Amendment No.

CHAMBER ACTION

Senate House

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1 Representative Pafford offered the following:
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3 **Amendment (with title amendment)**
4 Remove everything after the enacting clause and insert:
5 Section 1. Paragraph (k) is added to subsection (3) of
6 section 409.907, Florida Statutes, and subsection (13) is added
7 to that section, to read:
8 409.907 Medicaid provider agreements.—The agency may make
9 payments for medical assistance and related services rendered to
10 Medicaid recipients only to an individual or entity who has a
11 provider agreement in effect with the agency, who is performing
12 services or supplying goods in accordance with federal, state,
13 and local law, and who agrees that no person shall, on the
14 grounds of handicap, race, color, or national origin, or for any
15 other reason, be subjected to discrimination under any program

16 or activity for which the provider receives payment from the
17 agency.
18 (3) The provider agreement developed by the agency, in
19 addition to the requirements specified in subsections (1) and
20 (2), shall require the provider to:
21 (k) Fully comply with the agency's Medicaid Encounter Data
22 System.
23 (13) By January 1, 2011, and annually thereafter until
24 full compliance is reached, the agency shall submit to the
25 Governor, the President of the Senate, and the Speaker of the
26 House of Representatives a report that summarizes data regarding
27 the agency's Medicaid Encounter Data System, including the
28 number of participating providers, the level of compliance of
29 each provider, and an analysis of service utilization, service
30 trends, and specific problem areas.
31 Section 2. Subsection (4) of section 409.908, Florida
32 Statutes, is amended to read:
33 409.908 Reimbursement of Medicaid providers.—Subject to
34 specific appropriations, the agency shall reimburse Medicaid
35 providers, in accordance with state and federal law, according
36 to methodologies set forth in the rules of the agency and in
37 policy manuals and handbooks incorporated by reference therein.
38 These methodologies may include fee schedules, reimbursement
39 methods based on cost reporting, negotiated fees, competitive
40 bidding pursuant to s. 287.057, and other mechanisms the agency
41 considers efficient and effective for purchasing services or
42 goods on behalf of recipients. If a provider is reimbursed based
43 on cost reporting and submits a cost report late and that cost

44 report would have been used to set a lower reimbursement rate
45 for a rate semester, then the provider's rate for that semester
46 shall be retroactively calculated using the new cost report, and
47 full payment at the recalculated rate shall be effected
48 retroactively. Medicare-granted extensions for filing cost
49 reports, if applicable, shall also apply to Medicaid cost
50 reports. Payment for Medicaid compensable services made on
51 behalf of Medicaid eligible persons is subject to the
52 availability of moneys and any limitations or directions
53 provided for in the General Appropriations Act or chapter 216.
54 Further, nothing in this section shall be construed to prevent
55 or limit the agency from adjusting fees, reimbursement rates,
56 lengths of stay, number of visits, or number of services, or
57 making any other adjustments necessary to comply with the
58 availability of moneys and any limitations or directions
59 provided for in the General Appropriations Act, provided the
60 adjustment is consistent with legislative intent.
61 (4) Subject to any limitations or directions provided for
62 in the General Appropriations Act, alternative health plans,
63 health maintenance organizations, and prepaid health plans shall
64 be reimbursed a fixed, prepaid amount negotiated, or
65 competitively bid pursuant to s. 287.057, by the agency and
66 prospectively paid to the provider monthly for each Medicaid
67 recipient enrolled. The amount may not exceed the average amount
68 the agency determines it would have paid, based on claims
69 experience, for recipients in the same or similar category of
70 eligibility. The agency shall calculate capitation rates on a

71 regional basis and~~, beginning September 1, 1995,~~ shall include
72 age-band differentials in such calculations.
73 (a) Beginning October 1, 2010, the agency shall begin a
74 budget-neutral adjustment of capitation rates based on aggregate
75 risk scores for each provider's enrollees. During the first 2
76 years of the adjustment, the agency shall ensure that no
77 provider has an aggregate risk score that varies by more than 10
78 percent from the aggregate weighted average for all providers.
79 The risk-adjusted capitation rates shall be phased in as
80 follows:
81 1. In the first contract year, 75 percent of the
82 capitation rate shall be based on the current methodology and 25
83 percent shall be based on the risk-adjusted capitation rate
84 methodology.
85 2. In the second contract year, 50 percent of the
86 capitation rate shall be based on the current methodology and 50
87 percent shall be based on the risk-adjusted capitation rate
88 methodology.
89 3. In the third contract year, the risk-adjusted
90 capitation rate methodology shall be fully implemented.
91 (b) The Secretary of Health Care Administration shall
92 convene a technical advisory panel to advise the agency in the
93 area of risk-adjusted rate setting during the transition to
94 risk-adjusted capitation rates described in paragraph (a). The
95 panel shall include representatives of prepaid plans in counties
96 that are not included as demonstration sites under s.
97 409.91211(1). The panel shall advise the agency regarding:

98 1. The selection of a base year of encounter data to be
99 used to set risk-adjusted capitation rates.
100 2. The completeness and accuracy of the encounter data
101 set.
102 3. The effect of risk-adjusted capitation rates on prepaid
103 plans based on a review of a simulated rate-setting process.
104 Section 3. Paragraphs (b) and (d) of subsection (4) of
105 section 409.912, Florida Statutes, are amended, and subsection
106 (54) is added to that section, to read:
107 409.912 Cost-effective purchasing of health care.—The
108 agency shall purchase goods and services for Medicaid recipients
109 in the most cost-effective manner consistent with the delivery
110 of quality medical care. To ensure that medical services are
111 effectively utilized, the agency may, in any case, require a
112 confirmation or second physician's opinion of the correct
113 diagnosis for purposes of authorizing future services under the
114 Medicaid program. This section does not restrict access to
115 emergency services or poststabilization care services as defined
116 in 42 C.F.R. part 438.114. Such confirmation or second opinion
117 shall be rendered in a manner approved by the agency. The agency
118 shall maximize the use of prepaid per capita and prepaid
119 aggregate fixed-sum basis services when appropriate and other
120 alternative service delivery and reimbursement methodologies,
121 including competitive bidding pursuant to s. 287.057, designed
122 to facilitate the cost-effective purchase of a case-managed
123 continuum of care. The agency shall also require providers to
124 minimize the exposure of recipients to the need for acute
125 inpatient, custodial, and other institutional care and the

