By the Committee on Health Care; and Senators Peaden, Carlton and Atwater

587-869-06

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

1 areas; authorizing the agency to make direct
2 payments to hospitals and physicians for the
3 costs associated with graduate medical
4 education under Medicaid reform; including the
5 Children's Medical Services Network in the
6 Department of Health within those programs
7 intended by the Legislature to participate in
8 the pilot program to the extent possible;
9 requiring that the agency implement standards
10 of quality assurance and performance
11 improvement in the demonstration areas of the
12 pilot program; requiring the agency to
13 establish an encounter database to compile data
14 from managed care plans; requiring the agency
15 to implement procedures to minimize the risk of
16 Medicaid fraud and abuse in all managed care
17 plans in the demonstration areas; clarifying
18 that the assignment process for the pilot
19 program is exempt from certain mandatory
20 procedures for Medicaid managed care enrollment
21 specified in s. 409.9122, F.S.; revising the
22 automatic assignment process in the
23 demonstration areas; requiring that the agency
24 report any modifications to the approved waiver
25 and special terms and conditions to the
26 Legislature within specified time periods;
27 authorizing the agency to implement the
28 provisions of the waiver approved by federal
29 Centers for Medicare and Medicaid Services;
30 requiring an annual review by the Office of
31 Insurance Regulation of the pilot program's

1 rate-setting methodology; providing that, if
2 any conflict exists between the provisions
3 contained in s. 409.91211, F.S., and ch. 409,
4 F.S., concerning the implementation of the
5 pilot program, the provisions contained in s.
6 409.91211, F.S., control; creating s.
7 409.91213, F.S.; requiring the agency to submit
8 quarterly and annual progress reports to the
9 Legislature; providing requirements for the
10 reports; amending s. 641.2261, F.S.; revising
11 the application of solvency requirements to
12 include Medicaid provider service networks;
13 updating a reference; requiring that the agency
14 report to the Legislature the
15 pre-implementation milestones concerning the
16 low-income pool which have been approved by the
17 Federal Government and the status of those
18 remaining to be approved; providing an
19 effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Subsection (9) of section 409.911, Florida
24 Statutes, is amended, and subsection (10) is added to that
25 section, to read:
26 409.911 Disproportionate share program.--Subject to
27 specific allocations established within the General
28 Appropriations Act and any limitations established pursuant to
29 chapter 216, the agency shall distribute, pursuant to this
30 section, moneys to hospitals providing a disproportionate
31 share of Medicaid or charity care services by making quarterly

Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(9) The Agency for Health Care Administration shall create a Medicaid Disproportionate Share Council.

(a) The purpose of the council is to study and make recommendations regarding:

1. The formula for the regular disproportionate share program and alternative financing options.

2. Enhanced Medicaid funding through the Special Medicaid Payment program.

3. The federal status of the upper-payment-limit funding option and how this option may be used to promote health care initiatives determined by the council to be state health care priorities.

4. The development of the low-income pool plan as required by the federal Centers for Medicare and Medicaid Services using the objectives established in s. 409.91211(1)(c).

(b) The council shall include representatives of the Executive Office of the Governor and of the agency; representatives from teaching, public, private nonprofit, private for-profit, and family practice teaching hospitals; and representatives from other groups as needed. The agency must ensure that there is fair representation of each group specified in this paragraph.

(c) The council shall submit its findings and recommendations to the Governor and the Legislature no later than March ~~February~~ 1 of each year.

1 (d) This subsection shall stand repealed June 30,
2 2006, unless reviewed and saved from repeal through
3 reenactment by the Legislature.
4 (10) The Agency for Health Care Administration shall
5 create a Medicaid Low-Income Pool Council by July 1, 2006. The
6 Low-Income Pool Council shall consist of 17 members, including
7 three representatives of statutory teaching hospitals, three
8 representatives of public hospitals, three representatives of
9 nonprofit hospitals, three representatives of for-profit
10 hospitals, two representatives of rural hospitals, two
11 representatives of units of local government which contribute
12 funding, and one representative of family practice teaching
13 hospitals. The council shall:
14 (a) Make recommendations on the financing of the
15 low-income pool and the disproportionate share hospital
16 program and the distribution of their funds.
17 (b) Advise the Agency for Health Care Administration
18 on the development of the low-income pool plan required by the
19 federal Centers for Medicare and Medicaid Services pursuant to
20 the Medicaid reform waiver.
21 (c) Advise the Agency for Health Care Administration
22 on the distribution of hospital funds used to adjust inpatient
23 hospital rates, rebase rates, or otherwise exempt hospitals
24 from reimbursement limits as financed by intergovernmental
25 transfers.
26 (d) Submit its findings and recommendations to the
27 Governor and the Legislature no later than February 1 of each
28 year.
29 Section 2. Paragraphs (b) and (d) of subsection (4) of
30 section 409.912, Florida Statutes, are amended to read:
31

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1 409.912 Cost-effective purchasing of health care.--The
2 agency shall purchase goods and services for Medicaid
3 recipients in the most cost-effective manner consistent with
4 the delivery of quality medical care. To ensure that medical
5 services are effectively utilized, the agency may, in any
6 case, require a confirmation or second physician's opinion of
7 the correct diagnosis for purposes of authorizing future
8 services under the Medicaid program. This section does not
9 restrict access to emergency services or poststabilization
10 care services as defined in 42 C.F.R. part 438.114. Such
11 confirmation or second opinion shall be rendered in a manner
12 approved by the agency. The agency shall maximize the use of
13 prepaid per capita and prepaid aggregate fixed-sum basis
14 services when appropriate and other alternative service
15 delivery and reimbursement methodologies, including
16 competitive bidding pursuant to s. 287.057, designed to
17 facilitate the cost-effective purchase of a case-managed
18 continuum of care. The agency shall also require providers to
19 minimize the exposure of recipients to the need for acute
20 inpatient, custodial, and other institutional care and the
21 inappropriate or unnecessary use of high-cost services. The
22 agency shall contract with a vendor to monitor and evaluate
23 the clinical practice patterns of providers in order to
24 identify trends that are outside the normal practice patterns
25 of a provider's professional peers or the national guidelines
26 of a provider's professional association. The vendor must be
27 able to provide information and counseling to a provider whose
28 practice patterns are outside the norms, in consultation with
29 the agency, to improve patient care and reduce inappropriate
30 utilization. The agency may mandate prior authorization, drug
31 therapy management, or disease management participation for

