CHAMBER ACTION

The Fiscal Council recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to Medicaid reform; providing legislative findings and intent; providing waiver authority to the Agency for Health Care Administration; providing for implementation of demonstration projects; providing definitions; identifying categorical groups for eligibility under the waiver; establishing the choice counseling process; requiring managed care plans to include mandatory Medicaid services; requiring managed care plans to provide a wellness and disease management program, pharmacy benefits, and behavioral health care benefits; requiring the agency to establish enhanced benefit coverage and providing procedures therefor; establishing flexible spending accounts and individual development accounts; providing for the agency to establish a catastrophic coverage fund or purchase stop-loss coverage to cover certain services; providing for cost sharing by recipients, and requirements; requiring a managed care plan to have a certificate of operation from

the agency before operating under the waiver; providing certification requirements; providing for reimbursement of provider service networks; providing an exemption from competitive bid requirements for provider service networks under certain circumstances; providing for continuance of contracts previously awarded for a specified period of time; requiring the agency to have accountability and quality assurance standards; requiring the agency to establish a medical care database; providing data collection requirements; requiring certain entities certified to operate a managed care plan to comply with ss. 641.3155 and 641.513, F.S.; providing for the agency to develop a rate setting and risk adjustment system; authorizing the agency to allow recipients to opt out of Medicaid and purchase health care coverage through an employer-sponsored insurer; requiring the agency to apply and enforce certain provisions of law relating to Medicaid fraud and abuse; providing penalties; providing for integration of state funding to persons who are age 60 and above; requiring the agency to provide a choice of managed care plans to recipients; providing requirements for managed care plans; requiring the agency to withhold certain funding contingent upon the performance of a plan; requiring the plan to rebate certain profits to the agency; authorizing the agency to limit the number of enrollees in a plan under certain circumstances; providing for eligibility determination and choice counseling for persons age 60 and above; providing for imposition of

liquidated damages; authorizing the agency to grant a modification of certificate-of-need conditions to nursing homes under certain circumstances; requiring integration of Medicare and Medicaid services; providing legislative intent; providing for awarding of funds for managed care delivery system development, contingent upon an appropriation; requiring the agency conduct a study of the feasibility of establishing a Medicaid buy-in program for individuals with disabilities; providing applicability; granting rulemaking authority to the agency; requiring legislative authority to implement the waiver; requiring the Office of Program Policy Analysis and Government Accountability to evaluate the Medicaid reform waiver and issue reports; requiring the agency to submit status reports; requiring the agency to contract for certain evaluation comparisons; providing for future review and repeal of the act; providing an effective date.

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

Section 1. Medicaid reform.--

(1) LEGISLATIVE FINDINGS AND INTENT.--

(a) The Legislature finds that:

1. The current Florida Medicaid program is a 3-decade-old program that is no longer appropriate for 21st century health care financing and delivery;

2. Expenditures in the Florida Medicaid program are growing at an unsustainable rate, limiting funding for other essential state services;

3. Caps on payments to providers have resulted in a fee system which does not recognize the true cost of providing Medicaid care and services to consumers;

4. The current Medicaid health care financing system has not given Medicaid providers the ability to respond to changes and innovations in health care delivery resulting in restricted access to needed care and services for recipients;

5. Every Medicaid recipient deserves a "medical home" which provides incentives for providers or consumers to maximize wellness, prevention of disease, and early intervention and assists in the avoidance of more costly and dangerous medical conditions;

6. The current Medicaid system locks recipients into government-funded health care; does not maximize personal responsibility and the use of private insurance mechanisms; does not provide incentives and mechanisms for Medicaid recipients to become gainfully employed and privately insured; does not serve the needs of consumers in the state, health care providers, or taxpayers; and is in need of meaningful reform; and

7. The elderly and persons with disabilities are locked into a system of supply-induced demand in which the services that are provided to recipients are dictated by what government funds rather than by the needs, abilities, and desires of consumers.

(b) It is, therefore, the intent of the Legislature that the Agency for Health Care Administration and other entities involved in the state's health care financing and delivery system begin the process of reforming the state's system of delivery of Medicaid services to bring more predictability to budget growth, to incorporate free market incentives, and to empower Medicaid consumers to make informed choices, direct their own health care, and ensure appropriate care in an appropriate setting.

(2) WAIVER AUTHORITY.--Notwithstanding any other law to the contrary, the Agency for Health Care Administration is authorized to seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to reform the Florida Medicaid program pursuant to this section in urban and rural demonstration sites. This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanisms for hospitals and contingent upon protection of the disproportionate share program authorized pursuant to chapter 409, Florida Statutes. The agency is directed to negotiate with the Centers for Medicare and Medicaid Services to include in the approved waiver a methodology whereby savings from the demonstration waiver may be used to increase total upper-payment-limit and disproportionate share payments. Any increased funds shall be reinvested in programs that provide direct services to uninsured individuals in a cost-effective manner and reduce reliance on hospital emergency care.

(3) IMPLEMENTATION OF DEMONSTRATION PROJECTS.--The agency shall include in the federal waiver request the authority to

establish managed care demonstration projects in at least one urban and one rural area.