126 inappropriate or unnecessary use of high-cost services. The
127 agency shall contract with a vendor to monitor and evaluate the
128 clinical practice patterns of providers in order to identify
129 trends that are outside the normal practice patterns of a
130 provider's professional peers or the national guidelines of a
131 provider's professional association. The vendor must be able to
132 provide information and counseling to a provider whose practice
133 patterns are outside the norms, in consultation with the agency,
134 to improve patient care and reduce inappropriate utilization.
135 The agency may mandate prior authorization, drug therapy
136 management, or disease management participation for certain
137 populations of Medicaid beneficiaries, certain drug classes, or
138 particular drugs to prevent fraud, abuse, overuse, and possible
139 dangerous drug interactions. The Pharmaceutical and Therapeutics
140 Committee shall make recommendations to the agency on drugs for
141 which prior authorization is required. The agency shall inform
142 the Pharmaceutical and Therapeutics Committee of its decisions
143 regarding drugs subject to prior authorization. The agency is
144 authorized to limit the entities it contracts with or enrolls as
145 Medicaid providers by developing a provider network through
146 provider credentialing. The agency may competitively bid single-
147 source-provider contracts if procurement of goods or services
148 results in demonstrated cost savings to the state without
149 limiting access to care. The agency may limit its network based
150 on the assessment of beneficiary access to care, provider
151 availability, provider quality standards, time and distance
152 standards for access to care, the cultural competence of the
153 provider network, demographic characteristics of Medicaid

154 beneficiaries, practice and provider-to-beneficiary standards,
155 appointment wait times, beneficiary use of services, provider
156 turnover, provider profiling, provider licensure history,
157 previous program integrity investigations and findings, peer
158 review, provider Medicaid policy and billing compliance records,
159 clinical and medical record audits, and other factors. Providers
160 shall not be entitled to enrollment in the Medicaid provider
161 network. The agency shall determine instances in which allowing
162 Medicaid beneficiaries to purchase durable medical equipment and
163 other goods is less expensive to the Medicaid program than long-
164 term rental of the equipment or goods. The agency may establish
165 rules to facilitate purchases in lieu of long-term rentals in
166 order to protect against fraud and abuse in the Medicaid program
167 as defined in s. 409.913. The agency may seek federal waivers
168 necessary to administer these policies.
169 (4) The agency may contract with:
170 (b) An entity that is providing comprehensive behavioral
171 health care services to certain Medicaid recipients through a
172 capitated, prepaid arrangement pursuant to the federal waiver
173 provided for by s. 409.905(5). Such entity must be licensed
174 under chapter 624, chapter 636, or chapter 641, or authorized
175 under paragraph (c), and must possess the clinical systems and
176 operational competence to manage risk and provide comprehensive
177 behavioral health care to Medicaid recipients. As used in this
178 paragraph, the term "comprehensive behavioral health care
179 services" means covered mental health and substance abuse
180 treatment services that are available to Medicaid recipients.
181 The secretary of the Department of Children and Family Services

182 shall approve provisions of procurements related to children in
183 the department's care or custody before enrolling such children
184 in a prepaid behavioral health plan. Any contract awarded under
185 this paragraph must be competitively procured. In developing the
186 behavioral health care prepaid plan procurement document, the
187 agency shall ensure that the procurement document requires the
188 contractor to develop and implement a plan to ensure compliance
189 with s. 394.4574 related to services provided to residents of
190 licensed assisted living facilities that hold a limited mental
191 health license. Except as provided in subparagraph 8., and
192 except in counties where the Medicaid managed care pilot program
193 is authorized pursuant to s. 409.91211, the agency shall seek
194 federal approval to contract with a single entity meeting these
195 requirements to provide comprehensive behavioral health care
196 services to all Medicaid recipients not enrolled in a Medicaid
197 managed care plan authorized under s. 409.91211, a Medicaid
198 provider service network authorized under paragraph (d), or a
199 Medicaid health maintenance organization in an AHCA area. In an
200 AHCA area where the Medicaid managed care pilot program is
201 authorized pursuant to s. 409.91211 in one or more counties, the
202 agency may procure a contract with a single entity to serve the
203 remaining counties as an AHCA area or the remaining counties may
204 be included with an adjacent AHCA area and are subject to this
205 paragraph. Each entity must offer a sufficient choice of
206 providers in its network to ensure recipient access to care and
207 the opportunity to select a provider with whom they are
208 satisfied. The network shall include all public mental health
209 hospitals. To ensure unimpaired access to behavioral health care

210 services by Medicaid recipients, all contracts issued pursuant
211 to this paragraph must require 80 percent of the capitation paid
212 to the managed care plan, including health maintenance
213 organizations or provider service networks, to be expended for
214 the provision of behavioral health care services. If the managed
215 care plan expends less than 80 percent of the capitation paid
216 for the provision of behavioral health care services, the
217 difference shall be returned to the agency. The agency shall
218 provide the plan with a certification letter indicating the
219 amount of capitation paid during each calendar year for
220 behavioral health care services pursuant to this section. The
221 agency may reimburse for substance abuse treatment services on a
222 fee-for-service basis until the agency finds that adequate funds
223 are available for capitated, prepaid arrangements.
224 1. By January 1, 2001, the agency shall modify the
225 contracts with the entities providing comprehensive inpatient
226 and outpatient mental health care services to Medicaid
227 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
228 Counties, to include substance abuse treatment services.
229 2. By July 1, 2003, the agency and the Department of
230 Children and Family Services shall execute a written agreement
231 that requires collaboration and joint development of all policy,
232 budgets, procurement documents, contracts, and monitoring plans
233 that have an impact on the state and Medicaid community mental
234 health and targeted case management programs.
235 3. Except as provided in subparagraph 8., by July 1, 2006,
236 the agency and the Department of Children and Family Services
237 shall contract with managed care entities in each AHCA area