1 certain populations of Medicaid beneficiaries, certain drug
2 classes, or particular drugs to prevent fraud, abuse, overuse,
3 and possible dangerous drug interactions. The Pharmaceutical
4 and Therapeutics Committee shall make recommendations to the
5 agency on drugs for which prior authorization is required. The
6 agency shall inform the Pharmaceutical and Therapeutics
7 Committee of its decisions regarding drugs subject to prior
8 authorization. The agency is authorized to limit the entities
9 it contracts with or enrolls as Medicaid providers by
10 developing a provider network through provider credentialing.
11 The agency may competitively bid single-source-provider
12 contracts if procurement of goods or services results in
13 demonstrated cost savings to the state without limiting access
14 to care. The agency may limit its network based on the
15 assessment of beneficiary access to care, provider
16 availability, provider quality standards, time and distance
17 standards for access to care, the cultural competence of the
18 provider network, demographic characteristics of Medicaid
19 beneficiaries, practice and provider-to-beneficiary standards,
20 appointment wait times, beneficiary use of services, provider
21 turnover, provider profiling, provider licensure history,
22 previous program integrity investigations and findings, peer
23 review, provider Medicaid policy and billing compliance
24 records, clinical and medical record audits, and other
25 factors. Providers shall not be entitled to enrollment in the
26 Medicaid provider network. The agency shall determine
27 instances in which allowing Medicaid beneficiaries to purchase
28 durable medical equipment and other goods is less expensive to
29 the Medicaid program than long-term rental of the equipment or
30 goods. The agency may establish rules to facilitate purchases
31 in lieu of long-term rentals in order to protect against fraud

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1 and abuse in the Medicaid program as defined in s. 409.913.
2 The agency may seek federal waivers necessary to administer
3 these policies.
4 (4) The agency may contract with:
5 (b) An entity that is providing comprehensive
6 behavioral health care services to certain Medicaid recipients
7 through a capitated, prepaid arrangement pursuant to the
8 federal waiver provided for by s. 409.905(5). Such an entity
9 must be licensed under chapter 624, chapter 636, or chapter
10 641 and must possess the clinical systems and operational
11 competence to manage risk and provide comprehensive behavioral
12 health care to Medicaid recipients. As used in this paragraph,
13 the term "comprehensive behavioral health care services" means
14 covered mental health and substance abuse treatment services
15 that are available to Medicaid recipients. The secretary of
16 the Department of Children and Family Services shall approve
17 provisions of procurements related to children in the
18 department's care or custody prior to enrolling such children
19 in a prepaid behavioral health plan. Any contract awarded
20 under this paragraph must be competitively procured. In
21 developing the behavioral health care prepaid plan procurement
22 document, the agency shall ensure that the procurement
23 document requires the contractor to develop and implement a
24 plan to ensure compliance with s. 394.4574 related to services
25 provided to residents of licensed assisted living facilities
26 that hold a limited mental health license. Except as provided
27 in subparagraph 8., <u>and except in counties where the Medicaid</u>
28 <u>managed care pilot program is authorized pursuant s.</u>
29 <u>409.91211,</u> the agency shall seek federal approval to contract
30 with a single entity meeting these requirements to provide
31 comprehensive behavioral health care services to all Medicaid

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recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid

1 recipients in Hillsborough, Highlands, Hardee, Manatee, and
2 Polk Counties, to include substance abuse treatment services.
3 2. By July 1, 2003, the agency and the Department of
4 Children and Family Services shall execute a written agreement
5 that requires collaboration and joint development of all
6 policy, budgets, procurement documents, contracts, and
7 monitoring plans that have an impact on the state and Medicaid
8 community mental health and targeted case management programs.
9 3. Except as provided in subparagraph 8., by July 1,
10 2006, the agency and the Department of Children and Family
11 Services shall contract with managed care entities in each
12 AHCA area except area 6 or arrange to provide comprehensive
13 inpatient and outpatient mental health and substance abuse
14 services through capitated prepaid arrangements to all
15 Medicaid recipients who are eligible to participate in such
16 plans under federal law and regulation. In AHCA areas where
17 eligible individuals number less than 150,000, the agency
18 shall contract with a single managed care plan to provide
19 comprehensive behavioral health services to all recipients who
20 are not enrolled in a Medicaid health maintenance organization
21 or a Medicaid capitated managed care plan authorized under s.
22 409.91211. The agency may contract with more than one
23 comprehensive behavioral health provider to provide care to
24 recipients who are not enrolled in a Medicaid capitated
25 managed care plan authorized under s. 409.91211 or a Medicaid
26 health maintenance organization in AHCA areas where the
27 eligible population exceeds 150,000. In an AHCA area where the
28 Medicaid managed care pilot program is authorized pursuant to
29 s. 409.91211 in one or more counties, the agency may procure a
30 contract with a single entity to serve the remaining counties
31 as an AHCA area or the remaining counties may be included with

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1 an adjacent AHCA area and shall be subject to this paragraph.
2 Contracts for comprehensive behavioral health providers
3 awarded pursuant to this section shall be competitively
4 procured. Both for-profit and not-for-profit corporations
5 shall be eligible to compete. Managed care plans contracting
6 with the agency under subsection (3) shall provide and receive
7 payment for the same comprehensive behavioral health benefits
8 as provided in AHCA rules, including handbooks incorporated by
9 reference. In AHCA area 11, the agency shall contract with at
10 least two comprehensive behavioral health care providers to
11 provide behavioral health care to recipients in that area who
12 are enrolled in, or assigned to, the MediPass program. One of
13 the behavioral health care contracts shall be with the
14 existing provider service network pilot project, as described
15 in paragraph (d), for the purpose of demonstrating the
16 cost-effectiveness of the provision of quality mental health
17 services through a public hospital-operated managed care
18 model. Payment shall be at an agreed-upon capitated rate to
19 ensure cost savings. Of the recipients in area 11 who are
20 assigned to MediPass under the provisions of s.
21 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled
22 recipients shall be assigned to the existing provider service
23 network in area 11 for their behavioral care.
24 4. By October 1, 2003, the agency and the department
25 shall submit a plan to the Governor, the President of the
26 Senate, and the Speaker of the House of Representatives which
27 provides for the full implementation of capitated prepaid
28 behavioral health care in all areas of the state.
29 a. Implementation shall begin in 2003 in those AHCA
30 areas of the state where the agency is able to establish
31 sufficient capitation rates.

