A bill to be entitled

An act relating to Medicaid managed care; providing a short title; creating the "Independence at Home Act"; providing legislative findings; directing the Agency for Health Care Administration to establish an Independence at Home Chronic Care Coordination Pilot Project; providing for Independence at Home programs within the pilot project; specifying objectives of the programs; providing for implementation and independent evaluation of the pilot project; providing eligibility criteria for participation; providing rulemaking authority to the agency; providing for best-practices teleconferences; providing definitions; providing for enrollment of program participants; providing program requirements; providing requirements for plan development; providing terms and conditions of agreements between the agency and Independence at Home organizations; requiring a report to the Legislature; establishing quality, performance, and participation standards; providing for terms, modification, termination, and nonrenewal of agreements; requiring mandatory minimum savings and for computation thereof; providing a waiver of coinsurance for house calls; providing an effective date.

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

Section 1. Short title.—This act may be cited as the "Independence at Home Act."

Section 2. Legislative findings.—The Legislature finds,

pursuant to the November 2007 Congressional Budget Office's Long-Term Outlook for Health Care Spending, that:

(1) Unless changes are made to the way health care is delivered, the growing demand for resources caused by rising health care costs and, to a lesser extent, the nation's expanding elderly and chronically ill population will confront Floridians with increasingly difficult choices between health care and other priorities. However, opportunities exist to constrain health care costs without adverse health care consequences.

(2) Medicaid beneficiaries with multiple chronic conditions account for a disproportionate share of Medicaid spending compared to their representation in the overall Medicaid population, and evidence suggests that such patients often receive poorly coordinated care, including conflicting information from health providers and different diagnoses of the same symptoms.

(3) People with chronic conditions account for 76 percent of all hospital admissions, 88 percent of all prescriptions filled, and 72 percent of physician visits.

(4) Hospital utilization and emergency room visits for patients with multiple chronic conditions can be reduced and significant savings can be achieved through the use of interdisciplinary teams of health care professionals caring for patients in their places of residence.

Section 3. Independence at Home Act; purpose.—The purpose of the Independence at Home Act is to:

(1) Create a chronic care coordination pilot project to

bring primary care medical services to the highest cost Medicaid beneficiaries with multiple chronic conditions in their home or place of residence so that they may be as independent as possible for as long as possible in a comfortable setting.

(2) Generate savings by providing better, more coordinated care across all treatment settings to the highest cost Medicaid beneficiaries with multiple chronic conditions, reducing duplicative and unnecessary services, and avoiding unnecessary hospitalizations, nursing home admissions, and emergency room visits.

(3) Hold providers accountable for improving beneficiary outcomes, ensuring patient and caregiver satisfaction, and achieving cost savings to Medicaid on an annual basis.

(4) Create incentives for practitioners and providers to develop methods and technologies for providing better and lower cost health care to the highest cost Medicaid beneficiaries with the greatest incentives provided in the case of highest cost Medicaid beneficiaries.

(5) Contain the central elements of proven home-based primary care delivery models that have been utilized for years by the United States Department of Veterans Affairs and its house calls program to deliver coordinated care for chronic conditions in the comfort of the patient's home or place of residence.

Section 4. Independence at Home Chronic Care Coordination Pilot Project.—

(1) IMPLEMENTATION BY THE AGENCY FOR HEALTH CARE ADMINISTRATION.—The Secretary of Health Care Administration

shall provide for the phased-in development, implementation, and evaluation of the Independence at Home Chronic Care Coordination Pilot Project described in this section to meet the following objectives:

(a) To improve patient outcomes, compared to outcomes achieved by comparable beneficiaries who do not participate in such a program, through reduced hospitalizations, nursing home admissions, and emergency room visits and increased symptom self-management and other similar results.

(b) To improve patient and caregiver satisfaction, as demonstrated through a quantitative pretest and posttest survey developed by the agency that measures patient and caregiver satisfaction relating to coordination of care, provision of educational information, timeliness of response, and similar care features.

