



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: bobbie.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 services; 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 **programs 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 developmental disabilities

- 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 program 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.

1 A bill to be entitled
2 An act relating to Medicaid managed care; creating pt. IV
3 of ch. 409, F.S.; creating s. 409.961, F.S.; providing for
4 statutory construction; providing applicability of
5 specified provisions throughout the part; providing
6 rulemaking authority for specified agencies; creating s.
7 409.962, F.S.; providing definitions; creating s. 409.963,
8 F.S.; designating the Agency for Health Care
9 Administration as the single state agency to administer
10 the Medicaid program; providing for specified agency
11 responsibilities; requiring client consent for release of
12 medical records; creating s. 409.964, F.S.; establishing
13 the Medicaid program as the statewide, integrated managed
14 care program for all covered services; authorizing the
15 agency to apply for and implement waivers; providing for
16 public notice and comment; creating s. 409.965, F.S.;
17 providing for mandatory enrollment; providing for
18 exemptions; creating s. 409.966, F.S.; providing
19 requirements for qualified plans that provide services in
20 the Medicaid managed care program; providing for a medical
21 home network to be designated as a qualified plan;
22 establishing provider service network requirements for
23 qualified plans; providing for qualified plan selection;
24 requiring the agency to use an invitation to negotiate;
25 requiring the agency to compile and publish certain
26 information; establishing regions for separate procurement
27 of plans; providing quality selection criteria for plan
28 selection; establishing quality selection criteria;

29 providing limitations on serving recipients during the
 30 pendency of litigation; providing that a qualified plan
 31 that participates in an invitation to negotiate in more
 32 than one region may not serve Medicaid recipients until
 33 all administrative challenges are finalized; creating s.
 34 409.967, F.S.; providing for managed care plan
 35 accountability; establishing contract terms; providing for
 36 contract extension under certain circumstances;
 37 establishing payments to noncontract providers;
 38 establishing requirements for access; requiring plans to
 39 establish and maintain an electronic database;
 40 establishing requirements for the database; requiring
 41 plans to provide encounter data; requiring the agency to
 42 establish performance standards for plans; providing
 43 program integrity requirements; establishing a grievance
 44 resolution process; providing for penalties for early
 45 termination of contracts or reduction in enrollment
 46 levels; creating s. 409.968, F.S.; establishing managed
 47 care plan payments; providing payment requirements for
 48 provider service networks; creating s. 409.969, F.S.;
 49 requiring enrollment in managed care plans by specified
 50 Medicaid recipients; creating requirements for plan
 51 selection by recipients; providing for choice counseling;
 52 establishing choice counseling requirements; authorizing
 53 disenrollment under certain circumstances; defining the
 54 term "good cause" for purposes of disenrollment; providing
 55 time limits on an internal grievance process; providing
 56 requirements for agency determination regarding

57 disenrollment; requiring recipients to stay in plans for a
 58 specified time; creating s. 409.970, F.S.; requiring the
 59 agency to maintain an encounter data system; providing
 60 requirements for prepaid plans to submit data; creating s.
 61 409.971, F.S.; creating the managed medical assistance
 62 program; providing deadlines to begin and finalize
 63 implementation of the program; creating s. 409.972, F.S.;
 64 providing for mandatory and voluntary enrollment; creating
 65 s. 409.973, F.S.; establishing minimum benefits for
 66 managed care plans to cover; authorizing plans to
 67 customize benefit packages; requiring plans to establish
 68 enhanced benefits programs; providing terms for enhanced
 69 benefits package; establishing reserve requirements for
 70 plans to fund enhanced benefits programs; creating s.
 71 409.974, F.S.; establishing a specified number of
 72 qualified plans to be selected in each region;
 73 establishing a deadline for issuing invitations to
 74 negotiate; establishing quality selection criteria;
 75 establishing the Children's Medical Service Network as a
 76 qualified plan; creating s. 409.975; establishing managed
 77 care plan accountability; creating a medical loss ratio
 78 requirement; authorizing plans to limit providers in
 79 networks; mandating certain providers be offered contracts
 80 in the first year; requiring certain provider types to
 81 participate in plans; requiring plans to monitor the
 82 quality and performance history of providers; requiring
 83 specified programs and procedures be established by plans;
 84 establishing provider payments for hospitals; establishing

