1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.911, F.S.;
3 adding a duty to the Medicaid Disproportionate Share
4 Council; providing a future repeal of the Disproportionate
5 Share Council; creating the Medicaid Low-Income Pool
6 Council; providing for membership and duties; amending s.
7 409.912, F.S.; authorizing the Agency for Health Care
8 Administration to contract with comprehensive behavioral
9 health plans in separate counties within or adjacent to an
10 AHCA area; providing that specified federally qualified
11 health centers or entities that are owned by one or more
12 federally qualified health centers are exempt from the
13 requirements imposed by law on health maintenance
14 organizations and health care services; providing
15 exceptions; conforming provisions to the solvency
16 requirements in s. 641.2261, F.S.; deleting the
17 competitive-procurement requirement for provider service
18 networks; updating a reference to the provider service
19 network; amending s. 409.91211, F.S.; specifying the
20 process for statewide expansion of the Medicaid managed
21 care demonstration program; requiring that matching funds
22 for the Medicaid managed care pilot program be provided by
23 local governmental entities; providing for distribution of
24 funds by the agency; providing legislative intent with
25 respect to the low-income pool plan required under the
26 Medicaid reform waiver; specifying the agency's powers,
27 duties, and responsibilities with respect to implementing
28 the Medicaid managed care pilot program; revising the

29 guidelines for allowing a provider service network to
30 receive fee-for-service payments in the demonstration
31 areas; authorizing the agency to make direct payments to
32 hospitals and physicians for the costs associated with
33 graduate medical education under Medicaid reform;
34 including the Children's Medical Services Network in the
35 Department of Health within those programs intended by the
36 Legislature to participate in the pilot program to the
37 extent possible; requiring that the agency implement
38 standards of quality assurance and performance improvement
39 in the demonstration areas of the pilot program; requiring
40 the agency to establish an encounter database to compile
41 data from managed care plans; requiring the agency to
42 implement procedures to minimize the risk of Medicaid
43 fraud and abuse in all managed care plans in the
44 demonstration areas; clarifying that the assignment
45 process for the pilot program is exempt from certain
46 mandatory procedures for Medicaid managed care enrollment
47 specified in s. 409.9122, F.S.; revising the automatic
48 assignment process in the demonstration areas; requiring
49 that the agency report any modifications to the approved
50 waiver and special terms and conditions to the Legislature
51 within specified time periods; authorizing the agency to
52 implement the provisions of the waiver approved by federal
53 Centers for Medicare and Medicaid Services; requiring the
54 Secretary of Health Care Administration to convene a
55 technical advisory panel to advise the agency in matters
56 relating to rate setting, benefit design, and choice

57 counseling; providing for panel members; providing certain
58 requirements for managed care plans providing benefits to
59 TANF and SSI recipients; providing for capitation rates to
60 be phased in; providing an exception for high-risk,
61 specialty populations; requiring the certification of
62 rates by an actuary and federal approval; providing that,
63 if any conflict exists between the provisions contained in
64 s. 409.91211, F.S., and ch. 409, F.S., concerning the
65 implementation of the pilot program, the provisions
66 contained in s. 409.91211, F.S., control; creating s.
67 409.91213, F.S.; requiring the agency to submit quarterly
68 and annual progress reports to the Legislature; providing
69 requirements for the reports; amending s. 641.2261, F.S.;
70 revising the application of solvency requirements to
71 include Medicaid provider service networks; updating a
72 reference; requiring that the agency report to the
73 Legislature the pre-implementation milestones concerning
74 the low-income pool which have been approved by the
75 Federal Government and the status of those remaining to be
76 approved; amending s. 216.346, F.S.; revising provisions
77 relating to contracts between state agencies; providing an
78 effective date.
79
80 Be It Enacted by the Legislature of the State of Florida:
81
82 Section 1. Subsection (9) of section 409.911, Florida
83 Statutes, is amended, and subsection (10) is added to that
84 section, to read:

85 409.911 Disproportionate share program.--Subject to
86 specific allocations established within the General
87 Appropriations Act and any limitations established pursuant to
88 chapter 216, the agency shall distribute, pursuant to this
89 section, moneys to hospitals providing a disproportionate share
90 of Medicaid or charity care services by making quarterly
91 Medicaid payments as required. Notwithstanding the provisions of
92 s. 409.915, counties are exempt from contributing toward the
93 cost of this special reimbursement for hospitals serving a
94 disproportionate share of low-income patients.
95 (9) The Agency for Health Care Administration shall create
96 a Medicaid Disproportionate Share Council.
97 (a) The purpose of the council is to study and make
98 recommendations regarding:
99 1. The formula for the regular disproportionate share
100 program and alternative financing options.
101 2. Enhanced Medicaid funding through the Special Medicaid
102 Payment program.
103 3. The federal status of the upper-payment-limit funding
104 option and how this option may be used to promote health care
105 initiatives determined by the council to be state health care
106 priorities.
107 4. The development of the low-income pool plan as required
108 by the federal Centers for Medicare and Medicaid Services using
109 the objectives established in s. 409.91211(1)(c).
110 (b) The council shall include representatives of the
111 Executive Office of the Governor and of the agency;
112 representatives from teaching, public, private nonprofit,

113 private for-profit, and family practice teaching hospitals; and
114 representatives from other groups as needed. The agency must
115 ensure that there is fair representation of each group specified
116 in this paragraph.
117 (c) The council shall submit its findings and
118 recommendations to the Governor and the Legislature no later
119 than March ~~February~~ 1 of each year.
120 (d) This subsection shall stand repealed June 30, 2006,
121 unless reviewed and saved from repeal through reenactment by the
122 Legislature.
123 (10) The Agency for Health Care Administration shall
124 create a Medicaid Low-Income Pool Council by July 1, 2006. The
125 Low-Income Pool Council shall consist of 17 members, including
126 three representatives of statutory teaching hospitals, three
127 representatives of public hospitals, three representatives of
128 nonprofit hospitals, three representatives of for-profit
129 hospitals, two representatives of rural hospitals, two
130 representatives of units of local government which contribute
131 funding, and one representative of family practice teaching
132 hospitals. The council shall:
133 (a) Make recommendations on the financing of the low-
134 income pool and the disproportionate share hospital program and
135 the distribution of their funds.
136 (b) Advise the Agency for Health Care Administration on
137 the development of the low-income pool plan required by the
138 federal Centers for Medicare and Medicaid Services pursuant to
139 the Medicaid reform waiver.

140 (c) Advise the Agency for Health Care Administration on
141 the distribution of hospital funds used to adjust inpatient
142 hospital rates, rebase rates, or otherwise exempt hospitals from
143 reimbursement limits as financed by intergovernmental transfers.
144 (d) Submit its findings and recommendations to the
145 Governor and the Legislature no later than February 1 of each
146 year.
147 Section 2. Paragraphs (b), (c), and (d) of subsection (4)
148 of section 409.912, Florida Statutes, are amended to read:
149 409.912 Cost-effective purchasing of health care.--The
150 agency shall purchase goods and services for Medicaid recipients
151 in the most cost-effective manner consistent with the delivery
152 of quality medical care. To ensure that medical services are
153 effectively utilized, the agency may, in any case, require a
154 confirmation or second physician's opinion of the correct
155 diagnosis for purposes of authorizing future services under the
156 Medicaid program. This section does not restrict access to
157 emergency services or poststabilization care services as defined
158 in 42 C.F.R. part 438.114. Such confirmation or second opinion
159 shall be rendered in a manner approved by the agency. The agency
160 shall maximize the use of prepaid per capita and prepaid
161 aggregate fixed-sum basis services when appropriate and other
162 alternative service delivery and reimbursement methodologies,
163 including competitive bidding pursuant to s. 287.057, designed
164 to facilitate the cost-effective purchase of a case-managed
165 continuum of care. The agency shall also require providers to
166 minimize the exposure of recipients to the need for acute
167 inpatient, custodial, and other institutional care and the

