Health & Human Services Quality Subcommittee

Tuesday, February 8, 2011
9:00 AM
Webster Hall (212 Knott)

Dean Cannon
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Quality Subcommittee

Start Date and Time: Tuesday, February 08, 2011 09:00 am

End Date and Time: Tuesday, February 08, 2011 11:00 am

Location: Webster Hall (212 Knott)

Duration: 2.00 hrs

Workshop on Medicaid Reform

The purpose of the workshop is to hear public testimony. Participants are invited to provide feedback and to recommend changes to HB 7223 and HB 7225 from the 2010 Legislative Session related to plan and provider relations. Discussion might address, but is not limited to, sections 7, 8, 9, 15, 16, and 17 of HB 7223.

Anyone wishing to speak at the workshop must complete the appearance request form and return to the Health & Human Services Quality Subcommittee by 3:00 p.m. on Monday, February 7, 2011.

The form can be found on the MyFloridaHouse.gov website or can be completed at the committee suite in 214 House Office Building. Online forms may be submitted via email to: bobbye.iseminger@myfloridahouse.gov or faxed to our office at (850) 488-9933.

NOTICE FINALIZED on 02/01/2011 16:14 by Iseminger.Bobbye

Summary of HB 7223
and HB 7225, Engrossed

Summary of HB 7223 and HB 7225, Engrossed

I. The House Medicaid proposal consists of two bills:

a. **HB 7223** creates a new part and numerous new sections of law in Chapter 409 that will be phased in over a 5-year period.

b. **HB 7225** makes date-specific, conforming changes to current law (e.g., set expiration dates for certain sections of existing law). The bill also authorizes some immediate changes in the Medicaid program.

II. The Florida Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care. AHCA is authorized to apply for and implement waivers necessary for this program.

III. General provisions that apply across the Medicaid program:

a. **All Medicaid recipients are enrolled in managed care** unless explicitly exempt. Exempt populations include those who receive limited benefits (e.g. women only eligible for family planning or breast and cervical cancer cervices; aliens eligible for emergency services).

b. **Plans qualified** to participate include

   i. provider service networks (**PSN**),

   ii. exclusive provider organizations,

   iii. health maintenance organizations (**HMO**),

   iv. health insurers

c. Plans may target special populations based on age, medical condition or diagnosis, but **all plans must cover or arrange for all services** for enrollees. The bill eliminates the existence of "carve-out" plans.

d. In order to ensure plans have a sufficient number of enrollees to be viable, a limited number of plans will be selected through a **competitive selection process**.

    i. Each region will have a **minimum** number of plans (3-5).

    ii. Each region will have a **maximum** number of plans (7-10).

    iii. Each region will have a **guaranteed participation for one or two PSNs**, provided there are responsive bidders, to ensure consumer choice and competition between different models of managed care (PSN v HMO).

    iv. Each region will have a guaranteed number of plans for the developmentally disabled population (2-6).

e. Medicaid payment rates will be negotiated as part of the selection process but will be based on historic utilization and spending, adjusted for clinical risk ("**risk adjusted rates**").

f. **In addition to price**, the competitive selection process will also evaluate a managed care organization's

    i. Accreditation;

    ii. Experience with similar populations;

    iii. Availability and accessibility of primary care providers;

    iv. Community partnerships that create re-investment opportunities;

    v. Commitment to quality improvement;

    vi. Additional benefits, particularly dental care, disease management and other enhanced services;

    vii. History of voluntary or involuntary withdrawals.

viii. Pre-bid agreements with physicians to meet network requirements or provide sufficient compensation to meet network requirements over the 5-year contract term.

ix. Pre-bid agreements with select providers of critical services required to participate in the chosen plans in each program (e.g., teaching hospitals, nursing homes and ICF/DDs).

g. **Preference** will be given in the competitive selection process to

i. Organizations that are **medical homes**. Plans must assist and incentivize primary care providers to become medical homes.

ii. Organizations that **recruit minority providers**.

iii. Organizations that cover both acute and long term care services.

h. Plans will be selected on a **regional basis**

i. **The Panhandle Region:** Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington

1. The smallest region with a little more than 200,000 current Medicaid enrollees. Region 1 would be capped at a maximum of 3 managed care plans.

ii. **The North Central/ Northeast Florida Region:** Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, Union, Volusia.

iii. **The West Central Florida Region:** Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, Sarasota.

1. The largest region, with nearly 700,000 current Medicaid enrollees.

iv. **The Central Florida Region:** Brevard, Lake, Orange, Osceola, Seminole, Sumter.

v. **The Southeast Florida Region:** Broward, Hendry, Indian River, Martin, Okeechobee, Palm Beach, St. Lucie.

vi. **The South Florida Region:** Collier, Miami-Dade, Monroe

Medical/Long Term	**Area 1**	**Area 2**	**Area 3**	**Area 4**	**Area 5**	**Area 6**	**Total Statewide**
Total Enrollees	203,337	433,428	692,564	370,747	426,008	552,024	2,678,108
Minimum plans	3	4	5	4	4	5	25
PSN plans if responsive	1	1	2	1	1	2	8
Maximum plans	3	7	10	8	7	9	44
DD plans Min – Max (1 PSN each)	2	2 – 5	3 – 6	3 – 6	3 – 6	3 – 6	16 – 31

i. Managed care plans will be held **accountable**.

i. AHCA will establish 5-year contracts with **no renewals**.

ii. Plans will be required to **pay for emergency services**.

iii. Plans will be required to meet **network adequacy standards** and maintain an accurate database of providers online and accessible to AHCA and the public. The public will have the opportunity to post feedback about providers.

iv. **Performance standards** will be established and raised over the term of the contract.

v. Plans will be required to maintain program integrity functions including specific activities that **reduce fraud and abuse**:

1. Provider credentialing and monitoring

2. Prepayment and post payment reviews;

3. Reporting procedures;

4. Mandatory compliance plans;

5. Designation of a program integrity compliance officer.

vi. **Grievance resolution process** will be required and AHCA will maintain a process for those recipient complaints that are not resolved by the plans.

vii. **Penalties for reducing enrollment or early withdrawal**, including reimbursement of transition costs and a fine of up to 5% of the capitation payment.

viii. **Specific requirements for enrollment, choice counseling, automatic assignment and disenrollment are established**. When a recipient with a specific condition or diagnosis does not choose a plan, the recipient will be automatically enrolled into a specialty plan if one is available.

ix. Plans must provide **30-days written notice to recipients** prior to the recipient's provider being excluded from the plan for failure to meet quality or performance criteria.

x. **Ongoing Medicaid encounter data analysis** by AHCA to determine whether there has been systemic under-utilization, inappropriate utilization, or systemic claim denials.

xi. **Repayment of intergovernmental transfers** is guaranteed by ensuring that providers are paid the exact amount the agency determines and are paid within 15 days.

IV. Specific provisions that apply to managed medical assistance – primary and acute care

a. **Implementation** shall begin January 1, 2012, with full implementation by **October 1, 2013**.

b. Enrollment

i. All non-exempt Medicaid recipients will be required to enroll in a managed care organization (PSN, HMO).

ii. Exempt persons who may **voluntarily enroll** include:
1. Recipients with other creditable coverage.
2. Recipients in residential placements.
3. Refugee assistance recipients.
4. Residents of a developmental disability center

iii. Fee-for-service Medicaid is maintained only for exempt persons and those who may, but do not, voluntarily enroll.

c. Benefits

i. All current mandatory and optional services.

ii. Plans may customize benefits, subject to review by AHCA.

iii. Plans are required to maintain an enhanced benefits program.

d. **Children's Medical Services** is a qualified plan statewide and exempt from competitive procurement, but must meet other plan requirements.

e. **Accountability measures** specific to managed medical assistance

i. **Medical loss ratio** thresholds

1. Less than 75% = payback up to 85% and no auto-enrollment

2. 75%-85% = payback up to 85%

3. Greater than 92% = evaluation to determine effectiveness of care management

4. 95% or more and determined to be failing to adequately manage care = no auto-enrollment

ii. Plans are required to have specific p**rograms for pregnant women and infants**.

iii. Plans must achieve an **EPSDT screening** rate of at least 80%.

f. **Rules** for plans and providers:

i. **Plans may** limit providers

1. Must offer a contract in first period to:

a. FQHCs
b. Medical home primary care providers
c. Select providers of critical services

2. After 12 months, these providers may be excluded for failure to meet quality standards

ii. **Providers may** limit plans, but providers with special state-granted designations must agree to contract with qualified plans:

1. Statutory teaching hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)

2. Trauma hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)

3. RIPCCs (must ensure that center has adequate medical staff to fulfill contractual obligations)

4. Specialty licensed children's hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)

5. Providers with an active Medicaid agreement and CON (hospitals and hospices)

iii. **Hospital payments** must be a minimum of the Medicaid rate up to 150% of Medicaid unless approved by AHCA.

iv. Requires **performance measurement** of providers with transparent metrics.

v. The **Medicaid Resolution Board** will resolve disputes between plans and hospitals, and plans and hospital medical staff.

g. **Medically needy** recipients shall be enrolled in managed care.

i. Plans **must accept and provide 12 months continuous eligibility** to Medically Needy enrollees;

ii. Enrollees must **pay the premium up to their share of cost**; contingent on federal approval

iii. Plans must provide at least a **120-day grace period** before disenrolling for failure to pay premiums.

V. Specific provisions that apply to long-term care

a. **Implementation** will begin July 1, 2011, and be complete in all regions by October 1, 2012.

b. **Eligibility**

i. Medicaid recipients who are 65+ or disabled and meet level of care standards as determined by CARES

ii. All recipients in a nursing facility or enrolled in a waiver on the day managed care plans become available in their region

c. Two **types of plans**

   i. Comprehensive plans that combine medical and home and community based services

   ii. Long-term care plans that only provide home and community based services

d. Long-term care managed care **plan requirements**

   i. Must provide both residential care (nursing facility or other) and a comprehensive range of home and community based services.

   ii. Medicare plans are qualified plans for long-term care managed care.

   iii. PACE plans are qualified but exempt from procurement.

   iv. Qualified plans must have specialized staffing with experience in serving elders and the disabled.

   v. A limited number of plans are selected in specific regions.

   vi. Follow specific standards for availability and accessibility of home and community based services.

e. **Home and community based care**:

   i. **Payment rates** reflect an adjustment to create incentives for keeping individuals out of nursing homes as long as possible; at least 3% up to 5% re-balancing of nursing home and home and community based care is expected each year.

   ii. **CARES staff** will continue to evaluate whether an individual needs a nursing facility level of care and will initially assign the individual to a level of care.

f. **Medical loss ratio** thresholds

i. Less than 75% = payback up to 85% and no auto-enrollment

ii. 75% - 85% = payback up to 85%

iii. Greater than 92% = evaluation to determine effectiveness of care management

iv. 95% or more and determined to be failing to adequately manage care = no auto-enrollment

g. Auto-assignments can be quality based.

h. **Preservation of roles for traditional aging service providers**

i. Aging Resources Centers will be a community access point for seniors seeking services and will either offer choice counseling to enrollees through a contract with AHCA, or will work cooperatively with choice counseling vendors.

ii. Plans must include all nursing homes and hospices and these providers are must agree to participate in a plan's network if offered a contract.

iii. Nursing homes and hospices will receive a "pass through" payment for services from the plan.

iv. A plan's network must include:

1. Adult Day Center Centers
2. Adult Family Care Homes
3. Assisted Living Facilities
4. Health Care Services Pools
5. Home Health Agencies
6. Homemaker and Companion Services
7. Hospices
8. Lead Agencies
9. Nurse Registries
10. Nursing Homes

i. **Hospice Services**

i. Recipients referred for hospice services will have 30 days to select another plan to access a preferred hospice

VI. Specific provisions that apply to <u>developmental disabilities</u>

a. **Implementation** will begin January 1, 2014, and be complete in all regions by October 1, 2015.

b. Two **types of plans**

i. Comprehensive plans that combine medical and home and community based services

ii. Long-term care plans that only provide home and community based services

c. **Eligibility**

i. Criteria are the same as the current Medicaid waiver program and the Intermediate Care for the Developmental Disabilities program.

ii. All recipients of these services on the date the plans become available in their region will be eligible to enroll in the Plans.

d. The **benefits** that will be required of participating plans are substantially the same as those currently offered under the four-tier Medicaid waiver program and the Intermediate Care for Developmental Disabilities program.

e. To be **qualified**, a managed care plan must

i. Have staffing with experience serving persons with developmental disabilities

ii. Provider service networks must include certain licensed residential providers with 10 years of experience in developmental disabilities.

iii. Plans must involve consumers and families in design and oversight of plans.

iv. Plans must contract with all residential providers upon implementation of the new program to ensure no disruption in living situations.

v. AHCA will give preference to those plans that have pre-bid agreements with providers to meet network requirements.

vi. Plans must provide 90-days' written notice to recipients prior to the recipient's provider being excluded from the plan for failure to meet quality or performance criteria.

f. **Medical loss ratio** thresholds

i. At least 92% of premiums must be spent on direct care cost and services

g. **Payment**

i. AHCA will pay plans based on five specific levels of care for enrolled individuals.

ii. APD will perform the initial assessment and assignment of persons into levels of care.

iii. Rates paid to intermediate care for the developmental disabilities facilities and intensive behavior residential habilitation facilities will be determined by AHCA.

h. Residents of Sunland Marianna, Tacachale and the mentally retarded defendant program are exempt from mandatory enrollment in the new program, but may voluntarily enroll if they so choose.

VII. Immediate changes to begin transition of current Medicaid system

a. The agency is directed to seek an **extension and modification of the 1115 waiver**.

b. The **reform pilot is expanded to Miami-Dade County**, beginning July 1, 2010, with full implementation expected by June 30, 2011.

c. **Payment** of existing managed care plans will change in two ways

   i. All plans (whether in reform counties or elsewhere in the state) will begin a **3-year transition to risk-adjusted rates**.

   ii. The agency will begin a 3-year process to modify the basis for setting capitation rates to include **consideration of encounter data**. AHCA is required to review available encounter data to establish actuarially sound rates prior to using the encounter data to adjust rates for prepaid plans.

   iii. Rates will be **immediately risk-adjusted for public hospitals** in Miami-Dade County

d. **Miami-Dade County IGTs are preserved** by directing the agency to develop a methodology, such as a supplemental capitation rate, to be paid to prepaid plans or providers under contract with trauma, children's or safety net hospitals.

e. All plans statewide (both in reform areas and elsewhere) are required to **develop enhanced benefit plans** and **report encounter data**.

f. All Medicaid recipients statewide will be permitted to use their Medicaid premium to **purchase private insurance**.

g. The agency will establish a **uniform method of accounting and reporting medical and non-medical expenses** and the plans will begin reporting.

h. Provisions for **designation of medical homes** are established.

i. **Prepaid PSNs are permitted to provide comprehensive behavioral health** and specific requirements are established for the reconciliation process that determines shared savings.

j. AHCA is required to contract with **prepaid dental plans** until the Medicaid Managed Medical Assistance prgram is fully implemented in all regions.

k. AHCA is **authorized to accept Medicare plans as Medicaid plans** and make appropriate payments for dually eligible enrollees. Medicare crossover providers can be enrolled as Medicaid providers for both payment and claims processing.

l. Area One of APD will participate in an **ibudget (individual budget) demonstration project** to test the effectiveness of the ibudget proposal serving people with developmental disabilities in the Medicaid program.

A bill to be entitled

An act relating to Medicaid managed care; creating pt. IV of ch. 409, F.S.; creating s. 409.961, F.S.; providing for statutory construction; providing applicability of specified provisions throughout the part; providing rulemaking authority for specified agencies; creating s. 409.962, F.S.; providing definitions; creating s. 409.963, F.S.; designating the Agency for Health Care Administration as the single state agency to administer the Medicaid program; providing for specified agency responsibilities; requiring client consent for release of medical records; creating s. 409.964, F.S.; establishing the Medicaid program as the statewide, integrated managed care program for all covered services; authorizing the agency to apply for and implement waivers; providing for public notice and comment; creating s. 409.965, F.S.; providing for mandatory enrollment; providing for exemptions; creating s. 409.966, F.S.; providing requirements for qualified plans that provide services in the Medicaid managed care program; providing for a medical home network to be designated as a qualified plan; establishing provider service network requirements for qualified plans; providing for qualified plan selection; requiring the agency to use an invitation to negotiate; requiring the agency to compile and publish certain information; establishing regions for separate procurement of plans; providing quality selection criteria for plan selection; establishing quality selection criteria;

providing limitations on serving recipients during the pendency of litigation; providing that a qualified plan that participates in an invitation to negotiate in more than one region may not serve Medicaid recipients until all administrative challenges are finalized; creating s. 409.967, F.S.; providing for managed care plan accountability; establishing contract terms; providing for contract extension under certain circumstances; establishing payments to noncontract providers; establishing requirements for access; requiring plans to establish and maintain an electronic database; establishing requirements for the database; requiring plans to provide encounter data; requiring the agency to establish performance standards for plans; providing program integrity requirements; establishing a grievance resolution process; providing for penalties for early termination of contracts or reduction in enrollment levels; creating s. 409.968, F.S.; establishing managed care plan payments; providing payment requirements for provider service networks; creating s. 409.969, F.S.; requiring enrollment in managed care plans by specified Medicaid recipients; creating requirements for plan selection by recipients; providing for choice counseling; establishing choice counseling requirements; authorizing disenrollment under certain circumstances; defining the term "good cause" for purposes of disenrollment; providing time limits on an internal grievance process; providing requirements for agency determination regarding

disenrollment; requiring recipients to stay in plans for a specified time; creating s. 409.970, F.S.; requiring the agency to maintain an encounter data system; providing requirements for prepaid plans to submit data; creating s. 409.971, F.S.; creating the managed medical assistance program; providing deadlines to begin and finalize implementation of the program; creating s. 409.972, F.S.; providing for mandatory and voluntary enrollment; creating s. 409.973, F.S.; establishing minimum benefits for managed care plans to cover; authorizing plans to customize benefit packages; requiring plans to establish enhanced benefits programs; providing terms for enhanced benefits package; establishing reserve requirements for plans to fund enhanced benefits programs; creating s. 409.974, F.S.; establishing a specified number of qualified plans to be selected in each region; establishing a deadline for issuing invitations to negotiate; establishing quality selection criteria; establishing the Children's Medical Service Network as a qualified plan; creating s. 409.975; establishing managed care plan accountability; creating a medical loss ratio requirement; authorizing plans to limit providers in networks; mandating certain providers be offered contracts in the first year; requiring certain provider types to participate in plans; requiring plans to monitor the quality and performance history of providers; requiring specified programs and procedures be established by plans; establishing provider payments for hospitals; establishing

conflict resolution procedures; establishing the Medicaid Resolution Board for specified purposes; establishing plan requirements for medically needy recipients; creating s. 409.976, F.S.; providing for managed care plan payment; requiring the agency to establish a methodology to ensure certain types of payments to specified providers; establishing eligibility for payments; requiring the agency to establish payment rates for statewide inpatient psychiatric programs; requiring payments to managed care plans to be reconciled to reimburse actual payments to statewide inpatient psychiatric programs; creating s. 409.977, F.S.; providing for enrollment; establishing choice counseling requirements; providing for automatic enrollment of certain recipients; establishing opt-out opportunities for recipients; creating s. 409.978, F.S.; requiring the Agency for Health Care Administration be responsible for administering the long-term care managed care program; providing implementation dates for the long-term care managed care program; providing duties for the Department of Elderly Affairs relating to assisting the agency in implementing the program; creating s. 409.979, F.S.; providing eligibility requirements for the long-term care managed care program; creating s. 409.980, F.S.; providing the benefits that a managed care plan shall provide when participating in the long-term care managed care program; creating s. 409.981, F.S.; providing criteria for qualified plans; designating regions for plan implementation throughout the state; providing criteria

for the selection of plans to participate in the long-term care managed care program; creating s. 409.982, F.S.; providing the agency shall establish a uniform accounting and reporting methods for plans; providing spending thresholds and consequences relating to spending thresholds; providing for mandatory participation in plans of certain service providers; providing providers can be excluded from plans for failure to meet quality or performance criteria; providing the plans must monitor participating providers using specified criteria; providing certain providers that must be included in plan networks; providing provider payment specifications for nursing homes and hospices; creating s. 409.983, F.S.; providing for negotiation of rates between the agency and the plans participating in the long-term care managed care program; providing specific criteria for calculating and adjusting plan payments; allowing the CARES program to assign plan enrollees to a level of care ; providing incentives for adjustments of payment rates; providing the agency shall establish nursing facility-specific and hospice services payment rates; creating s. 409.984, F.S.; providing that prior to contracting with another vender, the agency shall offer to contract with the aging resource centers to provide choice counseling for the long-term care managed care program; providing criteria for automatic assignments of plan enrollees who fail to chose a plan; creating s. 409.985, F.S.; providing that the agency shall operate the Comprehensive Assessment and

Review for Long-Term Care Services program through an interagency agreement with the Department of Elderly Affairs; providing duties of the program; defining the term "nursing facility care"; creating s. 409.986, F.S.; providing authority and agency duties related to long-term care plans; creating s. 409.987, F.S.; providing eligibility requirements for long-term care plans; creating s. 409.988, F.S.; providing benefits for long-term care plans; creating s. 409.989, F.S.; establishing criteria for qualified plans; specifying minimum and maximum number of plans and selection criteria; creating s. 409.990, F.S.; providing requirements for managed care plan accountability; specifying limitations on providers in plan networks; providing for evaluation and payment of network providers; creating s. 409.991, F.S.; providing for payment of managed care plans; providing duties for the Agency for Persons with Disabilities to assign plan enrollees into a payment rate level of care; establishing level of care criteria; providing payment requirements for intensive behavior residential habilitation providers and intermediate care facilities for the developmentally disabled; creating s. 409.992, F.S.; providing requirements for enrollment and choice counseling; specifying enrollment exceptions for certain Medicaid recipients; providing an effective date.