85 | conflict resolution procedures; establishing the Medicaid
 86 | Resolution Board for specified purposes; establishing plan
 87 | requirements for medically needy recipients; creating s.
 88 | 409.976, F.S.; providing for managed care plan payment;
 89 | requiring the agency to establish a methodology to ensure
 90 | certain types of payments to specified providers;
 91 | establishing eligibility for payments; requiring the
 92 | agency to establish payment rates for statewide inpatient
 93 | psychiatric programs; requiring payments to managed care
 94 | plans to be reconciled to reimburse actual payments to
 95 | statewide inpatient psychiatric programs; creating s.
 96 | 409.977, F.S.; providing for enrollment; establishing
 97 | choice counseling requirements; providing for automatic
 98 | enrollment of certain recipients; establishing opt-out
 99 | opportunities for recipients; creating s. 409.978, F.S.;
 100 | requiring the Agency for Health Care Administration be
 101 | responsible for administering the long-term care managed
 102 | care program; providing implementation dates for the long-
 103 | term care managed care program; providing duties for the
 104 | Department of Elderly Affairs relating to assisting the
 105 | agency in implementing the program; creating s. 409.979,
 106 | F.S.; providing eligibility requirements for the long-term
 107 | care managed care program; creating s. 409.980, F.S.;
 108 | providing the benefits that a managed care plan shall
 109 | provide when participating in the long-term care managed
 110 | care program; creating s. 409.981, F.S.; providing
 111 | criteria for qualified plans; designating regions for plan
 112 | implementation throughout the state; providing criteria

113 for the selection of plans to participate in the long-term
 114 care managed care program; creating s. 409.982, F.S.;

115 providing the agency shall establish a uniform accounting
 116 and reporting methods for plans; providing spending
 117 thresholds and consequences relating to spending
 118 thresholds; providing for mandatory participation in plans
 119 of certain service providers; providing providers can be
 120 excluded from plans for failure to meet quality or
 121 performance criteria; providing the plans must monitor
 122 participating providers using specified criteria;

123 providing certain providers that must be included in plan
 124 networks; providing provider payment specifications for
 125 nursing homes and hospices; creating s. 409.983, F.S.;

126 providing for negotiation of rates between the agency and
 127 the plans participating in the long-term care managed care
 128 program; providing specific criteria for calculating and
 129 adjusting plan payments; allowing the CARES program to
 130 assign plan enrollees to a level of care ; providing
 131 incentives for adjustments of payment rates; providing the
 132 agency shall establish nursing facility-specific and
 133 hospice services payment rates; creating s. 409.984, F.S.;

134 providing that prior to contracting with another vender,
 135 the agency shall offer to contract with the aging resource
 136 centers to provide choice counseling for the long-term
 137 care managed care program; providing criteria for
 138 automatic assignments of plan enrollees who fail to chose
 139 a plan; creating s. 409.985, F.S.; providing that the
 140 agency shall operate the Comprehensive Assessment and

141 Review for Long-Term Care Services program through an
 142 interagency agreement with the Department of Elderly
 143 Affairs; providing duties of the program; defining the
 144 term "nursing facility care"; creating s. 409.986, F.S.;
 145 providing authority and agency duties related to long-term
 146 care plans; creating s. 409.987, F.S.; providing
 147 eligibility requirements for long-term care plans;
 148 creating s. 409.988, F.S.; providing benefits for long-
 149 term care plans; creating s. 409.989, F.S.; establishing
 150 criteria for qualified plans; specifying minimum and
 151 maximum number of plans and selection criteria; creating
 152 s. 409.990, F.S.; providing requirements for managed care
 153 plan accountability; specifying limitations on providers
 154 in plan networks; providing for evaluation and payment of
 155 network providers; creating s. 409.991, F.S.; providing
 156 for payment of managed care plans; providing duties for
 157 the Agency for Persons with Disabilities to assign plan
 158 enrollees into a payment rate level of care; establishing
 159 level of care criteria; providing payment requirements for
 160 intensive behavior residential habilitation providers and
 161 intermediate care facilities for the developmentally
 162 disabled; creating s. 409.992, F.S.; providing
 163 requirements for enrollment and choice counseling;
 164 specifying enrollment exceptions for certain Medicaid
 165 recipients; providing an effective date.