168 inappropriate or unnecessary use of high-cost services. The
169 agency shall contract with a vendor to monitor and evaluate the
170 clinical practice patterns of providers in order to identify
171 trends that are outside the normal practice patterns of a
172 provider's professional peers or the national guidelines of a
173 provider's professional association. The vendor must be able to
174 provide information and counseling to a provider whose practice
175 patterns are outside the norms, in consultation with the agency,
176 to improve patient care and reduce inappropriate utilization.
177 The agency may mandate prior authorization, drug therapy
178 management, or disease management participation for certain
179 populations of Medicaid beneficiaries, certain drug classes, or
180 particular drugs to prevent fraud, abuse, overuse, and possible
181 dangerous drug interactions. The Pharmaceutical and Therapeutics
182 Committee shall make recommendations to the agency on drugs for
183 which prior authorization is required. The agency shall inform
184 the Pharmaceutical and Therapeutics Committee of its decisions
185 regarding drugs subject to prior authorization. The agency is
186 authorized to limit the entities it contracts with or enrolls as
187 Medicaid providers by developing a provider network through
188 provider credentialing. The agency may competitively bid single-
189 source-provider contracts if procurement of goods or services
190 results in demonstrated cost savings to the state without
191 limiting access to care. The agency may limit its network based
192 on the assessment of beneficiary access to care, provider
193 availability, provider quality standards, time and distance
194 standards for access to care, the cultural competence of the
195 provider network, demographic characteristics of Medicaid

196 beneficiaries, practice and provider-to-beneficiary standards,
197 appointment wait times, beneficiary use of services, provider
198 turnover, provider profiling, provider licensure history,
199 previous program integrity investigations and findings, peer
200 review, provider Medicaid policy and billing compliance records,
201 clinical and medical record audits, and other factors. Providers
202 shall not be entitled to enrollment in the Medicaid provider
203 network. The agency shall determine instances in which allowing
204 Medicaid beneficiaries to purchase durable medical equipment and
205 other goods is less expensive to the Medicaid program than long-
206 term rental of the equipment or goods. The agency may establish
207 rules to facilitate purchases in lieu of long-term rentals in
208 order to protect against fraud and abuse in the Medicaid program
209 as defined in s. 409.913. The agency may seek federal waivers
210 necessary to administer these policies.
211 (4) The agency may contract with:
212 (b) An entity that is providing comprehensive behavioral
213 health care services to certain Medicaid recipients through a
214 capitated, prepaid arrangement pursuant to the federal waiver
215 provided for by s. 409.905(5). Such an entity must be licensed
216 under chapter 624, chapter 636, or chapter 641 and must possess
217 the clinical systems and operational competence to manage risk
218 and provide comprehensive behavioral health care to Medicaid
219 recipients. As used in this paragraph, the term "comprehensive
220 behavioral health care services" means covered mental health and
221 substance abuse treatment services that are available to
222 Medicaid recipients. The secretary of the Department of Children
223 and Family Services shall approve provisions of procurements

224 related to children in the department's care or custody prior to
225 enrolling such children in a prepaid behavioral health plan. Any
226 contract awarded under this paragraph must be competitively
227 procured. In developing the behavioral health care prepaid plan
228 procurement document, the agency shall ensure that the
229 procurement document requires the contractor to develop and
230 implement a plan to ensure compliance with s. 394.4574 related
231 to services provided to residents of licensed assisted living
232 facilities that hold a limited mental health license. Except as
233 provided in subparagraph 8., and except in counties where the
234 Medicaid managed care pilot program is authorized pursuant s.
235 409.91211, the agency shall seek federal approval to contract
236 with a single entity meeting these requirements to provide
237 comprehensive behavioral health care services to all Medicaid
238 recipients not enrolled in a Medicaid managed care plan
239 authorized under s. 409.91211 or a Medicaid health maintenance
240 organization in an AHCA area. In an AHCA area where the Medicaid
241 managed care pilot program is authorized pursuant to s.
242 409.91211 in one or more counties, the agency may procure a
243 contract with a single entity to serve the remaining counties as
244 an AHCA area or the remaining counties may be included with an
245 adjacent AHCA area and shall be subject to this paragraph. Each
246 entity must offer sufficient choice of providers in its network
247 to ensure recipient access to care and the opportunity to select
248 a provider with whom they are satisfied. The network shall
249 include all public mental health hospitals. To ensure unimpaired
250 access to behavioral health care services by Medicaid
251 recipients, all contracts issued pursuant to this paragraph

252 shall require 80 percent of the capitation paid to the managed
253 care plan, including health maintenance organizations, to be
254 expended for the provision of behavioral health care services.
255 In the event the managed care plan expends less than 80 percent
256 of the capitation paid pursuant to this paragraph for the
257 provision of behavioral health care services, the difference
258 shall be returned to the agency. The agency shall provide the
259 managed care plan with a certification letter indicating the
260 amount of capitation paid during each calendar year for the
261 provision of behavioral health care services pursuant to this
262 section. The agency may reimburse for substance abuse treatment
263 services on a fee-for-service basis until the agency finds that
264 adequate funds are available for capitated, prepaid
265 arrangements.
266 1. By January 1, 2001, the agency shall modify the
267 contracts with the entities providing comprehensive inpatient
268 and outpatient mental health care services to Medicaid
269 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
270 Counties, to include substance abuse treatment services.
271 2. By July 1, 2003, the agency and the Department of
272 Children and Family Services shall execute a written agreement
273 that requires collaboration and joint development of all policy,
274 budgets, procurement documents, contracts, and monitoring plans
275 that have an impact on the state and Medicaid community mental
276 health and targeted case management programs.
277 3. Except as provided in subparagraph 8., by July 1, 2006,
278 the agency and the Department of Children and Family Services
279 shall contract with managed care entities in each AHCA area

280 except area 6 or arrange to provide comprehensive inpatient and
281 outpatient mental health and substance abuse services through
282 capitated prepaid arrangements to all Medicaid recipients who
283 are eligible to participate in such plans under federal law and
284 regulation. In AHCA areas where eligible individuals number less
285 than 150,000, the agency shall contract with a single managed
286 care plan to provide comprehensive behavioral health services to
287 all recipients who are not enrolled in a Medicaid health
288 maintenance organization or a Medicaid capitated managed care
289 plan authorized under s. 409.91211. The agency may contract with
290 more than one comprehensive behavioral health provider to
291 provide care to recipients who are not enrolled in a Medicaid
292 capitated managed care plan authorized under s. 409.91211 or a
293 Medicaid health maintenance organization in AHCA areas where the
294 eligible population exceeds 150,000. In an AHCA area where the
295 Medicaid managed care pilot program is authorized pursuant to s.
296 409.91211 in one or more counties, the agency may procure a
297 contract with a single entity to serve the remaining counties as
298 an AHCA area or the remaining counties may be included with an
299 adjacent AHCA area and shall be subject to this paragraph.
300 Contracts for comprehensive behavioral health providers awarded
301 pursuant to this section shall be competitively procured. Both
302 for-profit and not-for-profit corporations shall be eligible to
303 compete. Managed care plans contracting with the agency under
304 subsection (3) shall provide and receive payment for the same
305 comprehensive behavioral health benefits as provided in AHCA
306 rules, including handbooks incorporated by reference. In AHCA
307 area 11, the agency shall contract with at least two

308 comprehensive behavioral health care providers to provide
309 behavioral health care to recipients in that area who are
310 enrolled in, or assigned to, the MediPass program. One of the
311 behavioral health care contracts shall be with the existing
312 provider service network pilot project, as described in
313 paragraph (d), for the purpose of demonstrating the cost-
314 effectiveness of the provision of quality mental health services
315 through a public hospital-operated managed care model. Payment
316 shall be at an agreed-upon capitated rate to ensure cost
317 savings. Of the recipients in area 11 who are assigned to
318 MediPass under the provisions of s. 409.9122(2)(k), a minimum of
319 50,000 of those MediPass-enrolled recipients shall be assigned
320 to the existing provider service network in area 11 for their
321 behavioral care.
322 4. By October 1, 2003, the agency and the department shall
323 submit a plan to the Governor, the President of the Senate, and
324 the Speaker of the House of Representatives which provides for
325 the full implementation of capitated prepaid behavioral health
326 care in all areas of the state.
327 a. Implementation shall begin in 2003 in those AHCA areas
328 of the state where the agency is able to establish sufficient
329 capitation rates.
330 b. If the agency determines that the proposed capitation
331 rate in any area is insufficient to provide appropriate
332 services, the agency may adjust the capitation rate to ensure
333 that care will be available. The agency and the department may
334 use existing general revenue to address any additional required

