1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.912, F.S.,
3 providing instructions to the Agency for Health Care
4 Administration regarding seeking federal approval for
5 certain contracts; providing that contacts with provider
6 service networks must meet certain standards for
7 expenditures for behavioral health care service; providing
8 that certain contracts with providers service networks may
9 not be cancelled without specified notice; providing
10 additional terms for cancelation; providing contracts for
11 Medicaid services that are prepaid or for fixed-sum must
12 meet certain medical loss ratios or the agency shall
13 recoup and redistribute payments; amending s. 409.91207,
14 F.S.; providing purposes and principals for creating
15 medical homes; providing definitions; providing for the
16 organization of medical home networks and provider service
17 networks certified as medical homes; requiring each
18 medical home to provide specified services; providing for
19 the establishment of a statewide advisory panel; providing
20 for membership and duties of the panel; providing for
21 travel expenses and per diem for members of the statewide
22 advisory panel and medical advisory group; directing the
23 agency to provide staff support to the panel; directing
24 the panel to establish a medical advisory group to promote
25 and assist in the establishment of medical homes;
26 providing for enrollment of Medicaid beneficiaries in
27 medial homes; providing for financing of medical home
28 networks; providing responsibilities of the agency;

29 requiring the agency to adopt rules; providing for
30 distribution of savings achieved by network providers
31 under certain circumstances; requiring the agency to
32 collaborate with the Office of Insurance Regulation to
33 encourage licensed insurers to incorporate the principles
34 of the medical home network in insurance plans; requiring
35 medical home network providers to maintain certain records
36 and data; amending s. 409.91211, F.S., providing that a
37 hospital who receives low income pool funds shall serve
38 Medicaid recipients regardless of county of residence;
39 revising the period for phasing in financial risk for
40 certain provider service networks; amending s. 409.9122,
41 F.S., revising the assignment of Medicaid recipients
42 eligible for managed care plan enrollment who are subject
43 to mandatory assignment but who fail to make a choice;
44 amending s. 408.907, F.S., revising the requirements of a
45 Medicaid provider agreement to include certain data;
46 providing that the agency shall submit a specified report
47 on the agency's medical encounter data; amending s.
48 409.908, F.S., providing the agency shall adjust
49 capitation rates for certain Medicaid providers; providing
50 criteria for the adjustments; providing a phase in
51 schedule; creating a technical advisory panel to advise
52 the agency in the area of risk adjusted rate setting;
53 providing membership; providing duties; providing an
54 effective date.
55
56 Be It Enacted by the Legislature of the State of Florida:

57
58 Section 1. Paragraphs (b) and (d) of subsection (4) of
59 section 409.912, Florida Statutes, are amended to read and
60 subsection (54) is created to read:
61 409.912 Cost-effective purchasing of health care.—The
62 agency shall purchase goods and services for Medicaid recipients
63 in the most cost-effective manner consistent with the delivery
64 of quality medical care. To ensure that medical services are
65 effectively utilized, the agency may, in any case, require a
66 confirmation or second physician's opinion of the correct
67 diagnosis for purposes of authorizing future services under the
68 Medicaid program. This section does not restrict access to
69 emergency services or poststabilization care services as defined
70 in 42 C.F.R. part 438.114. Such confirmation or second opinion
71 shall be rendered in a manner approved by the agency. The agency
72 shall maximize the use of prepaid per capita and prepaid
73 aggregate fixed-sum basis services when appropriate and other
74 alternative service delivery and reimbursement methodologies,
75 including competitive bidding pursuant to s. 287.057, designed
76 to facilitate the cost-effective purchase of a case-managed
77 continuum of care. The agency shall also require providers to
78 minimize the exposure of recipients to the need for acute
79 inpatient, custodial, and other institutional care and the
80 inappropriate or unnecessary use of high-cost services. The
81 agency shall contract with a vendor to monitor and evaluate the
82 clinical practice patterns of providers in order to identify
83 trends that are outside the normal practice patterns of a
84 provider's professional peers or the national guidelines of a

85 provider's professional association. The vendor must be able to
86 provide information and counseling to a provider whose practice
87 patterns are outside the norms, in consultation with the agency,
88 to improve patient care and reduce inappropriate utilization.
89 The agency may mandate prior authorization, drug therapy
90 management, or disease management participation for certain
91 populations of Medicaid beneficiaries, certain drug classes, or
92 particular drugs to prevent fraud, abuse, overuse, and possible
93 dangerous drug interactions. The Pharmaceutical and Therapeutics
94 Committee shall make recommendations to the agency on drugs for
95 which prior authorization is required. The agency shall inform
96 the Pharmaceutical and Therapeutics Committee of its decisions
97 regarding drugs subject to prior authorization. The agency is
98 authorized to limit the entities it contracts with or enrolls as
99 Medicaid providers by developing a provider network through
100 provider credentialing. The agency may competitively bid single-
101 source-provider contracts if procurement of goods or services
102 results in demonstrated cost savings to the state without
103 limiting access to care. The agency may limit its network based
104 on the assessment of beneficiary access to care, provider
105 availability, provider quality standards, time and distance
106 standards for access to care, the cultural competence of the
107 provider network, demographic characteristics of Medicaid
108 beneficiaries, practice and provider-to-beneficiary standards,
109 appointment wait times, beneficiary use of services, provider
110 turnover, provider profiling, provider licensure history,
111 previous program integrity investigations and findings, peer
112 review, provider Medicaid policy and billing compliance records,