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 167
 168

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

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

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

174 409.961 Statutory construction; applicability; rules.—It
 175 is the intent of the Legislature that if any conflict exists
 176 between the provisions contained in this part and provisions
 177 contained in other parts of this chapter, the provisions
 178 contained in this part shall control. The provisions of ss.
 179 409.961–409.970 apply only to the Medicaid managed medical
 180 assistance program, long-term care managed care program, and
 181 managed long-term care for persons with developmental
 182 disabilities program, as provided in this part. The agency shall
 183 adopt any rules necessary to comply with or administer this part
 184 and all rules necessary to comply with federal requirements. In
 185 addition, the department shall adopt and accept the transfer of
 186 any rules necessary to carry out the department's
 187 responsibilities for receiving and processing Medicaid
 188 applications and determining Medicaid eligibility and for
 189 ensuring compliance with and administering this part, as those
 190 rules relate to the department's responsibilities, and any other
 191 provisions related to the department's responsibility for the
 192 determination of Medicaid eligibility.

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

195 409.962 Definitions.—As used in this part, except as
 196 otherwise specifically provided, the term:

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

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

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

207 (4) "Long-term care comprehensive plan" means a long-term
 208 care plan that also provides the services described in s.
 209 409.973.

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

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

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

221 (8) "Medicaid" means the medical assistance program
 222 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.
 223 1396 et seq., and regulations thereunder, as administered in
 224 this state by the agency.

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

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

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

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

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

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

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

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

261 409.963 Single state agency.—The Agency for Health Care
 262 Administration is designated as the single state agency
 263 authorized to manage, operate, and make payments for medical
 264 assistance and related services under Title XIX of the Social
 265 Security Act. Subject to any limitations or directions provided
 266 for in the General Appropriations Act, these payments shall be
 267 made only for services included in the program, only on behalf
 268 of eligible individuals, and only to qualified providers in
 269 accordance with federal requirements for Title XIX of the Social
 270 Security Act and the provisions of state law. This program of
 271 medical assistance is designated as the "Medicaid program." The
 272 department is responsible for Medicaid eligibility
 273 determinations, including, but not limited to, policy, rules,
 274 and the agreement with the Social Security Administration for
 275 Medicaid eligibility determinations for Supplemental Security
 276 Income recipients, as well as the actual determination of
 277 eligibility. As a condition of Medicaid eligibility, subject to
 278 federal approval, the agency and the department shall ensure
 279 that each Medicaid recipient consents to the release of her or

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

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

284 409.964 Managed care program; state plan; waivers.—The
 285 Medicaid program is established as a statewide, integrated
 286 managed care program for all covered services, including long-
 287 term care services. The agency shall apply for and implement
 288 state plan amendments or waivers of applicable federal laws and
 289 regulations necessary to implement the program. Prior to seeking
 290 a waiver, the agency shall provide public notice and the
 291 opportunity for public comment and shall include public feedback
 292 in the waiver application. The agency shall include the public
 293 feedback in the application. The agency shall hold one public
 294 meeting in each of the regions described in s. 409.966(2) and
 295 the time period for public comment for each region shall end no
 296 sooner than 30 days after the completion of the public meeting
 297 in that region.

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

300 409.965 Mandatory enrollment.—All Medicaid recipients
 301 shall receive covered services through the statewide managed
 302 care program, except as provided by this part pursuant to an
 303 approved federal waiver. The following Medicaid recipients are
 304 exempt from participation in the statewide managed care program:

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

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

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

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

313 409.966 Qualified plans; selection.-

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

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

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

331 (2) QUALIFIED PLAN SELECTION.-The agency shall select a
 332 limited number of qualified plans to participate in the Medicaid
 333 program using invitations to negotiate in accordance with s.
 334 287.057(3)(a). At least 30 days prior to issuing an invitation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

417 4. Contracts with multiple and diverse suppliers of home

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

426
 427 After negotiations are conducted, the agency shall select the
 428 qualified plans that are determined to be responsive and provide
 429 the best value to the state. Preference shall be given to
 430 organizations designated as medical home networks pursuant to s.
 431 409.91207 or organizations with the greatest number of primary
 432 care providers that are recognized as patient-centered medical
 433 homes by the National Committee for Quality Assurance or
 434 organizations with networks that reflect recruitment of minority
 435 physicians and other minority providers.