335 match but may not over-obligate existing funds on an annualized
336 basis.
337 c. Subject to any limitations provided for in the General
338 Appropriations Act, the agency, in compliance with appropriate
339 federal authorization, shall develop policies and procedures
340 that allow for certification of local and state funds.
341 5. Children residing in a statewide inpatient psychiatric
342 program, or in a Department of Juvenile Justice or a Department
343 of Children and Family Services residential program approved as
344 a Medicaid behavioral health overlay services provider shall not
345 be included in a behavioral health care prepaid health plan or
346 any other Medicaid managed care plan pursuant to this paragraph.
347 6. In converting to a prepaid system of delivery, the
348 agency shall in its procurement document require an entity
349 providing only comprehensive behavioral health care services to
350 prevent the displacement of indigent care patients by enrollees
351 in the Medicaid prepaid health plan providing behavioral health
352 care services from facilities receiving state funding to provide
353 indigent behavioral health care, to facilities licensed under
354 chapter 395 which do not receive state funding for indigent
355 behavioral health care, or reimburse the unsubsidized facility
356 for the cost of behavioral health care provided to the displaced
357 indigent care patient.
358 7. Traditional community mental health providers under
359 contract with the Department of Children and Family Services
360 pursuant to part IV of chapter 394, child welfare providers
361 under contract with the Department of Children and Family
362 Services in areas 1 and 6, and inpatient mental health providers

363 licensed pursuant to chapter 395 must be offered an opportunity
364 to accept or decline a contract to participate in any provider
365 network for prepaid behavioral health services.
366 8. For fiscal year 2004-2005, all Medicaid eligible
367 children, except children in areas 1 and 6, whose cases are open
368 for child welfare services in the HomeSafeNet system, shall be
369 enrolled in MediPass or in Medicaid fee-for-service and all
370 their behavioral health care services including inpatient,
371 outpatient psychiatric, community mental health, and case
372 management shall be reimbursed on a fee-for-service basis.
373 Beginning July 1, 2005, such children, who are open for child
374 welfare services in the HomeSafeNet system, shall receive their
375 behavioral health care services through a specialty prepaid plan
376 operated by community-based lead agencies either through a
377 single agency or formal agreements among several agencies. The
378 specialty prepaid plan must result in savings to the state
379 comparable to savings achieved in other Medicaid managed care
380 and prepaid programs. Such plan must provide mechanisms to
381 maximize state and local revenues. The specialty prepaid plan
382 shall be developed by the agency and the Department of Children
383 and Family Services. The agency is authorized to seek any
384 federal waivers to implement this initiative.
385 (c) A federally qualified health center or an entity owned
386 by one or more federally qualified health centers or an entity
387 owned by other migrant and community health centers receiving
388 non-Medicaid financial support from the Federal Government to
389 provide health care services on a prepaid or fixed-sum basis to
390 recipients. A federally qualified health center or an entity

391 that is owned by one or more federally qualified health centers
392 and is reimbursed by the agency on a prepaid basis is exempt
393 from parts I and III of chapter 641, but must comply with the
394 solvency requirements in s. 641.2261(2) and meet the appropriate
395 requirements governing financial reserve, quality assurance, and
396 patients' rights established by the agency. ~~Such prepaid health~~
397 ~~care services entity must be licensed under parts I and III of~~
398 ~~chapter 641, but shall be prohibited from serving Medicaid~~
399 ~~recipients on a prepaid basis, until such licensure has been~~
400 ~~obtained. However, such an entity is exempt from s. 641.225 if~~
401 ~~the entity meets the requirements specified in subsections (17)~~
402 ~~and (18).~~
403 (d) A provider service network may be reimbursed on a fee-
404 for-service or prepaid basis. A provider service network which
405 is reimbursed by the agency on a prepaid basis shall be exempt
406 from parts I and III of chapter 641, but must comply with the
407 solvency requirements in s. 641.2261(2) and meet appropriate
408 financial reserve, quality assurance, and patient rights
409 requirements as established by the agency. ~~The agency shall~~
410 ~~award contracts on a competitive bid basis and shall select~~
411 ~~bidders based upon price and quality of care.~~ Medicaid
412 recipients assigned to a provider service network ~~demonstration~~
413 ~~project~~ shall be chosen equally from those who would otherwise
414 have been assigned to prepaid plans and MediPass. The agency is
415 authorized to seek federal Medicaid waivers as necessary to
416 implement the provisions of this section. Any contract
417 previously awarded to a provider service network operated by a
418 hospital pursuant to this subsection shall remain in effect for

419 a period of 3 years following the current contract expiration
420 date, regardless of any contractual provisions to the contrary.
421 A provider service network is a network established or organized
422 and operated by a health care provider, or group of affiliated
423 health care providers, including minority physician networks and
424 emergency room diversion programs that meet the requirements of
425 s. 409.91211, which provides a substantial proportion of the
426 health care items and services under a contract directly through
427 the provider or affiliated group of providers and may make
428 arrangements with physicians or other health care professionals,
429 health care institutions, or any combination of such individuals
430 or institutions to assume all or part of the financial risk on a
431 prospective basis for the provision of basic health services by
432 the physicians, by other health professionals, or through the
433 institutions. The health care providers must have a controlling
434 interest in the governing body of the provider service network
435 organization.
436 Section 3. Section 409.91211, Florida Statutes, is amended
437 to read:
438 409.91211 Medicaid managed care pilot program.--
439 (1)(a) The agency is authorized to seek and implement
440 experimental, pilot, or demonstration project waivers, pursuant
441 to s. 1115 of the Social Security Act, to create a statewide
442 initiative to provide for a more efficient and effective service
443 delivery system that enhances quality of care and client
444 outcomes in the Florida Medicaid program pursuant to this
445 section. Phase one of the demonstration shall be implemented in
446 two geographic areas. One demonstration site shall include only

447 Broward County. A second demonstration site shall initially
448 include Duval County and shall be expanded to include Baker,
449 Clay, and Nassau Counties within 1 year after the Duval County
450 program becomes operational. The agency shall implement
451 expansion of the program to include the remaining counties of
452 the state and remaining eligibility groups in accordance with
453 the process specified in the federally-approved special terms
454 and conditions numbered 11-W-00206/4, as approved by the federal
455 Centers for Medicare and Medicaid Services on October 19, 2005,
456 with a goal of full statewide implementation by June 30, 2011.
457 (b) This waiver authority is contingent upon federal
458 approval to preserve the upper-payment-limit funding mechanism
459 for hospitals, including a guarantee of a reasonable growth
460 factor, a methodology to allow the use of a portion of these
461 funds to serve as a risk pool for demonstration sites,
462 provisions to preserve the state's ability to use
463 intergovernmental transfers, and provisions to protect the
464 disproportionate share program authorized pursuant to this
465 chapter. Upon completion of the evaluation conducted under s. 3,
466 ch. 2005-133, Laws of Florida, the agency may request statewide
467 expansion of the demonstration projects. Statewide phase-in to
468 additional counties shall be contingent upon review and approval
469 by the Legislature. Under the upper-payment-limit program, or
470 the low-income pool as implemented by the Agency for Health Care
471 Administration pursuant to federal waiver, the state matching
472 funds required for the program shall be provided by local
473 governmental entities through intergovernmental transfers in
474 accordance with published federal statutes and regulations. The