113 clinical and medical record audits, and other factors. Providers
114 shall not be entitled to enrollment in the Medicaid provider
115 network. The agency shall determine instances in which allowing
116 Medicaid beneficiaries to purchase durable medical equipment and
117 other goods is less expensive to the Medicaid program than long-
118 term rental of the equipment or goods. The agency may establish
119 rules to facilitate purchases in lieu of long-term rentals in
120 order to protect against fraud and abuse in the Medicaid program
121 as defined in s. 409.913. The agency may seek federal waivers
122 necessary to administer these policies.
123 (4) The agency may contract with:
124 (b) An entity that is providing comprehensive behavioral
125 health care services to certain Medicaid recipients through a
126 capitated, prepaid arrangement pursuant to the federal waiver
127 provided for by s. 409.905(5). Such entity must be licensed
128 under chapter 624, chapter 636, or chapter 641, or authorized
129 under paragraph (c), and must possess the clinical systems and
130 operational competence to manage risk and provide comprehensive
131 behavioral health care to Medicaid recipients. As used in this
132 paragraph, the term "comprehensive behavioral health care
133 services" means covered mental health and substance abuse
134 treatment services that are available to Medicaid recipients.
135 The secretary of the Department of Children and Family Services
136 shall approve provisions of procurements related to children in
137 the department's care or custody before enrolling such children
138 in a prepaid behavioral health plan. Any contract awarded under
139 this paragraph must be competitively procured. In developing the
140 behavioral health care prepaid plan procurement document, the

141 agency shall ensure that the procurement document requires the
142 contractor to develop and implement a plan to ensure compliance
143 with s. 394.4574 related to services provided to residents of
144 licensed assisted living facilities that hold a limited mental
145 health license. Except as provided in subparagraph 8., and
146 except in counties where the Medicaid managed care pilot program
147 is authorized pursuant to s. 409.91211, the agency shall seek
148 federal approval to contract with a single entity meeting these
149 requirements to provide comprehensive behavioral health care
150 services to all Medicaid recipients not enrolled in a Medicaid
151 managed care plan authorized under s. 409.91211, a Medicaid
152 provider service network authorized under paragraph (d) of this
153 subsection, or a Medicaid health maintenance organization in an
154 AHCA area. In an AHCA area where the Medicaid managed care pilot
155 program is authorized pursuant to s. 409.91211 in one or more
156 counties, the agency may procure a contract with a single entity
157 to serve the remaining counties as an AHCA area or the remaining
158 counties may be included with an adjacent AHCA area and are
159 subject to this paragraph. Each entity must offer a sufficient
160 choice of providers in its network to ensure recipient access to
161 care and the opportunity to select a provider with whom they are
162 satisfied. The network shall include all public mental health
163 hospitals. To ensure unimpaired access to behavioral health care
164 services by Medicaid recipients, all contracts issued pursuant
165 to this paragraph must require 80 percent of the capitation paid
166 to the managed care plan, including health maintenance
167 organizations or provider service networks, to be expended for
168 the provision of behavioral health care services. If the managed

169 care plan expends less than 80 percent of the capitation paid
170 for the provision of behavioral health care services, the
171 difference shall be returned to the agency. The agency shall
172 provide the plan with a certification letter indicating the
173 amount of capitation paid during each calendar year for
174 behavioral health care services pursuant to this section. The
175 agency may reimburse for substance abuse treatment services on a
176 fee-for-service basis until the agency finds that adequate funds
177 are available for capitated, prepaid arrangements.
178 1. By January 1, 2001, the agency shall modify the
179 contracts with the entities providing comprehensive inpatient
180 and outpatient mental health care services to Medicaid
181 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
182 Counties, to include substance abuse treatment services.
183 2. By July 1, 2003, the agency and the Department of
184 Children and Family Services shall execute a written agreement
185 that requires collaboration and joint development of all policy,
186 budgets, procurement documents, contracts, and monitoring plans
187 that have an impact on the state and Medicaid community mental
188 health and targeted case management programs.
189 3. Except as provided in subparagraph 8., by July 1, 2006,
190 the agency and the Department of Children and Family Services
191 shall contract with managed care entities in each AHCA area
192 except area 6 or arrange to provide comprehensive inpatient and
193 outpatient mental health and substance abuse services through
194 capitated prepaid arrangements to all Medicaid recipients who
195 are eligible to participate in such plans under federal law and
196 regulation. In AHCA areas where eligible individuals number less

197 than 150,000, the agency shall contract with a single managed
198 care plan to provide comprehensive behavioral health services to
199 all recipients who are not enrolled in a Medicaid health
200 maintenance organization or a Medicaid capitated managed care
201 plan authorized under s. 409.91211. The agency may contract with
202 more than one comprehensive behavioral health provider to
203 provide care to recipients who are not enrolled in a Medicaid
204 capitated managed care plan authorized under s. 409.91211 or a
205 Medicaid health maintenance organization in AHCA areas where the
206 eligible population exceeds 150,000. In an AHCA area where the
207 Medicaid managed care pilot program is authorized pursuant to s.
208 409.91211 in one or more counties, the agency may procure a
209 contract with a single entity to serve the remaining counties as
210 an AHCA area or the remaining counties may be included with an
211 adjacent AHCA area and shall be subject to this paragraph.
212 Contracts for comprehensive behavioral health providers awarded
213 pursuant to this section shall be competitively procured. Both
214 for-profit and not-for-profit corporations are eligible to
215 compete. Managed care plans contracting with the agency under
216 subsection (3) shall provide and receive payment for the same
217 comprehensive behavioral health benefits as provided in AHCA
218 rules, including handbooks incorporated by reference. In AHCA
219 area 11, the agency shall contract with at least two
220 comprehensive behavioral health care providers to provide
221 behavioral health care to recipients in that area who are
222 enrolled in, or assigned to, the MediPass program. One of the
223 behavioral health care contracts must be with the existing
224 provider service network pilot project, as described in