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

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

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

455 409.967 Managed care plan accountability.—

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

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

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

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

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

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

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

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

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

520 1. A provider credentialing system and ongoing provider
 521 monitoring;

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

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

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

530 5. Designation of a program integrity compliance officer.

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

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

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

551 (i) Electronic claims.—Plans shall accept electronic
 552 claims in compliance with federal standards.

553 (j) Medical home development.—The managed care plan, if
 554 not designated as a medical home network pursuant to s.
 555 409.91207, must develop a plan to assist and to provide
 556 incentives for its primary care providers to become recognized

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

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

561 409.968 Managed care plan payment.—

562 (1) Prepaid plans shall receive per-member, per-month
 563 payments negotiated pursuant to the procurements described in s.
 564 409.966. Payments shall be risk-adjusted rates based on
 565 historical utilization and spending data, projected forward, and
 566 adjusted to reflect the eligibility category, geographic area,
 567 and the clinical risk profile of the recipients.

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

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

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

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

611 409.969 Enrollment; choice counseling; automatic
612 assignment; disenrollment.-

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

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

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

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

648 (c) An explanation of benefit limits.

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

651 (e) Plan performance data.

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

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

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

671 (b) The agency must make a determination and take final
 672 action on a recipient's request so that disenrollment occurs no
 673 later than the first day of the second month after the month the
 674 request was made. If the agency fails to act within the
 675 specified timeframe, the recipient's request to disenroll is
 676 deemed to be approved as of the date agency action was required.
 677 Recipients who disagree with the agency's finding that good
 678 cause does not exist for disenrollment shall be advised of their
 679 right to pursue a Medicaid fair hearing to dispute the agency's
 680 finding.

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

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

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

696 409.970 Encounter data.—The agency shall maintain and
 697 operate the Medicaid Encounter Data System to collect, process,
 698 store, and report on covered services provided to all Medicaid
 699 recipients enrolled in prepaid plans. Prepaid plans shall submit
 700 encounter data electronically in a format that complies with the
 701 Health Insurance Portability and Accountability Act provisions
 702 for electronic claims and in accordance with deadlines
 703 established by the agency. Prepaid plans must certify that the
 704 data reported is accurate and complete. The agency is
 705 responsible for validating the data submitted by the plans. The
 706 agency shall make encounter data available to those plans
 707 accepting enrollees who are assigned to them from other plans
 708 leaving a region.

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

711 409.971 Managed medical assistance program.—The agency
 712 shall make payments for primary and acute medical assistance and
 713 related services using a managed care model. By January 1, 2012,
 714 the agency shall begin implementation of the statewide managed
 715 medical assistance program, with full implementation in all
 716 regions by October 1, 2013.

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

719 409.972 Mandatory and voluntary enrollment.—
 720 (1) Persons eligible for the program known as "medically
 721 needy" pursuant to s. 409.904(2)(a) shall enroll in managed care
 722 plans. Medically needy recipients shall meet the share of cost

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

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

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

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

737 (c) Persons eligible for refugee assistance.

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

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

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

747 409.973 Benefits.—

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

750 (a) Advanced registered nurse practitioner services.