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

Section 1. Sections 409.961 through 409.992, Florida Statutes, are designated as part IV of chapter 409, Florida Statutes, entitled "Medicaid Managed Care."

Section 2. Section 409.961, Florida Statutes, is created to read:

409.961 Statutory construction; applicability; rules.—It is the intent of the Legislature that if any conflict exists between the provisions contained in this part and provisions contained in other parts of this chapter, the provisions contained in this part shall control. The provisions of ss. 409.961-409.970 apply only to the Medicaid managed medical assistance program, long-term care managed care program, and managed long-term care for persons with developmental disabilities program, as provided in this part. The agency shall adopt any rules necessary to comply with or administer this part and all rules necessary to comply with federal requirements. In addition, the department shall adopt and accept the transfer of any rules necessary to carry out the department's responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility and for ensuring compliance with and administering this part, as those rules relate to the department's responsibilities, and any other provisions related to the department's responsibility for the determination of Medicaid eligibility.

Section 3. Section 409.962, Florida Statutes, is created to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(1) "Agency" means the Agency for Health Care Administration. The agency is the Medicaid agency for the state, as provided under federal law.

(2) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, goods, or services.

(3) "Direct care management" means care management activities that involve direct interaction between providers and patients.

(4) "Long-term care comprehensive plan" means a long-term care plan that also provides the services described in s. 409.973.

(5) "Long-term care plan" means a specialty plan that provides institutional and home and community-based services.

(6) "Long term care provider service network" means an entity certified pursuant to s. 409.912(4)(d), of which a controlling interest is owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

(7) "Managed care plan" means a qualified plan under contract with the agency to provide services in the Medicaid program.

(8) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in this state by the agency.

(9) "Medicaid recipient" or "recipient" means an individual who the department or, for Supplemental Security Income, the Social Security Administration determines is eligible pursuant to federal and state law to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(10) "Medical home network" means a qualified plan designated by the agency as a medical home network in accordance with the criteria established in s. 409.91207.

(11) "Prepaid plan" means a qualified plan that is licensed or certified as a risk-bearing entity in the state and is paid a prospective per-member, per-month payment by the agency.

(12) "Provider service network" means an entity certified pursuant to s. 409.912(4)(d) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

(13) "Qualified plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized

under chapter 641, or a provider service network authorized under s. 409.912(4)(d) that is eligible to participate in the statewide managed care program.

(14) "Specialty plan" means a qualified plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

Section 4. Section 409.963, Florida Statutes, is created to read:

409.963 Single state agency.—The Agency for Health Care Administration is designated as the single state agency authorized to manage, operate, and make payments for medical assistance and related services under Title XIX of the Social Security Act. Subject to any limitations or directions provided for in the General Appropriations Act, these payments shall be made only for services included in the program, only on behalf of eligible individuals, and only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated as the "Medicaid program." The department is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility. As a condition of Medicaid eligibility, subject to federal approval, the agency and the department shall ensure that each Medicaid recipient consents to the release of her or

his medical records to the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

Section 5. Section 409.964, Florida Statutes is created to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Prior to seeking a waiver, the agency shall provide public notice and the opportunity for public comment and shall include public feedback in the waiver application. The agency shall include the public feedback in the application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2) and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.

Section 6. Section 409.965, Florida Statutes, is created to read:

409.965 Mandatory enrollment.—All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver. The following Medicaid recipients are exempt from participation in the statewide managed care program:

(1) Women who are only eligible for family planning services.

(2) Women who are only eligible for breast and cervical cancer services.

(3) Persons who are eligible for emergency Medicaid for aliens.

Section 7. Section 409.966, Florida Statutes, is created to read:

409.966 Qualified plans; selection.—

(1) QUALIFIED PLANS.-Services in the Medicaid managed care program shall be provided by qualified plans.

(a) A qualified plan may request the agency to designate the plan as a medical home network if it meets the criteria established in s. 409.91207.

(b) A provider service network must be capable of providing all covered services to a mandatory Medicaid managed care enrollee or may limit the provision of services to a specific target population based on the age, chronic disease state, or the medical condition of the enrollee to whom the network will provide services. A specialty provider service network must be capable of coordinating care and delivering or arranging for the delivery of all covered services to the target population. A provider service network may partner with an insurer licensed under chapter 627 or a health maintenance organization licensed under chapter 641 to meet the requirements of a Medicaid contract.

(2) QUALIFIED PLAN SELECTION.-The agency shall select a limited number of qualified plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(3)(a). At least 30 days prior to issuing an invitation

to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county. The source of the data in the report shall include both historic fee-for-service claims and validated data from the Medicaid Encounter Data System. The report shall be made available in electronic form and shall delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. Separate and simultaneous procurements shall be conducted in each of the following regions:

(a) Region I, which shall consist of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties.

(b) Region II, which shall consist of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, Union, and Volusia Counties.

(c) Region III, which shall consist of Charlotte, DeSoto, Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota Counties.

(d) Region IV, which shall consist of Brevard, Indian River, Lake, Orange, Osceola, Seminole, and Sumter Counties.

(e) Region V, which shall consist of Broward, Glades, Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

(f) Region VI, which shall consist of Collier, Dade, and Monroe Counties.

(3) QUALITY SELECTION CRITERIA.-The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of qualified plans:

(a) Accreditation by the National Committee for Quality Assurance or another nationally recognized accrediting body.

(b) Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

(c) Availability and accessibility of primary care and specialty physicians in the provider network.

(d) Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

(e) Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

(f) Provision of additional benefits, particularly dental care and disease management, and other enhanced-benefit programs.

(g) History of voluntary or involuntary withdrawal from any state Medicaid program or program area.

(h) Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give special weight to such evidence, and the evaluation shall be based on the following factors:

1. Contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(b).

2. Specific arrangements that provide evidence that the compensation offered is sufficient to retain primary and specialty physicians in sufficient numbers to continue to comply with the standards established pursuant to s. 409.967(2) throughout the 5-year contract term.

3. Contracts with community pharmacies located in rural areas; contracts with community pharmacies servicing specialty disease populations, including, but not limited to, HIV/AIDS patients, hemophiliacs, patients suffering from end-stage renal disease, diabetes, or cancer; community pharmacies located within distinct cultural communities that reflect the unique cultural dynamics of such communities, including, but not limited to, languages spoken, ethnicities served, unique disease states serviced, and geographic location within neighborhoods of such culturally distinct populations; and community pharmacies providing value-added services to patients, such as free delivery, immunizations, disease management, diabetes education, and medication utilization review.

4. Contracts with multiple and diverse suppliers of home

medical equipment and supplies distributed throughout the region that ensure patient choice, continuity of services, and redundant capacity to prevent service disruption during disaster response. The network of home medical equipment and supply providers shall include fully accredited and locally owned and operated companies with a proven ability to provide quality products, personalized service, 24-hour access to service, and appropriate response time.

After negotiations are conducted, the agency shall select the qualified plans that are determined to be responsive and provide the best value to the state. Preference shall be given to organizations designated as medical home networks pursuant to s. 409.91207 or organizations with the greatest number of primary care providers that are recognized as patient-centered medical homes by the National Committee for Quality Assurance or organizations with networks that reflect recruitment of minority physicians and other minority providers.

(4) ADMINISTRATIVE CHALLENGE.—Any qualified plan that participates in an invitation to negotiate in more than one region and is selected in at least one region may not begin serving Medicaid recipients in any region for which it was selected until all administrative challenges to procurements required by this section to which the qualified plan is a party have been finalized. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the

Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

Section 8. Section 409.967, Florida Statutes, is created to read:

409.967 Managed care plan accountability.—

(1) The agency shall establish a 5-year contract with each of the qualified plans selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the terms of a plan contract to cover any delays in transition to a new plan.

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract shall require:

(a) Emergency services.—Plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider within 30 days after receipt of a complete and correct claim. Plans must give providers of these services a specific explanation for each claim denied for being incomplete or incorrect. Providers shall have an opportunity to resubmit corrected claims for reconsideration within 30 days after receiving notice from the managed care plans of the claims being incomplete or incorrect. Payments for noncontracted

emergency services and care shall be made at the rate the agency would pay for such services from the same provider. Claims from noncontracted providers shall be accepted by the qualified plan for at least 1 year after the date the services are provided.

(b) Access.—The agency shall establish specific standards for the number, type, and regional distribution of providers in plan networks to ensure access to care. Each plan must maintain a region-wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database shall be available online to both the agency and the public and shall have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

(c) Encounter data.—Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of plans' enrollees to allow comparison of service utilization among plans and against

expected levels of use. The analysis shall be used to identify possible cases of systemic under-utilization or denials of claims and inappropriate service utilization such as higher than expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the primary focus areas for the analysis shall be the use of prescription drugs.

(d) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract. Each plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system shall include incentives and disincentives for network providers.

(e) Program integrity.—Each plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

(f) Grievance resolution.—Each plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees consistent with the requirements of s. 641.511. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees. The agency shall maintain a process for provider service networks consistent with s. 408.7056.

(g) Penalties.—Plans that reduce enrollment levels or leave a region prior to the end of the contract term shall reimburse the agency for the cost of enrollment changes and other transition activities, including the cost of additional choice counseling services. If more than one plan leaves a region at the same time, costs shall be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing plans shall pay a per enrollee penalty not to exceed 5 percent of 1 month's payment. Plans shall provide the agency notice no less than 180 days prior to withdrawing from a region.

(h) Prompt payment.—All managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(i) Electronic claims.-Plans shall accept electronic claims in compliance with federal standards.

(j) Medical home development.-The managed care plan, if not designated as a medical home network pursuant to s. 409.91207, must develop a plan to assist and to provide incentives for its primary care providers to become recognized

as patient-centered medical homes by the National Committee for Quality Assurance.

Section 9. Section 409.968, Florida Statutes, is created to read:

409.968 Managed care plan payment.—

(1) Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in s. 409.966. Payments shall be risk-adjusted rates based on historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area, and the clinical risk profile of the recipients.

(2) Beginning September 1, 2010, the agency shall update the rate-setting methodology by initiating a transition to rates based on statewide encounter data submitted by Medicaid managed care plans pursuant to s. 409.970. Prior to this transition, the agency shall conduct appropriate tests and establish specific milestones in order to determine that the Medicaid Encounter Data system consists of valid, complete, and sound data for a sufficient period of time to provide a reliable basis for establishing actuarially sound payment rates. The transition shall be implemented within 3 years or less, and shall utilize such other data sources as necessary and reliable to make appropriate adjustments during the transition. The agency shall establish a technical advisory panel to obtain input from the prepaid plans regarding the incorporation of encounter data in the rate setting process.

(3) Provider service networks may be prepaid plans and receive per-member, per-month payments negotiated pursuant to

the procurement process described in s. 409.966. Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 5 years of the plan's operation in a given region or until the contract year that begins on October 1, 2015, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of incurred but not reported claims within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.

Section 10. Section 409.969, Florida Statutes, is created to read:

409.969 Enrollment; choice counseling; automatic assignment; disenrollment.—

(1) ENROLLMENT.—All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted in this part. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans. All recipients shall be offered choice counseling services in accordance with this section.

(2) CHOICE COUNSELING.—The agency shall provide choice counseling for Medicaid recipients. The agency may contract for the provision of choice counseling. Any such contract shall be for a period of 5 years. The agency may renew a contract for an additional 5-year period; however, prior to renewal of the contract the agency shall hold at least one public meeting in each of the regions covered by the choice counseling vendor. The agency may extend the term of the contract to cover any delays in transition to a new contractor. Printed choice information and choice counseling shall be offered in the native or preferred language of the recipient, consistent with federal requirements. The manner and method of choice counseling shall be modified as necessary to assure culturally competent, effective communication with people from diverse cultural backgrounds. The agency shall maintain a record of the recipients who receive such services, identifying the scope and method of the services provided. The agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

(a) An explanation that each recipient has the right to choose a managed care plan at the time of enrollment in Medicaid and again at regular intervals set by the agency, and that if a recipient does not choose a plan, the agency will assign the recipient to a plan according to the criteria specified in this section.

(b) A list and description of the benefits provided in each plan.

(c) An explanation of benefit limits.

(d) A current list of providers participating in the network, including location and contact information.

(e) Plan performance data.

(3) DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may require a recipient to use the plan's grievance process prior to the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged.

(a) The managed care plan internal grievance process, when utilized, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the result of the

grievance process is approval of an enrollee's request to disenroll, the agency is not required to make a determination in the case.

(b) 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 good cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(c) Medicaid recipients enrolled in a managed care plan after the 90-day period shall remain in the plan for the remainder of the 12-month period. After 12 months, the recipient may select another plan. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the plan during that period.

(d) On the first day of the next month after receiving notice from a recipient that the recipient has moved to another region, the agency shall automatically disenroll the recipient from the plan the recipient is currently enrolled in and treat the recipient as if the recipient is a new Medicaid enrollee. At that time, the recipient may choose another plan pursuant to the enrollment process established in this section.

Section 11. Section 409.970, Florida Statutes, is created to read:

409.970 Encounter data.—The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans. Prepaid plans shall submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete. The agency is responsible for validating the data submitted by the plans. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

Section 12. Section 409.971, Florida Statutes, is created to read:

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. By January 1, 2012, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all regions by October 1, 2013.

Section 13. Section 409.972, Florida Statutes, is created to read:

409.972 Mandatory and voluntary enrollment.—

(1) Persons eligible for the program known as "medically needy" pursuant to s. 409.904(2)(a) shall enroll in managed care plans. Medically needy recipients shall meet the share of cost

by paying the plan premium, up to the share of cost amount, contingent upon federal approval.

(2) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the Department of Children and Families, and treatment facilities funded through the Substance Abuse and Mental Health program of the Department of Children and Families.

(c) Persons eligible for refugee assistance.

(d) Medicaid recipients who are residents of a developmental disability center including Sunland Center in Marianna and Tacachale in Gainesville.

(3) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided in part III of this chapter.

Section 14. Section 409.973, Florida Statutes, is created to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

(e) Dental services.

(f) Early periodic screening diagnosis and treatment services for recipients under age 21.

(g) Emergency services.

(h) Family planning services and supplies.

(i) Healthy start services.

(j) Hearing services.

(k) Home health agency services.

(l) Hospice services.

(m) Hospital inpatient services.

(n) Hospital outpatient services.

(o) Laboratory and imaging services.

(p) Medical supplies, equipment, prostheses, and orthoses.

(q) Mental health services.

(r) Nursing care.

(s) Optical services and supplies.

(t) Optometrist services.

(u) Physical, occupational, respiratory, and speech therapy services.

(v) Physician services.

(w) Podiatric services.

(x) Prescription drugs.

(y) Renal dialysis services.

(z) Respiratory equipment and supplies.

(aa) Rural health clinic services.

(bb) Substance abuse treatment services.

(cc) Transportation to access covered services.

(2) CUSTOMIZED BENEFITS.—Managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

(3) ENHANCED BENEFITS.—Each plan operating in the managed medical assistance program shall establish an incentive program that rewards specific healthy behaviors with credits in a flexible spending account.

(a) At the discretion of the recipient, credits shall be used to purchase otherwise uncovered health and related services during the entire period of, and for a maximum of 3 years after, the recipient's Medicaid eligibility, whether or not the recipient remains continuously enrolled in the plan in which the credits were earned.

(b) Enhanced benefits shall be structured to provide greater incentives for those diseases linked with lifestyle and conditions or behaviors associated with avoidable utilization of high-cost services.

(c) To fund these credits, each plan must maintain a reserve account in an amount of up to 2 percent of the plan's Medicaid premium revenue, or benchmark premium revenue in the case of provider service networks, based on an actuarial assessment of the value of the enhanced benefits program.

Section 15. Section 409.974, Florida Statutes, is created to read:

409.974 Qualified plans.—

(1) QUALIFIED PLAN SELECTION.-The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2012.

(a) The agency shall procure three plans for Region I. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(b) The agency shall procure at least four and no more than seven plans for Region II. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(c) The agency shall procure at least five plans and no more than ten plans for Region III. At least two plans shall be provider service networks, if any two provider service networks submit a responsive bid.

(d) The agency shall procure at least four plans and no more than eight plans for Region IV. At least one plan shall be a provider service network if any provider service network submits a responsive bid.

(e) The agency shall procure at least four plans and no more than seven plans for Region V. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(f) The agency shall procure at least five plans and no more than ten plans for Region VI. At least two plans shall be

provider service networks, if any two provider service networks submit a responsive bid.

If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of qualified plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

(2) QUALITY SELECTION CRITERIA.-In addition to the criteria established in s. 409.966, the agency shall consider evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with providers of critical services pursuant to s. 409.975(3)(a)-(d). The agency shall also consider whether the organization is a specialty plan. When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

(3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's Medical Services Network authorized under chapter 391 is a qualified plan for purposes of the managed medical assistance program. Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with

the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

Section 16. Section 409.975, Florida Statutes, is created to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) MEDICAL LOSS RATIO.—The agency shall establish and implement managed care plans that shall use a uniform method of accounting for and reporting medical, direct care management, and nonmedical costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(b) Plans that spend less than 85 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(c) Plans that spend more than 92 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management.

(d) Plans that spend 95 percent or more of Medicaid premium revenue on medical services and direct care management and are determined to be failing to appropriately manage care shall be excluded from automatic enrollments.

(2) PROVIDER NETWORKS.—Plans may limit the providers in their networks based on credentials, quality indicators, and price. However, in the first contract period after a qualified plan is selected in a region by the agency, the plan must offer a network contract to the following providers in the region:

(a) Federally qualified health centers.

(b) Primary care providers certified as medical homes.

(c) Providers listed in paragraphs (3)(a)-(d).

After 12 months of active participation in a plan's network, the plan may exclude any of the above-named providers from the network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days prior to the effective date of the exclusion.

(3) SELECT PROVIDER PARTICIPATION.—Providers may not be required to participate in any qualified plan selected by the agency except as provided in this subsection. The following

providers must agree to participate with each qualified plan selected by the agency in the regions where they are located:

(a) Statutory teaching hospitals as defined in s. 408.07(45).

(b) Hospitals that are trauma centers as defined in s. 395.4001(14).

(c) Hospitals that are regional perinatal intensive care centers as defined in s. 383.16(2).

(d) Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

(e) Hospitals with both an active Medicaid provider agreement under s. 409.907 and a certificate of need.

The hospitals described in paragraphs (a)-(d) shall make adequate arrangements for medical staff sufficient to fulfill their contractual obligations with the plans.

(4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the quality and performance of each participating provider. At the beginning of the contract period, each plan shall notify all its network providers of the metrics used by the plan for evaluating the provider's performance and determining continued participation in the network.

(5) PREGNANCY AND INFANT HEALTH.—Each plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for

Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs.

(6) SCREENING RATE.—Each plan shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent of those recipients continuously enrolled for at least 8 months.

(7) PROVIDER PAYMENT.—Plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. At a minimum, plans shall pay hospitals the Medicaid rate. Payments to hospitals shall not exceed 150 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

(8) CONFLICT RESOLUTION.—In order to protect the continued statewide operation of the Medicaid managed care program, the Medicaid Resolution Board is established to resolve disputes between managed care plans and hospitals and between managed care plans and the medical staff of the providers listed in s. 409.975(3)(a)-(d). The board shall consist of two members appointed by the Speaker of the House of Representatives, two members appointed by the President of the Senate, and three members appointed by the Governor. The costs of the board's activities to review and resolve disputes shall be shared equally by the parties to the dispute. Any managed care plan or above-named provider may initiate a review by the board for any conflict related to payment rates, contract terms, or other conditions. The board shall make recommendations to the agency regarding payment rates, procedures, or other contract terms to

resolve such conflicts. The agency may amend the terms of the contracts with the parties to ensure compliance with these recommendations. This process shall not be used to review and reverse any managed care plan decision to exclude any provider that fails to meet quality standards.

(9) MEDICALLY NEEDY ENROLLEES.—Each selected plan shall accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the department. The agency shall pay the remainder of the monthly premium. Plans must provide a grace period of at least 120 days before disenrolling recipients who fail to pay their shares of the premium.

Section 17. Section 409.976, Florida Statutes, is created to read:

409.976 Managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the managed medical assistance program pursuant to this section.

(1) Prepaid payment rates shall be negotiated between the agency and the qualified plans as part of the procurement described in s. 409.966.