(4) DEFINITIONS.--As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Enhanced benefit coverage" means additional health care services or alternative health care coverage which can be purchased by qualified recipients.

(c) "Flexible spending account" means an account that encourages consumer ownership and management of resources available for enhanced benefit coverage, wellness activities, preventive services, and other services to improve the health of the recipient.

(d) "Individual development account" means a dedicated savings account that is designed to encourage and enable a recipient to build assets in order to purchase health-related services or health-related products.

(e) "Managed care plan" or "plan" means an entity certified by the agency to accept a capitation payment, including, but not limited to, a health maintenance organization authorized under part I of chapter 641, Florida Statutes; an entity under part II or part III of chapter 641, Florida Statutes, or under chapter 627, chapter 636, chapter 391, or s. 409.912, Florida Statutes; a licensed mental health provider under chapter 394, Florida Statutes; a licensed substance abuse provider under chapter 397, Florida Statutes; a hospital under chapter 395, Florida Statutes; a provider service network as

defined in this section; or a state-certified contractor as defined in this section.

(f) "Medicaid buy-in" means a program under s. 4733 of the federal Balanced Budget Act of 1997 to provide Medicaid coverage to certain working individuals with disabilities and pursuant to the provisions of this section.

(g) "Medicaid opt-out option" means a program that allows a recipient to purchase health care insurance through an employer-sponsored plan instead of through a Medicaid-certified plan.

(h) "Plan benefits" means the mandatory services specified in s. 409.905, Florida Statutes; behavioral health services specified in s. 409.906(8), Florida Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services, including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk adjusted capitation rate. Plans shall provide coverage of all mandatory services, may vary in amount, duration, and scope of benefits, and may cover optional services to attract recipients and provide needed care. In all instances, the agency shall ensure that plan benefits include those services that are medically necessary, based on historical Medicaid utilization.

(i) "Provider service network" means an incorporated network:

1. Established or organized, and operated, by a health care provider or group of affiliated health care providers;

2. That provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group;

3. That may make arrangements with physicians, other health care professionals, and health care institutions, to assume all or part of the financial risk on a prospective basis for the provision of basic health services; and

4. Within which health care providers have a controlling interest in the governing body of the provider service network organization, as authorized by s. 409.912, Florida Statutes.

(j) "Shall" means the agency must include the provision of a subsection as delineated in this section in the waiver application and implement the provision to the extent allowed in the demonstration project sites by the Centers for Medicare and Medicaid Services and as approved by the Legislature pursuant to this section.

(k) "State-certified contractor" means an entity not authorized under part I, part II, or part III of chapter 641, Florida Statutes, or under chapter 624, chapter 627, or chapter 636, Florida Statutes, qualified by the agency to be certified as a managed care plan. The agency shall develop the standards necessary to authorize an entity to become a state-certified contractor.

(5) ELIGIBILITY.--

(a) The agency shall pursue waivers to reform Medicaid for the following categorical groups:

1. Temporary Assistance for Needy Families, consistent with ss. 402 and 1931 of the Social Security Act and chapter 409, chapter 414, or chapter 445, Florida Statutes.

2. Supplemental Security Income recipients as defined in Title XVI of the Social Security Act, except for persons who are dually eligible for Medicaid and Medicare, individuals 60 years of age or older, individuals who have developmental disabilities, and residents of institutions or nursing homes.

3. All children covered pursuant to Title XIX of the Social Security Act.

(b) The agency may pursue any appropriate federal waiver to reform Medicaid for the populations not identified by this subsection, including Title XXI children, if authorized by the Legislature.

(6) CHOICE COUNSELING.--

(a) At the time of eligibility determination, the agency shall provide the recipient with all the Medicaid health care options available in that community to assist the recipient in choosing health care coverage. A condition of enrollment is the choice of a plan. The recipient shall be able to choose a plan within 30 days after the recipient is eligible unless the recipient loses eligibility.

(b) In the managed care demonstration projects, the Medicaid recipients who are already enrolled in a managed care plan shall remain with that plan until they lose eligibility. The agency shall develop a method whereby newly eligible Medicaid recipients, Medicaid recipients with renewed

eligibility, and Medipass enrollees shall enroll in managed care plans certified pursuant to this section.

(c) A Medicaid recipient receiving services under this section is eligible for only emergency services until the recipient enrolls in a managed care plan.

(d) The agency shall ensure that the recipient is provided with:

1. A list and description of the benefits provided.

2. Information about cost sharing.

3. Plan performance data, if available.

4. An explanation of benefit limitations.

5. Contact information, including geographic locations and transportation limitations.

6. Any other information the agency determines would facilitate a recipient's understanding of the plan or insurance that would best meet his or her needs.

(e) The agency shall ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(f) To accommodate the needs of recipients, the agency shall ensure that the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also utilize

language lines and other services for impaired recipients, such as TTD/TTY.

(g) The agency shall require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced or a plan violated any of the provisions of s. 409.912(21), Florida Statutes, the choice counseling entity shall immediately report the violation to the agency's program integrity section for investigation. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this subsection.

