A bill to be entitled

An act relating to Medicaid; amending s. 409.907, F.S.; revising the requirements of a Medicaid provider agreement to include compliance with the Medicaid Encounter Data System; requiring the Agency for Health Care Administration to submit an annual report on the system to the Governor and Legislature; amending s. 409.908, F.S.; requiring the agency to adjust capitation rates for certain Medicaid providers; providing criteria for the adjustments; providing a phase-in schedule; requiring the Secretary of Health Care Administration to establish a technical advisory panel to advise the agency in the area of risk-adjusted rate setting; providing membership and duties; amending s. 409.912, F.S.; providing instructions to the agency regarding seeking federal approval for certain contracts that provide behavioral health care services; providing for certain contracts to remain in effect until a specified date; prohibiting the cancellation of certain contracts with provider service networks without specified notice; providing additional terms for cancellation; requiring contracts for Medicaid services that are on a prepaid or fixed-sum basis to meet certain medical loss ratios; providing for the agency to recoup and redistribute payments under certain circumstances; amending s. 409.91207, F.S.; providing purposes and principles for creating medical homes; providing definitions; providing for the organization of medical home networks and provider service networks

certified as medical homes; requiring a provider service network to provide certain notice to the agency prior to ceasing participation as a medical home; requiring each medical home to provide specified services; providing for abolishment of a task force upon the creation of a statewide advisory panel; providing for the establishment of the statewide advisory panel; providing membership, terms, and duties; directing the agency to provide staff support to the panel; directing the panel to establish a medical advisory group to assist in the establishment of medical home networks and provider service networks certified as medical homes; providing for travel expenses and per diem for members of the panel and the medical advisory group; providing for enrollment of MediPass beneficiaries in medical homes; providing for financing of medical home networks; providing duties of the agency; providing for distribution of savings achieved by network providers under certain circumstances; requiring the agency to collaborate with the Office of Insurance Regulation to encourage licensed insurers to incorporate the principles of the medical home network into insurance plans; requiring the Department of Management Services to develop a medical home option in the state group insurance program; requiring medical home network providers to maintain certain records and data; amending s. 409.91211, F.S.; requiring a provider that receives low-income pool funds to serve Medicaid recipients regardless of county of residence; revising the period for phasing in financial

risk for certain provider service networks; amending s. 409.9122, F.S.; revising the assignment of Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice; providing an effective date.

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

Section 1. Paragraph (k) is added to subsection (3) of section 409.907, Florida Statutes, and subsection (13) is added to that section, to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(k) Fully comply with the agency's Medicaid Encounter Data System.

(13) By January 1, 2011, and annually thereafter until full compliance is reached, the agency shall submit to the

Governor, the President of the Senate, and the Speaker of the House of Representatives a report that summarizes data regarding the agency's Medicaid Encounter Data System, including the number of participating providers, the level of compliance of each provider, and an analysis of service utilization, service trends, and specific problem areas.

Section 2. Subsection (4) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions

provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and~~, beginning September 1, 1995,~~ shall include age-band differentials in such calculations.

(a) Beginning October 1, 2010, the agency shall begin a budget-neutral adjustment of capitation rates based on aggregate risk scores for each provider's enrollees. During the first 2 years of the adjustment, the agency shall ensure that no provider has an aggregate risk score that varies by more than 10 percent from the aggregate weighted average for all providers. The risk-adjusted capitation rates shall be phased in as follows:

1. In the first contract year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted capitation rate methodology.

2. In the second contract year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted capitation rate methodology.

3. In the third contract year, the risk-adjusted capitation rate methodology shall be fully implemented.

(b) The Secretary of Health Care Administration shall convene a technical advisory panel to advise the agency in the area of risk-adjusted rate setting during the transition to risk-adjusted capitation rates described in paragraph (a). The panel shall include representatives of prepaid plans in counties that are not included as demonstration sites under s. 409.91211(1). The panel shall advise the agency regarding:

1. The selection of a base year of encounter data to be used to set risk-adjusted capitation rates.

2. The completeness and accuracy of the encounter data set.

3. The effect of risk-adjusted capitation rates on prepaid plans based on a review of a simulated rate-setting process.

Section 3. Paragraphs (b) and (d) of subsection (4) of section 409.912, Florida Statutes, are amended, and subsection (54) is added to that section, to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients

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

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

rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program

is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a Medicaid provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations or provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The

agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

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

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

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

MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

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

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

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

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

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

6. In converting to a prepaid system of delivery, the

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

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

8. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to

maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641~~,~~ but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency may ~~is authorized to~~ seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect through June 30, 2015 ~~for a period of 3 years following the current contract expiration date~~, regardless of any contractual provisions to the contrary. A contract awarded or renewed on or after July 1, 2010, to a provider service network shall prohibit the cancellation of the contract unless the network provides the agency with at least 90

days' notice. All members of the network must continue to provide services to Medicaid recipients assigned to that network during that 90-day period. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(54) An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall spend 85 percent of the Medicaid capitation revenue for health services to enrollees. The agency shall monitor medical loss ratios for all prepaid plans on a county-by-county basis. When a plan's 3-year average medical loss ratio in a county is less than 85 percent, the agency may recoup an amount equivalent to the difference between 85 percent of the capitation paid to the plan and the amount the plan paid for provision of services over the 3-year period. These recouped funds shall be dispersed in

proportionate amounts to plans that have spent in excess of 85 percent of their capitation on the provision of medical services.

Section 4. Section 409.91207, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 409.91207, F.S., for present text.)

409.91207 Medical homes.—

(1) PURPOSE AND PRINCIPLES.—The agency shall develop a method for recognizing the certification of a primary care provider or a provider service network as a medical home. The purpose of this certification is to foster and support improved care management through enhanced primary care case management and dissemination of best practices for coordinated and cost-effective care. The medical home modifies the processes and patterns of health care service delivery by applying the following principles:

(a) A personal medical provider leads an interdisciplinary team of professionals who share the responsibility of providing ongoing care to a specific panel of patients.

(b) The personal medical provider identifies a patient's health care needs and responds to those needs through direct care or arrangements with other qualified providers.

(c) Care is coordinated or integrated across all areas of health service delivery.

(d) Information technology is integrated into delivery systems to enhance clinical performance and monitor patient outcomes.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Case manager" means a person or persons employed by a medical home network or provider service network, or a member of such network, to work with primary care providers in the delivery of outreach, support services, and care coordination for medical home patients.

(b) "Medical home network" means a group of primary care providers and other health professionals and facilities who agree to cooperate with one another in order to coordinate care for Medicaid beneficiaries assigned to primary care providers in the network.

(c) "Primary care provider" means a health professional practicing in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine who is licensed as a physician under chapter 458 or chapter 459, a physician's assistant performing services delegated by a supervising physician pursuant to s. 458.347 or s. 459.022, or a registered nurse certified as an advanced registered nurse practitioner performing services pursuant to a protocol established with a supervising physician in accordance with s. 464.012. The term "primary care provider" also means a federally qualified health center.

(d) "Principal network provider" means a member of a medical home network or a provider service network who serves as the principal liaison between the agency and that network and who accepts responsibility for communicating the agency's directives concerning the project to all other network members.

(e) "Provider service network" has the same meaning as provided in s. 409.912(4)(d).

(f) "Tier One medical home" means:

1. A primary care provider that certifies to the agency that the provider meets the service capabilities established in paragraph (4)(a); or

2. A provider service network that certifies to the agency that all of its members who are primary care providers meet the service capabilities established in paragraph (4)(a).

(g) "Tier Two medical home" means:

1. A primary care provider that certifies to the agency that the provider meets the service capabilities established in paragraph (4)(b); or

2. A provider service network that certifies to the agency that at least 85 percent of its members who are primary care providers meet the service capabilities established in paragraph (4)(b) and the remainder of the primary care providers meet the service capabilities established in paragraph (4)(a).