- 751 | (b) Ambulatory surgical treatment center services.
- 752 | (c) Birthing center services.
- 753 | (d) Chiropractic services.
- 754 | (e) Dental services.
- 755 | (f) Early periodic screening diagnosis and treatment
- 756 | services for recipients under age 21.
- 757 | (g) Emergency services.
- 758 | (h) Family planning services and supplies.
- 759 | (i) Healthy start services.
- 760 | (j) Hearing services.
- 761 | (k) Home health agency services.
- 762 | (l) Hospice services.
- 763 | (m) Hospital inpatient services.
- 764 | (n) Hospital outpatient services.
- 765 | (o) Laboratory and imaging services.
- 766 | (p) Medical supplies, equipment, prostheses, and orthoses.
- 767 | (q) Mental health services.
- 768 | (r) Nursing care.
- 769 | (s) Optical services and supplies.
- 770 | (t) Optometrist services.
- 771 | (u) Physical, occupational, respiratory, and speech
- 772 | therapy services.
- 773 | (v) Physician services.
- 774 | (w) Podiatric services.
- 775 | (x) Prescription drugs.
- 776 | (y) Renal dialysis services.
- 777 | (z) Respiratory equipment and supplies.
- 778 | (aa) Rural health clinic services.

779 (bb) Substance abuse treatment services.
 780 (cc) Transportation to access covered services.
 781 (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
 782 benefit packages for nonpregnant adults, vary cost-sharing
 783 provisions, and provide coverage for additional services. The
 784 agency shall evaluate the proposed benefit packages to ensure
 785 services are sufficient to meet the needs of the plans'
 786 enrollees and to verify actuarial equivalence.
 787 (3) ENHANCED BENEFITS.—Each plan operating in the managed
 788 medical assistance program shall establish an incentive program
 789 that rewards specific healthy behaviors with credits in a
 790 flexible spending account.
 791 (a) At the discretion of the recipient, credits shall be
 792 used to purchase otherwise uncovered health and related services
 793 during the entire period of, and for a maximum of 3 years after,
 794 the recipient's Medicaid eligibility, whether or not the
 795 recipient remains continuously enrolled in the plan in which the
 796 credits were earned.
 797 (b) Enhanced benefits shall be structured to provide
 798 greater incentives for those diseases linked with lifestyle and
 799 conditions or behaviors associated with avoidable utilization of
 800 high-cost services.
 801 (c) To fund these credits, each plan must maintain a
 802 reserve account in an amount of up to 2 percent of the plan's
 803 Medicaid premium revenue, or benchmark premium revenue in the
 804 case of provider service networks, based on an actuarial
 805 assessment of the value of the enhanced benefits program.

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

808 409.974 Qualified plans.-

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

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

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

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

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

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

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

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

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

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

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

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

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

868 409.975 Managed care plan accountability.—In addition to
 869 the requirements of s. 409.967, plans and providers
 870 participating in the managed medical assistance program shall
 871 comply with the requirements of this section.

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

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

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

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

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

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

- 904 (a) Federally qualified health centers.
- 905 (b) Primary care providers certified as medical homes.
- 906 (c) Providers listed in paragraphs (3) (a)-(d).

907

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

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

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

920 (a) Statutory teaching hospitals as defined in s.
 921 408.07(45).

922 (b) Hospitals that are trauma centers as defined in s.
 923 395.4001(14).

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

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

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

930
 931 The hospitals described in paragraphs (a)-(d) shall make
 932 adequate arrangements for medical staff sufficient to fulfill
 933 their contractual obligations with the plans.

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

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

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

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

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

958 (8) CONFLICT RESOLUTION.—In order to protect the continued
959 statewide operation of the Medicaid managed care program, the
960 Medicaid Resolution Board is established to resolve disputes
961 between managed care plans and hospitals and between managed
962 care plans and the medical staff of the providers listed in s.
963 409.975(3)(a)-(d). The board shall consist of two members
964 appointed by the Speaker of the House of Representatives, two
965 members appointed by the President of the Senate, and three
966 members appointed by the Governor. The costs of the board's
967 activities to review and resolve disputes shall be shared
968 equally by the parties to the dispute. Any managed care plan or
969 above-named provider may initiate a review by the board for any
970 conflict related to payment rates, contract terms, or other
971 conditions. The board shall make recommendations to the agency
972 regarding payment rates, procedures, or other contract terms to

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

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

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

991 409.976 Managed care plan payment.—In addition to the
 992 payment provisions of s. 409.968, the agency shall provide
 993 payment to plans in the managed medical assistance program
 994 pursuant to this section.