225 paragraph (d), for the purpose of demonstrating the cost-
226 effectiveness of the provision of quality mental health services
227 through a public hospital-operated managed care model. Payment
228 shall be at an agreed-upon capitated rate to ensure cost
229 savings. Of the recipients in area 11 who are assigned to
230 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
231 MediPass-enrolled recipients shall be assigned to the existing
232 provider service network in area 11 for their behavioral care.
233 4. By October 1, 2003, the agency and the department shall
234 submit a plan to the Governor, the President of the Senate, and
235 the Speaker of the House of Representatives which provides for
236 the full implementation of capitated prepaid behavioral health
237 care in all areas of the state.
238 a. Implementation shall begin in 2003 in those AHCA areas
239 of the state where the agency is able to establish sufficient
240 capitation rates.
241 b. If the agency determines that the proposed capitation
242 rate in any area is insufficient to provide appropriate
243 services, the agency may adjust the capitation rate to ensure
244 that care will be available. The agency and the department may
245 use existing general revenue to address any additional required
246 match but may not over-obligate existing funds on an annualized
247 basis.
248 c. Subject to any limitations provided in the General
249 Appropriations Act, the agency, in compliance with appropriate
250 federal authorization, shall develop policies and procedures
251 that allow for certification of local and state funds.
252 5. Children residing in a statewide inpatient psychiatric

253 program, or in a Department of Juvenile Justice or a Department
254 of Children and Family Services residential program approved as
255 a Medicaid behavioral health overlay services provider may not
256 be included in a behavioral health care prepaid health plan or
257 any other Medicaid managed care plan pursuant to this paragraph.
258 6. In converting to a prepaid system of delivery, the
259 agency shall in its procurement document require an entity
260 providing only comprehensive behavioral health care services to
261 prevent the displacement of indigent care patients by enrollees
262 in the Medicaid prepaid health plan providing behavioral health
263 care services from facilities receiving state funding to provide
264 indigent behavioral health care, to facilities licensed under
265 chapter 395 which do not receive state funding for indigent
266 behavioral health care, or reimburse the unsubsidized facility
267 for the cost of behavioral health care provided to the displaced
268 indigent care patient.
269 7. Traditional community mental health providers under
270 contract with the Department of Children and Family Services
271 pursuant to part IV of chapter 394, child welfare providers
272 under contract with the Department of Children and Family
273 Services in areas 1 and 6, and inpatient mental health providers
274 licensed pursuant to chapter 395 must be offered an opportunity
275 to accept or decline a contract to participate in any provider
276 network for prepaid behavioral health services.
277 8. All Medicaid-eligible children, except children in area
278 1 and children in Highlands County, Hardee County, Polk County,
279 or Manatee County of area 6, that are open for child welfare
280 services in the HomeSafeNet system, shall receive their

281 behavioral health care services through a specialty prepaid plan
282 operated by community-based lead agencies through a single
283 agency or formal agreements among several agencies. The
284 specialty prepaid plan must result in savings to the state
285 comparable to savings achieved in other Medicaid managed care
286 and prepaid programs. Such plan must provide mechanisms to
287 maximize state and local revenues. The specialty prepaid plan
288 shall be developed by the agency and the Department of Children
289 and Family Services. The agency may seek federal waivers to
290 implement this initiative. Medicaid-eligible children whose
291 cases are open for child welfare services in the HomeSafeNet
292 system and who reside in AHCA area 10 are exempt from the
293 specialty prepaid plan upon the development of a service
294 delivery mechanism for children who reside in area 10 as
295 specified in s. 409.91211(3)(dd).
296 (d) A provider service network may be reimbursed on a fee-
297 for-service or prepaid basis. A provider service network which
298 is reimbursed by the agency on a prepaid basis shall be exempt
299 from parts I and III of chapter 641, but must comply with the
300 solvency requirements in s. 641.2261(2) and meet appropriate
301 financial reserve, quality assurance, and patient rights
302 requirements as established by the agency. Medicaid recipients
303 assigned to a provider service network shall be chosen equally
304 from those who would otherwise have been assigned to prepaid
305 plans and MediPass. The agency is authorized to seek federal
306 Medicaid waivers as necessary to implement the provisions of
307 this section. Any contract previously awarded to a provider
308 service network operated by a hospital pursuant to this

309 subsection shall remain in effect for a period of 5 ~~3~~ years
310 following the current contract expiration date, regardless of
311 any contractual provisions to the contrary. Any contract awarded
312 to a provider service network shall require that the network may
313 not cancel the contract without at least a 90 day notice. All
314 members of the network must continue to provide services to
315 Medicaid recipients assigned to that network during that 90 day
316 period. A provider service network is a network established or
317 organized and operated by a health care provider, or group of
318 affiliated health care providers, including minority physician
319 networks and emergency room diversion programs that meet the
320 requirements of s. 409.91211, which provides a substantial
321 proportion of the health care items and services under a
322 contract directly through the provider or affiliated group of
323 providers and may make arrangements with physicians or other
324 health care professionals, health care institutions, or any
325 combination of such individuals or institutions to assume all or
326 part of the financial risk on a prospective basis for the
327 provision of basic health services by the physicians, by other
328 health professionals, or through the institutions. The health
329 care providers must have a controlling interest in the governing
330 body of the provider service network organization.
331 (54) An entity that contracts with the agency on a prepaid
332 or fixed-sum basis for the provision of Medicaid services shall
333 spend 85% percent of the Medicaid capitation revenue for health
334 services to enrollees. The agency shall monitor medical loss
335 ratios for all prepaid plans on a county-by-county basis. When
336 a plan's 3-year average medical loss ratio in a county is less