(h) It is the intent of the Legislature, within the authority of the waiver and within available resources, that the agency promote health literacy and partner with the Department of Health to provide information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(i) The agency is authorized to contract with entities to perform choice counseling and may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(j) The agency shall develop processes to ensure that demonstration sites have sufficient levels of enrollment to

conduct a valid test of the managed care demonstration project model within a 2-year timeframe.

(7) PLANS.--

(a) Plan benefits.--The agency shall develop a capitated system of care that promotes choice and competition. Plan benefits shall include the mandatory services delineated in federal law and specified in s. 409.905, Florida Statutes; behavioral health services specified in s. 409.906(8), Florida Statutes; pharmacy services specified in s. 409.906(20), Florida Statutes; and other services including, but not limited to, Medicaid optional services specified in s. 409.906, Florida Statutes, for which a plan is receiving a risk-adjusted capitation rate. Plans shall provide coverage of all mandatory services, may vary in amount, duration, and scope of benefits, and may cover optional services to attract recipients and provide needed care. In all instances, the agency shall ensure that plan benefits include those services that are medically necessary, based on historical Medicaid utilization.

(b) Wellness and disease management.--

1. The agency shall require plans to provide a wellness disease management program for certain Medicaid recipients participating in the waiver. The agency shall require plans to develop disease management programs necessary to meet the needs of the population they serve.

2. The agency shall require a plan to develop appropriate disease management protocols and develop procedures for implementing those protocols, and determine the procedure for providing disease management services to plan enrollees. The

agency is authorized to allow a plan to contract separately with another entity for disease management services or provide disease management services directly through the plan.

3. The agency shall provide oversight to ensure that the service network provides the contractually agreed upon level of service.

4. The agency may establish performance contracts that reward a plan when measurable operational targets in both participation and clinical outcomes are reached or exceeded by the plan.

5. The agency may establish performance contracts that penalize a plan when measurable operational targets for both participation and clinical outcomes are not reached by the plan.

6. The agency shall develop oversight requirements and procedures to ensure that plans utilize standardized methods and clinical protocols for determining compliance with a wellness or disease management plan.

(c) Pharmacy benefits.--

1. The agency shall require plans to provide pharmacy benefits and include pharmacy benefits as part of the capitation risk structure to enable a plan to coordinate and fully manage all aspects of patient care as part of the plan or through a pharmacy benefits manager.

2. The agency may set standards for pharmacy benefits for managed care plans and specify the therapeutic classes of pharmacy benefits to enable a plan to coordinate and fully manage all aspects of patient care as part of the plan or through a pharmacy benefits manager.

3. Each plan shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for recipients inappropriately using their benefits, and other measures to reduce provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. The agency shall require plans to report incidences of pharmacy fraud and abuse and establish procedures for receiving and investigating fraud and abuse reports from plans in the demonstration project sites. Plans must report instances of fraud and abuse pursuant to chapter 641, Florida Statutes.

5. The agency may facilitate the establishment of a Florida managed care plan purchasing alliance. The purpose of the alliance is to form agreements among participating plans to purchase pharmaceuticals at a discount, to achieve rebates, or to receive best market price adjustments. Participation in the Florida managed care plan purchasing alliance shall be voluntary.

(d) Behavioral health care benefits.--

1. The agency shall include behavioral health care benefits as part of the capitation structure to enable a plan to coordinate and fully manage all aspects of patient care.

2. Managed care plans shall require their contracted behavioral health providers to have a member's behavioral treatment plan on file in the provider's medical record.

(8) ENHANCED BENEFIT COVERAGE.--

(a) The agency shall establish enhanced benefit coverage and a methodology to fund the enhanced benefit coverage.

(b) A recipient who complies with the objectives of a wellness or disease management plan, as determined by the agency, shall have access to the enhanced benefit coverage for the purpose of purchasing or securing health-care services or health-care products.

(c) The agency shall establish flexible spending accounts or similar accounts for recipients as approved in the waiver to be administered by the agency or by a managed care plan. The agency shall make deposits to a recipient's flexible spending account contingent upon compliance with a wellness plan or a disease management plan.

(d) The purpose of the flexible spending accounts is to allow waiver recipients to accumulate funds up to a maximum of $1,000 for purposes of activities allowed by federal regulations or as approved in the waiver.

(e) The agency may allow a plan to establish additional reward systems for compliance with a wellness or disease management objective that are supplemental to the enhanced benefit coverage.

(f) The agency shall establish individual development accounts or similar accounts for recipients as approved in the waiver. The agency shall make deposits into a recipient's individual development account contingent upon compliance with a wellness or a disease management plan.

(g) The purpose of an individual development account is to allow waiver recipients to accumulate funds up to a maximum of $1,000 for purposes of activities allowed by federal regulations or as approved in the waiver.

(h) A recipient shall choose to participate in a flexible spending account or an individual development account to accumulate funds pursuant to the provisions of this section.

(i) It is the intent of the Legislature that flexible spending accounts and individual development accounts encourage consumer management of resources for wellness activities, preventive services, and other services to improve the health of the recipient.