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1 b. If the agency determines that the proposed
2 capitation rate in any area is insufficient to provide
3 appropriate services, the agency may adjust the capitation
4 rate to ensure that care will be available. The agency and the
5 department may use existing general revenue to address any
6 additional required match but may not over-obligate existing
7 funds on an annualized basis.
8 c. Subject to any limitations provided for in the
9 General Appropriations Act, the agency, in compliance with
10 appropriate federal authorization, shall develop policies and
11 procedures that allow for certification of local and state
12 funds.
13 5. Children residing in a statewide inpatient
14 psychiatric program, or in a Department of Juvenile Justice or
15 a Department of Children and Family Services residential
16 program approved as a Medicaid behavioral health overlay
17 services provider shall not be included in a behavioral health
18 care prepaid health plan or any other Medicaid managed care
19 plan pursuant to this paragraph.
20 6. In converting to a prepaid system of delivery, the
21 agency shall in its procurement document require an entity
22 providing only comprehensive behavioral health care services
23 to prevent the displacement of indigent care patients by
24 enrollees in the Medicaid prepaid health plan providing
25 behavioral health care services from facilities receiving
26 state funding to provide indigent behavioral health care, to
27 facilities licensed under chapter 395 which do not receive
28 state funding for indigent behavioral health care, or
29 reimburse the unsubsidized facility for the cost of behavioral
30 health care provided to the displaced indigent care patient.
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1 7. Traditional community mental health providers under
2 contract with the Department of Children and Family Services
3 pursuant to part IV of chapter 394, child welfare providers
4 under contract with the Department of Children and Family
5 Services in areas 1 and 6, and inpatient mental health
6 providers licensed pursuant to chapter 395 must be offered an
7 opportunity to accept or decline a contract to participate in
8 any provider network for prepaid behavioral health services.
9 8. For fiscal year 2004-2005, all Medicaid eligible
10 children, except children in areas 1 and 6, whose cases are
11 open for child welfare services in the HomeSafeNet system,
12 shall be enrolled in MediPass or in Medicaid fee-for-service
13 and all their behavioral health care services including
14 inpatient, outpatient psychiatric, community mental health,
15 and case management shall be reimbursed on a fee-for-service
16 basis. Beginning July 1, 2005, such children, who are open for
17 child welfare services in the HomeSafeNet system, shall
18 receive their behavioral health care services through a
19 specialty prepaid plan operated by community-based lead
20 agencies either through a single agency or formal agreements
21 among several agencies. The specialty prepaid plan must result
22 in savings to the state comparable to savings achieved in
23 other Medicaid managed care and prepaid programs. Such plan
24 must provide mechanisms to maximize state and local revenues.
25 The specialty prepaid plan shall be developed by the agency
26 and the Department of Children and Family Services. The agency
27 is authorized to seek any federal waivers to implement this
28 initiative.
29 (d) A provider service network may be reimbursed on a
30 fee-for-service or prepaid basis. A provider service network
31 which is reimbursed by the agency on a prepaid basis shall be

exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. ~~The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care.~~ Medicaid recipients assigned to a provider service network ~~demonstration project~~ shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 3. Section 409.91211, Florida Statutes, is amended to read:

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1 409.91211 Medicaid managed care pilot program.--
2 (1)<u>(a)</u> The agency is authorized to seek <u>and implement</u>
3 experimental, pilot, or demonstration project waivers,
4 pursuant to s. 1115 of the Social Security Act, to create a
5 statewide initiative to provide for a more efficient and
6 effective service delivery system that enhances quality of
7 care and client outcomes in the Florida Medicaid program
8 pursuant to this section. Phase one of the demonstration shall
9 be implemented in two geographic areas. One demonstration site
10 shall include only Broward County. A second demonstration site
11 shall initially include Duval County and shall be expanded to
12 include Baker, Clay, and Nassau Counties within 1 year after
13 the Duval County program becomes operational. <u>The agency shall</u>
14 <u>implement expansion of the program to include the remaining</u>
15 <u>counties of the state and remaining eligibility groups in</u>
16 <u>accordance with the process specified in the</u>
17 <u>federally-approved special terms and conditions numbered</u>
18 <u>11-W-00206/4, with a goal of full statewide implementation by</u>
19 <u>June 30, 2011.</u>
20 <u>(b)</u> This waiver authority is contingent upon federal
21 approval to preserve the upper-payment-limit funding mechanism
22 for hospitals, including a guarantee of a reasonable growth
23 factor, a methodology to allow the use of a portion of these
24 funds to serve as a risk pool for demonstration sites,
25 provisions to preserve the state's ability to use
26 intergovernmental transfers, and provisions to protect the
27 disproportionate share program authorized pursuant to this
28 chapter. Upon completion of the evaluation conducted under s.
29 3, ch. 2005-133, Laws of Florida, the agency may request
30 statewide expansion of the demonstration projects. Statewide
31 phase-in to additional counties shall be contingent upon

1 review and approval by the Legislature. Under the
2 upper-payment-limit program, or the low-income pool as
3 implemented by the Agency for Health Care Administration
4 pursuant to federal waiver, the state matching funds required
5 for the program shall be provided by local governmental
6 entities through intergovernmental transfers. The Agency for
7 Health Care Administration shall distribute
8 upper-payment-limit, disproportionate share hospital, and
9 low-income pool funds according to federal regulations and
10 waivers and the low-income pool methodology approved by the
11 federal Centers for Medicare and Medicaid Services.
12 (c) It is the intent of the Legislature that the
13 low-income pool plan required by the terms and conditions of
14 the Medicaid reform waiver and submitted to the federal
15 Centers for Medicare and Medicaid Services propose the
16 distribution of the abovementioned program funds based on the
17 following objectives:
18 1. Assure a broad and fair distribution of available
19 funds based on the access provided by Medicaid participating
20 hospitals, regardless of their ownership status, through their
21 delivery of inpatient or outpatient care for Medicaid
22 beneficiaries and uninsured and underinsured individuals;
23 2. Assure accessible emergency inpatient and
24 outpatient care for Medicaid beneficiaries and uninsured and
25 underinsured individuals;
26 3. Enhance primary, preventive, and other ambulatory
27 care coverages for uninsured individuals;
28 4. Promote teaching and specialty hospital programs;
29 5. Promote the stability and viability of statutorily
30 defined rural hospitals and hospitals that serve as sole
31 community hospitals;

1 6. Recognize the extent of hospital uncompensated care
2 costs;
3 7. Maintain and enhance essential community hospital
4 care;
5 8. Maintain incentives for local governmental entities
6 to contribute to the cost of uncompensated care;
7 9. Promote measures to avoid preventable
8 hospitalizations;
9 10. Account for hospital efficiency; and
10 11. Contribute to a community's overall health system.
11 (2) The Legislature intends for the capitated managed
12 care pilot program to:
13 (a) Provide recipients in Medicaid fee-for-service or
14 the MediPass program a comprehensive and coordinated capitated
15 managed care system for all health care services specified in
16 ss. 409.905 and 409.906. For purposes of this section, the
17 term "capitated managed care plan" includes health maintenance
18 organizations authorized under chapter 641, exclusive provider
19 organizations authorized under chapter 627, health insurers
20 authorized under chapter 624, and provider service networks
21 that elect to be paid fee-for-service for up to 3 years as
22 authorized under this section.
23 (b) Stabilize Medicaid expenditures under the pilot
24 program compared to Medicaid expenditures in the pilot area
25 for the 3 years before implementation of the pilot program,
26 while ensuring:
27 1. Consumer education and choice.
28 2. Access to medically necessary services.
29 3. Coordination of preventative, acute, and long-term
30 care.
31 4. Reductions in unnecessary service utilization.