337 than 85% percent, the agency is authorized to recoup an amount
338 equivalent to the difference between 85% percent of the
339 capitation paid to the plan and the amount the plan paid for
340 provision of services over the three year period. These
341 recouped funds shall be dispersed in proportionate amounts to
342 plans that have spent in excess of 85 percent of their
343 capitation on the provision of medical services.
344 Section 2. Section 409.91207, Florida Statutes, is amended
345 to read:
346 (Substantial rewording of section. See
347 s. 409.91207, F.S., for present text.)
348 409.91207 Medical Homes.—
349 (1) PURPOSE AND PRINCIPLES.—The agency shall develop a
350 method for recognizing the certification of a primary care
351 provider or a provider service network as a medical home. The
352 purpose of this certification is to foster and support improved
353 care management through enhanced primary care case management
354 and dissemination of best practices for coordinated and cost-
355 effective care. The medical home modifies the processes and
356 patterns of health care service delivery by applying the
357 following principles:
358 (a) A personal medical provider leads an interdisciplinary
359 team of professionals who share the responsibility for providing
360 ongoing care to a specific panel of patients.
361 (b) The personal medical provider identifies a patient's
362 health care needs and responds to those needs through direct
363 care or arrangements with other qualified providers.

364 (c) Care is coordinated or integrated across all areas of
365 health service delivery.
366 (d) Information technology is integrated into delivery
367 systems to enhance clinical performance and monitor patient
368 outcomes.
369 (2) DEFINITIONS.—As used in this section, the term:
370 (a) "Case manager" means the person or persons employed by
371 a medical home network, provider service network, or by a member
372 of the network to work with primary care providers in the
373 delivery of outreach, support services, and care coordination
374 for medical home patients.
375 (b) "Medical home network" means a group of primary care
376 providers and other health professionals and facilities who
377 agree to cooperate with one another in order to coordinate care
378 for Medicaid beneficiaries assigned to primary care providers in
379 the network.
380 (c) "Primary care provider" means a health professional
381 practicing in the field of family medicine, general internal
382 medicine, geriatric medicine, or pediatric medicine who is
383 licensed as a physician under chapter 458 or chapter 459, a
384 physician's assistant performing services delegated by a
385 supervising physician pursuant to s. 458.347 or s. 459.022, or a
386 registered nurse certified as a nurse practitioner performing
387 services pursuant to a protocol established with a supervising
388 physician in accordance with s. 464.012.
389 (d) "Principal network provider" means a member of a
390 medical home network or provider service network who serves as
391 the principal liaison between the agency and that network and

392 who accepts responsibility for communicating the agency's
393 directives concerning the project to all other network members.
394 (e) "Provider service network" means a provider service
395 network as defined by s. 409.912(4)(d).
396 (f) "Tier One medical home" means:
397 1. a primary care provider who certifies to the agency
398 that the provider meets the service capabilities established in
399 paragraph (4)(a), or
400 2. a provider service network who certifies to the agency
401 that all of its members who are primary care providers meet the
402 service capabilities established in paragraph (4)(a)
403 (g) "Tier Two medical home" means:
404 1. a primary care provider who certifies to the agency
405 that the provider meets the service capabilities established in
406 paragraph (4)(b), or
407 2. a provider service network who certifies to the agency
408 that at least 85 percent of its members who are primary care
409 providers meet the service capabilities established in paragraph
410 (4)(b) and the remainder of the primary care providers meet the
411 service capabilities established in paragraph (4)(a) .
412 (f) "Tier Three medical home" means:
413 1. a primary care provider who certifies to the agency that
414 the provider meets the service capabilities established in
415 paragraph (4)(c), or
416 2. a provider service network who certifies to the agency
417 that at least 85 percent of its members who are primary care
418 providers meet the service capabilities established in paragraph

419 (4)(c) and the remainder of the primary care providers meet the
420 service capabilities established in paragraph (4)(b) .
421 (3) ORGANIZATION.—
422 (a) Each participating primary care provider shall be
423 a member of a medical home network or a provider service network
424 and shall be classified by the agency as a Tier One, Tier Two,
425 or Tier Three medical home upon certification by the provider of
426 compliance with the service capabilities for that tier. A
427 primary care provider or a provider service network may change
428 classification by certifying service capabilities consistent
429 with the standards for another tier. Certifications shall be
430 made annually.
431 (b) Each participating provider service network shall
432 be classified by the agency as a Tier One, Tier Two, or Tier
433 Three medical home upon certification by the network that the
434 network's primary care providers meet the service capabilities
435 for that tier. The provider service network may also certify to
436 the agency that it intends to serve a specific target population
437 based on disease, condition, or age.
438 (c) The members of each medical home network or provider
439 service network shall designate a principal network provider who
440 shall be responsible for maintaining an accurate list of
441 participating providers, forwarding this list to the agency and
442 updating the list as requested by the agency, and facilitating
443 communication between the agency and the participating
444 providers.
445 (d) A provider service network may only cease participation
446 as a medical home with at least 90 days notice to the agency.