(j) The agency shall develop standards and oversight procedures to monitor access to enhanced services, the use of flexible spending accounts, and the use of individual development accounts during the eligibility period and up to 3 years after loss of eligibility as approved by the waiver.

(k) It is the intent of the Legislature that the agency may develop an electronic benefit transfer system for the distribution of enhanced benefit funds earned by the recipient.

(9) COST SHARING.--

(a) For recipients enrolled in a Medicaid managed care plan, the agency may continue cost-sharing requirements as currently defined in s. 409.9081, Florida Statutes, or as approved under a waiver granted by the federal Centers for Medicare and Medicaid Services. Such approved cost-sharing requirements may include provisions requiring recipients to pay:

1. An enrollment fee;

2. A deductible;

3. Coinsurance or a portion of the plan premium; or

4. For families with higher levels of income, progressively higher percentages of the cost of the medical assistance.

(b) For recipients who opt out of Medicaid, cost sharing shall be governed by the policy of the plan in which the individual enrolls.

(c) If the employer-sponsored coverage requires that the cost-sharing provisions imposed under paragraph (a) include requirements that recipients pay a portion of the plan premium, the agency shall specify the manner in which the premium is paid. The agency may require that the premium be paid to the agency, an organization operating part of the medical assistance program, or the managed care plan.

(d) Cost-sharing provisions adopted under this section may be determined based on the maximum level authorized under an approved federal waiver.

(10) CATASTROPHIC COVERAGE.--

(a) All managed care plans shall provide coverage to the extent required by the agency up to a per-recipient service limitation threshold determined by the agency and within the capitation rate set by the agency. This limitation threshold may vary by eligibility group or other appropriate factors, including, but not limited to, recipients with special needs and recipients with certain disease states.

(b) The agency shall establish a fund or purchase stop-loss coverage from a plan under part I of chapter 641, Florida

Statutes, or a health insurer authorized under chapter 624, Florida Statutes, for purposes of covering services in excess of those covered by the managed care plan. The catastrophic coverage fund or stop-loss coverage shall provide for payment of medically necessary care for recipients who are enrolled in a plan and whose care has exceeded the predetermined service threshold. The agency may establish an aggregate maximum level of coverage in the catastrophic fund or for the stop-loss coverage.

(c) The agency shall develop policies and procedures to allow all plans to utilize the catastrophic coverage fund or stop-loss coverage for a Medicaid recipient in the plan who has reached the catastrophic coverage threshold.

(d) The agency shall contract for an administrative structure to manage the catastrophic coverage fund.

(11) CERTIFICATION.--Before any entity may operate a managed care plan under the waiver, it shall obtain a certificate of operation from the agency.

(a) Any entity operating under part I, part II, or part III of chapter 641, Florida Statutes, or under chapter 627, chapter 636, chapter 391, or s. 409.912, Florida Statutes; a licensed mental health provider under chapter 394, Florida Statutes; a licensed substance abuse provider under chapter 397, Florida Statutes; a hospital under chapter 395, Florida Statutes; a provider service network as defined in this section; or a state-certified contractor as defined in this section shall be in compliance with the requirements and standards developed by the agency. For purposes of the waiver established under this

section, provider service networks shall be exempt from the competitive bid requirements in s. 409.912, Florida Statutes. The agency, in consultation with the Office of Insurance Regulation, shall establish certification requirements. It is the intent of the Legislature that, to the extent possible, any project authorized by the state under this section include any federally qualified health center, federally qualified rural health clinic, county health department, or any other federally, state, or locally funded entity that serves the geographic area within the boundaries of that project. The certification process shall, at a minimum, include all requirements in the current Medicaid prepaid health plan contract and take into account the following requirements:

1. The entity has sufficient financial solvency to be placed at risk for the basic plan benefits under ss. 409.905, 409.906(8), and 409.906(20), Florida Statutes, and other covered services.

2. Any plan benefit package shall be actuarially equivalent to the premium calculated by the agency to ensure that competing plan benefits are equivalent in value. In all instances, the benefit package must provide services sufficient to meet the needs of the target population based on historical Medicaid utilization.

3. The entity has sufficient service network capacity to meet the needs of members under ss. 409.905, 409.906(8), and 409.906(20), Florida Statutes, and other covered services.

4. The entity's primary care providers are geographically accessible to the recipient.

5. The entity has the capacity to provide a wellness or disease management program.

6. The entity shall provide for ambulance service in accordance with ss. 409.908(13)(d) and 409.9128, Florida Statutes.

7. The entity has the infrastructure to manage financial transactions, recordkeeping, data collection, and other administrative functions.

8. The entity, if not a fully indemnified insurance program under chapter 624, chapter 627, chapter 636, or chapter 641, Florida Statutes, must meet the financial solvency requirements under this section.

(b) The agency has the authority to contract with entities not otherwise licensed as an insurer or risk-bearing entity under chapter 627 or chapter 641, Florida Statutes, as long as these entities meet the certification standards of this section and any additional standards as defined by the agency to qualify as managed care plans under this section.