475 Agency for Health Care Administration shall distribute upper-
476 payment-limit, disproportionate share hospital, and low-income
477 pool funds according to published federal statutes, regulations,
478 and waivers and the low-income pool methodology approved by the
479 federal Centers for Medicare and Medicaid Services.
480 (c) It is the intent of the Legislature that the low-
481 income pool plan required by the terms and conditions of the
482 Medicaid reform waiver and submitted to the federal Centers for
483 Medicare and Medicaid Services propose the distribution of the
484 abovementioned program funds based on the following objectives:
485 1. Assure a broad and fair distribution of available funds
486 based on the access provided by Medicaid participating
487 hospitals, regardless of their ownership status, through their
488 delivery of inpatient or outpatient care for Medicaid
489 beneficiaries and uninsured and underinsured individuals;
490 2. Assure accessible emergency inpatient and outpatient
491 care for Medicaid beneficiaries and uninsured and underinsured
492 individuals;
493 3. Enhance primary, preventive, and other ambulatory care
494 coverages for uninsured individuals;
495 4. Promote teaching and specialty hospital programs;
496 5. Promote the stability and viability of statutorily
497 defined rural hospitals and hospitals that serve as sole
498 community hospitals;
499 6. Recognize the extent of hospital uncompensated care
500 costs;
501 7. Maintain and enhance essential community hospital care;

502 8. Maintain incentives for local governmental entities to
503 contribute to the cost of uncompensated care;
504 9. Promote measures to avoid preventable hospitalizations;
505 10. Account for hospital efficiency; and
506 11. Contribute to a community's overall health system.
507 (2) The Legislature intends for the capitated managed care
508 pilot program to:
509 (a) Provide recipients in Medicaid fee-for-service or the
510 MediPass program a comprehensive and coordinated capitated
511 managed care system for all health care services specified in
512 ss. 409.905 and 409.906.
513 (b) Stabilize Medicaid expenditures under the pilot
514 program compared to Medicaid expenditures in the pilot area for
515 the 3 years before implementation of the pilot program, while
516 ensuring:
517 1. Consumer education and choice.
518 2. Access to medically necessary services.
519 3. Coordination of preventative, acute, and long-term
520 care.
521 4. Reductions in unnecessary service utilization.
522 (c) Provide an opportunity to evaluate the feasibility of
523 statewide implementation of capitated managed care networks as a
524 replacement for the current Medicaid fee-for-service and
525 MediPass systems.
526 (3) The agency shall have the following powers, duties,
527 and responsibilities with respect to the ~~development of a~~ pilot
528 program:

529 (a) To implement ~~develop and recommend~~ a system to deliver
530 all mandatory services specified in s. 409.905 and optional
531 services specified in s. 409.906, as approved by the Centers for
532 Medicare and Medicaid Services and the Legislature in the waiver
533 pursuant to this section. Services to recipients under plan
534 benefits shall include emergency services provided under s.
535 409.9128.
536 (b) To implement a pilot program, including ~~recommend~~
537 Medicaid eligibility categories~~, from those~~ specified in ss.
538 409.903 and 409.904, as authorized in an approved federal waiver
539 ~~which shall be included in the pilot program~~.
540 (c) To implement ~~determine and recommend how to design~~ the
541 managed care pilot program that maximizes ~~in order to take~~
542 ~~maximum advantage of~~ all available state and federal funds,
543 including those obtained through intergovernmental transfers,
544 the low-income pool, supplemental Medicaid payments ~~the upper-~~
545 ~~payment-level funding systems~~, and the disproportionate share
546 program. Within the parameters allowed by federal statute and
547 rule, the agency may seek options for making direct payments to
548 hospitals and physicians employed by or under contract with the
549 state's medical schools for the costs associated with graduate
550 medical education under Medicaid reform.
551 (d) To implement ~~determine and recommend~~ actuarially
552 sound, risk-adjusted capitation rates for Medicaid recipients in
553 the pilot program which ~~can be separated to~~ cover comprehensive
554 care, enhanced services, and catastrophic care.
555 (e) To implement ~~determine and recommend~~ policies and
556 guidelines for phasing in financial risk for approved provider

557 service networks over a 3-year period. These policies and
558 guidelines must ~~shall~~ include an option for a provider service
559 network to be paid ~~to pay~~ fee-for-service rates ~~that may include~~
560 ~~a savings-settlement option for at least 2 years~~. For any
561 provider service network established in a managed care pilot
562 area, the option to be paid fee-for-service rates shall include
563 a savings-settlement mechanism that is consistent with s.
564 409.912(44). This model shall ~~may~~ be converted to a risk-
565 adjusted capitated rate no later than the beginning of the
566 fourth ~~in the third~~ year of operation, and may be converted
567 earlier at the option of the provider service network. Federally
568 qualified health centers may be offered an opportunity to accept
569 or decline a contract to participate in any provider network for
570 prepaid primary care services.
571 (f) To implement ~~determine and recommend provisions~~
572 ~~related to~~ stop-loss requirements and the transfer of excess
573 cost to catastrophic coverage that accommodates the risks
574 associated with the development of the pilot program.
575 (g) To ~~determine and~~ recommend a process to be used by the
576 Social Services Estimating Conference to determine and validate
577 the rate of growth of the per-member costs of providing Medicaid
578 services under the managed care pilot program.
579 (h) To implement ~~determine and recommend~~ program standards
580 and credentialing requirements for capitated managed care
581 networks to participate in the pilot program, including those
582 related to fiscal solvency, quality of care, and adequacy of
583 access to health care providers. It is the intent of the
584 Legislature that, to the extent possible, any pilot program

585 authorized by the state under this section include any federally
586 qualified health center, federally qualified rural health
587 clinic, county health department, the Children's Medical
588 Services Network within the Department of Health, or other
589 federally, state, or locally funded entity that serves the
590 geographic areas within the boundaries of the pilot program that
591 requests to participate. This paragraph does not relieve an
592 entity that qualifies as a capitated managed care network under
593 this section from any other licensure or regulatory requirements
594 contained in state or federal law which would otherwise apply to
595 the entity. The standards and credentialing requirements shall
596 be based upon, but are not limited to:
597 1. Compliance with the accreditation requirements as
598 provided in s. 641.512.
599 2. Compliance with early and periodic screening,
600 diagnosis, and treatment screening requirements under federal
601 law.
602 3. The percentage of voluntary disenrollments.
603 4. Immunization rates.
604 5. Standards of the National Committee for Quality
605 Assurance and other approved accrediting bodies.
606 6. Recommendations of other authoritative bodies.
607 7. Specific requirements of the Medicaid program, or
608 standards designed to specifically meet the unique needs of
609 Medicaid recipients.
610 8. Compliance with the health quality improvement system
611 as established by the agency, which incorporates standards and

612 guidelines developed by the Centers for Medicare and Medicaid
613 Services as part of the quality assurance reform initiative.
614 9. The network's infrastructure capacity to manage
615 financial transactions, recordkeeping, data collection, and
616 other administrative functions.
617 10. The network's ability to submit any financial,
618 programmatic, or patient-encounter data or other information
619 required by the agency to determine the actual services provided
620 and the cost of administering the plan.
621 (i) To implement ~~develop and recommend~~ a mechanism for
622 providing information to Medicaid recipients for the purpose of
623 selecting a capitated managed care plan. For each plan available
624 to a recipient, the agency, at a minimum, shall ensure that the
625 recipient is provided with:
626 1. A list and description of the benefits provided.
627 2. Information about cost sharing.
628 3. Plan performance data, if available.
629 4. An explanation of benefit limitations.
630 5. Contact information, including identification of
631 providers participating in the network, geographic locations,
632 and transportation limitations.
633 6. Any other information the agency determines would
634 facilitate a recipient's understanding of the plan or insurance
635 that would best meet his or her needs.
636 (j) To implement ~~develop and recommend~~ a system to ensure
637 that there is a record of recipient acknowledgment that choice
638 counseling has been provided.