(h) "Tier Three medical home" means:

1. A primary care provider that certifies to the agency that the provider meets the service capabilities established in paragraph (4)(c); or

2. A provider service network that certifies to the agency that at least 85 percent of its members who are primary care providers meet the service capabilities established in paragraph (4)(c) and the remainder of the primary care providers meet the service capabilities established in paragraph (4)(b).

(3) ORGANIZATION.—

(a) Each participating primary care provider shall be a member of a medical home network or a provider service network and shall be classified by the agency as a Tier One, Tier Two, or Tier Three medical home upon certification by the provider of compliance with the service capabilities for that tier. A primary care provider or a provider service network may change classification by certifying service capabilities consistent with the standards for another tier. Certifications shall be made annually.

(b) Each participating provider service network shall be classified by the agency as a Tier One, Tier Two, or Tier Three medical home upon certification by the network that the network's primary care providers meet the service capabilities for that tier. The provider service network may also certify to the agency that it intends to serve a specific target population based on disease, condition, or age.

(c) The members of each medical home network or provider service network shall designate a principal network provider who shall be responsible for maintaining an accurate list of participating providers, forwarding this list to the agency, updating the list as requested by the agency, and facilitating communication between the agency and the participating providers.

(d) A provider service network may only cease participation as a medical home after providing at least 90 days' notice to the agency. All members of the provider service network must continue to serve the enrollees during this 90-day period. A provider service network that is reimbursed by the

agency on a prepaid basis may not receive any additional reimbursements for this 90-day period.

(4) SERVICE CAPABILITIES.—A medical home network or a provider service network certified as a medical home shall provide primary care; coordinate services to control chronic illnesses; provide disease management and patient education; provide or arrange for pharmacy, outpatient diagnostic, and specialty physician services; and provide for or coordinate with inpatient facilities and behavioral health, mental health, and rehabilitative service providers. The network shall place a priority on methods to manage pharmacy and behavioral health services.

(a) Tier One medical homes shall have the capability to:

1. Maintain a written copy of the mutual agreement between the medical home and the patient in the patient's medical record.

2. Supply all medically necessary primary and preventive services and provide all scheduled immunizations.

3. Organize clinical data in paper or electronic form using a patient-centered charting system.

4. Maintain and update patients' medication lists and review all medications during each office visit.

5. Maintain a system to track diagnostic tests and provide followup services regarding test results.

6. Maintain a system to track referrals, including self-referrals by members.

7. Supply care coordination and continuity of care through proactive contact with members and encourage family participation in care.

8. Supply education and support using various materials and processes appropriate for individual patient needs.

(b) Tier Two medical homes shall have all of the capabilities of a Tier One medical home and shall have the additional capability to:

1. Communicate electronically.

2. Supply voice-to-voice telephone coverage to panel members 24 hours per day, 7 days per week, to enable patients to speak to a licensed health care professional who triages and forwards calls, as appropriate.

3. Maintain an office schedule of at least 30 scheduled hours per week.

4. Use scheduling processes to promote continuity with clinicians, including providing care for walk-in, routine, and urgent care visits.

5. Implement and document behavioral health and substance abuse screening procedures and make referrals as needed.

6. Use data to identify and track patients' health and service use patterns.

7. Coordinate care and followup for patients receiving services in inpatient and outpatient facilities.

8. Implement processes to promote access to care and member communication.

(c) Tier Three medical homes shall have all of the capabilities of Tier One and Tier Two medical homes and shall have the additional capability to:

1. Maintain electronic medical records.

2. Develop a health care team that provides ongoing support, oversight, and guidance for all medical care received by the patient and documents contact with specialists and other health care providers caring for the patient.

3. Supply postvisit followup care for patients.

4. Implement specific evidence-based clinical practice guidelines for preventive and chronic care.

5. Implement a medication reconciliation procedure to avoid interactions or duplications.

6. Use personalized screening, brief intervention, and referral to treatment procedures for appropriate patients requiring specialty treatment.