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

998 (2) The agency shall develop a methodology to ensure the
 999 availability of intergovernmental transfers in the statewide
 1000 integrated managed care program to support providers that have

1001 historically served Medicaid recipients. Such providers include,
 1002 but are not limited to, safety net providers, trauma hospitals,
 1003 children's hospitals, statutory teaching hospitals, and medical
 1004 and osteopathic physicians employed by or under contract with a
 1005 medical school in this state. The agency may develop a
 1006 supplemental capitation rate, risk pool, or incentive payment to
 1007 plans that contract with these providers. A plan is eligible for
 1008 a supplemental payment only if there are sufficient
 1009 intergovernmental transfers available from allowable sources and
 1010 the plan can demonstrate that it pays a reimbursement rate not
 1011 less than the equivalent fee-for-service rate. The agency may
 1012 develop the supplemental capitation rate to consider rates
 1013 higher than the fee-for-service Medicaid rate when needed to
 1014 ensure access and supported by funds provided by a locality. The
 1015 agency shall evaluate the development of the rate cell to
 1016 accurately reflect the underlying utilization to the maximum
 1017 extent possible. This methodology may include interim rate
 1018 adjustments as permitted under federal regulations. Any such
 1019 methodology shall preserve federal funding to these entities and
 1020 must be actuarially sound. In the absence of federal approval
 1021 for the above methodology, the agency is authorized to set an
 1022 enhanced rate and require that plans pay the enhanced rate, if
 1023 the agency determines the enhanced rate is necessary to ensure
 1024 access to care by the providers described in this subsection.
 1025 The amount paid to the plans to make supplemental payments or to
 1026 enhance provider rates pursuant to this subsection shall be
 1027 reconciled to the exact amounts the plans are required to pay to
 1028 providers. The plans shall make the designated payments to

1029 providers within 15 business days of notification by the agency
 1030 regarding provider-specific distributions.

1031 (3) The agency shall establish payment rates for statewide
 1032 inpatient psychiatric programs. Payments to managed care plans
 1033 shall be reconciled to reimburse actual payments to statewide
 1034 inpatient psychiatric programs.

1035 Section 18. Section 409.977, Florida Statutes, is created
 1036 to read:

1037 409.977 Choice counseling and enrollment.-

1038 (1) CHOICE COUNSELING.-In addition to the choice
 1039 counseling information required by s. 409.969, the agency shall
 1040 make available clear and easily understandable choice
 1041 information to Medicaid recipients that includes:

1042 (a) Information about earning credits in the plan's
 1043 enhanced benefit program.

1044 (b) Information about cost sharing requirements of each
 1045 plan.

1046 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically
 1047 enroll into a managed care plan those Medicaid recipients who do
 1048 not voluntarily choose a plan pursuant to s. 409.969. The agency
 1049 shall automatically enroll recipients in plans that meet or
 1050 exceed the performance or quality standards established pursuant
 1051 to s. 409.967, and shall not automatically enroll recipients in
 1052 a plan that is deficient in those performance or quality
 1053 standards. When a specialty plan is available to accommodate a
 1054 specific condition or diagnosis of a recipient, the agency shall
 1055 assign the recipient to that plan. The agency may not engage in
 1056 practices that are designed to favor one managed care plan over

1057 another. When automatically enrolling recipients in plans, the
 1058 agency shall automatically enroll based on the following
 1059 criteria:

1060 (a) Whether the plan has sufficient network capacity to
 1061 meet the needs of the recipients.

1062 (b) Whether the recipient has previously received services
 1063 from one of the plan's primary care providers.

1064 (c) Whether primary care providers in one plan are more
 1065 geographically accessible to the recipient's residence than
 1066 those in other plans.

1067 (3) OPT-OUT OPTION.-The agency shall develop a process to
 1068 enable any recipient with access to employer-sponsored insurance
 1069 to opt out of all qualified plans in the Medicaid program and to
 1070 use Medicaid financial assistance to pay for the recipient's
 1071 share of the cost in any such plan. Contingent upon federal
 1072 approval, the agency shall also enable recipients with access to
 1073 other insurance or related products providing access to health
 1074 care services created pursuant to state law, including any
 1075 product available under the Cover Florida Health Access Program,
 1076 the Florida Health Choices Program, or any health exchange, to
 1077 opt out. The amount of financial assistance provided for each
 1078 recipient may not exceed the amount of the Medicaid premium that
 1079 would have been paid to a plan for that recipient.