639 (k) To implement ~~develop and recommend~~ a choice counseling
640 system to ensure that the choice counseling process and related
641 material are designed to provide counseling through face-to-face
642 interaction, by telephone, and in writing and through other
643 forms of relevant media. Materials shall be written at the
644 fourth-grade reading level and available in a language other
645 than English when 5 percent of the county speaks a language
646 other than English. Choice counseling shall also use language
647 lines and other services for impaired recipients, such as
648 TTD/TTY.
649 (l) To implement ~~develop and recommend~~ a system that
650 prohibits capitated managed care plans, their representatives,
651 and providers employed by or contracted with the capitated
652 managed care plans from recruiting persons eligible for or
653 enrolled in Medicaid, from providing inducements to Medicaid
654 recipients to select a particular capitated managed care plan,
655 and from prejudicing Medicaid recipients against other capitated
656 managed care plans. The system shall require the entity
657 performing choice counseling to determine if the recipient has
658 made a choice of a plan or has opted out because of duress,
659 threats, payment to the recipient, or incentives promised to the
660 recipient by a third party. If the choice counseling entity
661 determines that the decision to choose a plan was unlawfully
662 influenced or a plan violated any of the provisions of s.
663 409.912(21), the choice counseling entity shall immediately
664 report the violation to the agency's program integrity section
665 for investigation. Verification of choice counseling by the

666 recipient shall include a stipulation that the recipient
667 acknowledges the provisions of this subsection.
668 (m) To implement ~~develop and recommend~~ a choice counseling
669 system that promotes health literacy and provides information
670 aimed to reduce minority health disparities through outreach
671 activities for Medicaid recipients.
672 (n) To ~~develop and recommend a system for the agency to~~
673 contract with entities to perform choice counseling. The agency
674 may establish standards and performance contracts, including
675 standards requiring the contractor to hire choice counselors who
676 are representative of the state's diverse population and to
677 train choice counselors in working with culturally diverse
678 populations.
679 (o) To implement ~~determine and recommend descriptions of~~
680 ~~the~~ eligibility assignment processes ~~which will be used~~ to
681 facilitate client choice while ensuring pilot programs of
682 adequate enrollment levels. These processes shall ensure that
683 pilot sites have sufficient levels of enrollment to conduct a
684 valid test of the managed care pilot program within a 2-year
685 timeframe.
686 (p) To implement standards for plan compliance, including,
687 but not limited to, standards for quality assurance and
688 performance improvement, standards for peer or professional
689 reviews, grievance policies, and policies for maintaining
690 program integrity. The agency shall develop a data-reporting
691 system, seek input from managed care plans in order to establish
692 requirements for patient-encounter reporting, and ensure that
693 the data reported is accurate and complete.

694 1. In performing the duties required under this section,
695 the agency shall work with managed care plans to establish a
696 uniform system to measure and monitor outcomes for a recipient
697 of Medicaid services.
698 2. The system shall use financial, clinical, and other
699 criteria based on pharmacy, medical services, and other data
700 that is related to the provision of Medicaid services,
701 including, but not limited to:
702 a. The Health Plan Employer Data and Information Set
703 (HEDIS) or measures that are similar to HEDIS.
704 b. Member satisfaction.
705 c. Provider satisfaction.
706 d. Report cards on plan performance and best practices.
707 e. Compliance with the requirements for prompt payment of
708 claims under ss. 627.613, 641.3155, and 641.513.
709 f. Utilization and quality data for the purpose of
710 ensuring access to medically necessary services, including
711 underutilization or inappropriate denial of services.
712 3. The agency shall require the managed care plans that
713 have contracted with the agency to establish a quality assurance
714 system that incorporates the provisions of s. 409.912(27) and
715 any standards, rules, and guidelines developed by the agency.
716 4. The agency shall establish an encounter database in
717 order to compile data on health services rendered by health care
718 practitioners who provide services to patients enrolled in
719 managed care plans in the demonstration sites. The encounter
720 database shall:

721 a. Collect the following for each type of patient
722 encounter with a health care practitioner or facility,
723 including:
724 (I) The demographic characteristics of the patient.
725 (II) The principal, secondary, and tertiary diagnosis.
726 (III) The procedure performed.
727 (IV) The date and location where the procedure was
728 performed.
729 (V) The payment for the procedure, if any.
730 (VI) If applicable, the health care practitioner's
731 universal identification number.
732 (VII) If the health care practitioner rendering the
733 service is a dependent practitioner, the modifiers appropriate
734 to indicate that the service was delivered by the dependent
735 practitioner.
736 b. Collect appropriate information relating to
737 prescription drugs for each type of patient encounter.
738 c. Collect appropriate information related to health care
739 costs and utilization from managed care plans participating in
740 the demonstration sites.
741 5. To the extent practicable, when collecting the data the
742 agency shall use a standardized claim form or electronic
743 transfer system that is used by health care practitioners,
744 facilities, and payors.
745 6. Health care practitioners and facilities in the
746 demonstration sites shall electronically submit, and managed
747 care plans participating in the demonstration sites shall
748 electronically receive, information concerning claims payments

749 and any other information reasonably related to the encounter
750 database using a standard format as required by the agency.
751 7. The agency shall establish reasonable deadlines for
752 phasing in the electronic transmittal of full encounter data.
753 8. The system must ensure that the data reported is
754 accurate and complete.
755 ~~(p) To develop and recommend a system to monitor the~~
756 ~~provision of health care services in the pilot program,~~
757 ~~including utilization and quality of health care services for~~
758 ~~the purpose of ensuring access to medically necessary services.~~
759 ~~This system shall include an encounter data-information system~~
760 ~~that collects and reports utilization information. The system~~
761 ~~shall include a method for verifying data integrity within the~~
762 ~~database and within the provider's medical records.~~
763 (q) To implement ~~recommend~~ a grievance resolution process
764 for Medicaid recipients enrolled in a capitated managed care
765 network under the pilot program modeled after the subscriber
766 assistance panel, as created in s. 408.7056. This process shall
767 include a mechanism for an expedited review of no greater than
768 24 hours after notification of a grievance if the life of a
769 Medicaid recipient is in imminent and emergent jeopardy.
770 (r) To implement ~~recommend~~ a grievance resolution process
771 for health care providers employed by or contracted with a
772 capitated managed care network under the pilot program in order
773 to settle disputes among the provider and the managed care
774 network or the provider and the agency.
775 (s) To implement ~~develop and recommend~~ criteria in an
776 approved federal waiver to designate health care providers as

777 eligible to participate in the pilot program. ~~The agency and~~
778 ~~capitated managed care networks must follow national guidelines~~
779 ~~for selecting health care providers, whenever available.~~ These
780 criteria must include at a minimum those criteria specified in
781 s. 409.907.
782 (t) To use ~~develop and recommend~~ health care provider
783 agreements for participation in the pilot program.
784 (u) To require that all health care providers under
785 contract with the pilot program be duly licensed in the state,
786 if such licensure is available, and meet other criteria as may
787 be established by the agency. These criteria shall include at a
788 minimum those criteria specified in s. 409.907.
789 (v) To ensure that managed care organizations work
790 collaboratively ~~develop and recommend agreements~~ with other
791 state or local governmental programs or institutions for the
792 coordination of health care to eligible individuals receiving
793 services from such programs or institutions.
794 (w) To implement procedures to minimize the risk of
795 Medicaid fraud and abuse in all plans operating in the Medicaid
796 managed care pilot program authorized in this section.
797 1. The agency shall ensure that applicable provisions of
798 this chapter and chapters 414, 626, 641, and 932 which relate to
799 Medicaid fraud and abuse are applied and enforced at the
800 demonstration project sites.
801 2. Providers must have the certification, license, and
802 credentials that are required by law and waiver requirements.
803 3. The agency shall ensure that the plan is in compliance
804 with s. 409.912(21) and (22).