(c) In certifying a risk-bearing entity and determining the financial solvency of such an entity as a provider service network, the following shall apply:

1. The entity shall maintain a minimum surplus in an amount that is the greater of $1 million or 1.5 percent of projected annual premiums.

2. In lieu of the requirements in subparagraph 1., the agency may consider the following:

a. If the organization is a public entity, the agency may take under advisement a statement from the public entity that a

county supports the managed care plan with the county's full faith and credit. In order to qualify for the agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;

b. The state guarantees the solvency of the organization;

c. The organization is a federally qualified health center or is controlled by one or more federally qualified health centers and meets the solvency standards established by the state for such organization pursuant to s. 409.912(4)(c), Florida Statute; or

d. The entity meets the solvency requirements for federally approved provider-sponsored organizations as defined in 42 C.F.R. ss. 422.380-422.390. However, if the provider service network does not meet the solvency requirements of either chapter 627 or chapter 641, Florida Statutes, the provider service network is limited to the issuance of Medicaid plans.

(d) Each entity certified by the agency shall submit to the agency any financial, programmatic, or patient-encounter data or other information required by the agency to determine the actual services provided and the cost of administering the plan.

(e) Notwithstanding the provisions of s. 409.912, Florida Statutes, the agency shall extend the existing contract with a hospital-based provider service network for a period not to exceed 3 years.

(12) ACCOUNTABILITY AND QUALITY ASSURANCE.--The agency shall establish standards for plan compliance, including, but not limited to, quality assurance and performance improvement standards, peer or professional review standards, grievance policies, and program integrity policies. The agency shall develop a data reporting system, work with managed care plans to establish reasonable patient-encounter reporting requirements, and ensure that the data reported is accurate and complete.

(a) In performing the duties required under this section, the agency shall work with managed care plans to establish a uniform system to measure, improve, and monitor the clinical and functional outcomes of a recipient of Medicaid services. The system may use financial, clinical, and other criteria based on pharmacy, medical services, and other data related to the provision of Medicaid services, including, but not limited to:

1. Health Plan Employer Data and Information Set.

2. Member satisfaction.

3. Provider satisfaction.

4. Report cards on plan performance and best practices.

5. Quarterly reports on compliance with the prompt payment of claims requirements of ss. 627.613, 641.3155, and 641.513, Florida Statutes.

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

(c)1. The agency shall establish a medical care database to compile data on health services rendered by health care practitioners that provide services to patients enrolled in managed care plans in the demonstration sites. The medical care database shall:

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

(I) The demographic characteristics of the patient.

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

(III) The procedure performed.

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

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

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

(VII) If the health care practitioner rendering the service is a dependent practitioner, the modifiers appropriate to indicate that the service was delivered by the dependent practitioner.

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

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

2. To the extent practicable, when collecting the data required under sub-subparagraph 1.a., the agency shall utilize any standardized claim form or electronic transfer system being used by health care practitioners, facilities, and payers.

3. Health care practitioners and facilities in the demonstration sites shall submit, and managed care plans participating in the demonstration sites shall receive, claims for payment and any other information reasonably related to the medical care database electronically in a standard format as required by the agency.

4. The agency shall establish reasonable deadlines for phasing in of electronic transmittal of claims.

5. The plan shall ensure that the data reported is accurate and complete.

(d) The agency shall describe the evaluation methodology and standards that will be used to assess the success of the demonstration projects.

(13) STATUTORY COMPLIANCE.--Any entity certified under this section shall comply with ss. 627.613, 641.3155, and 641.513, Florida Statutes.

(14) RATE SETTING AND RISK ADJUSTMENT.--The agency shall develop an actuarially sound rate setting and risk adjustment system for payment to managed care plans that:

(a) Adjusts payment for differences in risk assumed by managed care plans, based on a widely recognized clinical diagnostic classification system or on categorical groups that are established in consultation with the federal Centers for Medicare and Medicaid Services.

(b) Includes a phase-in of patient-encounter level data reporting.

(c) Includes criteria to adjust risk and validation of the rates and risk adjustments.

(d) Establishes rates in consultation with an actuary and the federal Centers for Medicare and Medicaid Services and supported by actuarial analysis.

(e) Reimburses managed care demonstration projects on a capitated basis, except for the first year of operation of a provider service network. The agency shall develop contractual arrangements with the provider service network for a fee-for-service reimbursement methodology that does not exceed total payments under the risk-adjusted capitation during the first year of operation of a managed care demonstration project. Contracts must, at a minimum, require provider service networks to report patient-encounter data, reconcile costs to established risk-adjusted capitation rates at specified periods, and specify the method and process for settlement of cost differences at the end of the contract period.

(15) MEDICAID OPT-OUT OPTION.--

(a) The agency shall allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid certified plan.

(b) A recipient who chooses the Medicaid opt-out option shall have an opportunity for a specified period of time, as authorized under a waiver granted by the Centers for Medicare and Medicaid Services, to select and enroll in a Medicaid certified plan. If the recipient remains in the employer-sponsored plan after the specified period, the recipient shall remain in the opt-out program for at least 1 year or until the recipient no longer has access to employer-sponsored coverage, until the employer's open enrollment period for a person who

opts out in order to participate in employer-sponsored coverage, or until the person is no longer eligible for Medicaid, whichever time period is shorter.