(2) The agency shall develop a methodology to ensure the availability of intergovernmental transfers in the statewide integrated managed care program to support providers that have

historically served Medicaid recipients. Such providers include, but are not limited to, safety net providers, trauma hospitals, children's hospitals, statutory teaching hospitals, and medical and osteopathic physicians employed by or under contract with a medical school in this state. The agency may develop a supplemental capitation rate, risk pool, or incentive payment to plans that contract with these providers. A plan is eligible for a supplemental payment only if there are sufficient intergovernmental transfers available from allowable sources and the plan can demonstrate that it pays a reimbursement rate not less than the equivalent fee-for-service rate. The agency may develop the supplemental capitation rate to consider rates higher than the fee-for-service Medicaid rate when needed to ensure access and supported by funds provided by a locality. The agency shall evaluate the development of the rate cell to accurately reflect the underlying utilization to the maximum extent possible. This methodology may include interim rate adjustments as permitted under federal regulations. Any such methodology shall preserve federal funding to these entities and must be actuarially sound. In the absence of federal approval for the above methodology, the agency is authorized to set an enhanced rate and require that plans pay the enhanced rate, if the agency determines the enhanced rate is necessary to ensure access to care by the providers described in this subsection. The amount paid to the plans to make supplemental payments or to enhance provider rates pursuant to this subsection shall be reconciled to the exact amounts the plans are required to pay to providers. The plans shall make the designated payments to

providers within 15 business days of notification by the agency regarding provider-specific distributions.

(3) The agency shall establish payment rates for statewide inpatient psychiatric programs. Payments to managed care plans shall be reconciled to reimburse actual payments to statewide inpatient psychiatric programs.

Section 18. Section 409.977, Florida Statutes, is created to read:

409.977 Choice counseling and enrollment.—

(1) CHOICE COUNSELING.-In addition to the choice counseling information required by s. 409.969, the agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

(a) Information about earning credits in the plan's enhanced benefit program.

(b) Information about cost sharing requirements of each plan.

(2) AUTOMATIC ENROLLMENT.-The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. The agency may not engage in practices that are designed to favor one managed care plan over

another. When automatically enrolling recipients in plans, the agency shall automatically enroll based on the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

(b) Whether the recipient has previously received services from one of the plan's primary care providers.

(c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(3) OPT-OUT OPTION.-The agency shall develop a process to enable any recipient with access to employer-sponsored insurance to opt out of all qualified plans in the Medicaid program and to use Medicaid financial assistance to pay for the recipient's share of the cost in any such plan. Contingent upon federal approval, the agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Cover Florida Health Access Program, the Florida Health Choices Program, or any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a plan for that recipient.

Section 19. Section 409.978, Florida Statutes, is created to read:

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss.

409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. By July 1, 2011, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2012.

(2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model. Unless otherwise specified, the provisions of ss. 409.961-409.970 apply to the long-term care managed care program.

(3) The Department of Elderly Affairs shall assist the agency to develop specifications for use in the invitation to negotiate and the model contract; determine clinical eligibility for enrollment in managed long-term care plans; monitor plan performance and measure quality of service delivery; assist clients and families to address complaints with the plans; facilitate working relationships between plans and providers serving elders and disabled adults; and perform other functions specified in a memorandum of agreement.

Section 20. Section 409.979, Florida Statutes, is created to read:

409.979 Eligibility.—

(1) Medicaid recipients who meet all of the following criteria are eligible to participate in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older or eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care.

(2) Medicaid recipients who on the date long-term care managed care plans becomes available in the recipient's region, are residing in a nursing home facility or enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program:

(a) The Assisted Living for the Frail Elderly Waiver.

(b) The Aged and Disabled Adult Waiver.

(c) The Adult Day Health Care Waiver.

(d) The Consumer-Directed Care Plus Program as described in s. 409.221.

(e) The Program of All-inclusive Care for the Elderly.

(f) The Long-Term Care Community-Based Diversion Pilot Project as described in s. 430.705.

(g) The Channeling Services Waiver for Frail Elders.

Section 21. Section 409.980, Florida Statutes, is created to read:

409.980 Benefits.—Managed care plans shall cover, at a minimum, the following services:

(1) Nursing facility.

(2) Assisted living facility.

(3) Hospice.

(4) Adult day care.

(5) Medical equipment and supplies, including incontinence supplies.

(5) Personal care.

(7) Home accessibility adaptation.

(9) Behavior management.

(9) Home delivered meals.

(10) Case management.

(11) Therapies:

(a) Occupational therapy

(b) Speech therapy

(c) Respiratory therapy

(d) Physical therapy.

(12) Intermittent and skilled nursing.

(13) Medication administration.

(14) Medication management.

(15) Nutritional assessment and risk reduction.

(16) Caregiver training.

(17) Respite care.

(18) Transportation.

(19) Personal emergency response system.

Section 22. Section 409.981, Florida Statutes, is created to read:

409.981 Qualified plans.—

(1) QUALIFIED PLANS.—For purposes of the long-term care managed care program, qualified plans also include entities who are qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans. Such plans are eligible to participate in the statewide long-term care managed care program. Qualified plans that are

provider service networks must be long-term care provider service networks. Qualified plans may either be long-term care plans that cover benefits pursuant to s. 409.980, or comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.980.

(2) QUALIFIED PLAN SELECTION.—The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than July 1, 2011.

(a) The agency shall procure three plans for Region I. At least one plan shall be a provider service network, if any submit a responsive bid.

(b) The agency shall procure at least four and no more than seven plans for Region II. At least one plan shall be a provider service network, if any submit a responsive bid.

(c) The agency shall procure at least five plans and no more than ten plans for Region III. At least two plans shall be provider service networks, if any two submit a responsive bid.

(d) The agency shall procure at least four plans and no more than eight plans for Region IV. At least one plan shall be a provider service network if any submit a responsive bid.

(e) The agency shall procure at least four plans and no more than seven plans for Region V. At least one plan shall be a provider service network, if any submit a responsive bid.

(f) The agency shall procure at least five plans and no more than ten plans for Region VI. At least two plans shall be provider service networks, if any two submit a responsive bid.

If no provider service network submits a responsive bid, the agency shall procure one less qualified plan in each of the regions. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

(3) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider the following factors in the selection of qualified plans:

(a) Specialized staffing. Plan employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care.

(b) Network qualifications. Plan establishment of a network of service providers dispersed throughout the region and in sufficient numbers to meet specific service standards established by the agency for specialty services for persons receiving home and community-based care.

(c) Whether a plan is proposing to establish a comprehensive long-term care plan and whether the qualified plan has a contract to provide managed medical assistance services in the same region. The agency shall exercise a preference for such plans.

(d) Whether a plan is designated as a medical home network pursuant to s. 409.91207 or offers consumer-directed care services to enrollees pursuant to s. 409.221. Consumer-directed care services provide a flexible budget which is managed by

enrolled individuals and their families or representatives and allows them to choose providers of services, determine provider rates of payment and direct the delivery of services to best meet their special long-term care needs. When all other factors are equal among competing qualified plans, the agency shall exercise a preference for such plans.

(e) Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with providers of critical services pursuant to s. 409.982(2)(a)-(c).

(4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—The Program for All-Inclusive Care for the Elderly (PACE) is a qualified plan for purposes of the long-term care managed care program. Participation by PACE shall be pursuant to a contract with the agency and not subject to the procurement requirements or regional plan number limits of this section. PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.

Section 23. Section 409.982, Florida Statutes, is created to read:

409.982 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the long-term care managed care program shall comply with the requirements of this section.

(1) MEDICAL LOSS RATIO.—The agency shall establish and plans shall use a uniform method of accounting and reporting

long-term care service costs, direct care management costs, and administrative costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(b) Plans that spend less than 85 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be required to pay back the amount of the difference between actual spending and 85 percent of Medicaid premium revenue.

(c) Plans that spend more than 92 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency, shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management.

(d) Plans that spend 95 percent or more of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency, and are determined to be failing to appropriately manage care shall be excluded from automatic enrollments.

(2) PROVIDER NETWORKS.—Plans may limit the providers in

their networks based on credentials, quality indicators, and price. However, in the first contract period after a qualified plan is selected in a region by the agency, the plan must offer a network contract to the following providers in the region:

(a) Nursing homes.

(b) Hospices.

(c) Aging network service providers that have previously participated in home and community-based waivers serving elders or community-service programs administered by the Department of Elderly Affairs.

After 12 months of active participation in a plan's network, the plan may exclude any of the providers named in this subsection from the network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days prior to the effective date of the exclusion.

(3) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the plans they join. Nursing homes and hospices must participate in all qualified plans selected by the agency in the region in which the provider is located.

(4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the quality and performance of each participating provider. At the beginning of the contract period, each plan shall notify all its network providers of the metrics used by the plan for evaluating

the provider's performance and determining continued participation in the network.

(5) PROVIDER NETWORK STANDARDS.—The agency shall establish and each plan must comply with specific standards for the number, type, and regional distribution of providers in the plan's network, which must include:

(a) Adult day centers.

(b) Adult family care homes.

(c) Assisted living facilities.

(d) Health care services pools.

(e) Home health agencies.

(f) Homemaker and companion services.

(g) Hospices.

(h) Community Care for the Elderly Lead Agencies.

(i) Nurse registries.

(j) Nursing homes.

(6) PROVIDER PAYMENT.—Plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay nursing homes an amount equal to the nursing facility-specific payment rates set by the agency. Plans shall pay hospice providers an amount equal to the per diem rate set by the agency. For recipients residing in a nursing facility and receiving hospice services, the plan shall pay the hospice provider the per diem rate set by the agency minus the nursing facility component and shall pay the nursing facility the appropriate state rate.

Section 24. Section 409.983, Florida Statutes, is created to read:

409.983 Managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the long-term care managed care program pursuant to this section.

(1) Prepaid payment rates for long-term care managed care plans shall be negotiated between the agency and the qualified plans as part of the procurement described in s. 409.966.

(2) Payment rates for comprehensive long-term care plans covering services described in s. 409.973 shall be combined with rates for long-term care plans for services specified in s. 409.980.

(3) Payment rates for plans shall reflect historic utilization and spending for covered services projected forward and adjusted to reflect the level of care profile for enrollees of each plan. The payment shall be adjusted to provide an incentive for reducing institutional placements and increasing the utilization of home and community-based services.

(4) The initial assessment of an enrollee's level of care shall be made by the Comprehensive Assessment and Review for Long-Term-Care Services (CARES) program, which shall assign the recipient into one of the following levels of care:

(a) Level of care 1 consists of recipients residing in nursing homes or needing immediate placement in a nursing home.

(b) Level of care 2 consists of recipients who require the constant availability of routine medical and nursing treatment and care, and require extensive health-related care and services because of mental or physical incapacitation.

(c) Level of care 3 consists of recipients who require the

constant availability of routine medical and nursing treatment and care, have a limited need for health-related care and services, are mildly medically or physically incapacitated, and have a priority score of 5 or above.

The agency shall periodically adjust payment rates to account for changes in the level of care profile for each plan based on encounter data.

(5) The incentive adjustment for reducing institutional placements shall be modified in each successive rate period during the contract in order to encourage a progressive rebalancing of the spending distribution for institutional and community services. The expected change toward more home and community-based services shall be at least a 3 percent, up to a 5 percent, annual increase in the ratio of home and community-based service expenditures compared to nursing facility expenditures.

(6) The agency shall establish nursing facility-specific payment rates for each licensed nursing home based on facility costs adjusted for inflation and other factors. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to nursing facilities.

(7) The agency shall establish hospice payment rates. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to hospices.

Section 25. Section 409.984, Florida Statutes, is created to read:

409.984 Choice counseling; enrollment.—

(1) CHOICE COUNSELING.—Before contracting with a vendor to provide choice counseling as authorized under s. 409.969, the agency shall offer to contract with aging resource centers established under s. 430.2053 for choice counseling services. If the aging resource center is determined not to be the vendor that provides choice counseling, the agency shall establish a memorandum of understanding with the aging resource center to coordinate staffing and collaborate with the choice counseling vendor.

(2) AUTOMATIC ENROLLMENT.—The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. The agency shall assign individuals who are deemed dually eligible for Medicaid and Medicare to a plan that provides both Medicaid and Medicare services. The agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall take into account the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

(b) Whether the recipient has previously received services from one of the plan's home and community-based service providers.

(c) Whether the home and community-based providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(3) Notwithstanding the provisions of s. 409.969(3)(c), when a recipient is referred for hospice services, the recipient shall have a 30-day period during which the recipient may select to enroll in another plan to access the hospice provider of the recipient's choice.

Section 26. Section 409.985, Florida Statutes, is created to read:

409.985 Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program.—

(1) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) preadmission screening program to ensure that only individuals whose conditions require long-term care services are enrolled in the long-term care managed care program.

(2) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and review.

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). For the purposes of the long-term care managed

care program, "nursing facility care" means the individual:

(a) Requires the constant availability of routine medical and nursing treatment and care, and requires extensive health-related care and services because of mental or physical incapacitation; or

(b) Requires the constant availability of routine medical and nursing treatment and care, has a limited need for health-related care and services, is mildly medically or physically incapacitated, and has a priority score of 5 or above.

(4) For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage is being terminated for lack of progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believes that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

Section 27. Section 409.986, Florida Statutes, is created to read:

409.986 Managed long-term care for persons with developmental disabilities.—

(1) Pursuant to s. 409.963, the agency is responsible for administering the long-term care managed care program for persons with developmental disabilities described in ss. 409.986-409.992, but may delegate specific duties and responsibilities for the program to the Agency for Persons with Disabilities and other state agencies. By January 1, 2014, the agency shall begin implementation of statewide long-term care managed care for persons with developmental disabilities, with full implementation in all regions by October 1, 2015.

(2) The agency shall make payments for long-term care for persons with developmental disabilities, including home and community-based services, using a managed care model. Unless otherwise specified, the provisions of ss. 409.961-409.970 apply to the long-term care managed care program for persons with developmental disabilities.

(3) The Agency for Persons with Disabilities shall assist the agency to develop the specifications for use in the invitations to negotiate and the model contract; determine clinical eligibility for enrollment in long-term care plans for persons with developmental disabilities; assist the agency to monitor plan performance and measure quality; assist clients and families to address complaints with the plans; facilitate working relationships between plans and providers serving persons with developmental disabilities; and perform other functions specified in a memorandum of agreement.

Section 28. Section 409.987, Florida Statutes, is created to read:

409.987 Eligibility.—

(1) Medicaid recipients who meet all of the following criteria are eligible to be enrolled in a developmental disabilities comprehensive long-term care plan or developmental disabilities long-term care plan:

(a) Medicaid eligible pursuant to income and asset tests in state and federal law.

(b) A Florida resident who has a developmental disability as defined in s. 393.063.

(c) Meets the level of care need including:

1. The recipient's intelligence quotient is 59 or less;

2. The recipient's intelligence quotient is 60-69, inclusive, and the recipient has a secondary handicapping condition that includes cerebral palsy, spina bifida, Prader-Willi syndrome, epilepsy, or autism; or ambulation, sensory, chronic health, and behavioral problems;

3. The recipient's intelligence quotient is 60-69, inclusive, and the recipient has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or

4. The recipient is eligible under a primary disability of autism, cerebral palsy, spina bifida, or Prader-Willi syndrome. In addition, the condition must result in substantial functional limitations in three or more major life activities, including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living.

(d) Meets the level of care need for services in an intermediate care facility for the developmentally disabled.

(e) Is enrolled or has been offered enrollment in one of the four tier waivers established in s. 393.0661(3) or the recipient is a Medicaid-funded resident of a private intermediate care facility for the developmentally disabled on the date the managed long-term care plans for persons with disabilities become available in the recipient's region or the recipient has been offered enrollment in a developmental disabilities comprehensive long-term care plan or developmental disabilities long-term care plan.

(2) Unless specifically exempted, all eligible persons must be enrolled in a developmental disabilities comprehensive long-term care plan or a developmental disabilities long-term care plan. Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale Center in Gainesville, are exempt from mandatory enrollment but may voluntarily enroll in a long-term care plan.

Section 29. Section 409.988, Florida Statutes, is created to read:

409.988 Benefits.-Managed care plans shall cover, at a minimum, the services in this section. Plans may customize benefit packages or offer additional benefits to meet the needs of enrollees in the plan.

(1) Intermediate care for the developmentally disabled.

(2) Alternative residential services, including, but not limited to:

(a) Group homes and foster care homes licensed pursuant to chapters 393 and 409.

(b) Comprehensive transitional education programs licensed pursuant to chapter 393.

(c) Residential habilitation centers licensed pursuant to chapter 393.

(d) Assisted living facilities, and transitional living facilities licensed pursuant to chapters 400 and 429.

(3) Adult day training.

(4) Behavior analysis services.

(5) Companion services.

(6) Consumable medical supplies.

(7) Durable medical equipment and supplies.

(8) Environmental accessibility adaptations.

(9) In-home support services.

(10) Therapies, including occupational, speech, respiratory, and physical therapy.

(11) Personal care assistance.

(12) Residential habilitation services.

(13) Intensive behavioral residential habilitation services.

(14) Behavior focus residential habilitation services.

(15) Residential nursing services.

(16) Respite care.

(17) Case management.

(18) Supported employment.

(19) Supported living coaching.

(20) Transportation.

Section 30. Section 409.989, Florida Statutes, is created to read:

409.989 Qualified plans.—

(1) QUALIFIED PLANS.—Qualified plans that are a provider service network or the Children's Medical Services Network authorized under chapter 391 may be either developmental disabilities long-term care plans that cover benefits pursuant to s. 409.988, or developmental disabilities comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.988. Other qualified plans may only be developmental disabilities comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.988.

(2) SPECIALTY PROVIDER SERVICE NETWORKS.—Provider service networks targeted to serve persons with disabilities must include one or more owners licensed pursuant to s. 393.067 or s. 400.962 and with at least 10 years experience in serving this population.

(3) QUALIFIED PLAN SELECTION.—The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2014.

(a) The agency shall procure two plans for Region I. At least one plan shall be a provider service network, if any submit a responsive bid.

(b) The agency shall procure at least two and no more than five plans for Region II. At least one plan shall be a provider service network, if any submit a responsive bid.

(c) The agency shall procure at least three plans and no more than six plans for Region III. At least one plan shall be a provider service network, if any submit a responsive bid.

(d) The agency shall procure at least three plans and no more than six plans for Region IV. At least one plan shall be a provider service network if any submit a responsive bid.

(e) The agency shall procure at least three plans and no more than six plans for Region V. At least one plan shall be a provider service network, if any submit a responsive bid.

(f) The agency shall procure at least three plans and no more than six plans for Region VI. At least one plan shall be a provider service network, if any submit a responsive bid.

If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of qualified plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

(4) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider the following factors in the selection of qualified plans:

(a) Specialized staffing. Plan employment of executive managers with expertise and experience in serving persons with developmental disabilities.

(b) Network qualifications. Plan establishment of a network of service providers dispersed throughout the region and in sufficient numbers to meet specific accessibility standards established by the agency for specialty services for persons with developmental disabilities.

(c) Whether the plan has proposed to be a developmental disabilities comprehensive long-term care plan and has a contract to provide managed medical assistance services in the same region. The agency shall exercise a preference for such plans.

(d) Whether the plan offers consumer-directed care services to enrollees pursuant to s. 409.221. Consumer-directed care services provide a flexible budget which is managed by enrolled individuals and their families or representatives and allows them to choose providers of services, determine provider rates of payment and direct the delivery of services to best meet their special long-term care needs. When all other factors are equal among competing qualified plans, the agency shall exercise a preference for such plans.

(e) Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with providers of critical services pursuant to s. 409.990(2)a)-(b).

(5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's Medical Services Network authorized under chapter 391 is a qualified plan for purposes of the developmental disabilities long-term care plans and developmental disabilities comprehensive long-term care plans. Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency not subject to the procurement requirements or regional plan number limits of this

section. The Children's Medical Services Network must meet all other plan requirements.

Section 31. Section 409.990, Florida Statutes, is created to read:

409.990 Managed care plan accountability.—In addition to the requirements of s. 409.967, qualified plans and providers shall comply with the requirements of this section.

(1) MEDICAL LOSS RATIO.—The agency shall establish and plans shall use a uniform method of accounting and reporting long-term care service costs, direct care management costs, and administrative costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 92 percent of the Medicaid premium revenue.

(b) Plans that spend less than 92 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be required to pay back the amount between actual spending and 92 percent of the Medicaid premium revenue.

(2) PROVIDER NETWORKS.—Plans may limit the providers in their networks based on credentials, quality indicators, and

price. However, in the first contract period after a qualified plan is selected in a region by the agency, the plan must offer a network contract to the following providers in the region:

(a) Providers with licensed institutional care facilities for the developmentally disabled.

(b) Providers of alternative residential facilities specified in s.409.988.

After 12 months of active participation in a plan's network, the plan may exclude any of the above-named providers from the network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be issued at least 90 days before the effective date of the exclusion.

(3) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the plans they join. Licensed institutional care facilities for the developmentally disabled with an active Medicaid provider agreement must agree to participate in any qualified plan selected by the agency in the region in which the provider is located.

(4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the quality and performance of each participating provider. At the beginning of the contract period, each plan shall notify all its network providers of the metrics used by the plan for evaluating the provider's performance and determining continued participation in the network.

(5) PROVIDER PAYMENT.—Plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay intermediate care facilities for the developmentally disabled an amount equal to the facility-specific payment rate set by the agency.

(6) CONSUMER AND FAMILY INVOLVEMENT.—Plans must establish a family advisory committee to participate in program design and oversight.