238 except area 6 or arrange to provide comprehensive inpatient and
239 outpatient mental health and substance abuse services through
240 capitated prepaid arrangements to all Medicaid recipients who
241 are eligible to participate in such plans under federal law and
242 regulation. In AHCA areas where eligible individuals number less
243 than 150,000, the agency shall contract with a single managed
244 care plan to provide comprehensive behavioral health services to
245 all recipients who are not enrolled in a Medicaid health
246 maintenance organization or a Medicaid capitated managed care
247 plan authorized under s. 409.91211. The agency may contract with
248 more than one comprehensive behavioral health provider to
249 provide care to recipients who are not enrolled in a Medicaid
250 capitated managed care plan authorized under s. 409.91211 or a
251 Medicaid health maintenance organization in AHCA areas where the
252 eligible population exceeds 150,000. In an AHCA area where the
253 Medicaid managed care pilot program is authorized pursuant to s.
254 409.91211 in one or more counties, the agency may procure a
255 contract with a single entity to serve the remaining counties as
256 an AHCA area or the remaining counties may be included with an
257 adjacent AHCA area and shall be subject to this paragraph.
258 Contracts for comprehensive behavioral health providers awarded
259 pursuant to this section shall be competitively procured. Both
260 for-profit and not-for-profit corporations are eligible to
261 compete. Managed care plans contracting with the agency under
262 subsection (3) shall provide and receive payment for the same
263 comprehensive behavioral health benefits as provided in AHCA
264 rules, including handbooks incorporated by reference. In AHCA
265 area 11, the agency shall contract with at least two

266 comprehensive behavioral health care providers to provide
267 behavioral health care to recipients in that area who are
268 enrolled in, or assigned to, the MediPass program. One of the
269 behavioral health care contracts must be with the existing
270 provider service network pilot project, as described in
271 paragraph (d), for the purpose of demonstrating the cost-
272 effectiveness of the provision of quality mental health services
273 through a public hospital-operated managed care model. Payment
274 shall be at an agreed-upon capitated rate to ensure cost
275 savings. Of the recipients in area 11 who are assigned to
276 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
277 MediPass-enrolled recipients shall be assigned to the existing
278 provider service network in area 11 for their behavioral care.
279 4. By October 1, 2003, the agency and the department shall
280 submit a plan to the Governor, the President of the Senate, and
281 the Speaker of the House of Representatives which provides for
282 the full implementation of capitated prepaid behavioral health
283 care in all areas of the state.
284 a. Implementation shall begin in 2003 in those AHCA areas
285 of the state where the agency is able to establish sufficient
286 capitation rates.
287 b. If the agency determines that the proposed capitation
288 rate in any area is insufficient to provide appropriate
289 services, the agency may adjust the capitation rate to ensure
290 that care will be available. The agency and the department may
291 use existing general revenue to address any additional required
292 match but may not over-obligate existing funds on an annualized
293 basis.

294 c. Subject to any limitations provided in the General
295 Appropriations Act, the agency, in compliance with appropriate
296 federal authorization, shall develop policies and procedures
297 that allow for certification of local and state funds.
298 5. Children residing in a statewide inpatient psychiatric
299 program, or in a Department of Juvenile Justice or a Department
300 of Children and Family Services residential program approved as
301 a Medicaid behavioral health overlay services provider may not
302 be included in a behavioral health care prepaid health plan or
303 any other Medicaid managed care plan pursuant to this paragraph.
304 6. In converting to a prepaid system of delivery, the
305 agency shall in its procurement document require an entity
306 providing only comprehensive behavioral health care services to
307 prevent the displacement of indigent care patients by enrollees
308 in the Medicaid prepaid health plan providing behavioral health
309 care services from facilities receiving state funding to provide
310 indigent behavioral health care, to facilities licensed under
311 chapter 395 which do not receive state funding for indigent
312 behavioral health care, or reimburse the unsubsidized facility
313 for the cost of behavioral health care provided to the displaced
314 indigent care patient.
315 7. Traditional community mental health providers under
316 contract with the Department of Children and Family Services
317 pursuant to part IV of chapter 394, child welfare providers
318 under contract with the Department of Children and Family
319 Services in areas 1 and 6, and inpatient mental health providers
320 licensed pursuant to chapter 395 must be offered an opportunity

321 to accept or decline a contract to participate in any provider
322 network for prepaid behavioral health services.
323 8. All Medicaid-eligible children, except children in area
324 1 and children in Highlands County, Hardee County, Polk County,
325 or Manatee County of area 6, that are open for child welfare
326 services in the HomeSafeNet system, shall receive their
327 behavioral health care services through a specialty prepaid plan
328 operated by community-based lead agencies through a single
329 agency or formal agreements among several agencies. The
330 specialty prepaid plan must result in savings to the state
331 comparable to savings achieved in other Medicaid managed care
332 and prepaid programs. Such plan must provide mechanisms to
333 maximize state and local revenues. The specialty prepaid plan
334 shall be developed by the agency and the Department of Children
335 and Family Services. The agency may seek federal waivers to
336 implement this initiative. Medicaid-eligible children whose
337 cases are open for child welfare services in the HomeSafeNet
338 system and who reside in AHCA area 10 are exempt from the
339 specialty prepaid plan upon the development of a service
340 delivery mechanism for children who reside in area 10 as
341 specified in s. 409.91211(3)(dd).
342 (d) A provider service network may be reimbursed on a fee-
343 for-service or prepaid basis. A provider service network that
344 ~~which~~ is reimbursed by the agency on a prepaid basis shall be
345 exempt from parts I and III of chapter 641~~,~~ but must comply with
346 the solvency requirements in s. 641.2261(2) and meet appropriate
347 financial reserve, quality assurance, and patient rights
348 requirements as established by the agency. Medicaid recipients