805 4. The agency shall require that each plan establish
806 functions and activities governing program integrity in order to
807 reduce the incidence of fraud and abuse. Plans must report
808 instances of fraud and abuse pursuant to chapter 641.
809 5. The plan shall have written administrative and
810 management arrangements or procedures, including a mandatory
811 compliance plan, which are designed to guard against fraud and
812 abuse. The plan shall designate a compliance officer who has
813 sufficient experience in health care.
814 6.a. The agency shall require all managed care plan
815 contractors in the pilot program to report all instances of
816 suspected fraud and abuse. A failure to report instances of
817 suspected fraud and abuse is a violation of law and subject to
818 the penalties provided by law.
819 b. An instance of fraud and abuse in the managed care
820 plan, including, but not limited to, defrauding the state health
821 care benefit program by misrepresentation of fact in reports,
822 claims, certifications, enrollment claims, demographic
823 statistics, or patient-encounter data; misrepresentation of the
824 qualifications of persons rendering health care and ancillary
825 services; bribery and false statements relating to the delivery
826 of health care; unfair and deceptive marketing practices; and
827 false claims actions in the provision of managed care, is a
828 violation of law and subject to the penalties provided by law.
829 c. The agency shall require that all contractors make all
830 files and relevant billing and claims data accessible to state
831 regulators and investigators and that all such data is linked

832 into a unified system to ensure consistent reviews and
833 investigations.
834 ~~(w) To develop and recommend a system to oversee the~~
835 ~~activities of pilot program participants, health care providers,~~
836 ~~capitated managed care networks, and their representatives in~~
837 ~~order to prevent fraud or abuse, overutilization or duplicative~~
838 ~~utilization, underutilization or inappropriate denial of~~
839 ~~services, and neglect of participants and to recover~~
840 ~~overpayments as appropriate. For the purposes of this paragraph,~~
841 ~~the terms "abuse" and "fraud" have the meanings as provided in~~
842 ~~s. 409.913. The agency must refer incidents of suspected fraud,~~
843 ~~abuse, overutilization and duplicative utilization, and~~
844 ~~underutilization or inappropriate denial of services to the~~
845 ~~appropriate regulatory agency.~~
846 (x) To develop and provide actuarial and benefit design
847 analyses that indicate the effect on capitation rates and
848 benefits offered in the pilot program over a prospective 5-year
849 period based on the following assumptions:
850 1. Growth in capitation rates which is limited to the
851 estimated growth rate in general revenue.
852 2. Growth in capitation rates which is limited to the
853 average growth rate over the last 3 years in per-recipient
854 Medicaid expenditures.
855 3. Growth in capitation rates which is limited to the
856 growth rate of aggregate Medicaid expenditures between the 2003-
857 2004 fiscal year and the 2004-2005 fiscal year.
858 (y) To develop a mechanism to require capitated managed
859 care plans to reimburse qualified emergency service providers,

860 including, but not limited to, ambulance services, in accordance
861 with ss. 409.908 and 409.9128. The pilot program must include a
862 provision for continuing fee-for-service payments for emergency
863 services, including, but not limited to, individuals who access
864 ambulance services or emergency departments and who are
865 subsequently determined to be eligible for Medicaid services.
866 (z) To ensure that ~~develop a system whereby~~ school
867 districts participating in the certified school match program
868 pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by
869 Medicaid, subject to the limitations of s. 1011.70(1), for a
870 Medicaid-eligible child participating in the services as
871 authorized in s. 1011.70, as provided for in s. 409.9071,
872 regardless of whether the child is enrolled in a capitated
873 managed care network. Capitated managed care networks must make
874 a good faith effort to execute agreements with school districts
875 regarding the coordinated provision of services authorized under
876 s. 1011.70. County health departments and federal qualified
877 health centers delivering school-based services pursuant to ss.
878 381.0056 and 381.0057 must be reimbursed by Medicaid for the
879 federal share for a Medicaid-eligible child who receives
880 Medicaid-covered services in a school setting, regardless of
881 whether the child is enrolled in a capitated managed care
882 network. Capitated managed care networks must make a good faith
883 effort to execute agreements with county health departments and
884 federally qualified health centers regarding the coordinated
885 provision of services to a Medicaid-eligible child. To ensure
886 continuity of care for Medicaid patients, the agency, the
887 Department of Health, and the Department of Education shall

888 develop procedures for ensuring that a student's capitated
889 managed care network provider receives information relating to
890 services provided in accordance with ss. 381.0056, 381.0057,
891 409.9071, and 1011.70.
892 (aa) To implement ~~develop and recommend~~ a mechanism
893 whereby Medicaid recipients who are already enrolled in a
894 managed care plan or the MediPass program in the pilot areas
895 shall be offered the opportunity to change to capitated managed
896 care plans on a staggered basis, as defined by the agency. All
897 Medicaid recipients shall have 30 days in which to make a choice
898 of capitated managed care plans. Those Medicaid recipients who
899 do not make a choice shall be assigned to a capitated managed
900 care plan in accordance with paragraph (4)(a) and shall be
901 exempt from s. 409.9122. To facilitate continuity of care for a
902 Medicaid recipient who is also a recipient of Supplemental
903 Security Income (SSI), prior to assigning the SSI recipient to a
904 capitated managed care plan, the agency shall determine whether
905 the SSI recipient has an ongoing relationship with a provider or
906 capitated managed care plan, and, if so, the agency shall assign
907 the SSI recipient to that provider or capitated managed care
908 plan where feasible. Those SSI recipients who do not have such a
909 provider relationship shall be assigned to a capitated managed
910 care plan provider in accordance with paragraph (4)(a) and shall
911 be exempt from s. 409.9122.
912 (bb) To develop and recommend a service delivery
913 alternative for children having chronic medical conditions which
914 establishes a medical home project to provide primary care
915 services to this population. The project shall provide

916 community-based primary care services that are integrated with
917 other subspecialties to meet the medical, developmental, and
918 emotional needs for children and their families. This project
919 shall include an evaluation component to determine impacts on
920 hospitalizations, length of stays, emergency room visits, costs,
921 and access to care, including specialty care and patient and
922 family satisfaction.
923 (cc) To develop and recommend service delivery mechanisms
924 within capitated managed care plans to provide Medicaid services
925 as specified in ss. 409.905 and 409.906 to persons with
926 developmental disabilities sufficient to meet the medical,
927 developmental, and emotional needs of these persons.
928 (dd) To develop and recommend service delivery mechanisms
929 within capitated managed care plans to provide Medicaid services
930 as specified in ss. 409.905 and 409.906 to Medicaid-eligible
931 children in foster care. These services must be coordinated with
932 community-based care providers as specified in s. 409.1675,
933 where available, and be sufficient to meet the medical,
934 developmental, and emotional needs of these children.
935 (4)(a) A Medicaid recipient in the pilot area who is not
936 currently enrolled in a capitated managed care plan upon
937 implementation is not eligible for services as specified in ss.
938 409.905 and 409.906, for the amount of time that the recipient
939 does not enroll in a capitated managed care network. If a
940 Medicaid recipient has not enrolled in a capitated managed care
941 plan within 30 days after eligibility, the agency shall assign
942 the Medicaid recipient to a capitated managed care plan based on
943 the assessed needs of the recipient as determined by the agency

944 and the recipient shall be exempt from s. 409.9122. When making
945 assignments, the agency shall take into account the following
946 criteria:
947 1. A capitated managed care network has sufficient network
948 capacity to meet the needs of members.
949 2. The capitated managed care network has previously
950 enrolled the recipient as a member, or one of the capitated
951 managed care network's primary care providers has previously
952 provided health care to the recipient.
953 3. The agency has knowledge that the member has previously
954 expressed a preference for a particular capitated managed care
955 network as indicated by Medicaid fee-for-service claims data,
956 but has failed to make a choice.
957 4. The capitated managed care network's primary care
958 providers are geographically accessible to the recipient's
959 residence.
960 (b) When more than one capitated managed care network
961 provider meets the criteria specified in paragraph (3)(h), the
962 agency shall make recipient assignments consecutively by family
963 unit.
964 (c) If a recipient is currently enrolled with a Medicaid
965 managed care organization that also operates an approved reform
966 plan within a demonstration area and the recipient fails to
967 choose a plan during the reform enrollment process or during
968 redetermination of eligibility, the recipient shall be
969 automatically assigned by the agency into the most appropriate
970 reform plan operated by the recipient's current Medicaid managed
971 care plan. If the recipient's current managed care plan does not