447 All members of the provider service network must continue to
448 serve the enrollees during this 90 day period. A provider
449 service network that is reimbursed by the agency on a prepaid
450 basis shall not receive any additional reimbursements for this
451 90 day period.
452 (4) SERVICE CAPABILITIES.—A medical home network or a
453 provider service network certified as a medical home shall
454 provide primary care, coordinate services to control chronic
455 illnesses, provide disease management and patient education,
456 provide or arrange for pharmacy services, provide or arrange for
457 outpatient diagnostic and specialty physician services, and
458 provide for or coordinate with inpatient facilities, behavioral,
459 mental health, and rehabilitative service providers. The
460 network shall place a priority on methods to manage pharmacy and
461 behavioral services.
462 (a) Tier One medical homes shall have the capability to:
463 1. Maintain a written copy of the mutual agreement between
464 the medical home and the patient in the patient's medical
465 record.
466 2. Supply all medically necessary primary and preventive
467 services and provide all scheduled immunizations.
468 3. Organize clinical data in paper or electronic form
469 using a patient-centered charting system.
470 4. Maintain and update patients' medication lists and
471 review all medications during each office visit.
472 5. Maintain a system to track diagnostic tests and provide
473 followup services regarding test results.

474 6. Maintain a system to track referrals, including self-
475 referrals by members.
476 7. Supply care coordination and continuity of care through
477 proactive contact with members and encourage family
478 participation in care.
479 8. Supply education and support using various materials
480 and processes appropriate for individual patient needs.
481 (b) Tier Two medical homes shall have all of the
482 capabilities of a Tier One medical home and shall have the
483 additional capability to:
484 1. Communicate electronically.
485 2. Supply voice-to-voice telephone coverage to panel
486 members 24 hours per day, 7 days per week, to enable patients to
487 speak to a licensed health care professional who triages and
488 forwards calls, as appropriate.
489 3. Maintain an office schedule of at least 30 scheduled
490 hours per week.
491 4. Use scheduling processes to promote continuity with
492 clinicians, including providing care for walk-in, routine, and
493 urgent care visits.
494 5. Implement and document behavioral health and substance
495 abuse screening procedures and make referrals as needed.
496 6. Use data to identify and track patients' health and
497 service use patterns.
498 7. Coordinate care and followup for patients receiving
499 services in inpatient and outpatient facilities.
500 8. Implement processes to promote access to care and
501 member communication.

502 (c) Tier Three medical homes shall have all of the
503 capabilities of Tier One and Tier Two medical homes and shall
504 have the additional capability to:
505 1. Maintain electronic medical records.
506 2. Develop a health care team that provides ongoing
507 support, oversight, and guidance for all medical care received
508 by the patient and document contact with specialists and other
509 health care providers caring for the patient.
510 3. Supply postvisit followup care for patients.
511 4. Implement specific evidence-based clinical practice
512 guidelines for preventive and chronic care.
513 5. Implement a medication reconciliation procedure to
514 avoid interactions or duplications.
515 6. Use personalized screening, brief intervention, and
516 referral to treatment procedures for appropriate patients
517 requiring specialty treatment.
518 7. Offer at least 4 hours per week of after-hours care to
519 patients.
520 8. Use health assessment tools to identify patient needs
521 and risks.
522 (5) TASK FORCE; ADVISORY PANEL.—
523 (a) The Secretary of Health Care Administration shall
524 appoint a task force by August 1, 2009, to assist the agency in
525 the development and implementation of the medical home pilot
526 project. The task force must include, but is not limited to,
527 representatives of providers who could potentially participate
528 in a medical home network, Medicaid recipients, and existing
529 MediPass and managed care providers. Members of the task force

530 shall serve without compensation but are entitled to
531 reimbursement for per diem and travel expenses as provided in s.
532 112.061. When the statewide advisory panel created pursuant to
533 paragraph (b) has been appointed, the task force shall dissolve.
534 (b) A statewide advisory panel shall be established to
535 advise and assist the agency in developing a methodology for an
536 annual evaluation of each medical home network and provider
537 service network certified as a medical home. The panel shall
538 promote communication among medical home networks and provider
539 service networks certified as medical homes. The panel shall
540 consist of seven members, who shall be appointed as follows:
541 1. Two members appointed by the Speaker of the House of
542 Representatives, one of whom shall be a primary care physician
543 licensed under chapter 458 or chapter 459 and one of whom shall
544 be a representative of a hospital licensed under chapter 395.
545 2. Two members appointed by the President of the Senate,
546 one of whom shall be a physician licensed under chapter 458 or
547 chapter 459 who is a board-certified specialist and one of whom
548 shall be a representative of a Florida medical school.
549 3. Two members appointed by the Governor, one of whom
550 shall be a representative of a Florida-licensed insurer or a
551 health maintenance organization and one of whom shall be a
552 representative of Medicaid consumers.
553 4. The Secretary of Health Care Administration or his or
554 her designee.
555 (c) Panel members shall serve 4-year terms, except that
556 the initial terms shall be staggered as follows:

557 1. The Governor shall appoint one member for a term of 2
558 years and one member for a term of 4 year.
559 2. The President of the Senate shall appoint one member
560 for a term of 2 years and one member for a term of 4 year.
561 3. The Speaker of the House of Representatives shall
562 appoint one member for a term of 2 years and one member for a
563 term of 4 year.
564 (d) A vacancy shall be filled by appointment by the
565 original appointing authority for the unexpired portion of the
566 term.
567 (e) Members of the statewide advisory panel shall serve
568 without compensation but may be reimbursed for per diem and
569 travel expenses as provided in s. 112.061.
570 (f) The agency shall provide staff support to assist the
571 panel in the performance of its duties.
572 (g) The statewide advisory panel shall establish a medical
573 advisory group consisting of physicians licensed under chapter
574 458 or chapter 459 who shall act as ambassadors to their
575 communities for the promotion of and assistance in the
576 establishment of medical home networks and provider service
577 networks certified as medical homes. Members of the medical
578 advisory group shall serve without compensation and may be
579 reimbursed for per diem and travel expenses as provided in s.
580 112.061.
581 (6) ENROLLMENT.—Each beneficiary served by a certified
582 Tier One, Tier Two, or Tier Three medical home shall be given a
583 choice to enroll in a medical home network or provider service
584 network certified as a medical home. Enrollment shall be

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

585 effective upon the agency's receipt of a participation agreement
586 signed by the beneficiary.
587
588 (7) FINANCING.—
589 (a) Subject to a specific appropriation provided for in
590 the General Appropriations Act, medical home network members
591 shall be eligible to receive a monthly enhanced case management
592 fee as follows:
593 1. The Tier One medical homes shall receive:
594 a. $3.58 per child in a panel of enrollees; and
595 b. $5.02 per adult in a panel of enrollees.
596 2. The Tier Two medical homes shall receive:
597 a. $4.65 per child in a panel of enrollees; and
598 b. $6.52 per adult in a panel of enrollees.
599 3. The Tier Three medical homes shall receive:
600 a. $6.12 per child in a panel of enrollees; and
601 b. $8.69 per adult in a panel of enrollees.
602 (b) Services provided by a medical home network or a
603 provider service network with a fee-for-service contract with
604 the agency shall be reimbursed based on claims filed for
605 Medicaid fee-for-service payments. Services by a provider
606 service network with a contract with the agency for prepaid
607 services shall be paid pursuant to the contract and shall be
608 eligible to receive the credit provided in this subsection.
609 (c) Any hospital, as defined in s. 395.002(12),
610 participating in a medical home network or service provider
611 network certified as a medical home and employing case managers
612 for the network shall be eligible to receive a credit against

613 the assessment imposed under s. 395.701. The credit is
614 compensation for participating in the network by providing case
615 management and other network services.
616 1. The credit shall be prorated based on the number of
617 full-time equivalent case managers hired but shall not be more
618 than $75,000 for each full-time equivalent case manager. The
619 total credit may not exceed $450,000 for any hospital for any
620 state fiscal year.
621 2. To qualify for the credit, the hospital must employ
622 each full-time equivalent case manager for the entire hospital
623 fiscal year for which the credit is claimed.
624 3. The hospital must certify the number of full-time
625 equivalent case managers for whom it is entitled to a credit
626 using the certification process required under s. 395.701(2)(a).
627 4. The agency shall calculate the amount of the credit and
628 reduce the certified assessment for the hospital by the amount
629 of the credit.
630 (d) The enhanced payments to primary care providers shall
631 not affect the calculation of capitated rates under this
632 chapter.
633 (8) AGENCY DUTIES; RULEMAKING AUTHORITY.-
634 (a) The agency shall:
635 1. Maintain a record of certified primary care providers
636 and provider service networks by classification as Tier One,
637 Tier Two, or Tier Three medical homes.
638 2. Develop a standard form to be used by primary care
639 providers and provider service networks to certify to the agency
640 that they meet the necessary principles and service capabilities

641 for the tier in which they seek to be classified. The form shall
642 have a check box for each of the three tiers, a line to indicate
643 whether a primary care network intends to specialize in a target
644 population, a line to specify the target population, if any, and
645 a line for the signature of the provider or principal of an
646 entity. Checking the appropriate tier box and signing the form
647 shall be deemed certification for the purposes of this section.
648 3. Develop a process for managed care organizations to
649 certify themselves as Tier One, Tier Two, or Tier Three medical
650 homes based on established policies and procedures consistent
651 with the principles and corresponding service capabilities
652 provided for in subsections (1) and (4).
653 5. Establish a participation agreement to be executed by
654 Medipass recipients who choose to participate in the medical
655 home pilot project.
656 6. Track the spending for and utilization of services by
657 all enrolled medical home network patients.
658 7. Ensure that any provider service network is cost-
659 effective as defined in s. 409.912(44). The evaluation shall be
660 made at least annually.
661 (9) ACHIEVED SAVINGS.—Each medical home network or
662 provider service network certified as a medical home that
663 participates on a fee-for-service basis and that achieves
664 savings equal to or greater than the spending that would have
665 occurred if its enrollees participated in prepaid health plans
666 is eligible to receive funding based on the identified savings
667 pursuant to a specific appropriation provided for in the General
668 Appropriations Act. The funds must be distributed on a pro rata

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669 basis to the physicians who are members of the medical home
670 network to enable the compensation for their services to be as
671 close as possible to 100 percent of Medicare rates. Subject to
672 a specific appropriation, it is the intent of the Legislature
673 that the savings that result from the implementation of the
674 medical home network model be used to enable Medicaid fees to
675 physicians participating in medical home networks to be
676 equivalent to 100 percent of Medicare rates as soon as possible.
677 (10) COLLABORATION WITH PRIVATE INSURERS.—To enable the
678 state to participate in federal gainsharing initiatives, the
679 agency shall collaborate with the Office of Insurance Regulation
680 to encourage Florida-licensed insurers to incorporate medical
681 home network principles in the design of their individual and
682 employment-based plans. The Department of Management Services is
683 directed to develop a medical home option in the state group
684 insurance program.
685 (11) QUALITY ASSURANCE AND ACCOUNTABILITY.—Each primary
686 care provider participating in a medical home network or
687 provider service network certified as a medical home shall
688 maintain medical records and clinical data necessary for the
689 network to assess the use, cost, and outcome of services
690 provided to enrollees.
691 Section 3. Paragraph (b) of subsection (1) and paragraph
692 (e) of subsection (3) of section 409.91211, Florida Statutes,
693 are amended to read:
694 409.91211 Medicaid managed care pilot program.—
695 (1)
696 (b) This waiver authority is contingent upon federal