(c) Provide an opportunity to evaluate the feasibility of statewide implementation of capitated managed care networks as a replacement for the current Medicaid fee-for-service and MediPass systems.

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

(a) To implement ~~develop and recommend~~ a system to deliver all mandatory services specified in s. 409.905 and optional services specified in s. 409.906, as approved by the Centers for Medicare and Medicaid Services and the Legislature in the waiver pursuant to this section. Services to recipients under plan benefits shall include emergency services provided under s. 409.9128.

(b) To implement a pilot program, including ~~recommend~~ Medicaid eligibility categories~~, from those~~ specified in ss. 409.903 and 409.904, as authorized in an approved federal waiver ~~which shall be included in the pilot program~~.

(c) To implement ~~determine and recommend how to design~~ the managed care pilot program that maximizes ~~in order to take maximum advantage of~~ all available state and federal funds, including those obtained through intergovernmental transfers, the low-income pool, supplemental Medicaid payments ~~the upper payment level funding systems~~, and the disproportionate share program. Within the parameters allowed by federal statute and rule, the agency may seek options for making direct payments to hospitals and physicians employed by or under contract with the state's medical schools for the costs associated with graduate medical education under Medicaid reform.

1 (d) To implement ~~determine and recommend~~ actuarially
2 sound, risk-adjusted capitation rates for Medicaid recipients
3 in the pilot program which ~~can be separated to~~ cover
4 comprehensive care, enhanced services, and catastrophic care.
5 (e) To implement ~~determine and recommend~~ policies and
6 guidelines for phasing in financial risk for approved provider
7 service networks over a 3-year period. These policies and
8 guidelines must ~~shall~~ include an option for a provider service
9 network to be paid ~~to pay~~ fee-for-service rates ~~that may~~
10 ~~include a savings settlement option for at least 2 years~~. For
11 any provider service network established in a managed care
12 pilot area, the option to be paid fee-for-service rates shall
13 include a savings-settlement mechanism that is consistent with
14 s. 409.912(44). This model shall ~~may~~ be converted to a
15 risk-adjusted capitated rate no later than the beginning of
16 the fourth ~~in the third~~ year of operation, and may be
17 converted earlier at the option of the provider service
18 network. Federally qualified health centers may be offered an
19 opportunity to accept or decline a contract to participate in
20 any provider network for prepaid primary care services.
21 (f) To implement ~~determine and recommend provisions~~
22 ~~related to~~ stop-loss requirements and the transfer of excess
23 cost to catastrophic coverage that accommodates the risks
24 associated with the development of the pilot program.
25 (g) To ~~determine and~~ recommend a process to be used by
26 the Social Services Estimating Conference to determine and
27 validate the rate of growth of the per-member costs of
28 providing Medicaid services under the managed care pilot
29 program.
30 (h) To implement ~~determine and recommend~~ program
31 standards and credentialing requirements for capitated managed

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1 care networks to participate in the pilot program, including
2 those related to fiscal solvency, quality of care, and
3 adequacy of access to health care providers. It is the intent
4 of the Legislature that, to the extent possible, any pilot
5 program authorized by the state under this section include any
6 federally qualified health center, federally qualified rural
7 health clinic, county health department, the Children's
8 Medical Services Network within the Department of Health, or
9 other federally, state, or locally funded entity that serves
10 the geographic areas within the boundaries of the pilot
11 program that requests to participate. This paragraph does not
12 relieve an entity that qualifies as a capitated managed care
13 network under this section from any other licensure or
14 regulatory requirements contained in state or federal law
15 which would otherwise apply to the entity. The standards and
16 credentialing requirements shall be based upon, but are not
17 limited to:
18 1. Compliance with the accreditation requirements as
19 provided in s. 641.512.
20 2. Compliance with early and periodic screening,
21 diagnosis, and treatment screening requirements under federal
22 law.
23 3. The percentage of voluntary disenrollments.
24 4. Immunization rates.
25 5. Standards of the National Committee for Quality
26 Assurance and other approved accrediting bodies.
27 6. Recommendations of other authoritative bodies.
28 7. Specific requirements of the Medicaid program, or
29 standards designed to specifically meet the unique needs of
30 Medicaid recipients.
31

1 8. Compliance with the health quality improvement
2 system as established by the agency, which incorporates
3 standards and guidelines developed by the Centers for Medicare
4 and Medicaid Services as part of the quality assurance reform
5 initiative.
6 9. The network's infrastructure capacity to manage
7 financial transactions, recordkeeping, data collection, and
8 other administrative functions.
9 10. The network's ability to submit any financial,
10 programmatic, or patient-encounter data or other information
11 required by the agency to determine the actual services
12 provided and the cost of administering the plan.
13 (i) To <u>implement</u> ~~develop and recommend~~ a mechanism for
14 providing information to Medicaid recipients for the purpose
15 of selecting a capitated managed care plan. For each plan
16 available to a recipient, the agency, at a minimum, shall
17 ensure that the recipient is provided with:
18 1. A list and description of the benefits provided.
19 2. Information about cost sharing.
20 3. Plan performance data, if available.
21 4. An explanation of benefit limitations.
22 5. Contact information, including identification of
23 providers participating in the network, geographic locations,
24 and transportation limitations.
25 6. Any other information the agency determines would
26 facilitate a recipient's understanding of the plan or
27 insurance that would best meet his or her needs.
28 (j) To <u>implement</u> ~~develop and recommend~~ a system to
29 ensure that there is a record of recipient acknowledgment that
30 choice counseling has been provided.
31

(k) To implement ~~develop and recommend~~ a choice counseling system to 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 use language lines and other services for impaired recipients, such as TTD/TTY.

(l) To implement ~~develop and recommend~~ a system that prohibits capitated managed care plans, their representatives, and providers employed by or contracted with the capitated managed care plans from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular capitated managed care plan, and from prejudicing Medicaid recipients against other capitated managed care plans. The system 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), 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.