972 operate a reform plan in the demonstration area which adequately
973 meets the needs of the Medicaid recipient, the agency shall use
974 the automatic assignment process as prescribed in the special
975 terms and conditions numbered 11-W-00206/4. All enrollment and
976 choice counseling materials provided by the agency must contain
977 an explanation of the provisions of this paragraph for current
978 managed care recipients.
979 (d) ~~(c)~~ The agency may not engage in practices that are
980 designed to favor one capitated managed care plan over another
981 or that are designed to influence Medicaid recipients to enroll
982 in a particular capitated managed care network in order to
983 strengthen its particular fiscal viability.
984 (e) ~~(d)~~ After a recipient has made a selection or has been
985 enrolled in a capitated managed care network, the recipient
986 shall have 90 days in which to voluntarily disenroll and select
987 another capitated managed care network. After 90 days, no
988 further changes may be made except for cause. Cause shall
989 include, but not be limited to, poor quality of care, lack of
990 access to necessary specialty services, an unreasonable delay or
991 denial of service, inordinate or inappropriate changes of
992 primary care providers, service access impairments due to
993 significant changes in the geographic location of services, or
994 fraudulent enrollment. The agency may require a recipient to use
995 the capitated managed care network's grievance process as
996 specified in paragraph (3)(g) prior to the agency's
997 determination of cause, except in cases in which immediate risk
998 of permanent damage to the recipient's health is alleged. The
999 grievance process, when used, must be completed in time to

1000 permit the recipient to disenroll no later than the first day of
1001 the second month after the month the disenrollment request was
1002 made. If the capitated managed care network, as a result of the
1003 grievance process, approves an enrollee's request to disenroll,
1004 the agency is not required to make a determination in the case.
1005 The agency must make a determination and take final action on a
1006 recipient's request so that disenrollment occurs no later than
1007 the first day of the second month after the month the request
1008 was made. If the agency fails to act within the specified
1009 timeframe, the recipient's request to disenroll is deemed to be
1010 approved as of the date agency action was required. Recipients
1011 who disagree with the agency's finding that cause does not exist
1012 for disenrollment shall be advised of their right to pursue a
1013 Medicaid fair hearing to dispute the agency's finding.
1014 <u>(f)</u> ~~(e)~~ The agency shall apply for federal waivers from the
1015 Centers for Medicare and Medicaid Services to lock eligible
1016 Medicaid recipients into a capitated managed care network for 12
1017 months after an open enrollment period. After 12 months of
1018 enrollment, a recipient may select another capitated managed
1019 care network. However, nothing shall prevent a Medicaid
1020 recipient from changing primary care providers within the
1021 capitated managed care network during the 12-month period.
1022 <u>(g)</u> ~~(f)~~ The agency shall apply for federal waivers from the
1023 Centers for Medicare and Medicaid Services to allow recipients
1024 to purchase health care coverage through an employer-sponsored
1025 health insurance plan instead of through a Medicaid-certified
1026 plan. This provision shall be known as the opt-out option.

1027 1. A recipient who chooses the Medicaid opt-out option
1028 shall have an opportunity for a specified period of time, as
1029 authorized under a waiver granted by the Centers for Medicare
1030 and Medicaid Services, to select and enroll in a Medicaid-
1031 certified plan. If the recipient remains in the employer-
1032 sponsored plan after the specified period, the recipient shall
1033 remain in the opt-out program for at least 1 year or until the
1034 recipient no longer has access to employer-sponsored coverage,
1035 until the employer's open enrollment period for a person who
1036 opts out in order to participate in employer-sponsored coverage,
1037 or until the person is no longer eligible for Medicaid,
1038 whichever time period is shorter.
1039 2. Notwithstanding any other provision of this section,
1040 coverage, cost sharing, and any other component of employer-
1041 sponsored health insurance shall be governed by applicable state
1042 and federal laws.
1043 (5) This section does not authorize the agency to
1044 implement any provision of s. 1115 of the Social Security Act
1045 experimental, pilot, or demonstration project waiver to reform
1046 the state Medicaid program in any part of the state other than
1047 the two geographic areas specified in this section unless
1048 approved by the Legislature.
1049 (6) The agency shall develop and submit for approval
1050 applications for waivers of applicable federal laws and
1051 regulations as necessary to implement the managed care pilot
1052 project as defined in this section. The agency shall post all
1053 waiver applications under this section on its Internet website
1054 30 days before submitting the applications to the United States

1055 Centers for Medicare and Medicaid Services. All waiver
1056 applications shall be provided for review and comment to the
1057 appropriate committees of the Senate and House of
1058 Representatives for at least 10 working days prior to
1059 submission. All waivers submitted to and approved by the United
1060 States Centers for Medicare and Medicaid Services under this
1061 section must be approved by the Legislature. Federally approved
1062 waivers must be submitted to the President of the Senate and the
1063 Speaker of the House of Representatives for referral to the
1064 appropriate legislative committees. The appropriate committees
1065 shall recommend whether to approve the implementation of any
1066 waivers to the Legislature as a whole. The agency shall submit a
1067 plan containing a recommended timeline for implementation of any
1068 waivers and budgetary projections of the effect of the pilot
1069 program under this section on the total Medicaid budget for the
1070 2006-2007 through 2009-2010 state fiscal years. This
1071 implementation plan shall be submitted to the President of the
1072 Senate and the Speaker of the House of Representatives at the
1073 same time any waivers are submitted for consideration by the
1074 Legislature. The agency may implement the waiver and special
1075 terms and conditions numbered 11-W-00206/4, as approved by the
1076 federal Centers for Medicare and Medicaid Services. If the
1077 agency seeks approval by the Federal Government of any
1078 modifications to these special terms and conditions, the agency
1079 must provide written notification of its intent to modify these
1080 terms and conditions to the President of the Senate and the
1081 Speaker of the House of Representatives at least 15 days before
1082 submitting the modifications to the Federal Government for

1083 consideration. The notification must identify all modifications
1084 being pursued and the reason the modifications are needed. Upon
1085 receiving federal approval of any modifications to the special
1086 terms and conditions, the agency shall provide a report to the
1087 Legislature describing the federally approved modifications to
1088 the special terms and conditions within 7 days after approval by
1089 the Federal Government.
1090 (7)(a) The Secretary of Health Care Administration shall
1091 convene a technical advisory panel to advise the agency in the
1092 areas of risk-adjusted-rate setting, benefit design, and choice
1093 counseling. The panel shall include representatives from the
1094 Florida Association of Health Plans, representatives from
1095 provider-sponsored networks, a Medicaid consumer representative,
1096 and a representative from the Office of Insurance Regulation.
1097 (b) The technical advisory panel shall advise the agency
1098 concerning:
1099 1. The risk-adjusted rate methodology to be used by the
1100 agency, including recommendations on mechanisms to recognize the
1101 risk of all Medicaid enrollees and for the transition to a risk-
1102 adjustment system, including recommendations for phasing in risk
1103 adjustment and the use of risk corridors.
1104 2. Implementation of an encounter data system to be used
1105 for risk-adjusted rates.
1106 3. Administrative and implementation issues regarding the
1107 use of risk-adjusted rates, including, but not limited to, cost,
1108 simplicity, client privacy, data accuracy, and data exchange.
1109 4. Issues of benefit design, including the actuarial
1110 equivalence and sufficiency standards to be used.

1111 5. The implementation plan for the proposed choice-
1112 counseling system, including the information and materials to be
1113 provided to recipients, the methodologies by which recipients
1114 will be counseled regarding choice, criteria to be used to
1115 assess plan quality, the methodology to be used to assign
1116 recipients into plans if they fail to choose a managed care
1117 plan, and the standards to be used for responsiveness to
1118 recipient inquiries.
1119 (c) The technical advisory panel shall continue in
1120 existence and advise the agency on matters outlined in this
1121 subsection.
1122 (8) The agency must ensure, in the first two state fiscal
1123 years in which a risk-adjusted methodology is a component of
1124 rate setting, that no managed care plan providing comprehensive
1125 benefits to TANF and SSI recipients has an aggregate risk score
1126 that varies by more than 10 percent from the aggregate weighted
1127 mean of all managed care plans providing comprehensive benefits
1128 to TANF and SSI recipients in a reform area. The agency's
1129 payment to a managed care plan shall be based on such revised
1130 aggregate risk score.
1131 (9) After any calculations of aggregate risk scores or
1132 revised aggregate risk scores in subsection (8), the capitation
1133 rates for plans participating under s. 409.91211 shall be phased
1134 in as follows:
1135 (a) In the first year, the capitation rates shall be
1136 weighted so that 75 percent of each capitation rate is based on
1137 the current methodology and 25 percent is based on a new risk-
1138 adjusted capitation rate methodology.