(c) Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

(16) FRAUD AND ABUSE.--

(a) To minimize the risk of Medicaid fraud and abuse, the agency shall ensure that applicable provisions of chapters 409, 414, 626, 641, and 932, Florida Statutes, relating to Medicaid fraud and abuse, are applied and enforced at the demonstration project sites.

(b) Providers shall have the necessary certification, license and credentials as required by law and waiver requirements.

(c) The agency shall ensure that the plan is in compliance with the provisions of s. 409.912(21) and (22), Florida Statutes.

(d) The agency shall require each plan to establish program integrity functions and activities to reduce the incidence of fraud and abuse. Plans must report instances of fraud and abuse pursuant to chapter 641, Florida Statutes.

(e) The plan shall have written administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The plan shall designate a compliance officer with sufficient experience in health care.

(f)1. The agency shall require all contractors in the managed care plan to report all instances of suspected fraud and abuse. A failure to report instances of suspected fraud and abuse is a violation of law and subject to the penalties provided by law.

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

3. The agency shall require that all contractors make all files and relevant billing and claims data accessible to state regulators and investigators and that all such data be linked into a unified system for seamless reviews and investigations.

(17) INTEGRATED MANAGED LONG-TERM CARE SERVICES.--

(a) Contingent upon federal approval, the Agency for Health Care Administration may revise or apply for waivers pursuant to s. 1915 of the Social Security Act or apply for experimental, pilot, or demonstration project waivers pursuant to s. 1115 of the Social Security Act to reform Florida's Medicaid program in order to integrate all state funding for Medicaid services to persons who are 60 years of age or older into a managed care delivery system. Rates shall be developed in

accordance with 42 C.F.R. s. 438.60, certified by an actuary, and submitted for approval to the Centers for Medicare and Medicaid Services. The funds to be integrated shall include:

1. All Medicaid home and community-based waiver services funds.

2. All funds for all Medicaid services, including Medicaid nursing home services.

3. All funds paid for Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare, for which the state is responsible, but not to exceed the federal limits of liability specified in the state plan.

(b) When the agency integrates the funding for Medicaid services for recipients 60 years of age or older into a managed care delivery system under paragraph (a) in any area of the state, the agency shall provide to recipients a choice of plans which shall include:

1. Entities licensed under chapter 627 or chapter 641, Florida Statutes.

2. Any other entity certified by the agency to accept a capitation payment, including entities eligible to participate in the nursing home diversion program, other qualified providers as defined in s. 430.703(7), Florida Statutes, and community care for the elderly lead agencies.

(c) The agency may begin the integration of Medicaid services for the elderly into a managed care delivery system.

(d) When the agency integrates the funding for Medicaid nursing home and community-based care services into a managed

care delivery system, the agency shall ensure that a plan, in addition to other certification requirements:

1. Allows an enrollee to select any provider with whom the plan has a contract.

2. Makes a good faith effort to develop contracts with qualified providers currently under contract with the Department of Elderly Affairs, area agencies on aging, or community care for the elderly lead agencies.

3. Secures subcontracts with providers of nursing home and community-based long-term care services sufficient to ensure access to and choice of providers.

4. Develops and uses a service provider qualification system that describes the quality-of-care standards that providers of medical, health, and long-term care services must meet in order to obtain a contract from the plan.

5. Makes a good faith effort to develop contracts with all qualified nursing homes located in the area that are served by the plan, including those designated as Gold Seal.

6. Ensures that a Medicaid recipient enrolled in a managed care plan who is a resident of a facility licensed under chapter 400, Florida Statutes, and who does not choose to move to another setting is allowed to remain in the facility in which he or she is currently receiving care.

7. Includes persons who are in nursing homes and who convert from non-Medicaid payment sources to Medicaid. Plans shall be at risk for serving persons who convert to Medicaid. The agency shall ensure that persons who choose community alternatives instead of nursing home care and who meet level of

care and financial eligibility standards continue to receive Medicaid.

8. Demonstrates a quality assurance system and a performance improvement system that is satisfactory to the agency.

9. Develops a system to identify recipients who have special health care needs such as polypharmacy, mental health and substance abuse problems, falls, chronic pain, nutritional deficits, or cognitive deficits or who are ventilator-dependent in order to respond to and meet these needs.

10. Ensures a multidisciplinary team approach to recipient management that facilitates the sharing of information among providers responsible for delivering care to a recipient.

11. Ensures medical oversight of care plans and service delivery, regular medical evaluation of care plans, and the availability of medical consultation for care managers and service coordinators.

12. Develops, monitors, and enforces quality-of-care requirements using existing Agency for Health Care Administration survey and certification data, whenever possible, to avoid duplication of survey or certification activities between the plans and the agency.

13. Ensures a system of care coordination that includes educational and training standards for care managers and service coordinators.