(m) To implement ~~develop and recommend~~ a choice counseling system that promotes health literacy and provides

information aimed to reduce minority health disparities through outreach activities for Medicaid recipients.

(n) To ~~develop and recommend a system for the agency to~~ contract with entities to perform choice counseling. The agency may establish standards and performance contracts, including standards requiring the contractor to hire choice counselors who are representative of the state's diverse population and to train choice counselors in working with culturally diverse populations.

(o) To implement ~~determine and recommend descriptions of the~~ eligibility assignment processes ~~which will be used~~ to facilitate client choice while ensuring pilot programs of adequate enrollment levels. These processes shall ensure that pilot sites have sufficient levels of enrollment to conduct a valid test of the managed care pilot program within a 2-year timeframe.

(p) To implement standards for plan compliance, including, but not limited to, standards for quality assurance and performance improvement, standards for peer or professional reviews, grievance policies, and policies for maintaining program integrity. The agency shall develop a data-reporting system, seek input from managed care plans in order to establish requirements for patient-encounter reporting, and ensure that the data reported is accurate and complete.

1. In performing the duties required under this section, the agency shall work with managed care plans to establish a uniform system to measure and monitor outcomes for a recipient of Medicaid services.

2. The system shall use financial, clinical, and other criteria based on pharmacy, medical services, and other data

1 that is related to the provision of Medicaid services,
2 including, but not limited to:
3 a. The Health Plan Employer Data and Information Set
4 (HEDIS) or measures that are similar to HEDIS.
5 b. Member satisfaction.
6 c. Provider satisfaction.
7 d. Report cards on plan performance and best
8 practices.
9 e. Compliance with the requirements for prompt payment
10 of claims under ss. 627.613, 641.3155, and 641.513.
11 3. The agency shall require the managed care plans
12 that have contracted with the agency to establish a quality
13 assurance system that incorporates the provisions of s.
14 409.912(27) and any standards, rules, and guidelines developed
15 by the agency.
16 4. The agency shall establish an encounter database in
17 order to compile data on health services rendered by health
18 care practitioners who provide services to patients enrolled
19 in managed care plans in the demonstration sites. The
20 encounter database shall:
21 a. Collect the following for each type of patient
22 encounter with a health care practitioner or facility,
23 including:
24 (I) The demographic characteristics of the patient.
25 (II) The principal, secondary, and tertiary diagnosis.
26 (III) The procedure performed.
27 (IV) The date and location where the procedure was
28 performed.
29 (V) The payment for the procedure, if any.
30 (VI) If applicable, the health care practitioner's
31 universal identification number.

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(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 and utilization from managed care plans participating in the demonstration sites.

5. To the extent practicable, when collecting the data the agency shall use a standardized claim form or electronic transfer system that is used by health care practitioners, facilities, and payors.

6. Health care practitioners and facilities in the demonstration sites shall electronically submit, and managed care plans participating in the demonstration sites shall electronically receive, information concerning claims payments and any other information reasonably related to the encounter database using a standard format as required by the agency.

7. The agency shall establish reasonable deadlines for phasing in the electronic transmittal of full encounter data.

8. The system must ensure that the data reported is accurate and complete.

~~(p) To develop and recommend a system to monitor the provision of health care services in the pilot program, including utilization and quality of health care services for the purpose of ensuring access to medically necessary services. This system shall include an encounter data information system that collects and reports utilization information. The system shall include a method for verifying~~

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~~data integrity within the database and within the provider's medical records.~~

(q) To implement ~~recommend~~ a grievance resolution process for Medicaid recipients enrolled in a capitated managed care network under the pilot program modeled after the subscriber assistance panel, as created in s. 408.7056. This process shall include a mechanism for an expedited review of no greater than 24 hours after notification of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy.

(r) To implement ~~recommend~~ a grievance resolution process for health care providers employed by or contracted with a capitated managed care network under the pilot program in order to settle disputes among the provider and the managed care network or the provider and the agency.

(s) To implement ~~develop and recommend~~ criteria in an approved federal waiver to designate health care providers as eligible to participate in the pilot program. ~~The agency and capitated managed care networks must follow national guidelines for selecting health care providers, whenever available.~~ These criteria must include at a minimum those criteria specified in s. 409.907.

(t) To use ~~develop and recommend~~ health care provider agreements for participation in the pilot program.

(u) To require that all health care providers under contract with the pilot program be duly licensed in the state, if such licensure is available, and meet other criteria as may be established by the agency. These criteria shall include at a minimum those criteria specified in s. 409.907.

(v) To ensure that managed care organizations work collaboratively ~~develop and recommend agreements~~ with other

1 state or local governmental programs or institutions for the
2 coordination of health care to eligible individuals receiving
3 services from such programs or institutions.
4 (w) To implement procedures to minimize the risk of
5 Medicaid fraud and abuse in all plans operating in the
6 Medicaid managed care pilot program authorized in this
7 section.
8 1. The agency shall ensure that applicable provisions
9 of this chapter and chapters 414, 626, 641, and 932 which
10 relate to Medicaid fraud and abuse are applied and enforced at
11 the demonstration project sites.
12 2. Providers must have the certification, license, and
13 credentials that are required by law and waiver requirements.
14 3. The agency shall ensure that the plan is in
15 compliance with s. 409.912(21) and (22).
16 4. The agency shall require that each plan establish
17 functions and activities governing program integrity in order
18 to reduce the incidence of fraud and abuse. Plans must report
19 instances of fraud and abuse pursuant to chapter 641.
20 5. The plan shall have written administrative and
21 management arrangements or procedures, including a mandatory
22 compliance plan, which are designed to guard against fraud and
23 abuse. The plan shall designate a compliance officer who has
24 sufficient experience in health care.
25 6.a. The agency shall require all managed care plan
26 contractors in the pilot program to report all instances of
27 suspected fraud and abuse. A failure to report instances of
28 suspected fraud and abuse is a violation of law and subject to
29 the penalties provided by law.
30 b. An instance of fraud and abuse in the managed care
31 plan, including, but not limited to, defrauding the state

