A bill to be entitled

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

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

counseling; providing for panel members; providing certain requirements for managed care plans providing benefits to TANF and SSI recipients; providing for capitation rates to be phased in; providing an exception for high-risk, specialty populations; requiring the certification of rates by an actuary and federal approval; providing that, if any conflict exists between the provisions contained in s. 409.91211, F.S., and ch. 409, F.S., concerning the implementation of the pilot program, the provisions contained in s. 409.91211, F.S., control; creating s. 409.91213, F.S.; requiring the agency to submit quarterly and annual progress reports to the Legislature; providing requirements for the reports; amending s. 641.2261, F.S.; revising the application of solvency requirements to include Medicaid provider service networks; updating a reference; requiring that the agency report to the Legislature the pre-implementation milestones concerning the low-income pool which have been approved by the Federal Government and the status of those remaining to be approved; amending s. 216.346, F.S.; revising provisions relating to contracts between state agencies; providing an effective date.

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

Section 1. Subsection (9) of section 409.911, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate 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.

(d) This subsection shall stand repealed June 30, 2006, unless reviewed and saved from repeal through reenactment by the Legislature.

(10) The Agency for Health Care Administration shall create a Medicaid Low-Income Pool Council by July 1, 2006. The Low-Income Pool Council shall consist of 17 members, including three representatives of statutory teaching hospitals, three representatives of public hospitals, three representatives of nonprofit hospitals, three representatives of for-profit hospitals, two representatives of rural hospitals, two representatives of units of local government which contribute funding, and one representative of family practice teaching hospitals. The council shall:

(a) Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.

(b) Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.

(c) Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.

(d) Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

Section 2. Paragraphs (b), (c), and (d) of subsection (4) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the

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

beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements

related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid 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 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.

2. By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area

except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. 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. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two

comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service network in area 11 for their behavioral care.

4. By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required

match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

5. Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

6. In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

7. Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers

licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. A federally qualified health center or an entity

that is owned by one or more federally qualified health centers and is reimbursed by the agency on a prepaid basis is exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet the appropriate requirements governing financial reserve, quality assurance, and patients' rights established by the agency. ~~Such prepaid health care services entity must be licensed under parts I and III of chapter 641, but shall be prohibited from serving Medicaid recipients on a prepaid basis, until such licensure has been obtained. However, such an entity is exempt from s. 641.225 if the entity meets the requirements specified in subsections (17) and (18).~~

(d) A provider service network may be reimbursed on a fee-for-service or prepaid basis. A provider service network 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, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, 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:

409.91211 Medicaid managed care pilot program.--

(1)(a) The agency is authorized to seek and implement experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program pursuant to this section. Phase one of the demonstration shall be implemented in two geographic areas. One demonstration site shall include only

Broward County. A second demonstration site shall initially include Duval County and shall be expanded to include Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational. The agency shall implement expansion of the program to include the remaining counties of the state and remaining eligibility groups in accordance with the process specified in the federally-approved special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services on October 19, 2005, with a goal of full statewide implementation by June 30, 2011.

(b) This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The

Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services.

(c) It is the intent of the Legislature that the low-income pool plan required by the terms and conditions of the Medicaid reform waiver and submitted to the federal Centers for Medicare and Medicaid Services propose the distribution of the abovementioned program funds based on the following objectives:

1. Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

2. Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

3. Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;

4. Promote teaching and specialty hospital programs;

5. Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;

6. Recognize the extent of hospital uncompensated care costs;

7. Maintain and enhance essential community hospital care;

8. Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;

9. Promote measures to avoid preventable hospitalizations;

10. Account for hospital efficiency; and

11. Contribute to a community's overall health system.

(2) The Legislature intends for the capitated managed care pilot program to:

(a) Provide recipients in Medicaid fee-for-service or the MediPass program a comprehensive and coordinated capitated managed care system for all health care services specified in ss. 409.905 and 409.906.

(b) Stabilize Medicaid expenditures under the pilot program compared to Medicaid expenditures in the pilot area for the 3 years before implementation of the pilot program, while ensuring:

1. Consumer education and choice.

2. Access to medically necessary services.

3. Coordination of preventative, acute, and long-term care.

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.

(d) To implement ~~determine and recommend~~ actuarially sound, risk-adjusted capitation rates for Medicaid recipients in the pilot program which ~~can be separated to~~ cover comprehensive care, enhanced services, and catastrophic care.