1080 Section 19. Section 409.978, Florida Statutes, is created
 1081 to read:

1082 409.978 Long-term care managed care program.-

1083 (1) Pursuant to s. 409.963, the agency shall administer
 1084 the long-term care managed care program described in ss.

1085 409.978-409.985, but may delegate specific duties and
 1086 responsibilities for the program to the Department of Elderly
 1087 Affairs and other state agencies. By July 1, 2011, the agency
 1088 shall begin implementation of the statewide long-term care
 1089 managed care program, with full implementation in all regions by
 1090 October 1, 2012.

1091 (2) The agency shall make payments for long-term care,
 1092 including home and community-based services, using a managed
 1093 care model. Unless otherwise specified, the provisions of ss.
 1094 409.961-409.970 apply to the long-term care managed care
 1095 program.

1096 (3) The Department of Elderly Affairs shall assist the
 1097 agency to develop specifications for use in the invitation to
 1098 negotiate and the model contract; determine clinical eligibility
 1099 for enrollment in managed long-term care plans; monitor plan
 1100 performance and measure quality of service delivery; assist
 1101 clients and families to address complaints with the plans;
 1102 facilitate working relationships between plans and providers
 1103 servicing elders and disabled adults; and perform other functions
 1104 specified in a memorandum of agreement.

1105 Section 20. Section 409.979, Florida Statutes, is created
 1106 to read:

1107 409.979 Eligibility.-

1108 (1) Medicaid recipients who meet all of the following
 1109 criteria are eligible to participate in the long-term care
 1110 managed care program. The recipient must be:

1111 (a) Sixty-five years of age or older or eligible for
 1112 Medicaid by reason of a disability.

1113 (b) Determined by the Comprehensive Assessment Review and
 1114 Evaluation for Long-Term Care Services (CARES) Program to
 1115 require nursing facility care.

1116 (2) Medicaid recipients who on the date long-term care
 1117 managed care plans becomes available in the recipient's region,
 1118 are residing in a nursing home facility or enrolled in one of
 1119 the following long-term care Medicaid waiver programs are
 1120 eligible to participate in the long-term care managed care
 1121 program:

1122 (a) The Assisted Living for the Frail Elderly Waiver.

1123 (b) The Aged and Disabled Adult Waiver.

1124 (c) The Adult Day Health Care Waiver.

1125 (d) The Consumer-Directed Care Plus Program as described
 1126 in s. 409.221.

1127 (e) The Program of All-inclusive Care for the Elderly.

1128 (f) The Long-Term Care Community-Based Diversion Pilot
 1129 Project as described in s. 430.705.

1130 (g) The Channeling Services Waiver for Frail Elders.

1131 Section 21. Section 409.980, Florida Statutes, is created
 1132 to read:

1133 409.980 Benefits.—Managed care plans shall cover, at a
 1134 minimum, the following services:

1135 (1) Nursing facility.

1136 (2) Assisted living facility.

1137 (3) Hospice.

1138 (4) Adult day care.

1139 (5) Medical equipment and supplies, including incontinence
 1140 supplies.

- 1141 | (5) Personal care.
- 1142 | (7) Home accessibility adaptation.
- 1143 | (9) Behavior management.
- 1144 | (9) Home delivered meals.
- 1145 | (10) Case management.
- 1146 | (11) Therapies:
- 1147 | (a) Occupational therapy
- 1148 | (b) Speech therapy
- 1149 | (c) Respiratory therapy
- 1150 | (d) Physical therapy.
- 1151 | (12) Intermittent and skilled nursing.
- 1152 | (13) Medication administration.
- 1153 | (14) Medication management.
- 1154 | (15) Nutritional assessment and risk reduction.
- 1155 | (16) Caregiver training.
- 1156 | (17) Respite care.
- 1157 | (18) Transportation.
- 1158 | (19) Personal emergency response system.
- 1159 | Section 22. Section 409.981, Florida Statutes, is created
- 1160 | to read:
- 1161 | 409.981 Qualified plans.—
- 1162 | (1) QUALIFIED PLANS.—For purposes of the long-term care
- 1163 | managed care program, qualified plans also include entities who
- 1164 | are qualified under 42 C.F.R. part 422 as Medicare Advantage
- 1165 | Preferred Provider Organizations, Medicare Advantage Provider-
- 1166 | sponsored Organizations, and Medicare Advantage Special Needs
- 1167 | Plans. Such plans are eligible to participate in the statewide
- 1168 | long-term care managed care program. Qualified plans that are