(c) To achieve a minimum of 5 percent cost savings associated with the care of Medicaid beneficiaries served under this program who suffer from multiple high-cost chronic diseases.

(2) INITIAL IMPLEMENTATION; PHASE I.—

(a) For the purpose of carrying out this section and to the extent possible, the Agency for Health Care Administration shall enter into agreements with at least two unaffiliated Independence at Home organizations in each county in the state to provide chronic care coordination services for a period of 3 years or until those agreements are terminated by the agency. Agreements under this paragraph shall continue in effect until the agency makes a determination pursuant to subsection (3) or

until those agreements are supplanted by new agreements entered into under subsection (3).

(b) In selecting an Independence at Home organization under this subsection, the agency shall give a preference to the extent practicable to an organization that:

1. Has documented experience in furnishing the types of services covered under this subsection to eligible beneficiaries in their home or place of residence using qualified teams of health care professionals who are under the direction of a qualified Independence at Home physician or, in a case when such direction is provided by an Independence at Home physician to a physician assistant who has at least 1 year of experience providing medical and related services for chronically ill individuals in their homes, or other similar qualifications as determined by the agency to be appropriate for the Independence at Home program, by the physician assistant acting under the supervision of an Independence at Home physician and as permitted under state law, or by an Independence at Home nurse practitioner;

2. Has the capacity to provide services covered by this section to at least 150 eligible Medicaid beneficiaries; and

3. Uses electronic medical records, health information technology, and individualized plans of care.

(3) EXPANDED IMPLEMENTATION; PHASE II.—

(a) For periods beginning after the end of the 3-year initial implementation period under subsection (2), and subject to paragraph (b), the agency shall renew agreements described in subsection (2) with an Independence at Home organization that

has met all the objectives specified in subsection (1) and enter into agreements described in subsection (2) with any other organization located in the state that was not an Independence at Home organization during the initial implementation period and meets the qualifications for an Independence at Home organization under this section. The agency may terminate and decline to renew an agreement with an organization that has not met those objectives during the initial implementation period.

(b) The expanded implementation under paragraph (a) may not occur if the agency finds, not later than 60 days after the date of issuance of the independent evaluation under subsection (5), that continuation of the Independence at Home Chronic Care Coordination Pilot Project is not in the best interest of Medicaid beneficiaries participating under this section.

(4) ELIGIBILITY.—An organization is not prohibited from participating under this section during the expanded implementation phase under subsection (3) and, to the extent practicable, during the initial implementation phase under subsection (2) because of its small size as long as it meets the eligibility requirements of this section.

(5) INDEPENDENT EVALUATIONS.—

(a) The agency shall contract for an independent evaluation of the initial implementation phase under subsection (2) and provide an interim report to the Legislature regarding the evaluation as soon as practicable after the first year of phase I and provide a final report to the Legislature as soon as practicable following the conclusion of the phase I, but not later than 6 months following the end of phase I. The evaluation

shall be conducted by individuals with knowledge of chronic care coordination programs for the targeted patient population and prior experience in the evaluation of such programs.

(b) Each report shall include an assessment of the following factors and shall identify the characteristics of individual Independence at Home programs that are the most effective in producing improvements in:

1. Beneficiary, caregiver, and provider satisfaction.

2. Health outcomes appropriate for patients with multiple chronic diseases.

3. Cost savings to the program under this section, such as reductions in:

a. Hospital and skilled nursing facility admission rates and lengths of stay.

b. Hospital readmission rates.

c. Emergency department visits.

(c) Each report shall include data on the performance of Independence at Home organizations in responding to the needs of eligible Medicaid beneficiaries with specific chronic conditions and combinations of conditions and responding to the needs of the overall eligible beneficiary population.

(6) AGREEMENTS.—

(a) Beginning not later than July 1, 2012, the agency shall enter into agreements with Independence at Home organizations that meet the participation requirements of this section, including minimum performance standards developed under subsection (17), in order to provide access by eligible Medicaid beneficiaries to Independence at Home programs under this

section.