349 assigned to a provider service network shall be chosen equally
350 from those who would otherwise have been assigned to prepaid
351 plans and MediPass. The agency may ~~is authorized to~~ seek federal
352 Medicaid waivers as necessary to implement the provisions of
353 this section. Any contract previously awarded to a provider
354 service network operated by a hospital pursuant to this
355 subsection shall remain in effect through June 30, 2015 ~~for a~~
356 ~~period of 3 years following the current contract expiration~~
357 ~~date~~, regardless of any contractual provisions to the contrary.
358 A contract awarded or renewed on or after July 1, 2010, to a
359 provider service network shall prohibit the cancellation of the
360 contract unless the network provides the agency with at least 90
361 days' notice. All members of the network must continue to
362 provide services to Medicaid recipients assigned to that network
363 during that 90-day period. A provider service network is a
364 network established or organized and operated by a health care
365 provider, or group of affiliated health care providers,
366 including minority physician networks and emergency room
367 diversion programs that meet the requirements of s. 409.91211,
368 which provides a substantial proportion of the health care items
369 and services under a contract directly through the provider or
370 affiliated group of providers and may make arrangements with
371 physicians or other health care professionals, health care
372 institutions, or any combination of such individuals or
373 institutions to assume all or part of the financial risk on a
374 prospective basis for the provision of basic health services by
375 the physicians, by other health professionals, or through the
376 institutions. The health care providers must have a controlling

377 interest in the governing body of the provider service network
378 organization.
379 (54) An entity that contracts with the agency on a prepaid
380 or fixed-sum basis for the provision of Medicaid services shall
381 spend 85 percent of the Medicaid capitation revenue for health
382 services to enrollees. The agency shall monitor medical loss
383 ratios for all prepaid plans on a county-by-county basis. When a
384 plan's 3-year average medical loss ratio in a county is less
385 than 85 percent, the agency may recoup an amount equivalent to
386 the difference between 85 percent of the capitation paid to the
387 plan and the amount the plan paid for provision of services over
388 the 3-year period. These recouped funds shall be dispersed in
389 proportionate amounts to plans that have spent in excess of 85
390 percent of their capitation on the provision of medical
391 services.
392 Section 4. Section 409.91207, Florida Statutes, is amended
393 to read:
394 (Substantial rewording of section. See
395 s. 409.91207, F.S., for present text.)
396 409.91207 Medical homes.—
397 (1) PURPOSE AND PRINCIPLES.—The agency shall develop a
398 method for recognizing the certification of a primary care
399 provider or a provider service network as a medical home. The
400 purpose of this certification is to foster and support improved
401 care management through enhanced primary care case management
402 and dissemination of best practices for coordinated and cost-
403 effective care. The medical home modifies the processes and

404 patterns of health care service delivery by applying the
405 following principles:
406 (a) A personal medical provider leads an interdisciplinary
407 team of professionals who share the responsibility of providing
408 ongoing care to a specific panel of patients.
409 (b) The personal medical provider identifies a patient's
410 health care needs and responds to those needs through direct
411 care or arrangements with other qualified providers.
412 (c) Care is coordinated or integrated across all areas of
413 health service delivery.
414 (d) Information technology is integrated into delivery
415 systems to enhance clinical performance and monitor patient
416 outcomes.
417 (2) DEFINITIONS.—As used in this section, the term:
418 (a) "Case manager" means a person or persons employed by a
419 medical home network or provider service network, or a member of
420 such network, to work with primary care providers in the
421 delivery of outreach, support services, and care coordination
422 for medical home patients.
423 (b) "Medical home network" means a group of primary care
424 providers and other health professionals and facilities who
425 agree to cooperate with one another in order to coordinate care
426 for Medicaid beneficiaries assigned to primary care providers in
427 the network.
428 (c) "Primary care provider" means a health professional
429 practicing in the field of family medicine, general internal
430 medicine, geriatric medicine, or pediatric medicine who is
431 licensed as a physician under chapter 458 or chapter 459, a

432 physician's assistant performing services delegated by a
433 supervising physician pursuant to s. 458.347 or s. 459.022, or a
434 registered nurse certified as an advanced registered nurse
435 practitioner performing services pursuant to a protocol
436 established with a supervising physician in accordance with s.
437 464.012. The term "primary care provider" also means a federally
438 qualified health center.
439 (d) "Principal network provider" means a member of a
440 medical home network or a provider service network who serves as
441 the principal liaison between the agency and that network and
442 who accepts responsibility for communicating the agency's
443 directives concerning the project to all other network members.
444 (e) "Provider service network" has the same meaning as
445 provided in s. 409.912(4)(d).
446 (f) "Tier One medical home" means:
447 1. A primary care provider that certifies to the agency
448 that the provider meets the service capabilities established in
449 paragraph (4)(a); or
450 2. A provider service network that certifies to the agency
451 that all of its members who are primary care providers meet the
452 service capabilities established in paragraph (4)(a).
453 (g) "Tier Two medical home" means:
454 1. A primary care provider that certifies to the agency
455 that the provider meets the service capabilities established in
456 paragraph (4)(b); or
457 2. A provider service network that certifies to the agency
458 that at least 85 percent of its members who are primary care
459 providers meet the service capabilities established in paragraph

460 (4)(b) and the remainder of the primary care providers meet the
461 service capabilities established in paragraph (4)(a).
462 (h) "Tier Three medical home" means:
463 1. A primary care provider that certifies to the agency
464 that the provider meets the service capabilities established in
465 paragraph (4)(c); or
466 2. A provider service network that certifies to the agency
467 that at least 85 percent of its members who are primary care
468 providers meet the service capabilities established in paragraph
469 (4)(c) and the remainder of the primary care providers meet the
470 service capabilities established in paragraph (4)(b).
471 (3) ORGANIZATION.—
472 (a) Each participating primary care provider shall be a
473 member of a medical home network or a provider service network
474 and shall be classified by the agency as a Tier One, Tier Two,
475 or Tier Three medical home upon certification by the provider of
476 compliance with the service capabilities for that tier. A
477 primary care provider or a provider service network may change
478 classification by certifying service capabilities consistent
479 with the standards for another tier. Certifications shall be
480 made annually.
481 (b) Each participating provider service network shall be
482 classified by the agency as a Tier One, Tier Two, or Tier Three
483 medical home upon certification by the network that the
484 network's primary care providers meet the service capabilities
485 for that tier. The provider service network may also certify to
486 the agency that it intends to serve a specific target population
487 based on disease, condition, or age.