1 health care benefit program by misrepresentation of fact in
2 reports, claims, certifications, enrollment claims,
3 demographic statistics, or patient-encounter data;
4 misrepresentation of the qualifications of persons rendering
5 health care and ancillary services; bribery and false
6 statements relating to the delivery of health care; unfair and
7 deceptive marketing practices; and false claims actions in the
8 provision of managed care, is a violation of law and subject
9 to the penalties provided by law.
10 c. The agency shall require that all contractors make
11 all files and relevant billing and claims data accessible to
12 state regulators and investigators and that all such data is
13 linked into a unified system to ensure consistent reviews and
14 investigations.
15 ~~(w) To develop and recommend a system to oversee the~~
16 ~~activities of pilot program participants, health care~~
17 ~~providers, capitated managed care networks, and their~~
18 ~~representatives in order to prevent fraud or abuse,~~
19 ~~overutilization or duplicative utilization, underutilization~~
20 ~~or inappropriate denial of services, and neglect of~~
21 ~~participants and to recover overpayments as appropriate. For~~
22 ~~the purposes of this paragraph, the terms "abuse" and "fraud"~~
23 ~~have the meanings as provided in s. 409.913. The agency must~~
24 ~~refer incidents of suspected fraud, abuse, overutilization and~~
25 ~~duplicative utilization, and underutilization or inappropriate~~
26 ~~denial of services to the appropriate regulatory agency.~~
27 (x) To develop and provide actuarial and benefit
28 design analyses that indicate the effect on capitation rates
29 and benefits offered in the pilot program over a prospective
30 5-year period based on the following assumptions:
31

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1. Growth in capitation rates which is limited to the estimated growth rate in general revenue.

2. Growth in capitation rates which is limited to the average growth rate over the last 3 years in per-recipient Medicaid expenditures.

3. Growth in capitation rates which is limited to the growth rate of aggregate Medicaid expenditures between the 2003-2004 fiscal year and the 2004-2005 fiscal year.

(y) To develop a mechanism to require capitated managed care plans to reimburse qualified emergency service providers, including, but not limited to, ambulance services, in accordance with ss. 409.908 and 409.9128. The pilot program must include a provision for continuing fee-for-service payments for emergency services, including, but not limited to, individuals who access ambulance services or emergency departments and who are subsequently determined to be eligible for Medicaid services.

(z) To ensure that ~~develop a system whereby~~ school districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in a capitated managed care network. Capitated managed care networks must make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 must be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered

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1 services in a school setting, regardless of whether the child
2 is enrolled in a capitated managed care network. Capitated
3 managed care networks must make a good faith effort to execute
4 agreements with county health departments regarding the
5 coordinated provision of services to a Medicaid-eligible
6 child. To ensure continuity of care for Medicaid patients, the
7 agency, the Department of Health, and the Department of
8 Education shall develop procedures for ensuring that a
9 student's capitated managed care network provider receives
10 information relating to services provided in accordance with
11 ss. 381.0056, 381.0057, 409.9071, and 1011.70.
12 (aa) To implement ~~develop and recommend~~ a mechanism
13 whereby Medicaid recipients who are already enrolled in a
14 managed care plan or the MediPass program in the pilot areas
15 shall be offered the opportunity to change to capitated
16 managed care plans on a staggered basis, as defined by the
17 agency. All Medicaid recipients shall have 30 days in which to
18 make a choice of capitated managed care plans. Those Medicaid
19 recipients who do not make a choice shall be assigned to a
20 capitated managed care plan in accordance with paragraph
21 (4)(a) and shall be exempt from s. 409.9122. To facilitate
22 continuity of care for a Medicaid recipient who is also a
23 recipient of Supplemental Security Income (SSI), prior to
24 assigning the SSI recipient to a capitated managed care plan,
25 the agency shall determine whether the SSI recipient has an
26 ongoing relationship with a provider or capitated managed care
27 plan, and, if so, the agency shall assign the SSI recipient to
28 that provider or capitated managed care plan where feasible.
29 Those SSI recipients who do not have such a provider
30 relationship shall be assigned to a capitated managed care
31

1 plan provider in accordance with paragraph (4)(a) <u>and shall be</u>
2 <u>exempt from s. 409.9122</u>.
3 (bb) To develop and recommend a service delivery
4 alternative for children having chronic medical conditions
5 which establishes a medical home project to provide primary
6 care services to this population. The project shall provide
7 community-based primary care services that are integrated with
8 other subspecialties to meet the medical, developmental, and
9 emotional needs for children and their families. This project
10 shall include an evaluation component to determine impacts on
11 hospitalizations, length of stays, emergency room visits,
12 costs, and access to care, including specialty care and
13 patient and family satisfaction.
14 (cc) To develop and recommend service delivery
15 mechanisms within capitated managed care plans to provide
16 Medicaid services as specified in ss. 409.905 and 409.906 to
17 persons with developmental disabilities sufficient to meet the
18 medical, developmental, and emotional needs of these persons.
19 (dd) To develop and recommend service delivery
20 mechanisms within capitated managed care plans to provide
21 Medicaid services as specified in ss. 409.905 and 409.906 to
22 Medicaid-eligible children in foster care. These services must
23 be coordinated with community-based care providers as
24 specified in s. 409.1675, where available, and be sufficient
25 to meet the medical, developmental, and emotional needs of
26 these children.
27 (4)(a) A Medicaid recipient in the pilot area who is
28 not currently enrolled in a capitated managed care plan upon
29 implementation is not eligible for services as specified in
30 ss. 409.905 and 409.906, for the amount of time that the
31 recipient does not enroll in a capitated managed care network.

1 If a Medicaid recipient has not enrolled in a capitated
2 managed care plan within 30 days after eligibility, the agency
3 shall assign the Medicaid recipient to a capitated managed
4 care plan based on the assessed needs of the recipient as
5 determined by the agency and the recipient shall be exempt
6 from s. 409.9122. When making assignments, the agency shall
7 take into account the following criteria:
8 1. A capitated managed care network has sufficient
9 network capacity to meet the needs of members.
10 2. The capitated managed care network has previously
11 enrolled the recipient as a member, or one of the capitated
12 managed care network's primary care providers has previously
13 provided health care to the recipient.
14 3. The agency has knowledge that the member has
15 previously expressed a preference for a particular capitated
16 managed care network as indicated by Medicaid fee-for-service
17 claims data, but has failed to make a choice.
18 4. The capitated managed care network's primary care
19 providers are geographically accessible to the recipient's
20 residence.
21 (b) When more than one capitated managed care network
22 provider meets the criteria specified in paragraph (3)(h), the
23 agency shall make recipient assignments consecutively by
24 family unit.
25 (c) If a recipient is currently enrolled with a
26 Medicaid managed care organization that also operates an
27 approved reform plan within a demonstration area and the
28 recipient fails to choose a plan during the reform enrollment
29 process or during redetermination of eligibility, the
30 recipient shall be automatically assigned by the agency into
31 the most appropriate reform plan operated by the recipient's

current Medicaid managed care plan. If the recipient's current managed care plan does not operate a reform plan in the demonstration area which adequately meets the needs of the Medicaid recipient, the agency shall use the automatic assignment process as prescribed in the special terms and conditions numbered 11-W-00206/4. All enrollment and choice counseling materials provided by the agency must contain an explanation of the provisions of this paragraph for current managed care recipients.