Section 32. Section 409.991, Florida Statutes, is created to read:

409.991 Managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to developmental disabilities comprehensive long-term care plans and developmental disabilities long-term care plans pursuant to this section.

(1) Prepaid payment rates shall be negotiated between the agency and the qualified plans as part of the procurement described in s. 409.966.

(2) Payment for developmental disabilities comprehensive long-term care plans covering services pursuant to s. 409.973 shall be combined with payments for developmental disabilities long-term care plans for services specified in s. 409.988.

(3) Payment rates for plans covering service specified in s. 409.988 shall be based on historical utilization and spending for covered services projected forward and adjusted to reflect the level of care profile of each plan's enrollees.

(4) The Agency for Persons with Disabilities shall conduct the initial assessment of an enrollee's level of care. The

evaluation of level of care shall be based on assessment and service utilization information from the most recent version of the Questionnaire for Situational Information and encounter data.

(5) Payment rates for developmental disabilities long-term care plans shall be classified into five levels of care to account for variations in risk status and service needs among enrollees.

(a) Level of care 1 consists of individuals receiving services in an intermediate care facility for the developmentally disabled.

(b) Level of care 2 consists of individuals with intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others.

(c) Level of care 3 consists of individuals with service needs, including a licensed residential facility and a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or individuals in supported living who require more than 6 hours a day of in-home support services.

(d) Level of care 4 consists of individuals requiring less than moderate level of residential habilitation support in a residential placement, or individuals in independent or supported living situations, or who live in their family home.

(e) Level of care 5 consists of individuals requiring minimal support services while living in independent or

supported living situations and individuals who live in their family home.

The agency shall periodically adjust payment rates to account for changes in the level of care profile of each plan's enrollees based on encounter data.

(6) The agency shall establish intensive behavior residential habilitation rates for providers approved by the agency to provide this service. The agency shall also establish intermediate care facility for the developmentally disabled-specific payment rates for each licensed intermediate care facility based on facility costs adjusted for inflation and other factors. Payments to intermediate care facilities for the developmentally disabled and providers of intensive behavior residential habilitation service shall be reconciled to reimburse the plan's actual payments to the facilities.

Section 33. Section 409.992, Florida Statutes, is created to read:

409.992 Automatic enrollment.—

(1) The agency shall automatically enroll into a developmental disabilities comprehensive long-term care plan or a developmental disabilities long-term care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. The agency shall assign

individuals who are deemed dually eligible for Medicaid and Medicare, to a plan that provides both Medicaid and Medicare services. The agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall take into account the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

(b) Whether the recipient has previously received services from one of the plan's home and community-based service providers.

(c) Whether home and community-based providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

Section 34. This act shall take effect July 1, 2010.

A bill to be entitled

An act relating to Medicaid; amending s. 393.0661, F.S., relating to the home and community-based services delivery system for persons with developmental disabilities; providing for an establishment of an iBudget demonstration project by the Agency for Persons with Disabilities, in consultation with the Agency for Health Care Administration, in specified counties; providing for allocation of funds; providing goals; providing for an allocation algorithm and methodology for development of a client's iBudget; providing for the seeking of federal approval and waivers; providing for a transition to full implementation; providing for inapplicability of certain service limitations; providing for setting rates; providing for client training and education; providing for evaluation; requiring a report; requiring rulemaking; requiring the Agency for Persons with Disabilities to establish a transition plan for current Medicaid recipients under certain circumstances; providing for expiration of the section on a specified date; creating s. 400.0713, F.S.; requiring the Agency for Health Care Administration to establish a nursing home licensure workgroup; amending s. 408.040, F.S.; providing for suspension of conditions precedent to the issuance of a certificate of need for a nursing home, effective on a specified date; amending s. 408.0435, F.S.; extending the certificate-of-need moratorium for additional community nursing home beds; designating ss. 409.016-409.803, F.S.,

as pt. I of ch. 409, F.S., and entitling the part "Social and Economic Assistance"; designating ss. 409.810-409.821, F.S., as pt. II of ch. 409, F.S., and entitling the part "Kidcare"; designating ss. 409.901-409.9205, F.S., as part III of ch. 409, F.S., and entitling the part "Medicaid"; amending s. 409.907, F.S.; authorizing the Agency for Health Care Administration to enroll entities as Medicare crossover-only providers for payment and claims processing purposes only; specifying requirements for Medicare crossover-only agreements; amending s. 409.908, F.S.; providing penalties for providers that fail to report suspension or disenrollment from Medicare within a specified time; amending s. 409.912, F.S.; authorizing provider service networks to provide comprehensive behavioral health care services to certain Medicaid recipients; providing payment requirements for provider service networks; providing for the expiration of various provisions of the section on specified dates to conform to the reorganization of Medicaid managed care; requiring the Agency for Health Care Administration to contract on a prepaid or fixed-sum basis with certain prepaid dental health plans; requiring Medicaid-eligible children with open child welfare cases who reside in AHCA area 10 to be enrolled in specified capitated managed care plans; eliminating obsolete provisions and updating provisions within the section; amending ss. 409.91195 and 409.91196, F.S.; conforming cross-references; amending s. 409.91207, F.S.; providing authority of the Agency for Health Care

Administration with respect to the development of a method for designating qualified plans as a medical home network; providing purposes and principles for creating medical home networks; providing criteria for designation of a qualified plan as a medical home network; providing agency duties with respect thereto; amending s. 409.91211, F.S.; providing authority of the Agency for Health Care Administration to implement a managed care pilot program based on specified waiver authority with respect to the Medicaid reform program; continuing the existing pilot program in specified counties; requiring the agency to seek an extension of the waiver; providing for monthly reports; requiring approval of the Legislative Budget Commission for changes to specified terms and conditions ; providing for expansion of the managed care pilot program to Miami-Dade County; specifying managed care plans that are qualified to participate in the Medicaid managed care pilot program; providing requirements for qualified managed care plans; requiring the agency to develop and seek federal approval to implement methodologies to preserve intergovernmental transfers of funds and certified public expenditures from Miami-Dade County; requiring the agency to submit a plan and specified amendment to the Legislative Budget Commission; providing for a report; requiring Medicaid recipients in counties in which the managed care pilot program has been implemented to be enrolled in a qualified plan; providing a time limit for enrollment; requiring the agency to provide choice

counseling; providing requirements with respect to choice counseling information provided to Medicaid recipients; providing for automatic enrollment of certain Medicaid recipients; establishing criteria for automatic enrollment; providing procedures and requirements with respect to voluntary disenrollment of a recipient in a qualified plan; providing for an enrollment period; requiring qualified plans to establish a process for review of and response to grievances of enrollees; requiring qualified plans to submit quarterly reports; specifying services to be covered by qualified plans; authorizing qualified plans to offer specified customizations, variances, and coverage for additional services; requiring agency evaluation of proposed benefit packages; requiring qualified plans to reimburse the agency for the cost of specified enrollment changes; providing for access to encounter data; requiring participating plans to establish an incentive program to reward healthy behaviors; requiring the agency to continue budget-neutral adjustment of capitation rates for all prepaid plans in existing managed care pilot program counties; providing for transition to payment methodologies for Miami-Dade County plans; providing a phased schedule for risk-adjusted capitation rates; providing for immediate risk adjustment of rates for plans owned and operated by a public hospital in the county; providing a method to ensure budget neutrality until all rates in the county are risk-adjusted; requiring the

agency to submit an amendment to the Legislative Budget Commission requesting authority for payments; requiring the establishment of a technical advisory panel; providing for distribution of funds from a low-income pool; specifying purposes for such distribution; requiring the agency to maintain and operate the Medicaid Encounter Data System; requiring the agency to contract with the University of Florida for evaluation of the pilot program; requiring the agency to establish a specified initiative and publish certain information; amending s. 409.9122, F.S.; eliminating outdated provisions; providing for the expiration of various provisions of the section on specified dates to conform to the reorganization of Medicaid managed care; requiring the Agency for Health Care Administration to begin a budget-neutral adjustment of capitation rates for all Medicaid prepaid plans in the state on a specified date; providing the basis for the adjustment; providing a phased schedule for risk adjusted capitation rates; providing for the establishment of a technical advisory panel; requiring the agency to develop a process to enable any recipient with access to employer sponsored insurance to opt out of qualified plans in the Medicaid program; requiring the agency, contingent on federal approval, to enable recipients with access to other insurance or related products providing access to specified health care services to opt out of qualified plans in the Medicaid program; providing a limitation on the amount of financial assistance provided for each

recipient; requiring each qualified plan to establish an incentive program that rewards specific healthy behaviors; requiring plans to maintain a specified reserve account; requiring the agency to maintain and operate the Medicaid Encounter Data System; requiring the agency to conduct a review of encounter data and publish the results of the review prior to adjusting rates for prepaid plans; requiring the agency to establish a designated payment for specified Medicare Advantage Special Needs members; authorizing the agency to develop a designated payment for Medicaid-only covered services for which the state is responsible; requiring the agency to establish, and managed care plans to use, a uniform method of accounting for and reporting of medical and nonmedical costs; requiring reimbursement by Medicaid of school districts participating in a certified school match program for a Medicaid-eligible child participating in the services, effective on a specified date; requiring the agency, the Department of Health, and the Department of Education to develop procedures for ensuring that a student's managed care plan receives information relating to services provided; authorizing the Agency for Health Care Administration to create exceptions to mandatory enrollment in managed care under specified circumstances; amending s. 430.04, F.S.; eliminating outdated provisions; requiring the Department of Elderly Affairs to develop a transition plan for specified elder and disabled adults receiving long-term care Medicaid services when qualified

plans become available; providing for expiration thereof; amending s. 430.2053, F.S.; eliminating outdated provisions; providing additional duties of aging resource centers; providing an additional exception to direct services that may not be provided by an aging resource center; providing for the cessation of specified payments by the department as qualified plans become available; providing for a memorandum of understanding between the Agency for Health Care Administration and aging resource centers under certain circumstances; eliminating provisions requiring reports; amending s. 641.386, F.S.; conforming a cross-reference; repealing s. 430.701, F.S., relating to legislative findings and intent and approval for action relating to provider enrollment levels; repealing s. 430.702, F.S., relating to the Long-Term Care Community Diversion Pilot Project Act; repealing s. 430.703, F.S., relating to definitions; repealing s. 430.7031, F.S., relating to nursing home transition program; repealing s. 430.704, F.S., relating to evaluation of long-term care through the pilot projects; repealing s. 430.705, F.S., relating to implementation of long-term care community diversion pilot projects; repealing s. 430.706, F.S., relating to quality of care; repealing s. 430.707, F.S., relating to contracts; repealing s. 430.708, F.S., relating to certificate of need; repealing s. 430.709, F.S., relating to reports and evaluations; renumbering ss. 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.

402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and 402.87, F.S., respectively; amending s. 443.111, F.S.; conforming a cross-reference; providing contingent effective dates.

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

Section 1. Section 393.0661, Florida Statutes, is amended to read:

393.0661 Home and community-based services delivery system; comprehensive redesign.—The Legislature finds that the home and community-based services delivery system for persons with developmental disabilities and the availability of appropriated funds are two of the critical elements in making services available. Therefore, it is the intent of the Legislature that the Agency for Persons with Disabilities shall develop and implement a comprehensive redesign of the system.

(1) The redesign of the home and community-based services system shall include, at a minimum, all actions necessary to achieve an appropriate rate structure, client choice within a specified service package, appropriate assessment strategies, an efficient billing process that contains reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, and ensures that family/client budgets are linked to levels of need.

(a) The agency shall use an assessment instrument that is reliable and valid. The agency may contract with an external vendor or may use support coordinators to complete client

assessments if it develops sufficient safeguards and training to ensure ongoing inter-rater reliability.

(b) The agency, with the concurrence of the Agency for Health Care Administration, may contract for the determination of medical necessity and establishment of individual budgets.

(2) A provider of services rendered to persons with developmental disabilities pursuant to a federally approved waiver shall be reimbursed according to a rate methodology based upon an analysis of the expenditure history and prospective costs of providers participating in the waiver program, or under any other methodology developed by the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, and approved by the Federal Government in accordance with the waiver.

(3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve eligible clients through the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on a valid assessment instrument, client characteristics, and other appropriate assessment methods.

(a) Tier one is limited to clients who have service needs that cannot be met in tier two, three, or four for intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others.

(b) Tier two is limited to clients whose service needs include a licensed residential facility and who are authorized to receive a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or clients in supported living who receive more than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $55,000 per client each year.

(c) Tier three includes, but is not limited to, clients requiring residential placements, clients in independent or supported living situations, and clients who live in their family home. Total annual expenditures under tier three may not exceed $35,000 per client each year.

(d) Tier four is the family and supported living waiver and includes, but is not limited to, clients in independent or supported living situations and clients who live in their family home. Total annual expenditures under tier four may not exceed $14,792 per client each year.

(e) The Agency for Health Care Administration shall also seek federal approval to provide a consumer-directed option for persons with developmental disabilities which corresponds to the funding levels in each of the waiver tiers. The agency shall implement the four-tiered waiver system beginning with tiers one, three, and four and followed by tier two. The agency and the Agency for Health Care Administration may adopt rules necessary to administer this subsection.

(f) The agency shall seek federal waivers and amend contracts as necessary to make changes to services defined in

federal waiver programs administered by the agency as follows:

1. Supported living coaching services may not exceed 20 hours per month for persons who also receive in-home support services.

2. Limited support coordination services is the only type of support coordination service that may be provided to persons under the age of 18 who live in the family home.

3. Personal care assistance services are limited to 180 hours per calendar month and may not include rate modifiers. Additional hours may be authorized for persons who have intensive physical, medical, or adaptive needs if such hours are essential for avoiding institutionalization.

4. Residential habilitation services are limited to 8 hours per day. Additional hours may be authorized for persons who have intensive medical or adaptive needs and if such hours are essential for avoiding institutionalization, or for persons who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others. This restriction shall be in effect until the four-tiered waiver system is fully implemented.

5. Chore services, nonresidential support services, and homemaker services are eliminated. The agency shall expand the definition of in-home support services to allow the service provider to include activities previously provided in these eliminated services.

6. Massage therapy, medication review, and psychological assessment services are eliminated.

7. The agency shall conduct supplemental cost plan reviews

to verify the medical necessity of authorized services for plans that have increased by more than 8 percent during either of the 2 preceding fiscal years.

8. The agency shall implement a consolidated residential habilitation rate structure to increase savings to the state through a more cost-effective payment method and establish uniform rates for intensive behavioral residential habilitation services.

9. Pending federal approval, the agency may extend current support plans for clients receiving services under Medicaid waivers for 1 year beginning July 1, 2007, or from the date approved, whichever is later. Clients who have a substantial change in circumstances which threatens their health and safety may be reassessed during this year in order to determine the necessity for a change in their support plan.

10. The agency shall develop a plan to eliminate redundancies and duplications between in-home support services, companion services, personal care services, and supported living coaching by limiting or consolidating such services.

11. The agency shall develop a plan to reduce the intensity and frequency of supported employment services to clients in stable employment situations who have a documented history of at least 3 years' employment with the same company or in the same industry.

(4) The geographic differential for Miami-Dade, Broward, and Palm Beach Counties for residential habilitation services shall be 7.5 percent.

(5) The geographic differential for Monroe County for

residential habilitation services shall be 20 percent.

(6) Effective January 1, 2010, and except as otherwise provided in this section, a client served by the home and community-based services waiver or the family and supported living waiver funded through the agency shall have his or her cost plan adjusted to reflect the amount of expenditures for the previous state fiscal year plus 5 percent if such amount is less than the client's existing cost plan. The agency shall use actual paid claims for services provided during the previous fiscal year that are submitted by October 31 to calculate the revised cost plan amount. If the client was not served for the entire previous state fiscal year or there was any single change in the cost plan amount of more than 5 percent during the previous state fiscal year, the agency shall set the cost plan amount at an estimated annualized expenditure amount plus 5 percent. The agency shall estimate the annualized expenditure amount by calculating the average of monthly expenditures, beginning in the fourth month after the client enrolled, interrupted services are resumed, or the cost plan was changed by more than 5 percent and ending on August 31, 2009, and multiplying the average by 12. In order to determine whether a client was not served for the entire year, the agency shall include any interruption of a waiver-funded service or services lasting at least 18 days. If at least 3 months of actual expenditure data are not available to estimate annualized expenditures, the agency may not rebase a cost plan pursuant to this subsection. The agency may not rebase the cost plan of any client who experiences a significant change in recipient

condition or circumstance which results in a change of more than 5 percent to his or her cost plan between July 1 and the date that a rebased cost plan would take effect pursuant to this subsection.

(7) Nothing in this section or in any administrative rule shall be construed to prevent or limit the Agency for Health Care Administration, in consultation with the Agency for Persons with Disabilities, from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or from limiting enrollment, or making any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act.

(8) The Agency for Persons with Disabilities shall submit quarterly status reports to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor regarding the financial status of home and community-based services, including the number of enrolled individuals who are receiving services through one or more programs; the number of individuals who have requested services who are not enrolled but who are receiving services through one or more programs, with a description indicating the programs from which the individual is receiving services; the number of individuals who have refused an offer of services but who choose to remain on the list of individuals waiting for services; the number of individuals who have requested services but who are receiving no services; a frequency distribution indicating the length of time

individuals have been waiting for services; and information concerning the actual and projected costs compared to the amount of the appropriation available to the program and any projected surpluses or deficits. If at any time an analysis by the agency, in consultation with the Agency for Health Care Administration, indicates that the cost of services is expected to exceed the amount appropriated, the agency shall submit a plan in accordance with subsection (7) to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor to remain within the amount appropriated. The agency shall work with the Agency for Health Care Administration to implement the plan so as to remain within the appropriation.

(9)(a) The agency, in consultation with the Agency for Health Care Administration, shall establish an individual budget, referred to as an iBudget, demonstration project for each individual served through the Medicaid waiver program in Escambia, Okaloosa, Santa Rosa, and Walton Counties, which comprise area one of the agency. For the purpose of this subsection, the Medicaid waiver program includes the four-tiered waiver system established in subsection (3) or the Consumer Directed Care Plus Medicaid waiver program. The funds appropriated to the agency and used for Medicaid waiver program services to individuals in the demonstration project area shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. The iBudget system shall be designed to provide for enhanced client choice within a specified service package, appropriate assessment strategies, an efficient

consumer budgeting and billing process that includes reconciliation and monitoring components, a redefined role for support coordinators that avoids potential conflicts of interest, a flexible and streamlined service review process, and a methodology and process that ensure the equitable allocation of available funds to each client based on the client's level of need, as determined by the variables in the allocation algorithm.

1. In developing each client's iBudget, the agency shall use an allocation algorithm and methodology. The algorithm shall use variables that have been determined by the agency to have a statistically validated relationship to the client's level of need for services provided through the Medicaid waiver program. The algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the agency determines is valid and reliable, and information from other assessment processes.

2. The allocation methodology shall provide the algorithm that determines the amount of funds allocated to a client's iBudget. The agency may approve an increase in the amount of funds allocated, as determined by the algorithm, based on the client's having one or more of the following needs that cannot be accommodated within the funding as determined by the algorithm and having no other resources, supports, or services available to meet those needs:

a. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in

immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

(I) A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

(II) A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

(III) A chronic co-morbid condition. As used in this sub-sub-subparagraph, the term "co-morbid condition" means a medical condition existing simultaneously with but independently of another medical condition in a patient; or

(IV) A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

b. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy unless the increase is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition

when the service or treatment is expected to ameliorate the underlying condition. As used in this sub-subparagraph, the term "temporary" means lasting for a period of less than 12 consecutive months. However, the presence of such significant need for one-time or temporary support or services alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

c. A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy because of substantial changes in the client's circumstances, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the state Medicaid plan due to a change in age, or a significant change in medical or functional status that requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client's current iBudget. As used in this sub-subparagraph, the term "long-term" means lasting for a period of more than 12 continuous months. However, such significant increase in need for services of a permanent or long-term nature alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for adjustments required pursuant to this subparagraph and may use

the services of an independent actuary in determining the amount of the portions to be reserved.

3. A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided under subparagraph 2. A client's annual expenditures for Medicaid waiver services may not exceed the limits of his or her iBudget.

(b) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval for the iBudget demonstration project and amend current waivers, request a new waiver if appropriate, and amend contracts as necessary to implement the iBudget system to serve eligible, enrolled clients in the demonstration project area through the Medicaid waiver program.

(c) The agency shall transition all eligible, enrolled clients in the demonstration project area to the iBudget system. The agency may gradually phase in the iBudget system with full implementation by January 1, 2013.

1. The agency shall design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to the iBudget system. However, all iBudgets in the demonstration project area must be fully phased in by January 1, 2013.

(d) A client must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may

be available to the client before using funds from his or her iBudget to pay for support and services.

(e) The service limitations in subparagraphs (3)(f)1., 2., and 3. shall not apply to the iBudget system.

(f) Rates for any or all services established under rules of the agency shall be designated as the maximum rather than a fixed amount for individuals who receive an iBudget, except for services specifically identified in those rules that the agency determines are not appropriate for negotiation, which may include, but are not limited to, residential habilitation services.

(g) The agency shall ensure that clients and caregivers in the demonstration project area have access to training and education to inform them about the iBudget system and enhance their ability for self-direction. Such training shall be offered in a variety of formats and, at a minimum, shall address the policies and processes of the iBudget system; the roles and responsibilities of consumers, caregivers, waiver support coordinators, providers, and the agency; information available to help the client make decisions regarding the iBudget system; and examples of support and resources available in the community.