(e) To implement ~~determine and recommend~~ policies and guidelines for phasing in financial risk for approved provider

service networks over a 3-year period. These policies and guidelines must ~~shall~~ include an option for a provider service network to be paid ~~to pay~~ fee-for-service rates ~~that may include a savings settlement option for at least 2 years~~. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall ~~may~~ be converted to a risk-adjusted capitated rate no later than the beginning of the fourth ~~in the third~~ year of operation, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

(f) To implement ~~determine and recommend provisions related to~~ stop-loss requirements and the transfer of excess cost to catastrophic coverage that accommodates the risks associated with the development of the pilot program.

(g) To ~~determine and~~ recommend a process to be used by the Social Services Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the managed care pilot program.

(h) To implement ~~determine and recommend~~ program standards and credentialing requirements for capitated managed care networks to participate in the pilot program, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers. It is the intent of the Legislature that, to the extent possible, any pilot program

authorized by the state under this section include any federally qualified health center, federally qualified rural health clinic, county health department, the Children's Medical Services Network within the Department of Health, or other federally, state, or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate. This paragraph does not relieve an entity that qualifies as a capitated managed care network under this section from any other licensure or regulatory requirements contained in state or federal law which would otherwise apply to the entity. The standards and credentialing requirements shall be based upon, but are not limited to:

1. Compliance with the accreditation requirements as provided in s. 641.512.

2. Compliance with early and periodic screening, diagnosis, and treatment screening requirements under federal law.

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

7. Specific requirements of the Medicaid program, or standards designed to specifically meet the unique needs of Medicaid recipients.

8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and

guidelines developed by the Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.

9. The network's infrastructure capacity to manage financial transactions, recordkeeping, data collection, and other administrative functions.

10. The network's ability to submit 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.

(i) To implement ~~develop and recommend~~ a mechanism for providing information to Medicaid recipients for the purpose of selecting a capitated managed care plan. For each plan available to a recipient, the agency, at a minimum, 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 identification of providers participating in the network, 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.

(j) To implement ~~develop and recommend~~ a system to ensure that there is a record of recipient acknowledgment that choice counseling has been provided.

(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 that is related to the provision of Medicaid services, including, but not limited to:

a. The Health Plan Employer Data and Information Set (HEDIS) or measures that are similar to HEDIS.

b. Member satisfaction.

c. Provider satisfaction.

d. Report cards on plan performance and best practices.

e. Compliance with the requirements for prompt payment of claims under ss. 627.613, 641.3155, and 641.513.

f. Utilization and quality data for the purpose of ensuring access to medically necessary services, including underutilization or inappropriate denial of services.

3. 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) and any standards, rules, and guidelines developed by the agency.

4. The agency shall establish an encounter database in order to compile data on health services rendered by health care practitioners who provide services to patients enrolled in managed care plans in the demonstration sites. The encounter database shall:

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

(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 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 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 state or local governmental programs or institutions for the coordination of health care to eligible individuals receiving services from such programs or institutions.

(w) To implement procedures to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program authorized in this section.

1. The agency shall ensure that applicable provisions of this chapter and chapters 414, 626, 641, and 932 which relate to Medicaid fraud and abuse are applied and enforced at the demonstration project sites.

2. Providers must have the certification, license, and credentials that are required by law and waiver requirements.

3. The agency shall ensure that the plan is in compliance with s. 409.912(21) and (22).

4. The agency shall require that each plan establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse. Plans must report instances of fraud and abuse pursuant to chapter 641.

5. The plan shall have written administrative and management arrangements or procedures, including a mandatory compliance plan, which are designed to guard against fraud and abuse. The plan shall designate a compliance officer who has sufficient experience in health care.

6.a. The agency shall require all managed care plan contractors in the pilot program 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.

b. 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, or 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 false claims actions in the provision of managed care, is a violation of law and subject to the penalties provided by law.

c. 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 is linked

into a unified system to ensure consistent reviews and investigations.