7. Offer at least 4 hours per week of after-hours care to patients.

8. Use health assessment tools to identify patient needs and risks.

(5) TASK FORCE; ADVISORY PANEL.—

(a) The Secretary of Health Care Administration shall appoint a task force by August 1, 2009, to assist the agency in the development and implementation of the medical home pilot project. The task force must include, but is not limited to, representatives of providers who could potentially participate in a medical home network, Medicaid recipients, and existing MediPass and managed care providers. Members of the task force

shall serve without compensation but are may be reimbursed for per diem and travel expenses as provided in s. 112.061. When the statewide advisory panel created pursuant to paragraph (b) has been appointed, the task force shall dissolve.

(b) A statewide advisory panel shall be established to advise and assist the agency in developing a methodology for an annual evaluation of each medical home network and provider service network certified as a medical home. The panel shall promote communication among medical home networks and provider service networks certified as medical homes. The panel shall consist of seven members, as follows:

1. Two members appointed by the Speaker of the House of Representatives, one of whom shall be a primary care physician licensed under chapter 458 or chapter 459 and one of whom shall be a representative of a hospital licensed under chapter 395.

2. Two members appointed by the President of the Senate, one of whom shall be a physician licensed under chapter 458 or chapter 459 who is a board-certified specialist and one of whom shall be a representative of a Florida medical school.

3. Two members appointed by the Governor, one of whom shall be a representative of an insurer licensed to do business in this state or a health maintenance organization licensed under part I of chapter 641 and one of whom shall be a representative of Medicaid consumers.

4. The Secretary of Health Care Administration or his or her designee.

(c) Appointed members of the panel shall serve 4-year terms, except that the initial terms shall be staggered as follows:

1. The Governor shall appoint one member for a term of 2 years and one member for a term of 4 years.

2. The President of the Senate shall appoint one member for a term of 2 years and one member for a term of 4 years.

3. The Speaker of the House of Representatives shall appoint one member for a term of 2 years and one member for a term of 4 years.

(d) A vacancy in an appointed member's position shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(e) Members of the statewide advisory panel shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(f) The agency shall provide staff support to assist the panel in the performance of its duties.

(g) The statewide advisory panel shall establish a medical advisory group consisting of physicians licensed under chapter 458 or chapter 459 who shall act as ambassadors to their communities for the promotion of and assistance in the establishment of medical home networks and provider service networks certified as medical homes. Members of the medical advisory group shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(6) ENROLLMENT.—Each MediPass beneficiary served by a certified Tier One, Tier Two, or Tier Three medical home shall be given a choice to enroll in a medical home network or provider service network certified as a medical home. Enrollment shall be effective upon the agency's receipt of a participation agreement signed by the beneficiary.

(7) FINANCING.—

(a) Subject to a specific appropriation provided for in the General Appropriations Act, medical home network members shall be eligible to receive a monthly enhanced case management fee, as follows:

1. Tier One medical homes shall receive $3.58 per child in a panel of enrollees and $5.02 per adult in a panel of enrollees.

2. Tier Two medical homes shall receive $4.65 per child in a panel of enrollees and $6.52 per adult in a panel of enrollees.

3. Tier Three medical homes shall receive $6.12 per child in a panel of enrollees and $8.69 per adult in a panel of enrollees.

(b) Services provided by a medical home network or a provider service network with a fee-for-service contract with the agency shall be reimbursed based on claims filed for Medicaid fee-for-service payments. Services by a provider service network with a contract with the agency for prepaid services shall be paid pursuant to the contract and shall be eligible to receive the credit provided in this subsection.

(c) Any hospital, as defined in s. 395.002(12), participating in a medical home network or service provider network certified as a medical home that employs case managers for the network shall be eligible to receive a credit against the assessment imposed under s. 395.701. The credit is compensation for participating in the network by providing case management and other network services.