(h)1. The agency, in consultation with the Agency for Health Care Administration, shall prepare a design plan for the purchase of an evaluation by an independent contractor. The design plan to evaluate the iBudget demonstration project shall be submitted to the President of the Senate and the Speaker of

the House of Representatives for approval not later than December 31, 2010.

2. The agency shall prepare an evaluation that shall include, at a minimum, an analysis of cost savings, cost containment, and budget predictability. In addition, the evaluation shall review the demonstration with regard to consumer education, quality of care, affects on choice of and access to services, and satisfaction of demonstration project participants. The agency shall submit the evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2013.

(i) The agency shall adopt rules specifying the allocation algorithm and methodology; criteria and processes for clients to access reserved funds for extraordinary needs, temporarily or permanently changed needs, and one-time needs; and processes and requirements for selection and review of services, development of support and cost plans, and management of the iBudget system as needed to administer this subsection.

(10) The agency shall develop a transition plan for recipients who are receiving services in one of the four waiver tiers at the time qualified plans are available in each recipient's region pursuant to s. 409.989(3) to enroll those recipients in qualified plans.

(11) This section expires October 1, 2015.

Section 2. Section 400.0713, Florida Statutes, is created to read:

400.0713 Nursing home licensure workgroup.—The agency shall establish a workgroup to develop a plan for licensure

flexibility to assist nursing homes in developing comprehensive long-term care service capabilities.

Section 3. Paragraphs (b) and (d) of subsection (1) of section 408.040, Florida Statutes, are amended to read:

408.040 Conditions and monitoring.—

(1)

(b) The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent by the applicant that a specified percentage of the annual patient days at the facility will be utilized by patients eligible for care under Title XIX of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that a specified percentage of annual patient days will be utilized by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph in an area in which a community diversion pilot project is implemented. Effective July 1, 2011, the agency shall not consider, or impose conditions related to, patient day utilization by patients eligible for care under Title XIX the Social Security Act in making certificate-of-need determinations for nursing homes.

(d) If a nursing home is located in a county in which a long-term care community diversion pilot project has been implemented under s. 430.705 ~~or in a county in which an integrated, fixed-payment delivery program for Medicaid~~

~~recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid has been implemented under s. 409.912(5)~~, the nursing home may request a reduction in the percentage of annual patient days used by residents who are eligible for care under Title XIX of the Social Security Act, which is a condition of the nursing home's certificate of need. The agency shall automatically grant the nursing home's request if the reduction is not more than 15 percent of the nursing home's annual Medicaid-patient-days condition. A nursing home may submit only one request every 2 years for an automatic reduction. A requesting nursing home must notify the agency in writing at least 60 days in advance of its intent to reduce its annual Medicaid-patient-days condition by not more than 15 percent. The agency must acknowledge the request in writing and must change its records to reflect the revised certificate-of-need condition. This paragraph expires June 30, 2011.

Section 4. Subsection (1) of section 408.0435, Florida Statutes, is amended to read:

408.0435 Moratorium on nursing home certificates of need.—

(1) Notwithstanding the establishment of need as provided for in this chapter, a certificate of need for additional community nursing home beds may not be approved by the agency until after Medicaid managed care is implemented statewide pursuant to ss. 409.961-409.992, or October 1, 2015, whichever is earlier ~~July 1, 2011~~.

Section 5. Sections 409.016 through 409.803, Florida Statutes, are designated as part I of chapter 409, Florida Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."

Section 6. Sections 409.810 through 409.821, Florida Statutes, are designated as part II of chapter 409, Florida Statutes, and entitled "KIDCARE."

Section 7. Sections 409.901 through 409.9205, Florida Statutes, are designated as part III of chapter 409, Florida Statutes, and entitled "MEDICAID."

Section 8. Subsection (5) of section 409.907, Florida Statutes, is amended to read:

409.907 Medicaid provider agreements.—The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(5) The agency:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim form. The claim form shall require certification that the services or goods have been completely furnished to the recipient and that, with the exception of those services or goods specified by the agency, the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

(b) Is prohibited from demanding repayment from the

provider in any instance in which the Medicaid overpayment is attributable to error of the department in the determination of eligibility of a recipient.

(c) May adopt, and include in the provider agreement, such other requirements and stipulations on either party as the agency finds necessary to properly and efficiently administer the Medicaid program.

(d) May enroll entities as Medicare crossover-only providers for payment and claims processing purposes only. The provider agreement shall:

1. Require that the provider is an eligible Medicare provider, has a current provider agreement in place with the Centers for Medicare and Medicaid Services, and provides verification that the provider is currently in good standing with the agency.

2. Require that the provider notify the agency immediately, in writing, upon being suspended or disenrolled as a Medicare provider. If a provider does not provide such notification within 5 business days after suspension or disenrollment, sanctions may be imposed pursuant to this chapter and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

3. Require that all records pertaining to health care services provided to each of the provider's recipients be kept for a minimum of 5 years. The agreement shall also require that records and information relating to payments claimed by the provider for services under the agreement be delivered to the

agency or the Office of the Attorney General Medicaid Fraud Control Unit when requested. If a provider does not provide such records and information when requested, sanctions may be imposed pursuant to this chapter.

4. Disclose that the agreement is for the purposes of paying and processing Medicare crossover claims only.

This paragraph pertains solely to Medicare crossover-only providers. In order to become a standard Medicaid provider, the other requirements of this section and applicable rules must be met.

Section 9. Subsection (24) is added to section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected

retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(24) If a provider fails to notify the agency within 5 business days after suspension or disenrollment from Medicare, sanctions may be imposed pursuant to this chapter and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

Section 10. Section 409.912, Florida Statutes, is 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.

(1) The agency shall work with the Department of Children

and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services. This subsection expires October 1, 2013.

(2) The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920. This subsection expires October 1, 2015.

(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2013.

(4) The agency may contract with:

(a) An entity that provides no prepaid health care services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Office of Insurance Regulation of the Financial Services Commission that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225.

This paragraph expires October 1, 2013.

(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 entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), 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 before 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 5. ~~8.~~, and except in counties where the Medicaid managed care pilot program is authorized pursuant to 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, a provider service network as described in paragraph (d), 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 are subject to this paragraph. Each entity must offer a 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 must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for 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.~~

2.~~3.~~ Except as provided in subparagraph 5. ~~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, a provider service network as described in paragraph (d), 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, a provider service network as described in paragraph (d), 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 are eligible to compete. Managed care plans contracting with the agency under subsection (3) or paragraph (d), 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 must 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 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 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.~~

3.~~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 may 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.~~

4.~~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.

5.~~8.~~ All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that 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 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 may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 shall be enrolled in capitated managed care plans that, in coordination with available community-based care providers specified in s. 409.1671, provide sufficient medical, developmental, behavioral and emotional services to meet the needs of these children. ~~are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).~~

This paragraph expires October 1, 2013.

(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. This paragraph

expires October 1, 2013.

(d)1. A provider service network may be reimbursed on a fee-for-service or prepaid basis. Prepaid provider service networks receive per-member per-month payments. Provider service networks that do not choose to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 5 years of the plan's operation in a given region or until the contract year beginning October 1, 2015, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.

2. 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.

3. Medicaid recipients assigned to a provider service network 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. This subparagraph expires October 1, 2013. ~~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.~~

4. 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.

(e) An entity that provides only comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive 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. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. This paragraph expires October 1, 2013.

~~(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department services. The agency shall contract with vendors on a risk-sharing basis.~~

~~(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18 and pediatric emergency departments' diversion programs. The~~

~~networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.~~

(f) ~~(h)~~ An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Office of Insurance Regulation that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225. This paragraph expires October 1, 2012.

(g) ~~(i)~~ A Children's Medical Services Network, as defined in s. 391.021. This paragraph expires October 1, 2013.

~~(5) The Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery program for Medicaid recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid. The Agency for Health Care Administration shall implement the integrated program initially on a pilot basis in two areas of the state. The pilot areas shall be Area 7 and Area 11 of the Agency for Health Care Administration. Enrollment in the pilot areas shall be on a voluntary basis and in accordance with approved federal waivers and this section. The agency and its program contractors and providers shall not enroll any individual in the integrated~~

~~program because the individual or the person legally responsible for the individual fails to choose to enroll in the integrated program. Enrollment in the integrated program shall be exclusively by affirmative choice of the eligible individual or by the person legally responsible for the individual. The integrated program must transfer all Medicaid services for eligible elderly individuals who choose to participate into an integrated-care management model designed to serve Medicaid recipients in the community. The integrated program must combine all funding for Medicaid services provided to individuals who are 60 years of age or older or dually eligible for Medicare and Medicaid into the integrated program, including funds for Medicaid home and community-based waiver services; all Medicaid services authorized in ss. 409.905 and 409.906, excluding funds for Medicaid nursing home services unless the agency is able to demonstrate how the integration of the funds will improve coordinated care for these services in a less costly manner; and Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).~~

~~(a) Individuals who are 60 years of age or older or dually eligible for Medicare and Medicaid and enrolled in the developmental disabilities waiver program, the family and supported-living waiver program, the project AIDS care waiver program, the traumatic brain injury and spinal cord injury waiver program, the consumer-directed care waiver program, and the program of all-inclusive care for the elderly program, and residents of institutional care facilities for the developmentally disabled, must be excluded from the integrated~~

~~program.~~

~~(b) Managed care entities who meet or exceed the agency's minimum standards are eligible to operate the integrated program. Entities eligible to participate include managed care organizations licensed under chapter 641, including entities eligible to participate in the nursing home diversion program, other qualified providers as defined in s. 430.703(7), community care for the elderly lead agencies, and other state-certified community service networks that meet comparable standards as defined by the agency, in consultation with the Department of Elderly Affairs and the Office of Insurance Regulation, to be financially solvent and able to take on financial risk for managed care. Community service networks that are certified pursuant to the comparable standards defined by the agency are not required to be licensed under chapter 641. Managed care entities who operate the integrated program shall be subject to s. 408.7056. Eligible entities shall choose to serve enrollees who are dually eligible for Medicare and Medicaid, enrollees who are 60 years of age or older, or both.~~

~~(c) The agency must ensure that the capitation-rate-setting methodology for the integrated program is actuarially sound and reflects the intent to provide quality care in the least restrictive setting. The agency must also require integrated-program providers to develop a credentialing system for service providers and to contract with all Gold Seal nursing homes, where feasible, and exclude, where feasible, chronically poor-performing facilities and providers as defined by the agency. The integrated program must develop and maintain an~~

~~informal provider grievance system that addresses provider payment and contract problems. The agency shall also establish a formal grievance system to address those issues that were not resolved through the informal grievance system. The integrated program must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 400 or chapter 429 at the time of enrollment in the integrated program, the recipient must be permitted to continue to reside in the noncontracted facility as long as the recipient desires. The integrated program must also provide that, in the absence of a contract between the integrated-program provider and the residential facility licensed under chapter 400 or chapter 429, current Medicaid rates must prevail. The integrated-program provider must ensure that electronic nursing home claims that contain sufficient information for processing are paid within 10 business days after receipt. Alternately, the integrated-program provider may establish a capitated payment mechanism to prospectively pay nursing homes at the beginning of each month. The agency and the Department of Elderly Affairs must jointly develop procedures to manage the services provided through the integrated program in order to ensure quality and recipient choice.~~

~~(d) The Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the pilot project for the integrated, fixed-payment delivery program for Medicaid recipients created under this subsection. The evaluation shall begin as soon as Medicaid recipients are enrolled in the managed care pilot~~

~~program plans and shall continue for 24 months thereafter. The evaluation must include assessments of each managed care plan in the integrated program with regard to cost savings; consumer education, choice, and access to services; coordination of care; and quality of care. The evaluation must describe administrative or legal barriers to the implementation and operation of the pilot program and include recommendations regarding statewide expansion of the pilot program. The office shall submit its evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2009.~~

~~(e) The agency may seek federal waivers or Medicaid state plan amendments and adopt rules as necessary to administer the integrated program. The agency may implement the approved federal waivers and other provisions as specified in this subsection.~~

~~(f) No later than December 31, 2007, the agency shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives containing an analysis of the merits and challenges of seeking a waiver to implement a voluntary program that integrates payments and services for dually enrolled Medicare and Medicaid recipients who are 65 years of age or older.~~

~~(g) The implementation of the integrated, fixed-payment delivery program created under this subsection is subject to an appropriation in the General Appropriations Act.~~

(5) ~~(6)~~ The agency may contract with any public or private entity otherwise authorized by this section on a prepaid or

fixed-sum basis for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

(a) Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

(b) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;

(c) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;

(d) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or $200,000, whichever is greater;

(e) Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

(f) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency; and

(g) Provides organizational, operational, financial, and other information required by the agency.

This subsection expires October 1, 2013.

(6) ~~(7)~~ The agency may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the agency;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Office of Insurance Regulation.

This subsection expires October 1, 2013.

(7) ~~(8)(a)~~ The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law. This subsection expires October 1, 2013.

~~(b) For a period of no longer than 24 months after the effective date of this paragraph, when a member of an exclusive provider organization that is contracted by the agency to provide health care services to Medicaid recipients in rural areas without a health maintenance organization obtains services from a provider that participates in the Medicaid program in this state, the provider shall be paid in accordance with the appropriate fee schedule for services provided to eligible~~

~~Medicaid recipients. The agency may seek waiver authority to implement this paragraph.~~

(8)~~(9)~~ The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization. This subsection expires October 1, 2013.

(9)~~(10)~~ The agency shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those proscribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

This subsection expires October 1, 2013.

(10) ~~(11)~~ The agency, after notifying the Legislature, may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services. Prior to seeking legislative approval of such a waiver as authorized by this subsection, the agency shall provide notice and an opportunity for public comment. Notice shall be provided to all persons who have made requests of the agency for advance notice and shall be published in the Florida Administrative Weekly not less than 28 days prior to the intended action. This subsection expires October 1, 2015.

(11) ~~(12)~~ The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse. This subsection expires October 1, 2013.

(12) ~~(13)~~ The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with

public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area. This subsection expires October 1, 2013.

(13) ~~(14)(a)~~ The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use of services and to eliminate services that are medically unnecessary. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. Providers that demonstrate a pattern of submitting claims for medically unnecessary services shall be referred to the Medicaid program integrity unit for investigation. In its annual report, required in s. 409.913, the agency shall report on its efforts to control overutilization as described in this subsection ~~paragraph~~. This subsection expires October 1, 2013.

~~(b) The agency shall develop a procedure for determining whether health care providers and service vendors can provide the Medicaid program using a business case that demonstrates~~

~~whether a particular good or service can offset the cost of providing the good or service in an alternative setting or through other means and therefore should receive a higher reimbursement. The business case must include, but need not be limited to:~~

~~1. A detailed description of the good or service to be provided, a description and analysis of the agency's current performance of the service, and a rationale documenting how providing the service in an alternative setting would be in the best interest of the state, the agency, and its clients.~~

~~2. A cost-benefit analysis documenting the estimated specific direct and indirect costs, savings, performance improvements, risks, and qualitative and quantitative benefits involved in or resulting from providing the service. The cost-benefit analysis must include a detailed plan and timeline identifying all actions that must be implemented to realize expected benefits. The Secretary of Health Care Administration shall verify that all costs, savings, and benefits are valid and achievable.~~

~~(c) If the agency determines that the increased reimbursement is cost-effective, the agency shall recommend a change in the reimbursement schedule for that particular good or service. If, within 12 months after implementing any rate change under this procedure, the agency determines that costs were not offset by the increased reimbursement schedule, the agency may revert to the former reimbursement schedule for the particular good or service.~~

(14) ~~(15)~~ (a) The agency shall operate the Comprehensive

Assessment and Review for Long-Term Care Services (CARES) nursing facility preadmission screening program to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person and in the most economical manner possible. The CARES program shall also ensure that individuals participating in Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.

(b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and resident review.

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program. For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage is being terminated for lack of

progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believes that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

(d) For the purpose of initiating immediate prescreening and diversion assistance for individuals residing in nursing homes and in order to make families aware of alternative long-term care resources so that they may choose a more cost-effective setting for long-term placement, CARES staff shall conduct an assessment and review of a sample of individuals whose nursing home stay is expected to exceed 20 days, regardless of the initial funding source for the nursing home placement. CARES staff shall provide counseling and referral services to these individuals regarding choosing appropriate long-term care alternatives. This paragraph does not apply to continuing care facilities licensed under chapter 651 or to retirement communities that provide a combination of nursing home, independent living, and other long-term care services.

(e) By January 15 of each year, the agency shall submit a

report to the Legislature describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

3. Reasons the program is unable to place individuals in less restrictive settings when such individuals desired such services and could have been served in such settings;

4. Barriers to appropriate placement, including barriers due to policies or operations of other agencies or state-funded programs; and

5. Statutory changes necessary to ensure that individuals in need of long-term care services receive care in the least restrictive environment.

(f) The Department of Elderly Affairs shall track individuals over time who are assessed under the CARES program and who are diverted from nursing home placement. By January 15 of each year, the department shall submit to the Legislature a longitudinal study of the individuals who are diverted from nursing home placement. The study must include:

1. The demographic characteristics of the individuals assessed and diverted from nursing home placement, including, but not limited to, age, race, gender, frailty, caregiver status, living arrangements, and geographic location;

2. A summary of community services provided to individuals for 1 year after assessment and diversion;

3. A summary of inpatient hospital admissions for individuals who have been diverted; and

4. A summary of the length of time between diversion and subsequent entry into a nursing home or death.

~~(g) By July 1, 2005, the department and the Agency for Health Care Administration shall report to the President of the Senate and the Speaker of the House of Representatives regarding the impact to the state of modifying level-of-care criteria to eliminate the Intermediate II level of care.~~

This subsection expires October 1, 2012.

(15)~~(16)~~(a) The agency shall identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

1. The practice pattern identification program shall evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. The agency and its Drug Utilization Review Board shall consult with the Department of Health and a panel of practicing health care professionals consisting of the following: the Speaker of the House of Representatives and the President of the Senate shall each appoint three physicians licensed under chapter 458 or chapter 459; and the Governor shall appoint two pharmacists licensed under chapter 465 and one dentist licensed under chapter 466 who is an oral surgeon. Terms of the panel members shall expire at the discretion of the appointing official. The advisory panel shall be responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Practitioners who are prescribing inappropriately or inefficiently, as determined by the agency, may have their prescribing of certain drugs subject to prior authorization or may be terminated from all participation in the Medicaid program.

2. The agency shall also develop educational interventions designed to promote the proper use of medications by providers and beneficiaries.

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries

inappropriately using their benefits, and other steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

4. By September 30, 2002, the agency shall contract with an entity in the state to implement a wireless handheld clinical pharmacology drug information database for practitioners. The initiative shall be designed to enhance the agency's efforts to reduce fraud, abuse, and errors in the prescription drug benefit program and to otherwise further the intent of this paragraph.

5. By April 1, 2006, the agency shall contract with an entity to design a database of clinical utilization information or electronic medical records for Medicaid providers. This system must be web-based and allow providers to review on a real-time basis the utilization of Medicaid services, including, but not limited to, physician office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse.

6. The agency may apply for any federal waivers needed to administer this paragraph.

This subsection expires October 1, 2013.

(16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum basis shall meet the surplus requirements of s. 641.225. If an entity's surplus falls below an amount equal to the surplus requirements of s. 641.225, the agency shall prohibit the entity

from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and may not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

(a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or

(b) Where the entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:

1. Has been in operation for at least 5 years and has assets in excess of $50 million; or

2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.

This subsection expires October 1, 2013.

(17) ~~(18)~~ (a) The agency may require an entity contracting on a prepaid or fixed-sum basis to establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in this state. The entity shall deposit into that account 5 percent of the capitation payments made by the agency each month until a maximum total of 2 percent of the total current contract amount is reached. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the entity and two representatives of the agency. If the agency finds that the entity is insolvent, the agency may

draw upon the account solely with the two authorized signatures of representatives of the agency, and the funds may be disbursed to meet financial obligations incurred by the entity under the prepaid contract. If the contract is terminated, expired, or not continued, the account balance must be released by the agency to the entity upon receipt of proof of satisfaction of all outstanding obligations incurred under this contract.

(b) The agency may waive the insolvency protection account requirement in writing when evidence is on file with the agency of adequate insolvency insurance and reinsurance that will protect enrollees if the entity becomes unable to meet its obligations.

This subsection expires October 1, 2013.

(18) ~~(19)~~ An entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is outside the entity's authorized geographic service area as specified in its contract with the agency, and that provides services authorized by the entity to its members, at a rate negotiated with the hospital or physician for the provision of services or according to the lesser of the following:

(a) The usual and customary charges made to the general public by the hospital or physician; or

(b) The Florida Medicaid reimbursement rate established for the hospital or physician.

This subsection expires October 1, 2013.

(19)~~(20)~~ When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Office of Insurance Regulation pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase. This subsection expires October 1, 2013.

(20)~~(21)~~ Any entity contracting with the agency pursuant to this section to provide health care services to Medicaid recipients is prohibited from engaging in any of the following practices or activities:

(a) Practices that are discriminatory, including, but not limited to, attempts to discourage participation on the basis of actual or perceived health status.