~~(w) To develop and recommend a system to oversee the activities of pilot program participants, health care providers, capitated managed care networks, and their representatives in order to prevent fraud or abuse, overutilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of participants and to recover overpayments as appropriate. For the purposes of this paragraph, the terms "abuse" and "fraud" have the meanings as provided in s. 409.913. The agency must refer incidents of suspected fraud, abuse, overutilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency.~~

(x) To develop and provide actuarial and benefit design analyses that indicate the effect on capitation rates and benefits offered in the pilot program over a prospective 5-year period based on the following assumptions:

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 and federal qualified health centers 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 services in a school setting, 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 county health departments and federally qualified health centers regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall

develop procedures for ensuring that a student's capitated managed care network provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(aa) To implement ~~develop and recommend~~ a mechanism whereby Medicaid recipients who are already enrolled in a managed care plan or the MediPass program in the pilot areas shall be offered the opportunity to change to capitated managed care plans on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of capitated managed care plans. Those Medicaid recipients who do not make a choice shall be assigned to a capitated managed care plan in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122. To facilitate continuity of care for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a capitated managed care plan, the agency shall determine whether the SSI recipient has an ongoing relationship with a provider or capitated managed care plan, and, if so, the agency shall assign the SSI recipient to that provider or capitated managed care plan where feasible. Those SSI recipients who do not have such a provider relationship shall be assigned to a capitated managed care plan provider in accordance with paragraph (4)(a) and shall be exempt from s. 409.9122.

(bb) To develop and recommend a service delivery alternative for children having chronic medical conditions which establishes a medical home project to provide primary care services to this population. The project shall provide

community-based primary care services that are integrated with other subspecialties to meet the medical, developmental, and emotional needs for children and their families. This project shall include an evaluation component to determine impacts on hospitalizations, length of stays, emergency room visits, costs, and access to care, including specialty care and patient and family satisfaction.

(cc) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these persons.

(dd) To develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children in foster care. These services must be coordinated with community-based care providers as specified in s. 409.1675, where available, and be sufficient to meet the medical, developmental, and emotional needs of these children.

(4)(a) A Medicaid recipient in the pilot area who is not currently enrolled in a capitated managed care plan upon implementation is not eligible for services as specified in ss. 409.905 and 409.906, for the amount of time that the recipient does not enroll in a capitated managed care network. If a Medicaid recipient has not enrolled in a capitated managed care plan within 30 days after eligibility, the agency shall assign the Medicaid recipient to a capitated managed care plan based on the assessed needs of the recipient as determined by the agency

and the recipient shall be exempt from s. 409.9122. When making assignments, the agency shall take into account the following criteria:

1. A capitated managed care network has sufficient network capacity to meet the needs of members.

2. The capitated managed care network has previously enrolled the recipient as a member, or one of the capitated managed care network's primary care providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular capitated managed care network as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The capitated managed care network's primary care providers are geographically accessible to the recipient's residence.

(b) When more than one capitated managed care network provider meets the criteria specified in paragraph (3)(h), the agency shall make recipient assignments consecutively by family unit.

(c) If a recipient is currently enrolled with a Medicaid managed care organization that also operates an approved reform plan within a demonstration area and the recipient fails to choose a plan during the reform enrollment process or during redetermination of eligibility, the recipient shall be automatically assigned by the agency into 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 disenroll no later than the first day of the second month after the month the disenrollment request was made. If the capitated managed care network, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(f) ~~(e)~~ The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a capitated managed care network for 12 months after an open enrollment period. After 12 months of enrollment, a recipient may select another capitated managed care network. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the capitated managed care network during the 12-month period.

(g) ~~(f)~~ The agency shall apply for federal waivers from the Centers for Medicare and Medicaid Services to allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid-certified plan. This provision shall be known as the opt-out option.

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 appropriate committees of the Senate and House of Representatives for at least 10 working days prior to submission. All waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section must be approved by the Legislature. Federally approved waivers must be submitted to the President of the Senate and the Speaker of the House of Representatives for referral to the appropriate legislative committees. The appropriate committees shall recommend whether to approve the implementation of any waivers to the Legislature as a whole. The agency shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the pilot program under this section on the total Medicaid budget for the 2006-2007 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives at the same time any waivers are submitted for consideration by the Legislature. The agency may implement the waiver and special terms and conditions numbered 11-W-00206/4, as approved by the federal Centers for Medicare and Medicaid Services. If the agency seeks approval by the Federal Government of any modifications to these special terms and conditions, the agency must provide written notification of its intent to modify these terms and conditions to the President of the Senate and the Speaker of the House of Representatives at least 15 days before submitting the modifications to the Federal Government for

consideration. The notification must identify all modifications being pursued and the reason the modifications are needed. Upon receiving federal approval of any modifications to the special terms and conditions, the agency shall provide a report to the Legislature describing the federally approved modifications to the special terms and conditions within 7 days after approval by the Federal Government.