(d)~~(c)~~ The agency may not engage in practices that are designed to favor one capitated managed care plan over another or that are designed to influence Medicaid recipients to enroll in a particular capitated managed care network in order to strengthen its particular fiscal viability.

(e)~~(d)~~ After a recipient has made a selection or has been enrolled in a capitated managed care network, the recipient shall have 90 days in which to voluntarily disenroll and select another capitated managed care network. After 90 days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. The agency may require a recipient to use the capitated managed care network's grievance process as specified in paragraph (3)(g) prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when used, must be completed in time to permit the recipient to

1 disenroll no later than the first day of the second month
2 after the month the disenrollment request was made. If the
3 capitated managed care network, as a result of the grievance
4 process, approves an enrollee's request to disenroll, the
5 agency is not required to make a determination in the case.
6 The agency must make a determination and take final action on
7 a recipient's request so that disenrollment occurs no later
8 than the first day of the second month after the month the
9 request was made. If the agency fails to act within the
10 specified timeframe, the recipient's request to disenroll is
11 deemed to be approved as of the date agency action was
12 required. Recipients who disagree with the agency's finding
13 that cause does not exist for disenrollment shall be advised
14 of their right to pursue a Medicaid fair hearing to dispute
15 the agency's finding.
16 (f)~~(e)~~ The agency shall apply for federal waivers from
17 the Centers for Medicare and Medicaid Services to lock
18 eligible Medicaid recipients into a capitated managed care
19 network for 12 months after an open enrollment period. After
20 12 months of enrollment, a recipient may select another
21 capitated managed care network. However, nothing shall prevent
22 a Medicaid recipient from changing primary care providers
23 within the capitated managed care network during the 12-month
24 period.
25 (g)~~(f)~~ The agency shall apply for federal waivers from
26 the Centers for Medicare and Medicaid Services to allow
27 recipients to purchase health care coverage through an
28 employer-sponsored health insurance plan instead of through a
29 Medicaid-certified plan. This provision shall be known as the
30 opt-out option.
31

1. 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.

2. 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.

(5) 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 in any part of the state other than the two geographic areas specified in this section unless approved by the Legislature.

(6) The agency shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the managed care pilot 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. All waiver applications shall be provided for review and comment to the

1 appropriate committees of the Senate and House of
2 Representatives for at least 10 working days prior to
3 submission. All waivers submitted to and approved by the
4 United States Centers for Medicare and Medicaid Services under
5 this section must be approved by the Legislature. Federally
6 approved waivers must be submitted to the President of the
7 Senate and the Speaker of the House of Representatives for
8 referral to the appropriate legislative committees. The
9 appropriate committees shall recommend whether to approve the
10 implementation of any waivers to the Legislature as a whole.
11 The agency shall submit a plan containing a recommended
12 timeline for implementation of any waivers and budgetary
13 projections of the effect of the pilot program under this
14 section on the total Medicaid budget for the 2006-2007 through
15 2009-2010 state fiscal years. This implementation plan shall
16 be submitted to the President of the Senate and the Speaker of
17 the House of Representatives at the same time any waivers are
18 submitted for consideration by the Legislature. The agency may
19 implement the waiver and special terms and conditions numbered
20 11-W-00206/4, as approved by the federal Centers for Medicare
21 and Medicaid Services. If the agency seeks approval by the
22 Federal Government of any modifications to these special terms
23 and conditions, the agency must provide written notification
24 of its intent to modify these terms and conditions to the
25 President of the Senate and the Speaker of the House of
26 Representatives at least 15 days before submitting the
27 modifications to the Federal Government for consideration. The
28 notification must identify all modifications being pursued and
29 the reason the modifications are needed. Upon receiving
30 federal approval of any modifications to the special terms and
31 conditions, the agency shall provide a report to the

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1 Legislature describing the federally approved modifications to
2 the special terms and conditions within 7 days after approval
3 by the Federal Government.
4 (7) The Office of Insurance Regulation shall conduct
5 an annual review of the Medicaid managed care pilot program's
6 risk-adjusted rate-setting methodology as developed by the
7 agency. The Office of Insurance Regulation shall contract with
8 an independent actuary firm to assist in the annual review and
9 to provide technical expertise.
10 (a) After reviewing the actuarial analysis provided by
11 the agency, the Office of Insurance Regulation shall make
12 advisory recommendations to the Governor and the Legislature
13 regarding:
14 1. The methodology adopted by the agency for
15 risk-adjusted rates.
16 2. The risk-adjusted rate for each Medicaid
17 eligibility category in the demonstration program.
18 3. Administrative and implementation issues regarding
19 the use of risk-adjusted rates, including, but not limited to,
20 cost, simplicity, client privacy, data accuracy, and data
21 exchange.
22 (b) For each annual review, the Office of Insurance
23 Regulation shall solicit input concerning the agency's
24 rate-setting methodology from the Florida Association of
25 Health Plans, the Florida Hospital Association, the Florida
26 Medical Association, Medicaid recipient advocacy groups, and
27 other stakeholder representatives as necessary to obtain a
28 broad representation of perspectives on the effects of the
29 agency's adopted rate-setting methodology and recommendations
30 on possible modifications to the methodology.
31

1 (c) The Office of Insurance Regulation shall submit
2 its findings and advisory recommendations to the Governor and
3 the Legislature no later than February 1 of each year for
4 consideration by the Legislature for inclusion in the General
5 Appropriations Act.
6 (8)~~(7)~~ Upon review and approval of the applications
7 for waivers of applicable federal laws and regulations to
8 implement the managed care pilot program by the Legislature,
9 the agency may initiate adoption of rules pursuant to ss.
10 120.536(1) and 120.54 to implement and administer the managed
11 care pilot program as provided in this section.
12 (9) It is the intent of the Legislature that if any
13 conflict exists between the provisions contained in this
14 section and other provisions of this chapter which relate to
15 the implementation of the Medicaid managed care pilot program,
16 the provisions contained in this section shall control. The
17 agency shall provide a written report to the Legislature by
18 April 1, 2006, identifying any provisions of this chapter
19 which conflict with the implementation of the Medicaid managed
20 care pilot program created in this section. After April 1,
21 2006, the agency shall provide a written report to the
22 Legislature immediately upon identifying any provisions of
23 this chapter which conflict with the implementation of the
24 Medicaid managed care pilot program created in this section.
25 Section 4. Section 409.91213, Florida Statutes, is
26 created to read:
27 409.91213 Quarterly progress reports and annual
28 reports.--
29 (1) The agency shall submit to the Governor, the
30 President of the Senate, the Speaker of the House of
31 Representatives, the Minority Leader of the Senate, the