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing representatives, or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing

representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

2. False or misleading claims that the entity is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the entity.

3. False or misleading claims that the state or county recommends that a Medicaid recipient enroll with an entity.

4. Claims that a Medicaid recipient will lose benefits under the Medicaid program, or any other health or welfare benefits to which the recipient is legally entitled, if the recipient does not enroll with the entity.

(c) Granting or offering of any monetary or other valuable consideration for enrollment, except as authorized by subsection (23) ~~(24)~~.

(d) Door-to-door solicitation of recipients who have not contacted the entity or who have not invited the entity to make a presentation.

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

This subsection expires October 1, 2013.

(21) ~~(22)~~ The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action. This subsection expires October 1, 2013.

(22) ~~(23)~~ A health maintenance organization or a person or entity exempt from chapter 641 that is under contract with the agency for the provision of health care services to Medicaid recipients may not use or distribute marketing materials used to solicit Medicaid recipients, unless such materials have been approved by the agency. The provisions of this subsection do not apply to general advertising and marketing materials used by a health maintenance organization to solicit both non-Medicaid subscribers and Medicaid recipients. This subsection expires October 1, 2013.

(23) ~~(24)~~ Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641

that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the recipient, and are provided at no additional cost to the state. This subsection expires October 1, 2013.

(24) ~~(25)~~ The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients. This subsection expires October 1, 2013.

(25) ~~(26)~~ The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient. This subsection expires October 1, 2013.

(26) ~~(27)~~ The agency shall establish a health care quality improvement system for those entities contracting with the agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be

limited to, the following:

(a) Guidelines for internal quality assurance programs, including standards for:

1. Written quality assurance program descriptions.

2. Responsibilities of the governing body for monitoring, evaluating, and making improvements to care.

3. An active quality assurance committee.

4. Quality assurance program supervision.

5. Requiring the program to have adequate resources to effectively carry out its specified activities.

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

12. Accessibility and availability of medical records, as well as proper recordkeeping and process for record review.

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

16. Coordination of quality assurance activity with other management activity.

17. Delivering care to pregnant women and infants; to elderly and disabled recipients, especially those who are at risk of institutional placement; to persons with developmental disabilities; and to adults who have chronic, high-cost medical

conditions.

(b) Guidelines which require the entities to conduct quality-of-care studies which:

1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation.

2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues.

3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.

(c) Guidelines for external quality review of each contractor which require: focused studies of patterns of care; individual care review in specific situations; and followup activities on previous pattern-of-care study findings and individual-care-review findings. In designing the external quality review function and determining how it is to operate as part of the state's overall quality improvement system, the agency shall construct its external quality review organization and entity contracts to address each of the following:

1. Delineating the role of the external quality review organization.

2. Length of the external quality review organization contract with the state.

3. Participation of the contracting entities in designing external quality review organization review activities.

4. Potential variation in the type of clinical conditions

and health services delivery issues to be studied at each plan.

5. Determining the number of focused pattern-of-care studies to be conducted for each plan.

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

This subsection expires October 1, 2015.

(27) ~~(28)~~ In order to ensure that children receive health care services for which an entity has already been compensated, an entity contracting with the agency pursuant to this section shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months. The agency shall develop a method by which the EPSDT screening rate shall be calculated. For any entity which does not achieve the annual 60 percent rate, the entity must submit a corrective action plan for the agency's approval. If the entity does not meet the standard established in the corrective action plan during the specified timeframe, the agency is authorized to impose appropriate contract sanctions. At least annually, the agency shall publicly release the EPSDT Services screening rates of each entity it has contracted with on a prepaid basis to serve Medicaid recipients. This subsection expires October 1, 2013.

(28) ~~(29)~~ The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition

contained in paragraph (20)~~(21)~~(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but shall not include actual enrollment into a managed care plan. An application for enrollment shall not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency shall report to the Legislature on the effectiveness of such initiatives. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and is authorized to adopt rules to implement such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract. This subsection expires October 1, 2013.

(29)~~(30)~~ Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the provider's name and specialty and, separately, by specialty in alphabetical order. This subsection expires October 1, 2013.

(30)~~(31)~~ The agency shall establish an enhanced managed

care quality assurance oversight function, to include at least the following components:

(a) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant utilization of services.

(b) At least quarterly analysis and followup, including sanctions as appropriate, of quality findings of the Medicaid peer review organization and other external quality assurance programs.

(c) At least quarterly analysis and followup, including sanctions as appropriate, of the fiscal viability of managed care plans.

(d) At least quarterly analysis and followup, including sanctions as appropriate, of managed care participant satisfaction and disenrollment surveys.

(e) The agency shall conduct regular and ongoing Medicaid recipient satisfaction surveys.

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers. This subsection expires October 1, 2013.

(31) ~~(32)~~ Each managed care plan that is under contract with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Florida Department of Law Enforcement of all persons with

ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.03. This subsection expires October 1, 2013.

(32) ~~(33)~~ The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs. This subsection expires October 1, 2013.

(33) ~~(34)~~ The agency and entities that contract with the agency to provide health care services to Medicaid recipients under this section or ss. 409.91211 and 409.9122 must comply with the provisions of s. 641.513 in providing emergency services and care to Medicaid recipients and MediPass recipients. Where feasible, safe, and cost-effective, the agency shall encourage hospitals, emergency medical services providers, and other public and private health care providers to work together in their local communities to enter into agreements or arrangements to ensure access to alternatives to emergency services and care for those Medicaid recipients who need nonemergent care. The agency shall coordinate with hospitals, emergency medical services providers, private health plans, capitated managed care networks as established in s. 409.91211,

and other public and private health care providers to implement the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop and implement emergency department diversion programs for Medicaid recipients. This subsection expires October 1, 2013.

(34) ~~(35)~~ All entities providing health care services to Medicaid recipients shall make available, and encourage all pregnant women and mothers with infants to receive, and provide documentation in the medical records to reflect, the following:

(a) Healthy Start prenatal or infant screening.

(b) Healthy Start care coordination, when screening or other factors indicate need.

(c) Healthy Start enhanced services in accordance with the prenatal or infant screening results.

(d) Immunizations in accordance with recommendations of the Advisory Committee on Immunization Practices of the United States Public Health Service and the American Academy of Pediatrics, as appropriate.

(e) Counseling and services for family planning to all women and their partners.

(f) A scheduled postpartum visit for the purpose of voluntary family planning, to include discussion of all methods of contraception, as appropriate.

(g) Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

This subsection expires October 1, 2013.

(35) ~~(36)~~ Any entity that provides Medicaid prepaid health

plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise. This subsection expires October 1, 2013.

~~(37) The agency may seek and implement federal waivers necessary to provide for cost-effective purchasing of home health services, private duty nursing services, transportation, independent laboratory services, and durable medical equipment and supplies through competitive bidding pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid such services. The agency may exclude providers not selected through the bidding process from the Medicaid provider network.~~

(36)~~(38)~~ The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening. This subsection expires October 1, 2013.

(37)~~(39)~~(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:

1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established

pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the preferred drug list on an Internet website without following the rulemaking procedures of chapter 120. Antiretroviral agents are excluded from the preferred drug list. The agency shall also limit the amount of a prescribed drug dispensed to no more than a 34-day supply unless the drug products' smallest marketed package is greater than a 34-day supply, or the drug is determined by the agency to be a maintenance drug in which case a 100-day maximum supply may be authorized. The agency is authorized to seek any federal waivers necessary to implement these cost-control programs and to continue participation in the federal Medicaid rebate program, or alternatively to negotiate state-only manufacturer rebates. The agency may adopt rules to implement this subparagraph. The agency shall continue to provide unlimited contraceptive drugs and items. The agency must establish procedures to ensure that:

a. There is a response to a request for prior consultation by telephone or other telecommunication device within 24 hours after receipt of a request for prior consultation; and

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price

(AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

3. The agency shall develop and implement a process for managing the drug therapies of Medicaid recipients who are using significant numbers of prescribed drugs each month. The management process may include, but is not limited to, comprehensive, physician-directed medical-record reviews, claims analyses, and case evaluations to determine the medical necessity and appropriateness of a patient's treatment plan and drug therapies. The agency may contract with a private organization to provide drug-program-management services. The Medicaid drug benefit management program shall include initiatives to manage drug therapies for HIV/AIDS patients, patients using 20 or more unique prescriptions in a 180-day period, and the top 1,000 patients in annual spending. The agency shall enroll any Medicaid recipient in the drug benefit management program if he or she meets the specifications of this provision and is not enrolled in a Medicaid health maintenance organization.

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and location of pharmacies included in the Medicaid pharmacy network. A pharmacy credentialing process may include criteria such as a pharmacy's full-service status, location, size,

patient educational programs, patient consultation, disease management services, and other characteristics. The agency may impose a moratorium on Medicaid pharmacy enrollment when it is determined that it has a sufficient number of Medicaid-participating providers. The agency must allow dispensing practitioners to participate as a part of the Medicaid pharmacy network regardless of the practitioner's proximity to any other entity that is dispensing prescription drugs under the Medicaid program. A dispensing practitioner must meet all credentialing requirements applicable to his or her practice, as determined by the agency.

5. The agency shall develop and implement a program that requires Medicaid practitioners who prescribe drugs to use a counterfeit-proof prescription pad for Medicaid prescriptions. The agency shall require the use of standardized counterfeit-proof prescription pads by Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients. The agency may implement the program in targeted geographic areas or statewide.

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

7. The agency may establish a preferred drug list as described in this subsection, and, pursuant to the establishment of such preferred drug list, it is authorized to negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the Social Security Act and at no less than 14 percent of the average manufacturer price as defined in 42 U.S.C. s. 1936 on the last day of a quarter unless the federal or supplemental rebate, or both, equals or exceeds 29 percent. There is no upper limit on the supplemental rebates the agency may negotiate. The agency may determine that specific products, brand-name or generic, are competitive at lower rebate percentages. Agreement to pay the minimum supplemental rebate percentage will guarantee a manufacturer that the Medicaid Pharmaceutical and Therapeutics Committee will consider a product for inclusion on the preferred drug list. However, a pharmaceutical manufacturer is not guaranteed placement on the preferred drug list by simply paying the minimum supplemental rebate. Agency decisions will be made on the clinical efficacy of a drug and recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, as well as the price of competing products minus federal and state rebates. The agency is authorized to contract with an outside agency or contractor to conduct negotiations for supplemental rebates. For the purposes of this section, the term "supplemental rebates" means cash rebates. Effective July 1, 2004, value-added programs as a substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

8. The Agency for Health Care Administration shall expand home delivery of pharmacy products. To assist Medicaid patients in securing their prescriptions and reduce program costs, the agency shall expand its current mail-order-pharmacy diabetes-supply program to include all generic and brand-name drugs used by Medicaid patients with diabetes. Medicaid recipients in the current program may obtain nondiabetes drugs on a voluntary basis. This initiative is limited to the geographic area covered by the current contract. The agency may seek and implement any federal waivers necessary to implement this subparagraph.

9. The agency shall limit to one dose per month any drug prescribed to treat erectile dysfunction.

10.a. The agency may implement a Medicaid behavioral drug management system. The agency may contract with a vendor that has experience in operating behavioral drug management systems to implement this program. The agency is authorized to seek federal waivers to implement this program.

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid behavioral drugs. The program may include the following elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as

antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid beneficiaries who are outliers in their use of behavioral health drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of behavioral health drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple same-class behavioral health drugs, and may have other potential medication problems.

(V) Track spending trends for behavioral health drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement a disease management program with a model quality-based medication component for severely mentally ill individuals and emotionally disturbed children who are high

users of care.

11.a. The agency shall implement a Medicaid prescription drug management system. The agency may contract with a vendor that has experience in operating prescription drug management systems in order to implement this system. Any management system that is implemented in accordance with this subparagraph must rely on cooperation between physicians and pharmacists to determine appropriate practice patterns and clinical guidelines to improve the prescribing, dispensing, and use of drugs in the Medicaid program. The agency may seek federal waivers to implement this program.

b. The drug management system must be designed to improve the quality of care and prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid prescription drugs. The program must:

(I) Provide for the development and adoption of best practice guidelines for the prescribing and use of drugs in the Medicaid program, including translating best practice guidelines into practice; reviewing prescriber patterns and comparing them to indicators that are based on national standards and practice patterns of clinical peers in their community, statewide, and nationally; and determine deviations from best practice guidelines.

(II) Implement processes for providing feedback to and educating prescribers using best practice educational materials and peer-to-peer consultation.

(III) Assess Medicaid recipients who are outliers in their use of a single or multiple prescription drugs with regard to the numbers and types of drugs taken, drug dosages, combination drug therapies, and other indicators of improper use of prescription drugs.

(IV) Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs that may be redundant or contraindicated, or may have other potential medication problems.

(V) Track spending trends for prescription drugs and deviation from best practice guidelines.

(VI) Use educational and technological approaches to promote best practices, educate consumers, and train prescribers in the use of practice guidelines.

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

(IX) Implement disease management programs in cooperation with physicians and pharmacists, along with a model quality-based medication component for individuals having chronic medical conditions.

12. The agency is authorized to contract for drug rebate administration, including, but not limited to, calculating rebate amounts, invoicing manufacturers, negotiating disputes with manufacturers, and maintaining a database of rebate collections.

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the

General Appropriations Act and ensuring cost-effective prescribing practices.

14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may, but is not required to, prior-authorize the use of a product:

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency may post prior authorization criteria and protocol and updates to the list of drugs that are subject to prior authorization on an Internet website without amending its rule or engaging in additional rulemaking.

15. The agency, in conjunction with the Pharmaceutical and Therapeutics Committee, may require age-related prior authorizations for certain prescribed drugs. The agency may preauthorize the use of a drug for a recipient who may not meet the age requirement or may exceed the length of therapy for use of this product as recommended by the manufacturer and approved by the Food and Drug Administration. Prior authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug.

16. The agency shall implement a step-therapy prior authorization approval process for medications excluded from the

preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months prior to the alternative medications that are not listed. The step-therapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;

b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or

c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving the requirements for written clinical documentation for specific drugs in limited clinical situations.

17. The agency shall implement a return and reuse program

for drugs dispensed by pharmacies to institutional recipients, which includes payment of a $5 restocking fee for the implementation and operation of the program. The return and reuse program shall be implemented electronically and in a manner that promotes efficiency. The program must permit a pharmacy to exclude drugs from the program if it is not practical or cost-effective for the drug to be included and must provide for the return to inventory of drugs that cannot be credited or returned in a cost-effective manner. The agency shall determine if the program has reduced the amount of Medicaid prescription drugs which are destroyed on an annual basis and if there are additional ways to ensure more prescription drugs are not destroyed which could safely be reused. The agency's conclusion and recommendations shall be reported to the Legislature by December 1, 2005.

(b) The agency shall implement this subsection to the extent that funds are appropriated to administer the Medicaid prescribed-drug spending-control program. The agency may contract all or any part of this program to private organizations.

(c) The agency shall submit quarterly reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include, but need not be limited to, the progress made in implementing this subsection and its effect on Medicaid prescribed-drug expenditures.

(38) ~~(40)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such

periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(39) ~~(41)~~ The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. This subsection expires October 1, 2012.

~~(42) The agency shall develop and implement a utilization management program for Medicaid-eligible recipients for the management of occupational, physical, respiratory, and speech therapies. The agency shall establish a utilization program that may require prior authorization in order to ensure medically necessary and cost-effective treatments. The program shall be operated in accordance with a federally approved waiver program or state plan amendment. The agency may seek a federal waiver or state plan amendment to implement this program. The agency may also competitively procure these services from an outside vendor on a regional or statewide basis.~~

(40) ~~(43)~~ The agency shall ~~may~~ contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This subsection expires

October 1, 2013.

(41)~~(44)~~ The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(f), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which may be adjusted for health status. The agency shall conduct actuarially sound adjustments for health status in order to ensure such cost-effectiveness and shall publish the results on its Internet website and submit the results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31 of each year. Contracts established pursuant to this subsection which are not cost-effective may not be renewed. This subsection expires October 1, 2013.

(42)~~(45)~~ Subject to the availability of funds, the agency shall mandate a recipient's participation in a provider lock-in program, when appropriate, if a recipient is found by the agency to have used Medicaid goods or services at a frequency or amount not medically necessary, limiting the receipt of goods or services to medically necessary providers after the 21-day appeal process has ended, for a period of not less than 1 year. The lock-in programs shall include, but are not limited to,

pharmacies, medical doctors, and infusion clinics. The limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department. The agency shall seek any federal waivers necessary to implement this subsection. The agency shall adopt any rules necessary to comply with or administer this subsection. This subsection expires October 1, 2013.

(43) ~~(46)~~ The agency shall seek a federal waiver for permission to terminate the eligibility of a Medicaid recipient who has been found to have committed fraud, through judicial or administrative determination, two times in a period of 5 years.

~~(47) The agency shall conduct a study of available electronic systems for the purpose of verifying the identity and eligibility of a Medicaid recipient. The agency shall recommend to the Legislature a plan to implement an electronic verification system for Medicaid recipients by January 31, 2005.~~

(44) ~~(48)~~ (a) A provider is not entitled to enrollment in the Medicaid provider network. The agency may implement a Medicaid fee-for-service provider network controls, including, but not limited to, competitive procurement and provider credentialing. If a credentialing process is used, the agency may limit its provider network based upon the following considerations: beneficiary access to care, provider availability, provider quality standards and quality assurance processes, cultural competency, demographic characteristics of beneficiaries, practice standards, service wait times, provider turnover, provider licensure and accreditation history, program integrity history, peer review, Medicaid policy and billing

compliance records, clinical and medical record audit findings, and such other areas that are considered necessary by the agency to ensure the integrity of the program.

(b) The agency shall limit its network of durable medical equipment and medical supply providers. For dates of service after January 1, 2009, the agency shall limit payment for durable medical equipment and supplies to providers that meet all the requirements of this paragraph.

1. Providers must be accredited by a Centers for Medicare and Medicaid Services deemed accreditation organization for suppliers of durable medical equipment, prosthetics, orthotics, and supplies. The provider must maintain accreditation and is subject to unannounced reviews by the accrediting organization.

2. Providers must provide the services or supplies directly to the Medicaid recipient or caregiver at the provider location or recipient's residence or send the supplies directly to the recipient's residence with receipt of mailed delivery. Subcontracting or consignment of the service or supply to a third party is prohibited.

3. Notwithstanding subparagraph 2., a durable medical equipment provider may store nebulizers at a physician's office for the purpose of having the physician's staff issue the equipment if it meets all of the following conditions:

a. The physician must document the medical necessity and need to prevent further deterioration of the patient's respiratory status by the timely delivery of the nebulizer in the physician's office.

b. The durable medical equipment provider must have

written documentation of the competency and training by a Florida-licensed registered respiratory therapist of any durable medical equipment staff who participate in the training of physician office staff for the use of nebulizers, including cleaning, warranty, and special needs of patients.

c. The physician's office must have documented the training and competency of any staff member who initiates the delivery of nebulizers to patients. The durable medical equipment provider must maintain copies of all physician office training.

d. The physician's office must maintain inventory records of stored nebulizers, including documentation of the durable medical equipment provider source.

e. A physician contracted with a Medicaid durable medical equipment provider may not have a financial relationship with that provider or receive any financial gain from the delivery of nebulizers to patients.

4. Providers must have a physical business location and a functional landline business phone. The location must be within the state or not more than 50 miles from the Florida state line. The agency may make exceptions for providers of durable medical equipment or supplies not otherwise available from other enrolled providers located within the state.

5. Physical business locations must be clearly identified as a business that furnishes durable medical equipment or medical supplies by signage that can be read from 20 feet away. The location must be readily accessible to the public during normal, posted business hours and must operate no less than 5

hours per day and no less than 5 days per week, with the exception of scheduled and posted holidays. The location may not be located within or at the same numbered street address as another enrolled Medicaid durable medical equipment or medical supply provider or as an enrolled Medicaid pharmacy that is also enrolled as a durable medical equipment provider. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from the provisions in this paragraph.

6. Providers must maintain a stock of durable medical equipment and medical supplies on site that is readily available to meet the needs of the durable medical equipment business location's customers.

7. Providers must provide a surety bond of $50,000 for each provider location, up to a maximum of 5 bonds statewide or an aggregate bond of $250,000 statewide, as identified by Federal Employer Identification Number. Providers who post a statewide or an aggregate bond must identify all of their locations in any Medicaid durable medical equipment and medical supply provider enrollment application or bond renewal. Each provider location's surety bond must be renewed annually and the provider must submit proof of renewal even if the original bond is a continuous bond. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from the provisions in this paragraph.

8. Providers must obtain a level 2 background screening, as provided under s. 435.04, for each provider employee in

direct contact with or providing direct services to recipients of durable medical equipment and medical supplies in their homes. This requirement includes, but is not limited to, repair and service technicians, fitters, and delivery staff. The provider shall pay for the cost of the background screening.

9. The following providers are exempt from the requirements of subparagraphs 1. and 7.:

a. Durable medical equipment providers owned and operated by a government entity.

b. Durable medical equipment providers that are operating within a pharmacy that is currently enrolled as a Medicaid pharmacy provider.

c. Active, Medicaid-enrolled orthopedic physician groups, primarily owned by physicians, which provide only orthotic and prosthetic devices.