(7)(a) The Secretary of Health Care Administration shall convene a technical advisory panel to advise the agency in the areas of risk-adjusted-rate setting, benefit design, and choice counseling. The panel shall include representatives from the Florida Association of Health Plans, representatives from provider-sponsored networks, a Medicaid consumer representative, and a representative from the Office of Insurance Regulation.

(b) The technical advisory panel shall advise the agency concerning:

1. The risk-adjusted rate methodology to be used by the agency, including recommendations on mechanisms to recognize the risk of all Medicaid enrollees and for the transition to a risk-adjustment system, including recommendations for phasing in risk adjustment and the use of risk corridors.

2. Implementation of an encounter data system to be used for risk-adjusted rates.

3. Administrative and implementation issues regarding the use of risk-adjusted rates, including, but not limited to, cost, simplicity, client privacy, data accuracy, and data exchange.

4. Issues of benefit design, including the actuarial equivalence and sufficiency standards to be used.

5. The implementation plan for the proposed choice-counseling system, including the information and materials to be provided to recipients, the methodologies by which recipients will be counseled regarding choice, criteria to be used to assess plan quality, the methodology to be used to assign recipients into plans if they fail to choose a managed care plan, and the standards to be used for responsiveness to recipient inquiries.

(c) The technical advisory panel shall continue in existence and advise the agency on matters outlined in this subsection.

(8) The agency must ensure, in the first two state fiscal years in which a risk-adjusted methodology is a component of rate setting, that no managed care plan providing comprehensive benefits to TANF and SSI recipients has an aggregate risk score that varies by more than 10 percent from the aggregate weighted mean of all managed care plans providing comprehensive benefits to TANF and SSI recipients in a reform area. The agency's payment to a managed care plan shall be based on such revised aggregate risk score.

(9) After any calculations of aggregate risk scores or revised aggregate risk scores in subsection (8), the capitation rates for plans participating under s. 409.91211 shall be phased in as follows:

(a) In the first year, the capitation rates shall be weighted so that 75 percent of each capitation rate is based on the current methodology and 25 percent is based on a new risk-adjusted capitation rate methodology.

(b) In the second year, the capitation rates shall be weighted so that 50 percent of each capitation rate is based on the current methodology and 50 percent is based on a new risk-adjusted rate methodology.

(c) In the following fiscal year, the risk-adjusted capitation methodology may be fully implemented.

(10) Subsections (8) and (9) do not apply to managed care plans offering benefits exclusively to high-risk, specialty populations. The agency may set risk-adjusted rates immediately for such plans.

(11) Before the implementation of risk-adjusted rates, the rates shall be certified by an actuary and approved by the federal Centers for Medicare and Medicaid Services.

(12) For purposes of this section, the term "capitated managed care plan" includes health insurers authorized under chapter 624, exclusive provider organizations authorized under chapter 627, health maintenance organizations authorized under chapter 641, the Children's Medical Services Network under chapter 391, and provider service networks that elect to be paid fee-for-service for up to 3 years as authorized under this section.

(13)~~(7)~~ Upon review and approval of the applications for waivers of applicable federal laws and regulations to implement the managed care pilot program by the Legislature, the agency may initiate adoption of rules pursuant to ss. 120.536(1) and 120.54 to implement and administer the managed care pilot program as provided in this section.

(14) It is the intent of the Legislature that if any conflict exists between the provisions contained in this section and other provisions of this chapter which relate to the implementation of the Medicaid managed care pilot program, the provisions contained in this section shall control. The agency shall provide a written report to the Legislature by April 1, 2006, identifying any provisions of this chapter which conflict with the implementation of the Medicaid managed care pilot program created in this section. After April 1, 2006, the agency shall provide a written report to the Legislature immediately upon identifying any provisions of this chapter which conflict with the implementation of the Medicaid managed care pilot program created in this section.

Section 4. Section 409.91213, Florida Statutes, is created to read:

409.91213 Quarterly progress reports and annual reports.--

(1) The agency shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Office of Program Policy Analysis and Government Accountability the following reports:

(a) The quarterly progress report submitted to the United States Centers for Medicare and Medicaid Services no later than 60 days following the end of each quarter. The intent of this report is to present the agency's analysis and the status of various operational areas. The quarterly progress report must include, but need not be limited to:

1. Events occurring during the quarter or anticipated to occur in the near future which affect health care delivery, including, but not limited to, the approval of and contracts for new plans, which report must specify the coverage area, phase-in period, populations served, and benefits; the enrollment; grievances; and other operational issues.