697 approval to preserve the upper-payment-limit funding mechanism
698 for hospitals, including a guarantee of a reasonable growth
699 factor, a methodology to allow the use of a portion of these
700 funds to serve as a risk pool for demonstration sites,
701 provisions to preserve the state's ability to use
702 intergovernmental transfers, and provisions to protect the
703 disproportionate share program authorized pursuant to this
704 chapter. Upon completion of the evaluation conducted under s. 3,
705 ch. 2005-133, Laws of Florida, the agency may request statewide
706 expansion of the demonstration projects. Statewide phase-in to
707 additional counties shall be contingent upon review and approval
708 by the Legislature. Under the upper-payment-limit program, or
709 the low-income pool as implemented by the Agency for Health Care
710 Administration pursuant to federal waiver, the state matching
711 funds required for the program shall be provided by local
712 governmental entities through intergovernmental transfers in
713 accordance with published federal statutes and regulations. The
714 Agency for Health Care Administration shall distribute upper-
715 payment-limit, disproportionate share hospital, and low-income
716 pool funds according to published federal statutes, regulations,
717 and waivers and the low-income pool methodology approved by the
718 federal Centers for Medicare and Medicaid Services. A provider
719 who receives low income pool funds shall serve Medicaid
720 recipients regardless of their Florida county of residence and
721 shall not restrict access to care based on residency in a
722 Florida county other than the one in which the provider is
723 located.
724 (3) The agency shall have the following powers, duties,

725 and responsibilities with respect to the pilot program:
726 (e) To implement policies and guidelines for phasing in
727 financial risk for approved provider service networks that, for
728 purposes of this paragraph, include the Children's Medical
729 Services Network, over the longer of a 5-year period or through
730 October 1, 2015. These policies and guidelines must include an
731 option for a provider service network to be paid fee-for-service
732 rates. For any provider service network established in a managed
733 care pilot area, the option to be paid fee-for-service rates
734 must include a savings-settlement mechanism that is consistent
735 with s. 409.912(44). As of October 1, 2015 or, after five years
736 of operation, whichever is the longer period, this model must be
737 converted to a risk-adjusted capitated rate ~~by the beginning of~~
738 ~~the sixth year of operation,~~ and may be converted earlier at the
739 option of the provider service network. Federally qualified
740 health centers may be offered an opportunity to accept or
741 decline a contract to participate in any provider network for
742 prepaid primary care services.
743 Section 4. Paragraph (f) of subsection (2) of section
744 409.9122, Florida Statutes, is amended to read:
745 409.9122 Mandatory Medicaid managed care enrollment;
746 programs and procedures.—
747 (2)
748 (f) If a Medicaid recipient does not choose a managed care
749 plan or MediPass provider, the agency shall assign the Medicaid
750 recipient to a managed care plan ~~or MediPass provider~~. Medicaid
751 recipients eligible for managed care plan enrollment who are
752 subject to mandatory assignment but who fail to make a choice

753 shall be assigned to managed care plans until an enrollment is
754 achieved of 65 percent in provider service networks designated
755 as a medical home under s. 409.91207 and 35 percent in other ~~35~~
756 ~~percent in MediPass and 65 percent in~~ managed care plans~~, of all~~
757 ~~those eligible to choose managed care, is achieved~~. Once this
758 enrollment is achieved, the assignments shall be divided in the
759 same manner ~~order~~ to maintain the same ~~an~~ enrollment ratio ~~in~~
760 ~~MediPass and managed care plans which is in a 35 percent and 65~~
761 ~~percent proportion, respectively.~~ Thereafter, assignment of
762 Medicaid recipients who fail to make a choice shall be based
763 proportionally on the preferences of recipients who have made a
764 choice in the previous period. Such proportions shall be revised
765 at least quarterly to reflect an update of the preferences of
766 Medicaid recipients. The agency shall disproportionately assign
767 Medicaid-eligible recipients who are required to but have failed
768 to make a choice of managed care plan or MediPass, including
769 children, and who would be assigned to the MediPass program to
770 children's networks as described in s. 409.912(4)(g), Children's
771 Medical Services Network as defined in s. 391.021, exclusive
772 provider organizations, provider service networks, minority
773 physician networks, and pediatric emergency department diversion
774 programs authorized by this chapter or the General
775 Appropriations Act, in such manner as the agency deems
776 appropriate, until the agency has determined that the networks
777 and programs have sufficient numbers to be operated
778 economically. For purposes of this paragraph, when referring to
779 assignment, the term "managed care plans" includes health
780 maintenance organizations, exclusive provider organizations,