1 Minority Leader of the House of Representatives, and the
2 Office of Program Policy Analysis and Government
3 Accountability the following reports:
4 (a) The quarterly progress report submitted to the
5 United States Centers for Medicare and Medicaid Services no
6 later than 60 days following the end of each quarter. The
7 intent of this report is to present the agency's analysis and
8 the status of various operational areas. The quarterly
9 progress report must include, but need not be limited to:
10 1. Events occurring during the quarter or anticipated
11 to occur in the near future which affect health care delivery,
12 including, but not limited to, the approval of and contracts
13 for new plans, which report must specify the coverage area,
14 phase-in period, populations served, and benefits; the
15 enrollment; grievances; and other operational issues.
16 2. Action plans for addressing any policy and
17 administrative issues.
18 3. Agency efforts related to collecting and verifying
19 encounter data and utilization data.
20 4. Enrollment data disaggregated by plan and by
21 eligibility category, such as Temporary Assistance for Needy
22 Families or Supplemental Security Income; the total number of
23 enrollees; market share; and the percentage change in
24 enrollment by plan. In addition, the agency shall provide a
25 summary of voluntary and mandatory selection rates and
26 disenrollment data.
27 5. For purposes of monitoring budget neutrality,
28 enrollment data, member-month data, and expenditures in the
29 format for monitoring budget neutrality which is provided by
30 the federal Centers for Medicare and Medicaid Services.
31

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1 6. Activities and associated expenditures of the
2 low-income pool.
3 7. Activities related to the implementation of choice
4 counseling, including efforts to improve health literacy and
5 the methods used to obtain public input, such as recipient
6 focus groups.
7 8. Participation rates in the enhanced benefit
8 accounts program, including participation levels; a summary of
9 activities and associated expenditures; the number of accounts
10 established, including active participants and individuals who
11 continue to retain access to funds in an account but who no
12 longer actively participate; an estimate of quarterly deposits
13 in the accounts; and expenditures from the accounts.
14 9. Enrollment data concerning employer-sponsored
15 insurance which document the number of individuals selecting
16 to opt out when employer-sponsored insurance is available. The
17 agency shall include data that identify enrollee
18 characteristics, including the eligibility category, type of
19 employer-sponsored insurance, and type of coverage, such as
20 individual or family coverage. The agency shall develop and
21 maintain disenrollment reports specifying the reason for
22 disenrollment in an employer-sponsored insurance program. The
23 agency shall also track and report on those enrollees who
24 elect the option to reenroll in the Medicaid reform
25 demonstration.
26 10. Progress toward meeting the demonstration goals.
27 11. Evaluation activities.
28 (b) An annual report documenting accomplishments,
29 project status, quantitative and case-study findings,
30 utilization data, and policy and administrative difficulties
31 in the operation of the Medicaid waiver demonstration program.

1 <u>The agency shall submit the draft annual report no later than</u>
2 <u>October 1 after the end of each fiscal year.</u>
3 <u>(2) Beginning with the annual report for demonstration</u>
4 <u>year two, the agency shall include a section concerning the</u>
5 <u>administration of enhanced benefit accounts, the participation</u>
6 <u>rates, an assessment of expenditures, and an assessment of</u>
7 <u>potential cost savings.</u>
8 <u>(3) Beginning with the annual report for demonstration</u>
9 <u>year four, the agency shall include a section that provides</u>
10 <u>qualitative and quantitative data describing the impact the</u>
11 <u>low-income pool has had on the rate of uninsured people in</u>
12 <u>this state, beginning with the implementation of the</u>
13 <u>demonstration program.</u>
14 Section 5. Section 641.2261, Florida Statutes, is
15 amended to read:
16 641.2261 Application of ~~federal~~ solvency requirements
17 to provider-sponsored organizations <u>and Medicaid provider</u>
18 <u>service networks</u>.--
19 <u>(1)</u> The solvency requirements of ss. 1855 and 1856 of
20 the Balanced Budget Act of 1997 and <u>42 C.F.R. 422.350, subpart</u>
21 <u>H,</u> ~~rules adopted by the Secretary of the United States~~
22 ~~Department of Health and Human Services~~ apply to a health
23 maintenance organization that is a provider-sponsored
24 organization rather than the solvency requirements of this
25 part. However, if the provider-sponsored organization does not
26 meet the solvency requirements of this part, the organization
27 is limited to the issuance of Medicare+Choice plans to
28 eligible individuals. For the purposes of this section, the
29 terms "Medicare+Choice plans," "provider-sponsored
30 organizations," and "solvency requirements" have the same
31

1 meaning as defined in the federal act and federal rules and
2 regulations.
3 (2) The solvency requirements in 42 C.F.R. 422.350,
4 subpart H, and the solvency requirements established in
5 approved federal waivers pursuant to chapter 409, apply to a
6 Medicaid provider service network rather than the solvency
7 requirements of this part.
8 Section 6. The Agency for Health Care Administration
9 shall report to the Legislature by April 1, 2006, on the
10 specific pre-implementation milestones required by the special
11 terms and conditions related to the low-income pool which have
12 been approved by the Federal Government and the status of any
13 remaining pre-implementation milestones that have not been
14 approved by the Federal Government.
15 Section 7. This act shall take effect upon becoming a
16 law.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 2-B

The Committee Substitute retains the Disproportionate Share Hospital Council, requires the Council to make recommendations to the Agency for Health Care Administration (AHCA) on the development of the Low-Income Plan, requires AHCA to ensure fair representation of specified organizations on the Council, requires the Council to report to the Governor and Legislature by March 1st, and repeals the Council on June 30, 2006.

The Committee Substitute requires AHCA to create a Medicaid Low-Income Pool Council by July 1, 2006, specifies the membership and duties of the Council, and requires the Council to report to the Governor and Legislature by February 1 of each year.

The Committee Substitute requires the Office of Insurance Regulation (OIR) to conduct an annual review of the Medicaid reform rate-setting methodology that will be used in the pilot sites, requires OIR to contract with an independent actuary firm to assist in the review, requires OIR to solicit input concerning the agency's rate-setting methodology from specified organizations, and requires OIR to submit its findings and advisory recommendations to the Governor and Legislature no later than February 1 of each year.