2. Action plans for addressing any policy and administrative issues.

3. Agency efforts related to collecting and verifying encounter data and utilization data.

4. Enrollment data disaggregated by plan and by eligibility category, such as Temporary Assistance for Needy Families or Supplemental Security Income; the total number of enrollees; market share; and the percentage change in enrollment by plan. In addition, the agency shall provide a summary of voluntary and mandatory selection rates and disenrollment data.

5. For purposes of monitoring budget neutrality, enrollment data, member-month data, and expenditures in the format for monitoring budget neutrality which is provided by the federal Centers for Medicare and Medicaid Services.

6. Activities and associated expenditures of the low-income pool.

7. Activities related to the implementation of choice counseling, including efforts to improve health literacy and the methods used to obtain public input, such as recipient focus groups.

8. Participation rates in the enhanced benefit accounts program, including participation levels; a summary of activities

and associated expenditures; the number of accounts established, including active participants and individuals who continue to retain access to funds in an account but who no longer actively participate; an estimate of quarterly deposits in the accounts; and expenditures from the accounts.

9. Enrollment data concerning employer-sponsored insurance which document the number of individuals selecting to opt out when employer-sponsored insurance is available. The agency shall include data that identify enrollee characteristics, including the eligibility category, type of employer-sponsored insurance, and type of coverage, such as individual or family coverage. The agency shall develop and maintain disenrollment reports specifying the reason for disenrollment in an employer-sponsored insurance program. The agency shall also track and report on those enrollees who elect the option to reenroll in the Medicaid reform demonstration.

10. Progress toward meeting the demonstration goals.

11. Evaluation activities.

(b) An annual report documenting accomplishments, project status, quantitative and case-study findings, utilization data, and policy and administrative difficulties in the operation of the Medicaid waiver demonstration program. The agency shall submit the draft annual report no later than October 1 after the end of each fiscal year.

(2) Beginning with the annual report for demonstration year two, the agency shall include a section concerning the administration of enhanced benefit accounts, the participation

rates, an assessment of expenditures, and an assessment of potential cost savings.

(3) Beginning with the annual report for demonstration year four, the agency shall include a section that provides qualitative and quantitative data describing the impact the low-income pool has had on the rate of uninsured people in this state, beginning with the implementation of the demonstration program.

Section 5. Section 641.2261, Florida Statutes, is amended to read:

641.2261 Application of ~~federal~~ solvency requirements to provider-sponsored organizations and Medicaid provider service networks.--

(1) The solvency requirements of ss. 1855 and 1856 of the Balanced Budget Act of 1997 and 42 C.F.R. 422.350, subpart H, ~~rules adopted by the Secretary of the United States Department of Health and Human Services~~ apply to a health maintenance organization that is a provider-sponsored organization rather than the solvency requirements of this part. However, if the provider-sponsored organization does not meet the solvency requirements of this part, the organization is limited to the issuance of Medicare+Choice plans to eligible individuals. For the purposes of this section, the terms "Medicare+Choice plans," "provider-sponsored organizations," and "solvency requirements" have the same meaning as defined in the federal act and federal rules and regulations.

(2) The solvency requirements in 42 C.F.R. 422.350, subpart H, and the solvency requirements established in approved

federal waivers pursuant to chapter 409, apply to a Medicaid provider service network rather than the solvency requirements of this part.

Section 6. The Agency for Health Care Administration shall report to the Legislature by April 1, 2006, on the specific pre-implementation milestones required by the special terms and conditions related to the low-income pool which have been approved by the Federal Government and the status of any remaining pre-implementation milestones that have not been approved by the Federal Government.

Section 7. Section 216.346, Florida Statutes, is amended to read:

216.346 Contracts between state agencies; restriction on overhead or other indirect costs.--In any contract between state agencies, including any contract involving the State University System or the Florida Community College System, the agency receiving the contract or grant moneys shall charge no more than a reasonable percentage ~~5 percent~~ of the total cost of the contract or grant for overhead or indirect costs or any other costs not required for the payment of direct costs. This provision is not intended to limit an agency's ability to certify matching funds or designate in-kind contributions that will allow the drawdown of federal Medicaid dollars that do not affect state budgeting.

Section 8. This act shall take effect upon becoming a law.