488 (c) The members of each medical home network or provider
489 service network shall designate a principal network provider who
490 shall be responsible for maintaining an accurate list of
491 participating providers, forwarding this list to the agency,
492 updating the list as requested by the agency, and facilitating
493 communication between the agency and the participating
494 providers.
495 (d) A provider service network may only cease
496 participation as a medical home after providing at least 90
497 days' notice to the agency. All members of the provider service
498 network must continue to serve the enrollees during this 90-day
499 period. A provider service network that is reimbursed by the
500 agency on a prepaid basis may not receive any additional
501 reimbursements for this 90-day period.
502 (4) SERVICE CAPABILITIES.—A medical home network or a
503 provider service network certified as a medical home shall
504 provide primary care; coordinate services to control chronic
505 illnesses; provide disease management and patient education;
506 provide or arrange for pharmacy, outpatient diagnostic, and
507 specialty physician services; and provide for or coordinate with
508 inpatient facilities and behavioral health, mental health, and
509 rehabilitative service providers. The network shall place a
510 priority on methods to manage pharmacy and behavioral health
511 services.
512 (a) Tier One medical homes shall have the capability to:
513 1. Maintain a written copy of the mutual agreement between
514 the medical home and the patient in the patient's medical
515 record.

516 2. Supply all medically necessary primary and preventive
517 services and provide all scheduled immunizations.
518 3. Organize clinical data in paper or electronic form
519 using a patient-centered charting system.
520 4. Maintain and update patients' medication lists and
521 review all medications during each office visit.
522 5. Maintain a system to track diagnostic tests and provide
523 followup services regarding test results.
524 6. Maintain a system to track referrals, including self-
525 referrals by members.
526 7. Supply care coordination and continuity of care through
527 proactive contact with members and encourage family
528 participation in care.
529 8. Supply education and support using various materials
530 and processes appropriate for individual patient needs.
531 (b) Tier Two medical homes shall have all of the
532 capabilities of a Tier One medical home and shall have the
533 additional capability to:
534 1. Communicate electronically.
535 2. Supply voice-to-voice telephone coverage to panel
536 members 24 hours per day, 7 days per week, to enable patients to
537 speak to a licensed health care professional who triages and
538 forwards calls, as appropriate.
539 3. Maintain an office schedule of at least 30 scheduled
540 hours per week.
541 4. Use scheduling processes to promote continuity with
542 clinicians, including providing care for walk-in, routine, and
543 urgent care visits.

544 5. Implement and document behavioral health and substance
545 abuse screening procedures and make referrals as needed.
546 6. Use data to identify and track patients' health and
547 service use patterns.
548 7. Coordinate care and followup for patients receiving
549 services in inpatient and outpatient facilities.
550 8. Implement processes to promote access to care and
551 member communication.
552 (c) Tier Three medical homes shall have all of the
553 capabilities of Tier One and Tier Two medical homes and shall
554 have the additional capability to:
555 1. Maintain electronic medical records.
556 2. Develop a health care team that provides ongoing
557 support, oversight, and guidance for all medical care received
558 by the patient and documents contact with specialists and other
559 health care providers caring for the patient.
560 3. Supply postvisit followup care for patients.
561 4. Implement specific evidence-based clinical practice
562 guidelines for preventive and chronic care.
563 5. Implement a medication reconciliation procedure to
564 avoid interactions or duplications.
565 6. Use personalized screening, brief intervention, and
566 referral to treatment procedures for appropriate patients
567 requiring specialty treatment.
568 7. Offer at least 4 hours per week of after-hours care to
569 patients.
570 8. Use health assessment tools to identify patient needs
571 and risks.

572 (5) TASK FORCE; ADVISORY PANEL.—
573 (a) The Secretary of Health Care Administration shall
574 appoint a task force by August 1, 2009, to assist the agency in
575 the development and implementation of the medical home pilot
576 project. The task force must include, but is not limited to,
577 representatives of providers who could potentially participate
578 in a medical home network, Medicaid recipients, and existing
579 MediPass and managed care providers. Members of the task force
580 shall serve without compensation but are may be reimbursed for
581 per diem and travel expenses as provided in s. 112.061. When the
582 statewide advisory panel created pursuant to paragraph (b) has
583 been appointed, the task force shall dissolve.
584 (b) A statewide advisory panel shall be established to
585 advise and assist the agency in developing a methodology for an
586 annual evaluation of each medical home network and provider
587 service network certified as a medical home. The panel shall
588 promote communication among medical home networks and provider
589 service networks certified as medical homes. The panel shall
590 consist of seven members, as follows:
591 1. Two members appointed by the Speaker of the House of
592 Representatives, one of whom shall be a primary care physician
593 licensed under chapter 458 or chapter 459 and one of whom shall
594 be a representative of a hospital licensed under chapter 395.
595 2. Two members appointed by the President of the Senate,
596 one of whom shall be a physician licensed under chapter 458 or
597 chapter 459 who is a board-certified specialist and one of whom
598 shall be a representative of a Florida medical school.