781 provider service networks, minority physician networks,
782 Children's Medical Services Network, and pediatric emergency
783 department diversion programs authorized by this chapter or the
784 General Appropriations Act. When making assignments, the agency
785 shall take into account the following criteria:
786 1. A managed care plan has sufficient network capacity to
787 meet the need of members.
788 2. The managed care plan or MediPass has previously
789 enrolled the recipient as a member, or one of the managed care
790 plan's primary care providers or MediPass providers has
791 previously provided health care to the recipient.
792 3. The agency has knowledge that the member has previously
793 expressed a preference for a particular managed care plan or
794 MediPass provider as indicated by Medicaid fee-for-service
795 claims data, but has failed to make a choice.
796 4. The managed care plan's or MediPass primary care
797 providers are geographically accessible to the recipient's
798 residence.
799 Section 5. Paragraph (k) is added to subsection (3) of
800 section 409.907, Florida Statutes, and subsection (13) of that
801 section is created, to read:
802 409.907 Medicaid provider agreements.—The agency may make
803 payments for medical assistance and related services rendered to
804 Medicaid recipients only to an individual or entity who has a
805 provider agreement in effect with the agency, who is performing
806 services or supplying goods in accordance with federal, state,
807 and local law, and who agrees that no person shall, on the
808 grounds of handicap, race, color, or national origin, or for any

809 other reason, be subjected to discrimination under any program
810 or activity for which the provider receives payment from the
811 agency.
812 (3) The provider agreement developed by the agency, in
813 addition to the requirements specified in subsections (1) and
814 (2), shall require the provider to:
815 (k) Fully comply with the agency's medical encounter data
816 system.
817 (13) By January 1, 2011, and annually thereafter until
818 full compliance is reached, the agency shall submit to the
819 Governor, the President of the Senate, and the Speaker of the
820 House of Representatives a report that summarizes data regarding
821 the agency's medical encounter data system, including the number
822 of participating providers, the level of compliance of each
823 provider, and an analysis of service utilization, service
824 trends, and specific problem areas.
825
826 Section 6. Subsection (4) of section 409.908, Florida
827 Statutes, is amended to read:
828 409.908 Reimbursement of Medicaid providers.—Subject to
829 specific appropriations, the agency shall reimburse Medicaid
830 providers, in accordance with state and federal law, according
831 to methodologies set forth in the rules of the agency and in
832 policy manuals and handbooks incorporated by reference therein.
833 These methodologies may include fee schedules, reimbursement
834 methods based on cost reporting, negotiated fees, competitive
835 bidding pursuant to s. 287.057, and other mechanisms the agency
836 considers efficient and effective for purchasing services or

837 goods on behalf of recipients. If a provider is reimbursed based
838 on cost reporting and submits a cost report late and that cost
839 report would have been used to set a lower reimbursement rate
840 for a rate semester, then the provider's rate for that semester
841 shall be retroactively calculated using the new cost report, and
842 full payment at the recalculated rate shall be effected
843 retroactively. Medicare-granted extensions for filing cost
844 reports, if applicable, shall also apply to Medicaid cost
845 reports. Payment for Medicaid compensable services made on
846 behalf of Medicaid eligible persons is subject to the
847 availability of moneys and any limitations or directions
848 provided for in the General Appropriations Act or chapter 216.
849 Further, nothing in this section shall be construed to prevent
850 or limit the agency from adjusting fees, reimbursement rates,
851 lengths of stay, number of visits, or number of services, or
852 making any other adjustments necessary to comply with the
853 availability of moneys and any limitations or directions
854 provided for in the General Appropriations Act, provided the
855 adjustment is consistent with legislative intent.
856 (4) Subject to any limitations or directions provided for
857 in the General Appropriations Act, alternative health plans,
858 health maintenance organizations, and prepaid health plans shall
859 be reimbursed a fixed, prepaid amount negotiated, or
860 competitively bid pursuant to s. 287.057, by the agency and
861 prospectively paid to the provider monthly for each Medicaid
862 recipient enrolled. The amount may not exceed the average amount
863 the agency determines it would have paid, based on claims
864 experience, for recipients in the same or similar category of

865 eligibility. The agency shall calculate capitation rates on a
866 regional basis and~~, beginning September 1, 1995,~~ shall include
867 age-band differentials in such calculations.
868 (a) Beginning October 1, 2010, the agency shall begin a
869 budget neutral adjustment of capitation rates based on aggregate
870 risk scores for each provider's enrollees. During the first two
871 years of the adjustment, the agency shall ensure that no
872 provider has an aggregate risk score that varies by more than 10
873 percent from the aggregate weighted average for all providers.
874 The risk adjusted capitation rates shall be phased in as
875 follows:
876 1. In the first fiscal year, 75 percent of the capitation
877 rate shall be based on the current methodology and 25 percent
878 shall be based on the risk-adjusted capitation rate methodology.
879 2. In the second fiscal year, 50 percent of the capitation
880 rate shall be based on the current methodology and 50 percent
881 shall be based on the risk-adjusted rate methodology.
882 3. In the third fiscal year, the risk-adjusted capitation
883 methodology shall be fully implemented.
884 (b) The Secretary of the agency shall convene a technical
885 advisory panel to advise the agency in the area of risk adjusted
886 rate setting during the transition to risk adjusted capitation
887 rates described in paragraph (a). The panel shall include
888 representatives of prepaid plans in counties not included in the
889 demonstration sites under s. 409.91211(1). The panel shall
890 advise the agency regarding:
891 1. The selection of a base year of encounter data to be
892 used to set risk adjusted rates.

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893 2. The completeness and accuracy of the encounter dataset.
894 3. The effect of risk adjusted rates on prepaid plans
895 based on a review of a simulated rate setting process.
896
897 Section 7. This act shall take effect July 1, 2010.