1. The credit shall be prorated based on the number of full-time equivalent case managers hired but shall not be more than $75,000 for each full-time equivalent case manager. The total credit may not exceed $450,000 for any hospital for any state fiscal year.

2. To qualify for the credit, the hospital must employ each full-time equivalent case manager for the entire hospital fiscal year for which the credit is claimed.

3. The hospital must certify the number of full-time equivalent case managers for whom it is entitled to a credit using the certification process required under s. 395.701(2)(a).

4. The agency shall calculate the amount of the credit and reduce the certified assessment for the hospital by the amount of the credit.

(d) The enhanced payments to primary care providers shall not affect the calculation of capitated rates under this chapter.

(8) AGENCY DUTIES.—The agency shall:

(a) Maintain a record of certified primary care providers and provider service networks by classification as Tier One, Tier Two, or Tier Three medical homes.

(b) Develop a standard form to be used by primary care providers and provider service networks to certify to the agency that they meet the necessary principles and service capabilities for the tier in which they seek to be classified. The form shall have a check box for each of the three tiers, a line to indicate whether a primary care network intends to specialize in a target population, a line to specify the target population, if any, and a line for the signature of the provider or principal of an entity. Checking the appropriate tier box and signing the form shall be deemed certification for the purposes of this section.

(c) Develop a process for managed care organizations to certify themselves as Tier One, Tier Two, or Tier Three medical homes based on established policies and procedures consistent with the principles and corresponding service capabilities provided under subsections (1) and (4).

(d) Establish a participation agreement to be executed by Medipass recipients who choose to participate in the medical home pilot project.

(e) Track the spending for and utilization of services by all enrolled medical home network patients.

(f) Evaluate each provider service network at least annually to ensure that the network is cost-effective as defined in s. 409.912(44).

(9) ACHIEVED SAVINGS.—Each medical home network or provider service network certified as a medical home that participates on a fee-for-service basis and achieves savings equal to or greater than the spending that would have occurred if its enrollees participated in prepaid health plans is

eligible to receive funding based on the identified savings pursuant to a specific appropriation provided for in the General Appropriations Act. The funds must be distributed on a pro rata basis to the physicians who are members of the medical home network so that the compensation for their services is as close as possible to 100 percent of Medicare rates. Subject to a specific appropriation, it is the intent of the Legislature that the savings that result from the implementation of the medical home network model be used to enable Medicaid fees to physicians participating in medical home networks to be equivalent to 100 percent of Medicare rates as soon as possible.

(10) COLLABORATION WITH PRIVATE INSURERS.—To enable the state to participate in federal gainsharing initiatives, the agency shall collaborate with the Office of Insurance Regulation to encourage insurers licensed in this state to incorporate medical home network principles into the design of their individual and employment-based plans. The Department of Management Services is directed to develop a medical home option in the state group insurance program.

(11) QUALITY ASSURANCE AND ACCOUNTABILITY.—Each primary care and principal network provider participating in a medical home network or provider service network certified as a medical home shall maintain medical records and clinical data necessary for the network to assess the use, cost, and outcome of services provided to enrollees.

Section 5. Paragraph (b) of subsection (1) and paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.—

(1)

(b) This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. 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. A provider who receives low-income pool funds shall serve Medicaid recipients regardless of the recipient's county of residence in the state and may not restrict access to care based on residency

in a county in the state other than the one in which the provider is located.

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

(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 the longer of a 5-year period or through October 1, 2015. 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). As of October 1, 2015, or after 5 years of operation, whichever is the longer period, 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.

Section 6. Paragraph (f) of subsection (2) of section 409.9122, Florida Statutes, is amended to read:

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

(2)

(f) If a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid

recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 65 percent in provider service networks certified as medical homes under s. 409.91207 and 35 percent in other managed care plans ~~35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care,~~ is achieved. Once this enrollment is achieved, the assignments shall be divided in the same manner ~~order~~ to maintain the same ~~an~~ enrollment ratio ~~in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively~~. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who would be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated

economically. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

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

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

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

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

Section 7. This act shall take effect July 1, 2010.