(b) If the agency deems it necessary to serve the best interest of the Medicaid beneficiaries under this section, the agency may:

1. Require screening of all potential Independence at Home organizations, including owners, using fingerprinting, licensure checks, site visits, or other database checks before entering into an agreement.

2. Require a provisional period during which a new Independence at Home organization is subject to enhanced oversight that may include prepayment review, unannounced site visits, and payment caps.

3. Require applicants to disclose any previous affiliation with entities that have uncollected Medicaid debt and authorize the denial of enrollment if the agency determines that these affiliations pose undue risk to the program.

(7) RULEMAKING.—At least 3 months before entering into the first agreement under this section, the agency shall publish in the Florida Administrative Weekly the specifications for implementing this section. Such specifications shall describe the implementation process from the initial through the final implementation phases, including how the agency will identify and notify potential enrollees and how and when a Medicaid beneficiary may enroll, disenroll, of change enrollment in an Independence at Home program.

(8) PERIODIC PROGRESS REPORTS.—Semiannually during the first year, and annually thereafter, during the period of implementation of this section, the agency shall submit to the

appropriate committees of the House of Representatives and the Senate a report that describes the progress of the implementation of the pilot project and explains any variation from the Independence at Home program model as described in this section.

(9) ANNUAL BEST PRACTICES TELECONFERENCE.—During the initial implementation phase and to the extent practicable at intervals thereafter, the agency shall provide for an annual Independence at Home teleconference for Independence at Home organizations to share best practices and review treatment interventions and protocols that were successful in meeting the objectives specified in subsection (1).

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

(a) "Activities of daily living" means bathing, dressing, grooming, transferring, feeding, or toileting.

(b) "Caregiver" means, with respect to an individual with a qualifying functional impairment, a family member, friend, or neighbor who provides assistance to the individual.

(c) "Chronic conditions" includes the following:

1. Congestive heart failure.

2. Diabetes.

3. Chronic obstructive pulmonary disease.

4. Ischemic heart disease.

5. Peripheral arterial disease.

6. Stroke.

7. Alzheimer's disease and other forms of dementia designated by the agency.

8. Pressure ulcers.

9. Hypertension.

10. Myasthenia gravis.

11. Neurodegenerative diseases designated by the agency that result in high costs to the program, including amyotrophic lateral sclerosis (ALS), multiple sclerosis, and Parkinson's disease.

12. Any other chronic condition that the agency identifies as likely to result in high costs when such condition is present in combination with one or more of the chronic conditions specified in this paragraph.

(d) "Disqualification" does not include an individual:

1. Who resides in a setting that presents a danger to the safety of in-home health care providers and primary caregivers; or

2. Whose enrollment in an Independence at Home program is determined by the agency to be inappropriate.

(e) "Eligible beneficiary" means, with respect to an Independence at Home program, an individual who:

1. Is entitled to benefits under the Florida Medicaid program;

2. Has a qualifying functional impairment and has been diagnosed with two or more of the chronic conditions described in paragraph (c); and

3. Within the 12 months prior to the individual first enrolling with an Independence at Home program under this section, has received benefits under Medicare Part A for the following services:

a. Nonelective inpatient hospital services;

b. Services in the emergency department of a hospital;

c. Skilled nursing or subacute rehabilitation services in a Medicaid-certified nursing facility;

d. Comprehensive acute rehabilitation facility or comprehensive outpatient rehabilitation facility services; or

e. Skilled nursing or rehabilitation services through a Medicaid-certified home health agency.