1139 (b) In the second year, the capitation rates shall be
1140 weighted so that 50 percent of each capitation rate is based on
1141 the current methodology and 50 percent is based on a new risk-
1142 adjusted rate methodology.
1143 (c) In the following fiscal year, the risk-adjusted
1144 capitation methodology may be fully implemented.
1145 (10) Subsections (8) and (9) do not apply to managed care
1146 plans offering benefits exclusively to high-risk, specialty
1147 populations. The agency may set risk-adjusted rates immediately
1148 for such plans.
1149 (11) Before the implementation of risk-adjusted rates, the
1150 rates shall be certified by an actuary and approved by the
1151 federal Centers for Medicare and Medicaid Services.
1152 (12) For purposes of this section, the term "capitated
1153 managed care plan" includes health insurers authorized under
1154 chapter 624, exclusive provider organizations authorized under
1155 chapter 627, health maintenance organizations authorized under
1156 chapter 641, the Children's Medical Services Network under
1157 chapter 391, and provider service networks that elect to be paid
1158 fee-for-service for up to 3 years as authorized under this
1159 section.
1160 (13) ~~(7)~~ Upon review and approval of the applications for
1161 waivers of applicable federal laws and regulations to implement
1162 the managed care pilot program by the Legislature, the agency
1163 may initiate adoption of rules pursuant to ss. 120.536(1) and
1164 120.54 to implement and administer the managed care pilot
1165 program as provided in this section.

1166 (14) It is the intent of the Legislature that if any
1167 conflict exists between the provisions contained in this section
1168 and other provisions of this chapter which relate to the
1169 implementation of the Medicaid managed care pilot program, the
1170 provisions contained in this section shall control. The agency
1171 shall provide a written report to the Legislature by April 1,
1172 2006, identifying any provisions of this chapter which conflict
1173 with the implementation of the Medicaid managed care pilot
1174 program created in this section. After April 1, 2006, the agency
1175 shall provide a written report to the Legislature immediately
1176 upon identifying any provisions of this chapter which conflict
1177 with the implementation of the Medicaid managed care pilot
1178 program created in this section.
1179 Section 4. Section 409.91213, Florida Statutes, is created
1180 to read:
1181 409.91213 Quarterly progress reports and annual reports.--
1182 (1) The agency shall submit to the Governor, the President
1183 of the Senate, the Speaker of the House of Representatives, the
1184 Minority Leader of the Senate, the Minority Leader of the House
1185 of Representatives, and the Office of Program Policy Analysis
1186 and Government Accountability the following reports:
1187 (a) The quarterly progress report submitted to the United
1188 States Centers for Medicare and Medicaid Services no later than
1189 60 days following the end of each quarter. The intent of this
1190 report is to present the agency's analysis and the status of
1191 various operational areas. The quarterly progress report must
1192 include, but need not be limited to:

1193 1. Events occurring during the quarter or anticipated to
1194 occur in the near future which affect health care delivery,
1195 including, but not limited to, the approval of and contracts for
1196 new plans, which report must specify the coverage area, phase-in
1197 period, populations served, and benefits; the enrollment;
1198 grievances; and other operational issues.
1199 2. Action plans for addressing any policy and
1200 administrative issues.
1201 3. Agency efforts related to collecting and verifying
1202 encounter data and utilization data.
1203 4. Enrollment data disaggregated by plan and by
1204 eligibility category, such as Temporary Assistance for Needy
1205 Families or Supplemental Security Income; the total number of
1206 enrollees; market share; and the percentage change in enrollment
1207 by plan. In addition, the agency shall provide a summary of
1208 voluntary and mandatory selection rates and disenrollment data.
1209 5. For purposes of monitoring budget neutrality,
1210 enrollment data, member-month data, and expenditures in the
1211 format for monitoring budget neutrality which is provided by the
1212 federal Centers for Medicare and Medicaid Services.
1213 6. Activities and associated expenditures of the low-
1214 income pool.
1215 7. Activities related to the implementation of choice
1216 counseling, including efforts to improve health literacy and the
1217 methods used to obtain public input, such as recipient focus
1218 groups.
1219 8. Participation rates in the enhanced benefit accounts
1220 program, including participation levels; a summary of activities

1221 and associated expenditures; the number of accounts established,
1222 including active participants and individuals who continue to
1223 retain access to funds in an account but who no longer actively
1224 participate; an estimate of quarterly deposits in the accounts;
1225 and expenditures from the accounts.
1226 9. Enrollment data concerning employer-sponsored insurance
1227 which document the number of individuals selecting to opt out
1228 when employer-sponsored insurance is available. The agency shall
1229 include data that identify enrollee characteristics, including
1230 the eligibility category, type of employer-sponsored insurance,
1231 and type of coverage, such as individual or family coverage. The
1232 agency shall develop and maintain disenrollment reports
1233 specifying the reason for disenrollment in an employer-sponsored
1234 insurance program. The agency shall also track and report on
1235 those enrollees who elect the option to reenroll in the Medicaid
1236 reform demonstration.
1237 10. Progress toward meeting the demonstration goals.
1238 11. Evaluation activities.
1239 (b) An annual report documenting accomplishments, project
1240 status, quantitative and case-study findings, utilization data,
1241 and policy and administrative difficulties in the operation of
1242 the Medicaid waiver demonstration program. The agency shall
1243 submit the draft annual report no later than October 1 after the
1244 end of each fiscal year.
1245 (2) Beginning with the annual report for demonstration
1246 year two, the agency shall include a section concerning the
1247 administration of enhanced benefit accounts, the participation

1248 rates, an assessment of expenditures, and an assessment of
1249 potential cost savings.
1250 (3) Beginning with the annual report for demonstration
1251 year four, the agency shall include a section that provides
1252 qualitative and quantitative data describing the impact the low-
1253 income pool has had on the rate of uninsured people in this
1254 state, beginning with the implementation of the demonstration
1255 program.
1256 Section 5. Section 641.2261, Florida Statutes, is amended
1257 to read:
1258 641.2261 Application of federal solvency requirements to
1259 provider-sponsored organizations and Medicaid provider service
1260 networks.--
1261 (1) The solvency requirements of ss. 1855 and 1856 of the
1262 Balanced Budget Act of 1997 and 42 C.F.R. 422.350, subpart H,
1263 rules adopted by the Secretary of the United States Department
1264 of Health and Human Services apply to a health maintenance
1265 organization that is a provider-sponsored organization rather
1266 than the solvency requirements of this part. However, if the
1267 provider-sponsored organization does not meet the solvency
1268 requirements of this part, the organization is limited to the
1269 issuance of Medicare+Choice plans to eligible individuals. For
1270 the purposes of this section, the terms "Medicare+Choice plans,"
1271 "provider-sponsored organizations," and "solvency requirements"
1272 have the same meaning as defined in the federal act and federal
1273 rules and regulations.
1274 (2) The solvency requirements in 42 C.F.R. 422.350,
1275 subpart H, and the solvency requirements established in approved

1276 federal waivers pursuant to chapter 409, apply to a Medicaid
1277 provider service network rather than the solvency requirements
1278 of this part.
1279 Section 6. The Agency for Health Care Administration shall
1280 report to the Legislature by April 1, 2006, on the specific pre-
1281 implementation milestones required by the special terms and
1282 conditions related to the low-income pool which have been
1283 approved by the Federal Government and the status of any
1284 remaining pre-implementation milestones that have not been
1285 approved by the Federal Government.
1286 Section 7. Section 216.346, Florida Statutes, is amended
1287 to read:
1288 216.346 Contracts between state agencies; restriction on
1289 overhead or other indirect costs.--In any contract between state
1290 agencies, including any contract involving the State University
1291 System or the Florida Community College System, the agency
1292 receiving the contract or grant moneys shall charge no more than
1293 a reasonable percentage ~~5 percent~~ of the total cost of the
1294 contract or grant for overhead or indirect costs or any other
1295 costs not required for the payment of direct costs. This
1296 provision is not intended to limit an agency's ability to
1297 certify matching funds or designate in-kind contributions that
1298 will allow the drawdown of federal Medicaid dollars that do not
1299 affect state budgeting.
1300 Section 8. This act shall take effect upon becoming a law.