599 3. Two members appointed by the Governor, one of whom
600 shall be a representative of an insurer licensed to do business
601 in this state or a health maintenance organization licensed
602 under part I of chapter 641 and one of whom shall be a
603 representative of Medicaid consumers.
604 4. The Secretary of Health Care Administration or his or
605 her designee.
606 (c) Appointed members of the panel shall serve 4-year
607 terms, except that the initial terms shall be staggered as
608 follows:
609 1. The Governor shall appoint one member for a term of 2
610 years and one member for a term of 4 years.
611 2. The President of the Senate shall appoint one member
612 for a term of 2 years and one member for a term of 4 years.
613 3. The Speaker of the House of Representatives shall
614 appoint one member for a term of 2 years and one member for a
615 term of 4 years.
616 (d) A vacancy in an appointed member's position shall be
617 filled by appointment by the original appointing authority for
618 the unexpired portion of the term.
619 (e) Members of the statewide advisory panel shall serve
620 without compensation but may be reimbursed for per diem and
621 travel expenses as provided in s. 112.061.
622 (f) The agency shall provide staff support to assist the
623 panel in the performance of its duties.
624 (g) The statewide advisory panel shall establish a medical
625 advisory group consisting of physicians licensed under chapter
626 458 or chapter 459 who shall act as ambassadors to their

627 communities for the promotion of and assistance in the
628 establishment of medical home networks and provider service
629 networks certified as medical homes. Members of the medical
630 advisory group shall serve without compensation but may be
631 reimbursed for per diem and travel expenses as provided in s.
632 112.061.

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

639 (7) FINANCING.—

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

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

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

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

653 (b) Services provided by a medical home network or a
654 provider service network with a fee-for-service contract with

655 the agency shall be reimbursed based on claims filed for
656 Medicaid fee-for-service payments. Services by a provider
657 service network with a contract with the agency for prepaid
658 services shall be paid pursuant to the contract and shall be
659 eligible to receive the credit provided in this subsection.
660 (c) Any hospital, as defined in s. 395.002(12),
661 participating in a medical home network or service provider
662 network certified as a medical home that employs case managers
663 for the network shall be eligible to receive a credit against
664 the assessment imposed under s. 395.701. The credit is
665 compensation for participating in the network by providing case
666 management and other network services.
667 1. The credit shall be prorated based on the number of
668 full-time equivalent case managers hired but shall not be more
669 than $75,000 for each full-time equivalent case manager. The
670 total credit may not exceed $450,000 for any hospital for any
671 state fiscal year.
672 2. To qualify for the credit, the hospital must employ
673 each full-time equivalent case manager for the entire hospital
674 fiscal year for which the credit is claimed.
675 3. The hospital must certify the number of full-time
676 equivalent case managers for whom it is entitled to a credit
677 using the certification process required under s. 395.701(2)(a).
678 4. The agency shall calculate the amount of the credit and
679 reduce the certified assessment for the hospital by the amount
680 of the credit.

681 (d) The enhanced payments to primary care providers shall
682 not affect the calculation of capitated rates under this
683 chapter.
684 (8) AGENCY DUTIES.—The agency shall:
685 (a) Maintain a record of certified primary care providers
686 and provider service networks by classification as Tier One,
687 Tier Two, or Tier Three medical homes.
688 (b) Develop a standard form to be used by primary care
689 providers and provider service networks to certify to the agency
690 that they meet the necessary principles and service capabilities
691 for the tier in which they seek to be classified. The form shall
692 have a check box for each of the three tiers, a line to indicate
693 whether a primary care network intends to specialize in a target
694 population, a line to specify the target population, if any, and
695 a line for the signature of the provider or principal of an
696 entity. Checking the appropriate tier box and signing the form
697 shall be deemed certification for the purposes of this section.
698 (c) Develop a process for managed care organizations to
699 certify themselves as Tier One, Tier Two, or Tier Three medical
700 homes based on established policies and procedures consistent
701 with the principles and corresponding service capabilities
702 provided under subsections (1) and (4).
703 (d) Establish a participation agreement to be executed by
704 Medipass recipients who choose to participate in the medical
705 home pilot project.
706 (e) Track the spending for and utilization of services by
707 all enrolled medical home network patients.

708 (f) Evaluate each provider service network at least
709 annually to ensure that the network is cost-effective as defined
710 in s. 409.912(44).
711 (9) ACHIEVED SAVINGS.—Each medical home network or
712 provider service network certified as a medical home that
713 participates on a fee-for-service basis and achieves savings
714 equal to or greater than the spending that would have occurred
715 if its enrollees participated in prepaid health plans is
716 eligible to receive funding based on the identified savings
717 pursuant to a specific appropriation provided for in the General
718 Appropriations Act. The funds must be distributed on a pro rata
719 basis to the physicians who are members of the medical home
720 network so that the compensation for their services is as close
721 as possible to 100 percent of Medicare rates. Subject to a
722 specific appropriation, it is the intent of the Legislature that
723 the savings that result from the implementation of the medical
724 home network model be used to enable Medicaid fees to physicians
725 participating in medical home networks to be equivalent to 100
726 percent of Medicare rates as soon as possible.
727 (10) COLLABORATION WITH PRIVATE INSURERS.—To enable the
728 state to participate in federal gainsharing initiatives, the
729 agency shall collaborate with the Office of Insurance Regulation
730 to encourage insurers licensed in this state to incorporate
731 medical home network principles into the design of their
732 individual and employment-based plans. The Department of
733 Management Services is directed to develop a medical home option
734 in the state group insurance program.

735 (11) QUALITY ASSURANCE AND ACCOUNTABILITY.—Each primary
736 care and principal network provider participating in a medical
737 home network or provider service network certified as a medical
738 home shall maintain medical records and clinical data necessary
739 for the network to assess the use, cost, and outcome of services
740 provided to enrollees.
741 Section 5. Paragraph (b) of subsection (1) and paragraph
742 (e) of subsection (3) of section 409.91211, Florida Statutes,
743 are amended to read:
744 409.91211 Medicaid managed care pilot program.—
745 (1)
746 (b) This waiver authority is contingent upon federal
747 approval to preserve the upper-payment-limit funding mechanism
748 for hospitals, including a guarantee of a reasonable growth
749 factor, a methodology to allow the use of a portion of these
750 funds to serve as a risk pool for demonstration sites,
751 provisions to preserve the state's ability to use
752 intergovernmental transfers, and provisions to protect the
753 disproportionate share program authorized pursuant to this
754 chapter. Upon completion of the evaluation conducted under s. 3,
755 ch. 2005-133, Laws of Florida, the agency may request statewide
756 expansion of the demonstration projects. Statewide phase-in to
757 additional counties shall be contingent upon review and approval
758 by the Legislature. Under the upper-payment-limit program, or
759 the low-income pool as implemented by the Agency for Health Care
760 Administration pursuant to federal waiver, the state matching
761 funds required for the program shall be provided by local
762 governmental entities through intergovernmental transfers in