(f) "Independence at Home assessment" means a determination of eligibility of an individual for an Independence at Home program as an eligible beneficiary and includes a comprehensive medical history, physical examination, and assessment of the beneficiary's clinical and functional status that is conducted in person by an Independence at Home physician or an Independence at Home nurse practitioner or by a physician assistant, nurse practitioner, or clinical nurse specialist who is employed by an Independence at Home organization and is supervised by an Independence at Home physician or Independence at Home nurse practitioner. The individual conducting the assessment may not have an ownership interest in the Independence at Home organization unless the agency determines that it is impracticable to preclude such individual's involvement. The assessment shall include an evaluation of:

1. Activities of daily living and other comorbidities.

2. Medications and the client's adherence to medication plans.

3. Affect, cognition, executive function, and presence of mental disorders.

4. Functional status, including mobility, balance, gait, risk of falling, and sensory function.

5. Social functioning and social integration.

6. Environmental needs and a safety assessment.

7. The ability of the beneficiary's primary caregiver to assist with the beneficiary's care as well as the caregiver's own physical and emotional capacity, education, and training.

8. Whether, in the professional judgment of the individual conducting the assessment, the beneficiary is likely to benefit from an Independence at Home program.

9. Whether the conditions in the beneficiary's home or place of residence would permit the safe provision of services in the home or residence, respectively, under an Independence at Home program.

10. Whether the beneficiary has a designated primary care physician whom the beneficiary has seen in an office-based setting within the previous 12 months.

11. Other factors determined appropriate for consideration by the agency.

(g) "Independence at Home care team" means a team of qualified individuals that provides services to the participant as part of an Independence at Home program. The term includes a team consisting of an Independence at Home physician or an Independence at Home nurse practitioner, working with an Independence at Home coordinator, who may also be an Independence at Home physician or an Independence at Home nurse practitioner.

(h) "Independence at Home coordinator" means an individual

who:

1. Is employed by an Independence at Home organization and is responsible for coordinating all of the services of the participant's Independence at Home plan;

2. Is a licensed health professional, such as a physician, registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, or other health care professional as the agency determines appropriate, who has at least 1 year of experience providing and coordinating medical and related services for individuals in their homes; and

3. Serves as the primary point of contact responsible for communications with the participant and for facilitating communications with other health care providers under the plan.

(k) "Independence at Home nurse practitioner" means a nurse practitioner who:

1. Is employed by or affiliated with an Independence at Home organization or has another contractual relationship with the Independence at Home organization that requires the nurse practitioner to make in-home visits and to be responsible for the plans of care for the nurse practitioner's patients;

2. Practices in accordance with state law regarding scope of practice for nurse practitioners;

3. Is certified as:

a. A gerontological nurse practitioner by the American Academy of Nurse Practitioners Certification Program or the American Nurses Credentialing Center; or

b. A family nurse practitioner or adult nurse practitioner by the American Academy of Nurse Practitioners Certification

Program or the American Nurses Credentialing Center and holds a Certificate of Added Qualification in gerontology, elder care, or care of the older adult provided by the American Academy of Nurse Practitioners Certification Program, the American Nurses Credentialing Center, or a national nurse practitioner certification board deemed by the agency to be appropriate for an Independence at Home program; and

4. Has furnished services during the previous 12 months for which payment is made under this section.

(i) "Independence at Home organization" means a provider of services, a physician or physician group practice which receives payment for services furnished under Title XVIII of the Social Security Act, rather than only under this section, and which:

1. Has entered into an agreement under subsection (6) to provide an Independence at Home program under this section;

2.a. Provides all of the services of the Independence at Home plan in a participant's home or place of residence; or

b. If the organization is not able to provide all such services in the participant's home or residence, has adequate mechanisms for ensuring the provision of such services by one or more qualified entities;

3. Has Independence at Home physicians, clinical nurse specialists, nurse practitioners, or physician assistants available to respond to patient emergencies 24 hours a day, 7 days a week;

4. Accepts all eligible Medicaid beneficiaries from the organization's service area, as determined under the agreement

with the agency under this section, except to the extent that qualified staff are not available; and

5. Meets other requirements for such an organization under this section.

(j) "Independence at Home physician" means a physician who:

1. Is employed by or affiliated with an Independence at Home organization or has another contractual relationship with the Independence at Home organization that requires the physician to make in-home visits and be responsible for the plans of care for the physician's patients;

2. Is certified by:

a. The American Board of Family Physicians, the American Board of Internal Medicine, the American Osteopathic Board of Family Physicians, the American Osteopathic Board of Internal Medicine, the American Board of Emergency Medicine, or the American Board of Physical Medicine and Rehabilitation; or

b. A board recognized by the American Board of Medical Specialties and determined by the agency to be appropriate for the Independence at Home program;

3. Has a certification in geriatric medicine as provided by the American Board of Medical Specialties or has passed the clinical competency examination of the American Academy of Home Care Physicians and has substantial experience in the delivery of medical care in the home, including at least 2 years of experience in the management of Medicare or Medicaid patients and 1 year of experience in home-based medical care, including at least 200 house calls; and

4. Has furnished services during the previous 12 months for which payment is made under this section.

(l) "Independence at Home plan" means a plan established under subsection (13) for a specific participant in an Independence at Home program.

(m) "Independence at Home program" means a program described in subsection (12) that is operated by an Independence at Home organization.

(n) "Participant" means an eligible beneficiary who has voluntarily enrolled in an Independence at Home program.

(o) "Qualified entity" means a person or organization that is licensed or otherwise legally permitted to provide the specific service provided under an Independence at Home plan that the entity has agreed to provide.

(p) "Qualified individual" means an individual who is licensed or otherwise legally permitted to provide the specific service under an Independence at Home plan that the individual has agreed to provide.

(q) "Qualifying functional impairment" means an inability to perform, without the assistance of another person, three or more activities of daily living.

(11) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS.—

(a) The agency shall develop a model notice to be made available by participating providers and Independence at Home programs to Medicaid beneficiaries, and their caregivers, who are potentially eligible for an Independence at Home program. The notice shall include the following information:

1. A description of the potential advantages to the beneficiary participating in an Independence at Home program.

2. A description of the eligibility requirements to participate.

3. Notice that participation is voluntary.

4. A statement that all other Medicaid benefits remain available to Medicaid beneficiaries who enroll in an Independence at Home program.

5. Notice that those who enroll in an Independence at Home program are responsible for copayments for house calls made by Independence at Home physicians, physician assistants, or Independence at Home nurse practitioners, except that such copayments may be reduced or eliminated at the discretion of the Independence at Home physician, physician assistant, or Independence at Home nurse practitioner.

6. A description of the services that may be provided.

7. A description of the method for participating or withdrawing from participation in an Independence at Home program or becoming ineligible to participate.

(b) An eligible beneficiary may participate in an Independence at Home program through enrollment in the program on a voluntary basis and may terminate participation at any time. The beneficiary may also receive Independence at Home services from the Independence at Home organization of the beneficiary's choice but may not receive Independence at Home services from more than one Independence at Home organization at a time.

(12) INDEPENDENCE at HOME PROGRAM REQUIREMENTS.—Each

Independence at Home program shall, for each participant enrolled in the program:

(a) Designate an Independence at Home coordinator and either an Independence at Home physician or an Independence at Home nurse practitioner.

(b) Have a process to ensure that the participant receives an Independence at Home assessment before enrollment in the program.

(c) With the participation of the participant, or the participant's representative or caregiver, an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician, and, as permitted under state law, an Independence at Home nurse practitioner, or the Independence at Home coordinator, develop an Independence at Home plan for the participant in accordance with subsection (13).

(d) Ensure that the participant receives an Independence at Home assessment at least every 6 months after the original assessment to ensure that the Independence at Home plan for the participant remains current and appropriate.

(e) Implement all of the services under the participant's Independence at Home plan and, in instances in which the Independence at Home organization does not provide specific services within the Independence at Home plan, ensure that qualified entities successfully provide those specific services.