(45) ~~(49)~~ The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care, if any, or as a capitated rate provider for Medicaid services. Any savings shall be shared with the minority physician networks pursuant to the contract.

(c) For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall publish the audit results on its Internet website and submit the audit results annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

(d) The agency may apply for any federal waivers needed to implement this subsection.

This subsection expires October 1, 2013.

(46) ~~(50)~~ To the extent permitted by federal law and as allowed under s. 409.906, the agency shall provide reimbursement for emergency mental health care services for Medicaid recipients in crisis stabilization facilities licensed under s. 394.875 as long as those services are less expensive than the

same services provided in a hospital setting.

(47) ~~(51)~~ The agency shall work with the Agency for Persons with Disabilities to develop a home and community-based waiver to serve children and adults who are diagnosed with familial dysautonomia or Riley-Day syndrome caused by a mutation of the IKBKAP gene on chromosome 9. The agency shall seek federal waiver approval and implement the approved waiver subject to the availability of funds and any limitations provided in the General Appropriations Act. The agency may adopt rules to implement this waiver program.

(48) ~~(52)~~ The agency shall implement a program of all-inclusive care for children. The program of all-inclusive care for children shall be established to provide in-home hospice-like support services to children diagnosed with a life-threatening illness and enrolled in the Children's Medical Services network to reduce hospitalizations as appropriate. The agency, in consultation with the Department of Health, may implement the program of all-inclusive care for children after obtaining approval from the Centers for Medicare and Medicaid Services.

(49) ~~(53)~~ Before seeking an amendment to the state plan for purposes of implementing programs authorized by the Deficit Reduction Act of 2005, the agency shall notify the Legislature.

Section 11. Subsection (4) of section 409.91195, Florida Statutes, is amended to read:

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of

developing a Medicaid preferred drug list.

(4) Upon recommendation of the committee, the agency shall adopt a preferred drug list as described in s. 409.912(37)~~(39)~~. To the extent feasible, the committee shall review all drug classes included on the preferred drug list every 12 months, and may recommend additions to and deletions from the preferred drug list, such that the preferred drug list provides for medically appropriate drug therapies for Medicaid patients which achieve cost savings contained in the General Appropriations Act.

Section 12. Subsection (1) of section 409.91196, Florida Statutes, is amended to read:

409.91196 Supplemental rebate agreements; public records and public meetings exemption.—

(1) The rebate amount, percent of rebate, manufacturer's pricing, and supplemental rebate, and other trade secrets as defined in s. 688.002 that the agency has identified for use in negotiations, held by the Agency for Health Care Administration under s. 409.912(37)~~(39)~~(a)7. are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Section 13. Section 409.91207, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 409.91207, F.S., for present text.)

409.91207 Medical homes.—

(1) AUTHORITY.—The agency shall develop a method for designating qualified plans as a medical home network.

(2) PURPOSE AND PRINCIPLES.—Medical home networks foster and support coordinated and effective primary care through case

management, support to primary care providers, supplemental services, and dissemination of best practices. Medical home networks target patients with chronic illnesses and frequent service utilization in order to coordinate services, provide disease management and patient education, and improve quality of care. In addition to primary care, medical home networks are able to provide or arrange for pharmacy, outpatient diagnostic, and specialty physician services and coordinate with inpatient facilities and rehabilitative service providers.

(3) DESIGNATION.—A qualified plan may request agency designation as a medical home network if the plan is accredited as a medical home network by the National Committee for Quality Assurance or:

(a) The plan establishes a method for its enrollees to choose to participate as medical home patients and select a primary care provider that is certified as a medical home.

(b) At least 85 percent of the primary care providers in a medical home network are certified by the qualified plan as having the following service capabilities:

1. Supply all medically necessary primary and preventive services and provide all scheduled immunizations.

2. Organize clinical data in electronic form using a patient-centered charting system.

3. Maintain and update a patient's medication list and review all medications during each office visit.

4. Maintain a system to track diagnostic tests and provide followup services regarding test results.

5. Maintain a system to track referrals, including self-

referrals by members.

6. Supply care coordination and continuity of care through proactive contact with members and encourage family participation in care.

7. Supply education and support using various materials and processes appropriate for individual patient needs.

8. Communicate electronically.

9. Supply voice-to-voice telephone coverage to medical home patients 24 hours per day, 7 days per week, to enable medical home patients to speak to a licensed health care professional who triages and forwards calls, as appropriate.

10. Maintain an office schedule of at least 30 scheduled hours per week.

11. Use scheduling processes to promote continuity with clinicians, including providing care for walk-in, routine, and urgent care visits.

12. Implement and document behavioral health and substance abuse screening procedures and make referrals as needed.

13. Use data to identify and track patients' health and service use patterns.

14. Coordinate care and followup for patients receiving services in inpatient and outpatient facilities.

15. Implement processes to promote access to care and member communication.

16. Maintain electronic medical records.

17. Develop a health care team that provides ongoing support, oversight, and guidance for all medical care received by the patient and documents contact with specialists and other

health care providers caring for the patient.

18. Supply postvisit followup care for patients.

19. Implement specific evidence-based clinical practice guidelines for preventive and chronic care.

20. Implement a medication reconciliation procedure to avoid interactions or duplications.

21. Use personalized screening, brief intervention, and referral to treatment procedures for appropriate patients requiring specialty treatment.

22. Offer at least 4 hours per week of after-hours care to patients.

23. Use health assessment tools to identify patient needs and risks.

(c) The qualified plan offers support services to its primary care providers, including:

1. Case management, outreach, care coordination, and other targeted support services for medical home patients.

2. Ongoing assessment of spending and service utilization by all medical home network patients.

3. Periodic evaluation of patient outcomes.

4. Coordination with inpatient facilities, behavioral health, and rehabilitative service providers.

5. Establishing specific methods to manage pharmacy and behavioral health services.

6. Paying primary care providers. It is the intent of the Legislature that the savings that result from the implementation of the medical home network model be used to enable Medicaid fees to physicians participating in medical home networks to be

equivalent to 100 percent of Medicare rates as soon as possible.

(4) AGENCY DUTIES.—The agency shall:

(a) Maintain a record of qualified plans designated as medical home networks.

(b) Develop a standard form to be used by the qualified plans to certify to the agency that they meet the necessary service and primary care provider support capabilities to be designated a medical home.

Section 14. Section 409.91211, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 409.91211, F.S., for present text.)

409.91211.—Medicaid managed care pilot program.—

(1) AUTHORITY.—The agency is authorized to implement a managed care pilot program based on the Section 1115 waiver approved by the Centers for Medicare and Medicaid Services on October 19, 2005, including continued operation of the program in Baker, Broward, Clay, Duval, and Nassau Counties. The managed care pilot program shall be consistent with the provisions of this section, subject to federal approval.

(2) EXTENSION.—No later than July 1, 2010, the agency shall begin the process of requesting an extension of the Section 1115 waiver. The agency shall report at least monthly to the Legislature on progress in negotiating for the extension of the waiver. Changes to the terms and conditions relating to the low-income pool must be approved by the Legislative Budget Commission.

(3) EXPANSION.—The agency shall expand the managed care pilot program to Miami-Dade County in a manner that enrolls all eligible recipients in qualified plan commencing January 1, 2012, but no later than October 1, 2012.

(4) QUALIFIED PLANS.—Managed care plans qualified to participate in the Medicaid managed care pilot program include 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 authorized pursuant to s. 409.912(4)(d).

(5) PLAN REQUIREMENTS.—The agency shall apply the following requirements to all qualified plans:

(a) Prepaid rates shall be risk adjusted pursuant to subsection (17).

(b) All Medicaid recipients shall be offered the opportunity to use their Medicaid premium to pay for the recipient's share of cost pursuant to s. 409.9122(13).

(6) INTERGOVERNMENTAL TRANSFERS.—In order to preserve intergovernmental transfers of funds from Miami-Dade County, the agency shall develop methodologies, including, but not limited to, a supplemental capitation rate, risk pool, or incentive payments, which may be paid to prepaid plans or plans owned and operated by providers that contract with safety net providers, trauma hospitals, children's hospitals, and statutory teaching hospitals. In order to preserve certified public expenditures from Miami-Dade County, the agency shall seek federal approval to implement a methodology that allows supplemental payments to

be made directly to physicians employed by or under contract with a medical school in Florida in recognition of the costs associated with graduate medical education or their teaching mission. Alternatively, the agency may develop additional methodologies including, but not limited to, methodologies mentioned above, as well as capitated rates that exclude payments made to these physicians so that they may be paid directly. Once methodologies and payment mechanisms are approved, the agency shall submit the plan for preserving intergovernmental transfers and certified public expenditures to the Legislative Budget Commission. After the assignment and enrollment of all mandatory eligible persons in Miami-Dade County into managed care plans, an amendment shall be submitted to the Legislative Budget Commission requesting authority for the transfer of sufficient funds from appropriate line items within the Grants and Donations Trust Fund and the Medical Care Trust Fund within the Agency for Health Care Administration in the General Appropriations Act to the line item for Prepaid Health Plans within the General Appropriations Act. The agency shall submit a report to the Legislature regarding how the developed and approved methodologies and payment mechanisms may be applied to other counties in the state pursuant to managed care payments under s. 409.968.

(7) ENROLLMENT.—All Medicaid recipients in the counties in which the managed care pilot program has been implemented shall be enrolled in a qualified plan. Each recipient shall have a choice of plans and may select any plan unless that plan is restricted by contract to a specific population that does not

include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans. All recipients shall be offered choice counseling services in accordance with this section.

(8) CHOICE COUNSELING.—The agency shall provide choice counseling and may contract for the provision of choice counseling services. Choice counseling shall be provided in the native or preferred language of the recipient, consistent with federal requirements. The agency shall maintain a record of the recipients who receive such services, identifying the scope and method of the services provided. The agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

(a) An explanation that each recipient has the right to choose a qualified plan at the time of enrollment in Medicaid and again at regular intervals set by the agency and that, if a recipient does not choose a qualified plan, the agency will assign the recipient to a qualified plan according to the criteria specified in this section.

(b) A list and description of the benefits provided in each plan.

(c) Information about earning credits in the plan's enhanced benefit program.

(d) An explanation of benefit limits.

(e) Information about cost-sharing requirements of each plan.

(f) A current list of providers participating in the network, including location and contact information.

(g) Plan performance data.

(9) AUTOMATIC ENROLLMENT.—The agency shall automatically enroll Medicaid recipients who do not voluntarily choose a managed care plan. Enrollment shall be distributed among all qualified plans. When automatically enrolling recipients, the agency shall take into account the following criteria:

(a) The plan has sufficient network capacity to meet the needs of the recipients.

(b) The recipient has previously received services from one of the plan's primary care providers.

(c) Primary care providers in one plan are more geographically accessible to the recipient's residence.

The agency may not engage in practices that are designed to favor one qualified plan over another.

(10) DISENROLLMENT.—After a recipient has selected and enrolled in a qualified plan, the recipient shall have 90 days to voluntarily disenroll and select another qualified plan. After 90 days, further changes may be made only for good cause. "Good cause" includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the qualified plan's grievance process 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 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.

(11) ENROLLMENT PERIOD.—Medicaid recipients enrolled in a qualified plan after the 90-day period shall remain in the plan for 12 months. After 12 months, the recipient may select another plan. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the qualified plan during the 12-month period.

(12) GRIEVANCES.—Each qualified plan shall establish an internal process for reviewing and responding to grievances from enrollees. The contract shall specify timeframes for submission, plan response, and resolution. Grievances not resolved by a plan's internal process shall be submitted to the Subscriber Assistance Panel pursuant to s. 408.7056. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees. The agency shall establish a similar process for provider service networks.

(13) BENEFITS.—Qualified plans operating in the Medicaid managed care pilot program shall cover the services specified in ss. 409.905 and 409.906, emergency services provided under s. 409.9128, and such other services as the plan may offer. Plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional

services. The agency shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

(14) PENALTIES.—Qualified plans that reduce enrollment levels or leave a county where the managed care pilot program has been implemented shall reimburse the agency for the cost of enrollment changes, including the cost of additional choice counseling services. When more than one qualified plan leaves a county at the same time, costs shall be shared by the plans proportionate to their enrollments.

(15) ACCESS TO DATA.—The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a county where the managed care pilot program has been implemented.

(16) ENHANCED BENEFITS.—Each plan operating in the managed care pilot program shall establish an incentive program that rewards specific healthy behaviors with credits in a flexible spending account pursuant to s. 409.9122(14).

(17) PAYMENTS TO MANAGED CARE PLANS.—

(a) The agency shall continue the budget-neutral adjustment of capitation rates for all prepaid plans in existing managed care pilot program counties.

(b) Beginning September 1, 2010, the agency shall begin a budget-neutral adjustment of capitation rates for all prepaid plans in Miami-Dade County. The adjustment to capitation rates shall be based on aggregate risk scores for each prepaid plan's enrollees. During the first 2 years of the adjustment, the agency shall ensure that no plan has an aggregate risk score

that varies by more than 10 percent from the aggregate weighted average for all plans. Except as otherwise provided in this paragraph, the risk adjusted capitation rates shall be phased in as follows:

1. In the first fiscal year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted rate methodology.

2. In the second fiscal year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted methodology.

3. In the third fiscal year, the risk-adjusted capitation methodology shall be fully implemented.

The rates for plans owned and operated by a public hospital shall be risk-adjusted immediately. In order to meet the requirements of budget neutrality, and until such time as all rates in the county are risk-adjusted, the rate differential is contingent on the nonfederal share being provided through grants and donations from allowable nonstate sources. The agency shall submit an amendment to the Legislative Budget Commission requesting authority for such payments.

(c) During this period, the agency shall establish a technical advisory panel to obtain input from the prepaid plans affected by the transition to risk adjusted rates.

(18) LOW-INCOME POOL.—Funds from a low-income pool shall be distributed in accordance with the terms and conditions of the 1115 waiver and in a manner authorized by the General

Appropriations Act. The distribution of funds is intended for the following purposes:

(a) 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;

(b) Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

(c) Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;

(d) Promote teaching and specialty hospital programs;

(e) Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;

(f) Recognize the extent of hospital uncompensated care costs;

(g) Maintain and enhance essential community hospital care;

(h) Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;

(i) Promote measures to avoid preventable hospitalizations;

(j) Account for hospital efficiency; and

(k) Contribute to a community's overall health system.

(19) ENCOUNTER DATA.—The agency shall maintain and operate the Medicaid Encounter Data System pursuant to s. 409.9122(15).

(20) EVALUATION.—The agency shall contract with the University of Florida to complete a comprehensive evaluation of the managed care pilot program. The evaluation shall include an assessment of patient satisfaction, changes in benefits and coverage, implementation and impact of enhanced benefits, access to care and service utilization by enrolled recipients, and costs per enrollee. The agency shall establish an initiative to improve recipient access to information about plan performance. The agency shall publish on its Internet website information on plan performance, including, but not limited to, results of plan enrollee satisfaction surveys, data reported pursuant to s. 409.9122(17), and information on recipient grievances. The website shall be user-friendly and shall provide an opportunity for recipients to give web-based feedback on plans. Plans shall advise recipients of the information available on the agency's website and how to access it in the initial enrollment materials. The agency shall evaluate the initiative to determine whether it improves recipient access to information.

Section 15. Section 409.9122, Florida Statutes, is amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(1) It is the intent of the Legislature that the MediPass program be cost-effective, provide quality health care, and improve access to health services, and that the program be statewide. This subsection expires October 1, 2013.

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid

recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. Upon enrollment, individuals will be able to change their managed care option during the 90-day opt out period required by federal Medicaid regulations. The agency is authorized to seek the necessary Medicaid state plan amendment to implement this policy. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Centers for Medicare and Medicaid Services.

~~The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass.~~ 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 MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall 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 MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments 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 managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(b) A Medicaid recipient shall not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

(c) Medicaid recipients shall have a choice of managed care plans or MediPass. The Agency for Health Care Administration, the Department of Health, the Department of Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each Medicaid recipient

receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care, including MediPass.

2. Provides information on the comparative performance of managed care plans and MediPass in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care plan and MediPass in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their managed care coverage at the time they first enroll in Medicaid and again at regular intervals set by the agency. However, if a recipient does not choose a managed care plan or MediPass, the agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass.

(d) The agency shall develop a mechanism for providing information to Medicaid recipients for the purpose of making a managed care plan or MediPass selection. Examples of such mechanisms may include, but not be limited to, interactive information systems, mailings, and mass marketing materials. Managed care plans and MediPass providers are prohibited from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other

managed care plans or MediPass providers.

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned in accordance with paragraph (f). 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 managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

(f) If a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care

plans which is in a 35 percent and 65 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, ~~including children, and who would be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g),~~ Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass 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 managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(i) After a recipient has made his or her selection or has been enrolled in a managed care plan or MediPass, the recipient shall have 90 days to exercise the opportunity to voluntarily disenroll and select another managed care plan or MediPass. After 90 days, no further changes may be made except for good

cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process 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 utilized, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, 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.

(j) The agency shall apply for a federal waiver from the

Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General

Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass 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 managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

(l) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

<u>This subsection expires October 1, 2013.</u>

(3)(a) The agency shall establish quality-of-care standards for managed care plans. These standards 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.

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 assist 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 Medicaid Bureau of the Health Care Financing Administration as part of the quality assurance reform initiative.

(b) For the MediPass program, the agency shall establish standards which are based upon, but are not limited to:

1. Quality-of-care standards which are comparable to those required of managed care plans.

2. Credentialing standards for MediPass providers.

3. Compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements.

4. Immunization rates.

5. Specific requirements of the Medicaid program, or standards designed to specifically assist the unique needs of

Medicaid recipients.

This subsection expires October 1, 2013.

(4)(a) Each female recipient may select as her primary care provider an obstetrician/gynecologist who has agreed to participate as a MediPass primary care case manager.

(b) The agency shall establish a complaints and grievance process to assist Medicaid recipients enrolled in the MediPass program to resolve complaints and grievances. The agency shall investigate reports of quality-of-care grievances which remain unresolved to the satisfaction of the enrollee.

This subsection expires October 1, 2013.

(5)(a) The agency shall work cooperatively with the Social Security Administration to identify beneficiaries who are jointly eligible for Medicare and Medicaid and shall develop cooperative programs to encourage these beneficiaries to enroll in a Medicare participating health maintenance organization or prepaid health plans.

(b) The agency shall work cooperatively with the Department of Elderly Affairs to assess the potential cost-effectiveness of providing MediPass to beneficiaries who are jointly eligible for Medicare and Medicaid on a voluntary choice basis. If the agency determines that enrollment of these beneficiaries in MediPass has the potential for being cost-effective for the state, the agency shall offer MediPass to these beneficiaries on a voluntary choice basis in the counties where MediPass operates.

This subsection expires October 1, 2013.

(6) MediPass enrolled recipients may receive up to 10 visits of reimbursable services by participating Medicaid physicians licensed under chapter 460 and up to four visits of reimbursable services by participating Medicaid physicians licensed under chapter 461. Any further visits must be by prior authorization by the MediPass primary care provider. However, nothing in this subsection may be construed to increase the total number of visits or the total amount of dollars per year per person under current Medicaid rules, unless otherwise provided for in the General Appropriations Act. This subsection expires October 1, 2013.

~~(7) The agency shall investigate the feasibility of developing managed care plan and MediPass options for the following groups of Medicaid recipients:~~

~~(a) Pregnant women and infants.~~

~~(b) Elderly and disabled recipients, especially those who are at risk of nursing home placement.~~

~~(c) Persons with developmental disabilities.~~

~~(d) Qualified Medicare beneficiaries.~~

~~(e) Adults who have chronic, high-cost medical conditions.~~

~~(f) Adults and children who have mental health problems.~~

~~(g) Other recipients for whom managed care plans and MediPass offer the opportunity of more cost-effective care and greater access to qualified providers.~~

~~(8)(a) The agency shall encourage the development of public and private partnerships to foster the growth of health~~

~~maintenance organizations and prepaid health plans that will provide high-quality health care to Medicaid recipients.~~

~~(b) Subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216, the agency is authorized to enter into contracts with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid prepaid health plans.~~

~~1. The agency may contract with disproportionate share hospitals, county health departments, federally initiated or federally funded community health centers, and counties that operate either a hospital or a community clinic.~~

~~2. A contract may not be for more than $100,000 per year, and no contract may be extended with any particular provider for more than 2 years. The contract is intended only as seed or development funding and requires a commitment from the interested party.~~

~~3. A contract must require participation by at least one community health clinic and one disproportionate share hospital.~~

(7) ~~(9)~~ (a) The agency shall develop and implement a comprehensive plan to ensure that recipients are adequately informed of their choices and rights under all Medicaid managed care programs and that Medicaid managed care programs meet acceptable standards of quality in patient care, patient satisfaction, and financial solvency.

(b) The agency shall provide adequate means for informing patients of their choice and rights under a managed care plan at the time of eligibility determination.

(c) The agency shall require managed care plans and MediPass providers to demonstrate and document plans and activities, as defined by rule, including outreach and followup, undertaken to ensure that Medicaid recipients receive the health care service to which they are entitled.

This subsection expires October 1, 2013.

(8) ~~(10)~~ The agency shall consult with Medicaid consumers and their representatives on an ongoing basis regarding measurements of patient satisfaction, procedures for resolving patient grievances, standards for ensuring quality of care, mechanisms for providing patient access to services, and policies affecting patient care. This subsection expires October 1, 2013.