763 accordance with published federal statutes and regulations. The
764 Agency for Health Care Administration shall distribute upper-
765 payment-limit, disproportionate share hospital, and low-income
766 pool funds according to published federal statutes, regulations,
767 and waivers and the low-income pool methodology approved by the
768 federal Centers for Medicare and Medicaid Services. A provider
769 who receives low-income pool funds shall serve Medicaid
770 recipients regardless of the recipient's county of residence in
771 the state and may not restrict access to care based on residency
772 in a county in the state other than the one in which the
773 provider is located.
774 (3) The agency shall have the following powers, duties,
775 and responsibilities with respect to the pilot program:
776 (e) To implement policies and guidelines for phasing in
777 financial risk for approved provider service networks that, for
778 purposes of this paragraph, include the Children's Medical
779 Services Network, over the longer of a 5-year period or through
780 October 1, 2015. These policies and guidelines must include an
781 option for a provider service network to be paid fee-for-service
782 rates. For any provider service network established in a managed
783 care pilot area, the option to be paid fee-for-service rates
784 must include a savings-settlement mechanism that is consistent
785 with s. 409.912(44). As of October 1, 2015, or after 5 years of
786 operation, whichever is the longer period, this model must be
787 converted to a risk-adjusted capitated rate ~~by the beginning of~~
788 ~~the sixth year of operation,~~ and may be converted earlier at the
789 option of the provider service network. Federally qualified
790 health centers may be offered an opportunity to accept or

791 decline a contract to participate in any provider network for
792 prepaid primary care services.
793 Section 6. Paragraph (f) of subsection (2) of section
794 409.9122, Florida Statutes, is amended, and subsections (15)
795 through (18) are added to that section, to read:
796 409.9122 Mandatory Medicaid managed care enrollment;
797 programs and procedures.—
798 (2)
799 (f) If a Medicaid recipient does not choose a managed care
800 plan or MediPass provider, the agency shall assign the Medicaid
801 recipient to a managed care plan or MediPass provider. Medicaid
802 recipients eligible for managed care plan enrollment who are
803 subject to mandatory assignment but who fail to make a choice
804 shall be assigned to managed care plans until an enrollment of
805 65 percent in provider service networks certified as medical
806 homes under s. 409.91207 and 35 percent in other managed care
807 plans ~~35 percent in MediPass and 65 percent in managed care~~
808 ~~plans, of all those eligible to choose managed care,~~ is
809 achieved. Once this enrollment is achieved, the assignments
810 shall be divided in the same manner ~~order~~ to maintain the same
811 ~~an~~ enrollment ratio ~~in MediPass and managed care plans which is~~
812 ~~in a 35 percent and 65 percent proportion, respectively~~.
813 Thereafter, assignment of Medicaid recipients who fail to make a
814 choice shall be based proportionally on the preferences of
815 recipients who have made a choice in the previous period. Such
816 proportions shall be revised at least quarterly to reflect an
817 update of the preferences of Medicaid recipients. The agency
818 shall disproportionately assign Medicaid-eligible recipients who

819 are required to but have failed to make a choice of managed care
820 plan or MediPass, including children, and who would be assigned
821 to the MediPass program to children's networks as described in
822 s. 409.912(4)(g), Children's Medical Services Network as defined
823 in s. 391.021, exclusive provider organizations, provider
824 service networks, minority physician networks, and pediatric
825 emergency department diversion programs authorized by this
826 chapter or the General Appropriations Act, in such manner as the
827 agency deems appropriate, until the agency has determined that
828 the networks and programs have sufficient numbers to be operated
829 economically. For purposes of this paragraph, when referring to
830 assignment, the term "managed care plans" includes health
831 maintenance organizations, exclusive provider organizations,
832 provider service networks, minority physician networks,
833 Children's Medical Services Network, and pediatric emergency
834 department diversion programs authorized by this chapter or the
835 General Appropriations Act. When making assignments, the agency
836 shall take into account the following criteria:
837 1. A managed care plan has sufficient network capacity to
838 meet the need of members.
839 2. The managed care plan or MediPass has previously
840 enrolled the recipient as a member, or one of the managed care
841 plan's primary care providers or MediPass providers has
842 previously provided health care to the recipient.
843 3. The agency has knowledge that the member has previously
844 expressed a preference for a particular managed care plan or
845 MediPass provider as indicated by Medicaid fee-for-service
846 claims data, but has failed to make a choice.

847 4. The managed care plan's or MediPass primary care
848 providers are geographically accessible to the recipient's
849 residence.
850 (15)(a) Beginning September 1, 2010, the agency shall
851 begin a budget-neutral adjustment of capitation rates for all
852 Medicaid prepaid plans in the state. The adjustment to
853 capitation rates shall be based on aggregate risk scores for
854 each prepaid plan's enrollees. During the first 2 years of the
855 adjustment, the agency shall ensure that no plan has an
856 aggregate risk score that varies more than 10 percent from the
857 aggregate weighted average for all plans. The risk adjusted
858 capitation rates shall be phased in as follows:
859 1. In the first fiscal year, 75 percent of the capitation
860 rate shall be based on the current methodology and 25 percent
861 shall be based on the risk-adjusted rate methodology.
862 2. In the second fiscal year, 50 percent of the capitation
863 rate shall be based on the current methodology and 50 percent
864 shall be based on the risk-adjusted methodology.
865 3. In the third fiscal year, the risk-adjusted capitation
866 methodology shall be fully implemented.
867 (b) During this period, the agency shall establish a
868 technical advisory panel to obtain input from the prepaid plans
869 affected by the transition to risk adjusted rates.
870 (16) The agency shall maintain and operate the Medicaid
871 Encounter Data System to collect, process, store, and report on
872 covered services provided to all Florida Medicaid recipients
873 enrolled in prepaid managed care plans. Prepaid managed care
874 plans shall submit encounter data electronically in a format

