plans in the demonstration sites. The encounter database shall:

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

(I) The demographic characteristics of the patient.

(II) The principal, secondary, and tertiary diagnosis.

(III) The procedure performed.

(IV) The date and location where the procedure was performed.

(V) The payment for the procedure, if any.

(VI) If applicable, the health care practitioner's universal identification number.

(VII) If the health care practitioner rendering the service

is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

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

c. Collect appropriate information related to health care costs and utilization from managed care plans participating in the demonstration sites.

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

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

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

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

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

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

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

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

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

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

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

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

2. Providers must have the certification, license, and

credentials that are required by law and waiver requirements.

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

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

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

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

b. An instance of fraud and abuse in the managed care plan, including, but not limited to, defrauding the state health care benefit program by misrepresentation of fact in reports, claims, certifications, enrollment claims, demographic statistics, or patient-encounter data; misrepresentation of the qualifications of persons rendering health care and ancillary services; bribery and false statements relating to the delivery of health care; unfair and deceptive marketing practices; and false claims actions in the provision of managed care, is a violation of law and subject to the penalties provided by law.

c. The agency shall require that all contractors make all files and relevant billing and claims data accessible to state

regulators and investigators and that all such data is linked into a unified system to ensure consistent reviews and investigations.

(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.

(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.

(z) To ensure that 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 and federally qualified health centers 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.

(aa) To implement 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.

(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.

(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.

(dd) To implement service delivery mechanisms within a specialty plan ~~capitated managed care plans~~ to provide behavioral health care services ~~Medicaid services as specified~~

~~in ss. 409.905 and 409.906~~ to Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system. These services must be coordinated with community-based care providers as specified in s. 409.1671, where available, and be sufficient to meet the ~~medical,~~ developmental, behavioral, and emotional needs of these children. Children in area 10 who have an open case in the HomeSafeNet system shall be enrolled into the specialty plan. These service delivery mechanisms must be implemented no later than July 1, 2011 ~~2008~~, in AHCA area 10 in order for the children in AHCA area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)8. An administrative fee may be paid to the specialty plan for the coordination of services based on the receipt of the state share of that fee being provided through intergovernmental transfers.

(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 the recipient 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.

5. Plan performance as designed by the agency.

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

managed care recipients.

(d) Except for plan performance as provided for in paragraph (a), 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) 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)(q) 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) 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) 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 authorizes ~~does not authorize~~ the agency to seek an extension amendment and to continue operation ~~implement any provision~~ of the s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program ~~in any part of the state other than the two geographic areas specified in this section unless approved by the Legislature~~.

(6) The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to extend and expand ~~implement~~ the managed care pilot project as defined in this section. The agency shall seek public input on the waiver and post all waiver applications under this section on its Internet website for 30 days ~~before submitting the applications to the United States Centers for Medicare and Medicaid Services~~. The 30 days shall commence with the initial posting and must conclude 30 days prior to approval by 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 may implement the waiver and special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services. If the agency seeks approval by the Federal Government of any modifications to these special terms and conditions, the agency must provide written notification of its intent to modify these terms and conditions to the President of the Senate and the Speaker of the House of Representatives at least 15 days before submitting the modifications to the Federal Government for consideration. The notification must identify all modifications being pursued and the reason the modifications are needed. Upon receiving federal approval of any modifications to the special terms and conditions, the agency shall provide a report to the Legislature describing the federally approved modifications to the special terms and conditions within 7 days

after approval by the Federal Government.

Section 3. This act shall take effect July 1, 2010.