(9) ~~(11)~~ The agency may extend eligibility for Medicaid recipients enrolled in licensed and accredited health maintenance organizations for the duration of the enrollment period or for 6 months, whichever is earlier, provided the agency certifies that such an offer will not increase state expenditures. This subsection expires October 1, 2013.

(10) ~~(12)~~ A managed care plan that has a Medicaid contract shall at least annually review each primary care physician's active patient load and shall ensure that additional Medicaid recipients are not assigned to physicians who have a total active patient load of more than 3,000 patients. As used in this subsection, the term "active patient" means a patient who is seen by the same primary care physician, or by a physician assistant or advanced registered nurse practitioner under the

supervision of the primary care physician, at least three times within a calendar year. Each primary care physician shall annually certify to the managed care plan whether or not his or her patient load exceeds the limits established under this subsection and the managed care plan shall accept such certification on face value as compliance with this subsection. The agency shall accept the managed care plan's representations that it is in compliance with this subsection based on the certification of its primary care physicians, unless the agency has an objective indication that access to primary care is being compromised, such as receiving complaints or grievances relating to access to care. If the agency determines that an objective indication exists that access to primary care is being compromised, it may verify the patient load certifications submitted by the managed care plan's primary care physicians and that the managed care plan is not assigning Medicaid recipients to primary care physicians who have an active patient load of more than 3,000 patients. This subsection expires October 1, 2013.

~~(13) Effective July 1, 2003, the agency shall adjust the enrollee assignment process of Medicaid managed prepaid health plans for those Medicaid managed prepaid plans operating in Miami-Dade County which have executed a contract with the agency for a minimum of 8 consecutive years in order for the Medicaid managed prepaid plan to maintain a minimum enrollment level of 15,000 members per month. When assigning enrollees pursuant to this subsection, the agency shall give priority to providers that initially qualified under this subsection until such~~

~~providers reach and maintain an enrollment level of 15,000 members per month. A prepaid health plan that has a statewide Medicaid enrollment of 25,000 or more members is not eligible for enrollee assignments under this subsection.~~

(11)~~(14)~~ The agency shall include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including, but not limited to, upper payment limit or disproportionate share hospital payments, made to qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval or state plan amendment as needed to implement this adjustment.

(12)(a) Beginning September 1, 2010, the agency shall begin a budget-neutral adjustment of capitation rates for all Medicaid prepaid plans in the state. The adjustment to capitation rates shall be based on aggregate risk scores for each prepaid plan's enrollees. During the first 2 years of the adjustment, the agency shall ensure that no plan has an aggregate risk score that varies more than 10 percent from the aggregate weighted average for all plans. The risk adjusted capitation rates shall be phased in as follows:

1. In the first fiscal year, 75 percent of the capitation rate shall be based on the current methodology and 25 percent shall be based on the risk-adjusted rate methodology.

2. In the second fiscal year, 50 percent of the capitation rate shall be based on the current methodology and 50 percent shall be based on the risk-adjusted methodology.

3384 3. In the third fiscal year, the risk-adjusted capitation
3385 methodology shall be fully implemented.
3386 (b) During this period, the agency shall establish a
3387 technical advisory panel to obtain input from the prepaid plans
3388 affected by the transition to risk adjusted rates.
3389 (13) The agency shall develop a process to enable any
3390 recipient with access to employer sponsored insurance to opt out
3391 of all qualified plans in the Medicaid program and to use
3392 Medicaid financial assistance to pay for the recipient's share
3393 of cost in any such plan. Contingent on federal approval, the
3394 agency shall also enable recipients with access to other
3395 insurance or related products providing access to health care
3396 services created pursuant to state law, including any plan or
3397 product available pursuant to Cover Florida, the Florida Health
3398 Choices Program, or any health exchange, to opt out. The amount
3399 of financial assistance provided for each recipient shall not
3400 exceed the amount of the Medicaid premium that would have been
3401 paid to a plan for that recipient.
3402 (14) Each qualified plan shall establish an incentive
3403 program that rewards specific healthy behaviors with credits in
3404 a flexible spending account pursuant to s. 409.9122(14).
3405 (a) At the discretion of the recipient, credits shall be
3406 used to purchase otherwise uncovered health and related services
3407 during the entire period of and for a maximum of 3 years after
3408 the recipient's Medicaid eligibility, whether or not the
3409 recipient remains continuously enrolled in the plan in which the
3410 credits were earned.

(b) Enhanced benefits offered by a qualified plan shall be structured to provide greater incentives for those diseases linked with lifestyle and conditions or behaviors associated with avoidable utilization of high-cost services.

(c) To fund these credits, each plan must maintain a reserve account in an amount up to 2 percent of the plan's Medicaid premium revenue or benchmark premium revenue in the case of provider service networks based on an actuarial assessment of the value of the enhanced benefit program.

(15) The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Florida Medicaid recipients enrolled in prepaid managed care plans. Prepaid managed care plans shall submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid managed care plans must certify that the data reported is accurate and complete. The agency is responsible for validating the data submitted by the plans. Prior to utilizing validated encounter data to adjust rates for prepaid plans, the agency shall conduct a review to ensure adequate encounter data is available to establish actuarially sound rates. The review shall include a simulated rate-setting exercise, followed by an evaluation by independent actuaries and consideration of comments from the plans. The agency shall publish the results of the review on its website at least 30 days prior to adjusting rates.

(16) The agency may establish a per-member per-month payment for Medicare Advantage Special Needs members that are also eligible for Medicaid as a mechanism for meeting the state's cost sharing obligation. The agency may also develop a per-member per-month payment for Medicaid only covered services for which the state is responsible. The agency shall develop a mechanism to ensure that such per-member per-month payment enhances the value to the state and enrolled members by limiting cost sharing, enhancing the scope of Medicare supplemental benefits that are equal to or greater than Medicaid coverage for select services, and improving care coordination.

(17) The agency shall establish, and managed care plans shall use, a uniform method of accounting for and reporting medical and nonmedical costs. The agency shall make such information available to the public.

(18) Effective October 1, 2013, 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. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70 and county health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057. 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

managed care plan receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(19) The agency may, on a case-by-case basis, exempt a recipient from mandatory enrollment in a managed care plan when the recipient has a unique, time-limited disease or condition-related circumstance and managed care enrollment will interfere with ongoing care because the recipient's provider does not participate in the managed care plans available in the recipient's area.

Section 16. Subsection (18) of section 430.04, Florida Statutes, is amended to read:

430.04 Duties and responsibilities of the Department of Elderly Affairs.—The Department of Elderly Affairs shall:

(18) Administer all Medicaid waivers and programs relating to elders and their appropriations. The waivers include, but are not limited to:

~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as established in s. 430.502(7), (8), and (9).~~

(a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.

(b) ~~(c)~~ The Aged and Disabled Adult Waiver.

(c) ~~(d)~~ The Adult Day Health Care Waiver.

(d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined in s. 409.221.

(e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.

(f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot Project as described in s. 430.705.

(g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.

The department shall develop a transition plan for recipients receiving services in long-term care Medicaid waivers for elders or disabled adults on the date qualified plans become available in each recipient's region pursuant to s. 409.981(2) to enroll those recipients in qualified plans. This subsection expires October 1, 2012.

Section 17. Section 430.2053, Florida Statutes, is amended to read:

430.2053 Aging resource centers.—

(1) The department, in consultation with the Agency for Health Care Administration and the Department of Children and Family Services, shall develop pilot projects for aging resource centers. ~~By October 31, 2004, the department, in consultation with the agency and the Department of Children and Family Services, shall develop an implementation plan for aging resource centers and submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The plan must include qualifications for designation as a center, the functions to be performed by each center, and a process for determining that a current area agency on aging is ready to assume the functions of an aging resource center.~~

~~(2) Each area agency on aging shall develop, in consultation with the existing community care for the elderly lead agencies within their planning and service areas, a proposal that describes the process the area agency on aging intends to undertake to transition to an aging resource center~~

~~prior to July 1, 2005, and that describes the area agency's compliance with the requirements of this section. The proposals must be submitted to the department prior to December 31, 2004. The department shall evaluate all proposals for readiness and, prior to March 1, 2005, shall select three area agencies on aging which meet the requirements of this section to begin the transition to aging resource centers. Those area agencies on aging which are not selected to begin the transition to aging resource centers shall, in consultation with the department and the existing community care for the elderly lead agencies within their planning and service areas, amend their proposals as necessary and resubmit them to the department prior to July 1, 2005. The department may transition additional area agencies to aging resource centers as it determines that area agencies are in compliance with the requirements of this section.~~

~~(3) The Auditor General and the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall jointly review and assess the department's process for determining an area agency's readiness to transition to an aging resource center.~~

~~(a) The review must, at a minimum, address the appropriateness of the department's criteria for selection of an area agency to transition to an aging resource center, the instruments applied, the degree to which the department accurately determined each area agency's compliance with the readiness criteria, the quality of the technical assistance provided by the department to an area agency in correcting any weaknesses identified in the readiness assessment, and the~~

~~degree to which each area agency overcame any identified weaknesses.~~

~~(b) Reports of these reviews must be submitted to the appropriate substantive and appropriations committees in the Senate and the House of Representatives on March 1 and September 1 of each year until full transition to aging resource centers has been accomplished statewide, except that the first report must be submitted by February 1, 2005, and must address all readiness activities undertaken through December 31, 2004. The perspectives of all participants in this review process must be included in each report.~~

(2)~~(4)~~ The purposes of an aging resource center shall be:

(a) To provide Florida's elders and their families with a locally focused, coordinated approach to integrating information and referral for all available services for elders with the eligibility determination entities for state and federally funded long-term-care services.

(b) To provide for easier access to long-term-care services by Florida's elders and their families by creating multiple access points to the long-term-care network that flow through one established entity with wide community recognition.

(3)~~(5)~~ The duties of an aging resource center are to:

(a) Develop referral agreements with local community service organizations, such as senior centers, existing elder service providers, volunteer associations, and other similar organizations, to better assist clients who do not need or do not wish to enroll in programs funded by the department or the agency. The referral agreements must also include a protocol,

developed and approved by the department, which provides specific actions that an aging resource center and local community service organizations must take when an elder or an elder's representative seeking information on long-term-care services contacts a local community service organization prior to contacting the aging resource center. The protocol shall be designed to ensure that elders and their families are able to access information and services in the most efficient and least cumbersome manner possible.

(b) Provide an initial screening of all clients who request long-term-care services to determine whether the person would be most appropriately served through any combination of federally funded programs, state-funded programs, locally funded or community volunteer programs, or private funding for services.

(c) Determine eligibility for the programs and services listed in subsection (9) ~~(11)~~ for persons residing within the geographic area served by the aging resource center and determine a priority ranking for services which is based upon the potential recipient's frailty level and likelihood of institutional placement without such services.

(d) Manage the availability of financial resources for the programs and services listed in subsection (9) ~~(11)~~ for persons residing within the geographic area served by the aging resource center.

(e) When financial resources become available, refer a client to the most appropriate entity to begin receiving services. The aging resource center shall make referrals to lead

agencies for service provision that ensure that individuals who are vulnerable adults in need of services pursuant to s. 415.104(3)(b), or who are victims of abuse, neglect, or exploitation in need of immediate services to prevent further harm and are referred by the adult protective services program, are given primary consideration for receiving community-care-for-the-elderly services in compliance with the requirements of s. 430.205(5)(a) and that other referrals for services are in compliance with s. 430.205(5)(b).

(f) Convene a work group to advise in the planning, implementation, and evaluation of the aging resource center. The work group shall be comprised of representatives of local service providers, Alzheimer's Association chapters, housing authorities, social service organizations, advocacy groups, representatives of clients receiving services through the aging resource center, and any other persons or groups as determined by the department. The aging resource center, in consultation with the work group, must develop annual program improvement plans that shall be submitted to the department for consideration. The department shall review each annual improvement plan and make recommendations on how to implement the components of the plan.

(g) Enhance the existing area agency on aging in each planning and service area by integrating, either physically or virtually, the staff and services of the area agency on aging with the staff of the department's local CARES Medicaid ~~nursing home~~ preadmission screening unit and a sufficient number of staff from the Department of Children and Family Services'

Economic Self-Sufficiency Unit necessary to determine the financial eligibility for all persons age 60 and older residing within the area served by the aging resource center that are seeking Medicaid services, Supplemental Security Income, and food stamps.

(h) Assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program as qualified plans become available in each of the regions pursuant to s. 409.981(2).

(i) Provide choice counseling for the Medicaid long-term care managed care program by integrating, either physically or virtually, choice counseling staff and services as qualified plans become available in each of the regions pursuant to s. 409.981(2). Pursuant to s. 409.984(1), the agency may contract directly with the aging resource center to provide choice counseling services or may contract with another vendor if the aging resource center does not choose to provide such services.

(j) Assist Medicaid recipients enrolled in the Medicaid long-term care managed care program with informally resolving grievances with a managed care network and assist Medicaid recipients in accessing the managed care network's formal grievance process as qualified plans become available in each of the regions pursuant to s. 409.981(2).

(4) ~~(6)~~ The department shall select the entities to become aging resource centers based on each entity's readiness and ability to perform the duties listed in subsection (3) ~~(5)~~ and the entity's:

(a) Expertise in the needs of each target population the

center proposes to serve and a thorough knowledge of the providers that serve these populations.

(b) Strong connections to service providers, volunteer agencies, and community institutions.

(c) Expertise in information and referral activities.

(d) Knowledge of long-term-care resources, including resources designed to provide services in the least restrictive setting.

(e) Financial solvency and stability.

(f) Ability to collect, monitor, and analyze data in a timely and accurate manner, along with systems that meet the department's standards.

(g) Commitment to adequate staffing by qualified personnel to effectively perform all functions.

(h) Ability to meet all performance standards established by the department.

(5) ~~(7)~~ The aging resource center shall have a governing body which shall be the same entity described in s. 20.41(7), and an executive director who may be the same person as described in s. 20.41(7). The governing body shall annually evaluate the performance of the executive director.

(6) ~~(8)~~ The aging resource center may not be a provider of direct services other than choice counseling as qualified plans become available in each of the regions pursuant to s. 409.981(2), information and referral services, and screening.

(7) ~~(9)~~ The aging resource center must agree to allow the department to review any financial information the department determines is necessary for monitoring or reporting purposes,

including financial relationships.

(8)~~(10)~~ The duties and responsibilities of the community care for the elderly lead agencies within each area served by an aging resource center shall be to:

(a) Develop strong community partnerships to maximize the use of community resources for the purpose of assisting elders to remain in their community settings for as long as it is safely possible.

(b) Conduct comprehensive assessments of clients that have been determined eligible and develop a care plan consistent with established protocols that ensures that the unique needs of each client are met.

(9)~~(11)~~ The services to be administered through the aging resource center shall include those funded by the following programs:

(a) Community care for the elderly.

(b) Home care for the elderly.

(c) Contracted services.

(d) Alzheimer's disease initiative.

(e) Aged and disabled adult Medicaid waiver. This paragraph expires October 1, 2012.

(f) Assisted living for the frail elderly Medicaid waiver. This paragraph expires October 1, 2012.

(g) Older Americans Act.

(10)~~(12)~~ The department shall, prior to designation of an aging resource center, develop by rule operational and quality assurance standards and outcome measures to ensure that clients receiving services through all long-term-care programs

administered through an aging resource center are receiving the appropriate care they require and that contractors and subcontractors are adhering to the terms of their contracts and are acting in the best interests of the clients they are serving, consistent with the intent of the Legislature to reduce the use of and cost of nursing home care. The department shall by rule provide operating procedures for aging resource centers, which shall include:

(a) Minimum standards for financial operation, including audit procedures.

(b) Procedures for monitoring and sanctioning of service providers.

(c) Minimum standards for technology utilized by the aging resource center.

(d) Minimum staff requirements which shall ensure that the aging resource center employs sufficient quality and quantity of staff to adequately meet the needs of the elders residing within the area served by the aging resource center.

(e) Minimum accessibility standards, including hours of operation.

(f) Minimum oversight standards for the governing body of the aging resource center to ensure its continuous involvement in, and accountability for, all matters related to the development, implementation, staffing, administration, and operations of the aging resource center.

(g) Minimum education and experience requirements for executive directors and other executive staff positions of aging resource centers.

(h) Minimum requirements regarding any executive staff positions that the aging resource center must employ and minimum requirements that a candidate must meet in order to be eligible for appointment to such positions.

(11) ~~(13)~~ In an area in which the department has designated an area agency on aging as an aging resource center, the department and the agency shall not make payments for the services listed in subsection (9) ~~(11)~~ and the Long-Term Care Community Diversion Project for such persons who were not screened and enrolled through the aging resource center. The department shall cease making payments for recipients in qualified plans as qualified plans become available in each of the regions pursuant to s. 409.981(2).

(12) ~~(14)~~ Each aging resource center shall enter into a memorandum of understanding with the department for collaboration with the CARES unit staff. The memorandum of understanding shall outline the staff person responsible for each function and shall provide the staffing levels necessary to carry out the functions of the aging resource center.

(13) ~~(15)~~ Each aging resource center shall enter into a memorandum of understanding with the Department of Children and Family Services for collaboration with the Economic Self-Sufficiency Unit staff. The memorandum of understanding shall outline which staff persons are responsible for which functions and shall provide the staffing levels necessary to carry out the functions of the aging resource center.

(14) As qualified plans become available in each of the regions pursuant to s. 409.981(2), if an aging resource center

does not contract with the agency to provide Medicaid long-term care managed care choice counseling pursuant to s. 409.984(1), the aging resource center shall enter into a memorandum of understanding with the agency to coordinate staffing and collaborate with the choice counseling vendor. The memorandum of understanding shall identify the staff responsible for each function and shall provide the staffing levels necessary to carry out the functions of the aging resource center.

(15) ~~(16)~~ If any of the state activities described in this section are outsourced, either in part or in whole, the contract executing the outsourcing shall mandate that the contractor or its subcontractors shall, either physically or virtually, execute the provisions of the memorandum of understanding instead of the state entity whose function the contractor or subcontractor now performs.

(16) ~~(17)~~ In order to be eligible to begin transitioning to an aging resource center, an area agency on aging board must ensure that the area agency on aging which it oversees meets all of the minimum requirements set by law and in rule.

~~(18) The department shall monitor the three initial projects for aging resource centers and report on the progress of those projects to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2005. The report must include an evaluation of the implementation process.~~

(17) ~~(19)~~ (a) Once an aging resource center is operational, the department, in consultation with the agency, may develop capitation rates for any of the programs administered through

the aging resource center. Capitation rates for programs shall be based on the historical cost experience of the state in providing those same services to the population age 60 or older residing within each area served by an aging resource center. Each capitated rate may vary by geographic area as determined by the department.

(b) The department and the agency may determine for each area served by an aging resource center whether it is appropriate, consistent with federal and state laws and regulations, to develop and pay separate capitated rates for each program administered through the aging resource center or to develop and pay capitated rates for service packages which include more than one program or service administered through the aging resource center.

(c) Once capitation rates have been developed and certified as actuarially sound, the department and the agency may pay service providers the capitated rates for services when appropriate.

(d) The department, in consultation with the agency, shall annually reevaluate and recertify the capitation rates, adjusting forward to account for inflation, programmatic changes.

~~(20) The department, in consultation with the agency, shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by December 1, 2006, a report addressing the feasibility of administering the following services through aging resource centers beginning July 1, 2007:~~

~~(a) Medicaid nursing home services.~~

~~(b) Medicaid transportation services.~~

~~(c) Medicaid hospice care services.~~

~~(d) Medicaid intermediate care services.~~

~~(e) Medicaid prescribed drug services.~~

~~(f) Medicaid assistive care services.~~

~~(g) Any other long-term-care program or Medicaid service.~~

(18)~~(21)~~ This section shall not be construed to allow an aging resource center to restrict, manage, or impede the local fundraising activities of service providers.

Section 18. Subsection (4) of section 641.386, Florida Statutes, is amended to read:

641.386 Agent licensing and appointment required; exceptions.—

(4) All agents and health maintenance organizations shall comply with and be subject to the applicable provisions of ss. 641.309 and 409.912(20)~~(21)~~, and all companies and entities appointing agents shall comply with s. 626.451, when marketing for any health maintenance organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

Section 19. Effective October 1, 2012, sections 430.701, 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707, 430.708, and 430.709 Florida Statutes, are repealed.

Section 20. Sections 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and 402.87, Florida Statutes, respectively.

Section 21. Paragraph (a) of subsection (1) of section 443.111, Florida Statutes, is amended to read:

443.111 Payment of benefits.—

(1) MANNER OF PAYMENT.—Benefits are payable from the fund in accordance with rules adopted by the Agency for Workforce Innovation, subject to the following requirements:

(a) Benefits are payable by mail or electronically. Notwithstanding s. 402.82(4) ~~409.942(4)~~, The agency may develop a system for the payment of benefits by electronic funds transfer, including, but not limited to, debit cards, electronic payment cards, or any other means of electronic payment that the agency deems to be commercially viable or cost-effective. Commodities or services related to the development of such a system shall be procured by competitive solicitation, unless they are purchased from a state term contract pursuant to s. 287.056. The agency shall adopt rules necessary to administer the system.

Section 22. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2010, if HB 7223 or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.