875 that complies with the Health Insurance Portability and
876 Accountability Act provisions for electronic claims and in
877 accordance with deadlines established by the agency. Prepaid
878 managed care plans must certify that the data reported is
879 accurate and complete. The agency is responsible for validating
880 the data submitted by the plans.
881 (17) The agency shall establish, and managed care plans
882 shall use, a uniform method of accounting for and reporting
883 medical and nonmedical costs. The agency shall make such
884 information available to the public.
885 (18) The agency may, on a case-by-case basis, exempt a
886 recipient from mandatory enrollment in a managed care plan when
887 the recipient has a unique, time-limited disease or condition-
888 related circumstance and managed care enrollment will interfere
889 with ongoing care because the recipient's provider does not
890 participate in the managed care plans available in the
891 recipient's area.
892 Section 7. Section 409.91225, Florida Statutes, is created
893 to read:
894 409.91225 Managed care plan accountability.—The agency
895 shall establish and implement managed care plans that shall use
896 a uniform method of accounting for and reporting medical, direct
897 care management, and nonmedical costs. The agency shall evaluate
898 plan spending patterns beginning after the plan completes 2 full
899 years of operation and at least annually thereafter. The agency
900 shall implement the following thresholds and consequences of
901 various spending patterns:

902 (1) Plans that spend less than 75 percent of Medicaid
903 premium revenue on medical services and direct care management
904 as determined by the agency shall be excluded from automatic
905 enrollments and shall be required to pay back the amount between
906 actual spending and 85 percent of the Medicaid premium revenue.
907 (2) Plans that spend less than 85 percent of Medicaid
908 premium revenue on medical services and direct care management
909 as determined by the agency shall be required to pay back the
910 amount between actual spending and 85 percent of the Medicaid
911 premium revenue.
912 (3) Plans that spend more than 95 percent of Medicaid
913 premium revenue shall be evaluated by the agency to determine
914 whether higher expenditures are the result of failures in care
915 management. Such a determination may result in the plan being
916 excluded from automatic enrollments.
917 Section 8. This act shall take effect July 1, 2010.
918
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920 ---
921 **T I T L E A M E N D M E N T**
922 Remove the entire title and insert:
923 A bill to be entitled
924 An act relating to Medicaid; amending s. 409.907, F.S.;
925 revising the requirements of a Medicaid provider agreement
926 to include compliance with the Medicaid Encounter Data
927 System; requiring the Agency for Health Care
928 Administration to submit an annual report on the system to
929 the Governor and Legislature; amending s. 409.908, F.S.;

930 requiring the agency to adjust capitation rates for
931 certain Medicaid providers; providing criteria for the
932 adjustments; providing a phase-in schedule; requiring the
933 Secretary of Health Care Administration to establish a
934 technical advisory panel to advise the agency in the area
935 of risk-adjusted rate setting; providing membership and
936 duties; amending s. 409.912, F.S.; providing instructions
937 to the agency regarding seeking federal approval for
938 certain contracts that provide behavioral health care
939 services; providing for certain contracts to remain in
940 effect until a specified date; prohibiting the
941 cancellation of certain contracts with provider service
942 networks without specified notice; providing additional
943 terms for cancellation; requiring contracts for Medicaid
944 services that are on a prepaid or fixed-sum basis to meet
945 certain medical loss ratios; providing for the agency to
946 recoup and redistribute payments under certain
947 circumstances; amending s. 409.91207, F.S.; providing
948 purposes and principles for creating medical homes;
949 providing definitions; providing for the organization of
950 medical home networks and provider service networks
951 certified as medical homes; requiring a provider service
952 network to provide certain notice to the agency prior to
953 ceasing participation as a medical home; requiring each
954 medical home to provide specified services; providing for
955 abolishment of a task force upon the creation of a
956 statewide advisory panel; providing for the establishment
957 of the statewide advisory panel; providing membership,

958 terms, and duties; directing the agency to provide staff
959 support to the panel; directing the panel to establish a
960 medical advisory group to assist in the establishment of
961 medical home networks and provider service networks
962 certified as medical homes; providing for travel expenses
963 and per diem for members of the panel and the medical
964 advisory group; providing for enrollment of MediPass
965 beneficiaries in medical homes; providing for financing of
966 medical home networks; providing duties of the agency;
967 providing for distribution of savings achieved by network
968 providers under certain circumstances; requiring the
969 agency to collaborate with the Office of Insurance
970 Regulation to encourage licensed insurers to incorporate
971 the principles of the medical home network into insurance
972 plans; requiring the Department of Management Services to
973 develop a medical home option in the state group insurance
974 program; requiring medical home network providers to
975 maintain certain records and data; amending s. 409.91211,
976 F.S.; requiring a provider that receives low-income pool
977 funds to serve Medicaid recipients regardless of county of
978 residence; revising the period for phasing in financial
979 risk for certain provider service networks; amending s.
980 409.9122, F.S.; revising the assignment of Medicaid
981 recipients eligible for managed care plan enrollment who
982 are subject to mandatory assignment but who fail to make a
983 choice; requiring the Agency for Health Care
984 Administration to begin a budget-neutral adjustment of
985 capitation rates for all Medicaid prepaid plans in the

986 state on a specified date; providing the basis for the
987 adjustment; providing a phased schedule for risk adjusted
988 capitation rates; providing for the establishment of a
989 technical advisory panel; requiring the agency to maintain
990 and operate the Medicaid Encounter Data System; requiring
991 the agency to establish, and managed care plans to use, a
992 uniform method of accounting for and reporting of medical
993 and nonmedical costs; authorizing the Agency for Health
994 Care Administration to create exceptions to mandatory
995 enrollment in managed care under specified circumstances;
996 creating s. 409.91225, F.S.; establishing managed care
997 plan accountability; creating a medical-loss ratio
998 requirement; providing an effective date.