(f) Provide for an electronic medical record and electronic health information technology to coordinate the participant's care and to exchange information with the Medicaid

program and electronic monitoring and communication technologies and mobile diagnostic and therapeutic technologies as appropriate and accepted by the participant.

(13) INDEPENDENCE at HOME PLAN.—

(a) An Independence at Home plan for a participant shall be developed with the participant, an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and, as permitted under state law, an Independence at Home nurse practitioner or an Independence at Home coordinator, and, if appropriate, one or more of the participant's caregivers and shall:

1. Document the chronic conditions, comorbidities, and other health needs identified in the participant's Independence at Home assessment.

2. Determine which services under an Independence at Home plan described in paragraph (c) are appropriate for the participant.

3. Identify the qualified entity responsible for providing each service under such plan.

(b) If the individual responsible for conducting the participant's Independence at Home assessment and developing the Independence at Home plan is not the participant's Independence at Home coordinator, the Independence at Home physician or Independence at Home nurse practitioner is responsible for ensuring that the participant's Independence at Home coordinator has that plan, is familiar with the requirements of the plan, and has the appropriate contact information for all of the members of the Independence at Home care team.

(c) An Independence at Home organization shall coordinate and make available through referral to a qualified entity the services described in subparagraphs 1.-3. to the extent they are needed and covered under this section and shall provide the care coordination services described in subparagraph 4. to the extent they are appropriate and accepted by a participant. The services provided are:

1. Primary care services, such as physician visits and diagnosis, treatment, and preventive services.

2. Home health services, such as skilled nursing care and physical and occupational therapy.

3. Phlebotomy and ancillary laboratory and imaging services, including point-of-care laboratory and imaging diagnostics.

4. Coordination of care services, consisting of:

a. Monitoring and management of medications by a pharmacist who is certified in geriatric pharmacy by the Commission for Certification in Geriatric Pharmacy or possesses other comparable certification demonstrating knowledge and expertise in geriatric or chronic disease pharmacotherapy and providing assistance to participants and their caregivers with respect to selection of a prescription drug plan that best meets the needs of the participant's chronic conditions.

b. Coordination of all medical treatment furnished to the participant, regardless of whether that treatment is covered and available to the participant under this section.

c. Self-care education and preventive care consistent with the participant's condition.

d. Education for primary caregivers and family members.

e. Caregiver counseling services and information about and referral to other caregiver support and health care services in the community.

f. Referral to social services that provide personal care, meals, volunteers, and individual and family therapy.

g. Information about and access to hospice care.

h. Pain and palliative care and end-of-life care, including information about developing advance directives and physicians orders for life-sustaining treatment.

(14) PRIMARY TREATMENT ROLE WITHIN AN INDEPENDENCE AT HOME CARE TEAM.—An Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician, and, as permitted under state law, an Independence at Home nurse practitioner may assume the primary treatment role as permitted under state law.

(15) ADDITIONAL RESPONSIBILITIES.—

(a) Each Independence at Home organization offering an Independence at Home program shall monitor and report to the agency, in a manner specified by the agency, on:

1. Patient outcomes.

2. Beneficiary, caregiver, and provider satisfaction with respect to coordination of the participant's care.

3. The achievement of mandatory minimum savings described in subsection (21).

(b) Each Independence at Home organization shall provide the agency with listings of individuals employed by the organization, including contract employees and individuals with

an ownership interest in the organization, and comply with such additional requirements as the agency may specify.

(16) TERMS AND CONDITIONS.—

(a) An agreement under this section with an Independence at Home organization shall contain such terms and conditions as the agency may specify consistent with this section.

(b) The agency may not enter into an agreement with an Independence at Home organization under this section for the operation of an Independence at Home program unless:

1. The program and organization meet the requirements of subsection (12), minimum quality and performance standards developed under subsection (17), and such clinical, quality improvement, financial, program integrity, and other requirements as the agency deems to be appropriate for participants to be served.