14. Develops a business plan that demonstrates the ability of the plan to organize and operate a risk-bearing entity.

15. Furnishes evidence of liability insurance coverage or a self-insurance plan that is determined by the Office of Insurance Regulation to be adequate to respond to claims for injuries arising out of the furnishing of health care.

16. Complies with the prompt payment of claims requirements of ss. 627.613, 641.3155, and 641.513, Florida Statutes.

17. Provides for a periodic review of its facilities, as required by the agency, which does not duplicate other requirements of federal or state law. The agency shall provide provider survey results to the plan.

18. Provides enrollees the ability, to the extent possible, to choose care providers, including nursing home, assisted living, and adult day care service providers affiliated with a person's religious faith or denomination, nursing home and assisted living facility providers that are part of a retirement community in which an enrollee resides, and nursing homes and assisted living facilities that are geographically located as close as possible to an enrollee's family, friends, and social support system.

(e) In addition to other quality assurance standards required by law or by rule or in an approved federal waiver, and in consultation with the Department of Elderly Affairs and area agencies on aging, the agency shall develop quality assurance standards that are specific to the care needs of elderly individuals and that measure enrollee outcomes and satisfaction with care management, nursing home services, and other services that are provided to recipients 60 years of age or older by

managed care plans pursuant to this section. The agency shall contract with area agencies on aging to perform initial and ongoing measurement of the appropriateness, effectiveness, and quality of services that are provided to recipients age 60 years of age or older by managed care plans and to collect and report the resolution of enrollee grievances and complaints. The agency and the department shall coordinate the quality measurement activities performed by area agencies on aging with other quality assurance activities required by this section in a manner that promotes efficiency and avoids duplication.

(f) If there is not a contractual relationship between a nursing home provider and a plan in an area in which the demonstration project operates, the nursing home shall cooperate with the efforts of a plan to determine if a recipient would be more appropriately served in a community setting, and payments shall be made in accordance with Medicaid nursing home rates as calculated in the Medicaid state plan.

(g) The agency may develop innovative risk-sharing agreements that limit the level of custodial nursing home risk that the plan assumes, consistent with the intent of the Legislature to reduce the use and cost of nursing home care. Under risk-sharing agreements, the agency may reimburse the plan or a nursing home for the cost of providing nursing home care for Medicaid-eligible recipients who have been permanently placed and remain in nursing home care.

(h) The agency shall withhold a percentage of the capitation rate that would otherwise have been paid to a plan in order to create a quality reserve fund, which shall be annually

disbursed to those contracted plans that deliver high-quality services, have a low rate of enrollee complaints, have successful enrollee outcomes, are in compliance with quality improvement standards, and demonstrate other indicators determined by the agency to be consistent with high-quality service delivery.

(i) The agency shall implement a system of profit rebates that require a plan to rebate a portion of the plan's profits that exceed 3 percent. The portion of profit above 3 percent that is to be rebated shall be determined by the agency on a sliding scale; however, no profits above 15 percent may be retained by the plan. Rebates shall be paid to the agency.

(j) The agency may limit the number of persons enrolled in a plan who are not nursing home facility residents but who would be Medicaid eligible as defined under s. 409.904(3), Florida Statutes, if served in an approved home or community-based waiver program.

(k) Except as otherwise provided in this section, the Aging Resource Center, if available, shall be the entry point for eligibility determination for persons 60 years of age or older and shall provide choice counseling to assist recipients in choosing a plan. If an Aging Resource Center is not operating in an area or if the Aging Resource Center or area agency on aging has a contractual relationship with or has any ownership interest in a managed care plan, the agency may, in consultation with the Department of Elderly Affairs, designate other entities to perform these functions until an Aging Resource Center is established and has the capacity to perform these functions.

(l) In the event that a managed care plan does not meet its obligations under its contract with the agency or under the requirements of this section, the agency may impose liquidated damages. Such liquidated damages shall be calculated by the agency as reasonable estimates of the agency's financial loss and are not to be used to penalize the plan. If the agency imposes liquidated damages, the agency may collect those damages by reducing the amount of any monthly premium payments otherwise due to the plan by the amount of the damages. Liquidated damages are forfeited and will not be subsequently paid to a plan upon compliance or cure of default unless a determination is made after appeal that the damages should not have been imposed.

(m) In any area of the state in which the agency has implemented a demonstration project pursuant to this section, the agency may grant a modification of certificate-of-need conditions related to Medicaid participation to a nursing home that has experienced decreased Medicaid patient day utilization due to a transition to a managed care delivery system.

(n) Notwithstanding any other law to the contrary, the agency shall ensure that, to the extent possible, Medicare and Medicaid services are integrated. When possible, persons served by the managed care delivery system who are eligible for Medicare may choose to enroll in a Medicare managed health care plan operated by the same entity that is placed at risk for Medicaid services.

(o) It is the intent of the Legislature that the agency begin discussions with the federal Centers for Medicare and

Medicaid Services regarding the inclusion of Medicare in an integrated long-term care system.