2. The organization demonstrates to the satisfaction of the agency that the organization is able to assume financial risk for performance under the agreement with respect to payments made to the organization under the agreement through available reserves, reinsurance, or withholding of funding provided under this section or through such other means as the agency deems appropriate.

(17) MINIMUM QUALITY AND PERFORMANCE STANDARDS.—The agency shall develop mandatory minimum quality and performance standards for Independence at Home organizations and programs that are no more stringent that those established by the Centers for Medicare and Medicaid Services. The standards shall require:

(a) Improvement in participant outcomes and beneficiary,

caregiver, and provider satisfaction.

(b) Cost savings consistent with the requirements of subsection (20).

(c) For any year after the first year, and except for a program provided by the agency to serve a rural area, an average of at least 150 participants during the previous year.

(18) TERM OF AGREEMENT AND MODIFICATION.—The agreement under this section shall be, subject to paragraph (17)(c) and subsection (19), for a period of 3 years and the terms and conditions may be modified during the contract period by the agency as necessary to serve the best interest of the Medicaid beneficiaries under this section or the best interest of federal health care programs or upon the request of the Independence at Home organization.

(19) TERMINATION AND NONRENEWAL OF AGREEMENT.—

(a) If the agency determines that an Independence at Home organization has failed to meet the minimum performance standards under paragraph (17)(c) or other requirements under this section, or if the agency determines it necessary to serve the best interest of the Medicaid beneficiaries under this section or the best interest of federal health care programs, the agency may terminate the agreement of the organization at the end of the contract year.

(b) The agency shall terminate an agreement with an Independence at Home organization if the agency determines that the care being provided by that organization poses a threat to the health and safety of a participant.

(c) Notwithstanding any other provision of this section,

an Independence at Home organization may terminate an agreement with the agency to provide an Independence at Home program at the end of a contract year if the organization provides notification of the termination to the agency and the Medicaid beneficiaries participating in the program at least 90 days before the end of that contract year. Subsections (20) and (23) and paragraphs (24)(b) and (c) shall apply to the organization until the date of termination.

(d) The agency shall notify the participants in an Independence at Home program as soon as practicable if a determination is made to terminate an agreement with the Independence at Home organization involuntarily as provided in paragraphs (a) and (b). The notice shall inform the beneficiary of any other Independence at Home organizations that might be available to the beneficiary.

(20) MANDATORY MINIMUM SAVINGS.—

(a) Pursuant to an agreement under this subsection, each Independence at Home organization shall ensure that during any year of the agreement for its Independence at Home program, there is an aggregate savings in the cost to the program under this section for participating Medicaid beneficiaries, as calculated under paragraphs (c)-(e), that is not less than 5 percent of the product described in paragraph (b) for such participating Medicaid beneficiaries and for that program year.

(b) The product described in this subsection for participating Medicaid beneficiaries in an Independence at Home program for a year is the product of:

1. The estimated average monthly costs that would have

been incurred under Florida Medicaid, other than those in the Medicaid reform pilot program counties if those Medicaid beneficiaries had not participated in the Independence at Home program; and

2. The number of participant-months for that year. For purposes of this paragraph, the term "participant-month" means each month or part of a month in a program year that a beneficiary participates in an Independence at Home program.

(c) The agency shall contract with a nongovernmental organization or academic institution to independently develop an analytical model for determining whether an Independence at Home program achieves at least the savings required under paragraphs (a) and (b) relative to costs that would have been incurred by Medicaid in the absence of Independence at Home programs. The analytical model developed by the independent research organization for making these determinations shall utilize state-of-the-art econometric techniques, such as Heckman's selection correction methodologies, to account for sample selection bias, omitted variable bias, or problems with endogeneity.

(d) Using the model developed under paragraph (c), the agency shall compare the actual costs to Medicaid of beneficiaries participating in an Independence at Home program to the predicted costs to Medicaid for such beneficiaries to determine whether an Independence at Home program achieves the savings required under this subsection.