(18) FUNDING DEVELOPMENT COSTS OF ESSENTIAL COMMUNITY PROVIDERS.--It is the intent of the Legislature to facilitate the development of managed care delivery systems by networks of essential community providers, including current community care for the elderly lead agencies and other networks as defined in this section. To allow the assumption of responsibility and financial risk for managing a recipient through the entire continuum of Medicaid services, the agency shall, subject to appropriations included in the General Appropriations Act, award up to $500,000 per applicant for the purpose of funding managed care delivery system development costs. The terms of repayment may not extend beyond 6 years after the date when the funding begins and must include payment in full with a rate of interest equal to or greater than the federal funds rate. The agency shall establish a grant application process for awards.

(19) MEDICAID BUY-IN.--The agency shall conduct a study to determine the feasibility of establishing a Medicaid buy-in program for disabled individuals. The study shall consider the following:

(a) Income and eligibility requirements, including a minimum work requirement.

(b) Premiums or other cost-sharing charges based on income.

(c) Continuation of benefits for individuals who become involuntarily unemployed.

(d) Recommendations for administration of the program, including, but not limited to, premium collection and sliding scale premiums.

(20) APPLICABILITY.--

(a) The provisions of this section apply only to the demonstration project sites approved by the Legislature.

(b) The Legislature authorizes the Agency for Health Care Administration to apply and enforce any provision of law not referenced in this section to ensure the safety, quality, and integrity of the waiver.

(c) In any circumstance when the provisions of chapter 409, Florida Statutes, conflict with this section, this section shall prevail.

(21) RULEMAKING.--The Agency for Health Care Administration is authorized to adopt rules in consultation with the appropriate state agencies to implement the provisions of this section.

(22) IMPLEMENTATION.--

(a) This section does not authorize the agency to implement any provision of s. 1115 of the Social Security Act experimental, pilot, or demonstration project waiver to reform the state Medicaid program.

(b) The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care demonstration project as defined in this section. The agency shall post all waiver applications under this section on its Internet website 30 days before submitting the applications to

the United States Centers for Medicare and Medicaid Services. Notwithstanding s. 409.912(11), Florida Statutes, all waiver applications shall be submitted to the select committees on Medicaid reform of the Senate and the House of Representatives to be approved for submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be submitted to the select committees on Medicaid reform of the Senate and the House of Representatives in order to obtain authority for implementation as required by s. 409.912(11), Florida Statutes, before program implementation. The select committees on Medicaid reform shall recommend whether to approve the implementation of the waivers to the Legislature or to the Legislative Budget Commission if the Legislature is not in regular or special session. Integration of Medicaid services to the elderly may be implemented pursuant to subsection (17).

(23) EVALUATION.--

(a) Two years after the implementation of the waiver and again 5 years after the implementation of the waiver, the Office of Program Policy Analysis and Government Accountability, shall conduct an evaluation study and analyze the impact of the Medicaid reform waiver pursuant to this section to the extent allowed in the waiver demonstration sites by the Centers for Medicare and Medicaid Services and implemented as approved by the Legislature pursuant to this section. The Office of Program Policy Analysis and Government Accountability shall consult with appropriate legislative committees to select provisions of the waiver to evaluate from among the following:

1. Demographic characteristics of the recipient of the waiver.

2. Plan types and service networks.

3. Health benefit coverage.

4. Choice counseling.

5. Disease management.

6. Pharmacy benefits.

7. Behavioral health benefits.

8. Service utilization.

9. Catastrophic coverage.

10. Enhanced benefits.

11. Medicaid opt-out option.

12. Quality assurance and accountability.

13. Fraud and abuse.

14. Cost and cost benefit of the waiver.

15. Impact of the waiver on the agency.

16. Positive impact of plans on health disparities among minorities.

(b) The Office of Program Policy Analysis and Government Accountability shall submit the evaluation study report to the agency and shall submit quarterly reports to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the appropriate committees or councils of the Senate and the House of Representatives.

(c) One year after implementation of the integrated managed long-term care plan, the agency shall contract with an entity experienced in evaluating managed long-term care plans in another state to evaluate, at a minimum, demonstrated cost

savings realized and expected, consumer satisfaction, the range of services being provided under the program, and rate-setting methodology.

(d) The agency shall submit, every 6 months after the date of waiver implementation, a status report describing the progress made on the implementation of the waiver and identification of any issues or problems to the Governor's Office of Planning and Budgeting and the appropriate committees or councils of the Senate and the House of Representatives.

(e) The agency shall provide to the appropriate committees or councils of the Senate and House of Representatives copies of any report or evaluation regarding the waiver that is submitted to the Center for Medicare and Medicaid Services.

(f) The agency shall contract for an evaluation comparison of the waiver demonstration projects with the Medipass fee-for-service program including, at a minimum:

1. Administrative or organizational structure of the service delivery system.

2. Covered services and service utilization patterns of mandatory, optional, and other services.

3. Clinical or health outcomes.

4. Cost analysis, cost avoidance, and cost benefit.

(24) REVIEW AND REPEAL.--This section shall stand repealed on July 1, 2010, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. This act shall take effect July 1, 2005.