(e) The agency shall require that the model developed under paragraph (c) for determining savings shall be designed

according to instructions that control or adjust for inflation and risk factors, including age; race; gender; disability status; socioeconomic status; region of the state, such as county, municipality, or zip code; and such other factors as the agency determines to be appropriate, including adjustment for prior health care utilization. The agency may add to, modify, or substitute for those adjustment factors if the changes will improve the sensitivity or specificity of the calculation of cost savings.

(21) NOTICE OF SAVINGS CALCULATION.—No later than 30 days before the beginning of the first year of the pilot project and 120 days before the beginning of any Independence at Home program year after the first year of implementation, the agency shall publish in the Florida Administrative Weekly a description of the model developed under subparagraph (20)(c) and information for calculating savings required under paragraph (20)(a), including any revisions, sufficient to permit Independence at Home organizations to determine the savings they will be required to achieve during the program year to meet the savings requirement under paragraph (20)(a). In order to facilitate this notice, the agency may designate a single annual date for the beginning of all Independence at Home program years that shall not be later than July 1, 2012.

(22) MANNER OF PAYMENT.—Subject to subsection (23), payments shall be made by the agency to an Independence at Home organization at a rate negotiated between the agency and the organization under the agreement for:

(a) Independence at Home assessments.

(b) On a per-participant, per-month basis, the items and services required to be provided or made available under subparagraph (13)(c)4.

(23) ENSURING MANDATORY MINIMUM SAVINGS.—The agency shall require any Independence at Home organization that fails in any year to achieve the mandatory minimum savings described in subsection (20) to provide those savings by refunding payments made to the organization under subsection (22) during that year.

(24) BUDGET-NEUTRAL PAYMENT CONDITION.—

(a) The agency shall ensure that the cumulative, aggregate sum of Medicaid program benefit expenditures for participants in Independence at Home programs and funds paid to Independence at Home organizations under this section does not exceed the Medicaid program benefit expenditures under such parts that the agency estimates would have been made for such participants in the absence of such programs.

(b) If an Independence at Home organization achieves aggregate savings in a year in the initial implementation phase in excess of the product described in paragraph (20)(b), 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs during the initial implementation phase.

(c) If an Independence at Home organization achieves aggregate savings in a year in the expanded implementation phase in excess of 5 percent of the product described in paragraph (20)(b):

1. Insofar as the savings do not exceed 25 percent of the product, 80 percent of such aggregate savings shall be paid to

the organization and the remainder shall be retained by the programs established under this section.

2. Insofar as the savings exceed 25 percent of the product, at the agency's discretion, 50 percent of such excess aggregate savings shall be paid to the organization and the remainder shall be retained by the programs established under this section.

(25) WAIVER OF COINSURANCE FOR HOUSE CALLS.—A physician, physician assistant, or nurse practitioner furnishing services related to the Independence at Home program in the home or residence of a participant in an Independence at Home program may waive collection of any coinsurance that might otherwise be payable under s. 1833, Title I, Subtitle A of the Healthcare Equality and Accountability Act, with respect to such services, but only if the conditions described in 42 U.S.C. s. 1128A(i)(6)(A) are met.

(26) REPORT.—Not later than 3 months after the date of receipt of the independent evaluation provided under subsection (5) and each year thereafter during which this section is being implemented, the agency shall submit to the President of the Senate, the Speaker of the House of Representatives, and the chairs of the appropriate legislative committees a report that shall include:

(a) Whether the Independence at Home programs under this section are meeting the minimum quality and performance standards described in subsection (17).

(b) A comparative evaluation of Independence at Home organizations in order to identify which programs, and

characteristics of those programs, were the most effective in producing the best participant outcomes, patient and caregiver satisfaction, and cost savings.

(c) An evaluation of whether the participant eligibility criteria identified Medicaid beneficiaries who were in the top 10 percent of the highest cost Medicaid beneficiaries.

Section 5. This act shall take effect July 1, 2011.