1169 provider service networks must be long-term care provider
 1170 service networks. Qualified plans may either be long-term care
 1171 plans that cover benefits pursuant to s. 409.980, or
 1172 comprehensive long-term care plans that cover benefits pursuant
 1173 to ss. 409.973 and 409.980.

1174 (2) QUALIFIED PLAN SELECTION.—The agency shall select
 1175 qualified plans through the procurement described in s. 409.966.
 1176 The agency shall notice invitations to negotiate no later than
 1177 July 1, 2011.

1178 (a) The agency shall procure three plans for Region I. At
 1179 least one plan shall be a provider service network, if any
 1180 submit a responsive bid.

1181 (b) The agency shall procure at least four and no more
 1182 than seven plans for Region II. At least one plan shall be a
 1183 provider service network, if any submit a responsive bid.

1184 (c) The agency shall procure at least five plans and no
 1185 more than ten plans for Region III. At least two plans shall be
 1186 provider service networks, if any two submit a responsive bid.

1187 (d) The agency shall procure at least four plans and no
 1188 more than eight plans for Region IV. At least one plan shall be
 1189 a provider service network if any submit a responsive bid.

1190 (e) The agency shall procure at least four plans and no
 1191 more than seven plans for Region V. At least one plan shall be a
 1192 provider service network, if any submit a responsive bid.

1193 (f) The agency shall procure at least five plans and no
 1194 more than ten plans for Region VI. At least two plans shall be
 1195 provider service networks, if any two submit a responsive bid.

1196 If no provider service network submits a responsive bid, the
 1197 agency shall procure one less qualified plan in each of the
 1198 regions. Within 12 months after the initial invitation to
 1199 negotiate, the agency shall attempt to procure a qualified plan
 1200 that is a provider service network. The agency shall notice
 1201 another invitation to negotiate only with provider service
 1202 networks in such region where no provider service network has
 1203 been selected.

1204 (3) QUALITY SELECTION CRITERIA.--In addition to the criteria
 1205 established in s. 409.966, the agency shall consider the
 1206 following factors in the selection of qualified plans:

1207 (a) Specialized staffing. Plan employment of executive
 1208 managers with expertise and experience in serving aged and
 1209 disabled persons who require long-term care.

1210 (b) Network qualifications. Plan establishment of a
 1211 network of service providers dispersed throughout the region and
 1212 in sufficient numbers to meet specific service standards
 1213 established by the agency for specialty services for persons
 1214 receiving home and community-based care.

1215 (c) Whether a plan is proposing to establish a
 1216 comprehensive long-term care plan and whether the qualified plan
 1217 has a contract to provide managed medical assistance services in
 1218 the same region. The agency shall exercise a preference for such
 1219 plans.

1220 (d) Whether a plan is designated as a medical home network
 1221 pursuant to s. 409.91207 or offers consumer-directed care
 1222 services to enrollees pursuant to s. 409.221. Consumer-directed
 1223 care services provide a flexible budget which is managed by

1224 enrolled individuals and their families or representatives and
 1225 allows them to choose providers of services, determine provider
 1226 rates of payment and direct the delivery of services to best
 1227 meet their special long-term care needs. When all other factors
 1228 are equal among competing qualified plans, the agency shall
 1229 exercise a preference for such plans.

1230 (e) Evidence that a qualified plan has written agreements
 1231 or signed contracts or has made substantial progress in
 1232 establishing relationships with providers prior to the plan
 1233 submitting a response. The agency shall evaluate and give
 1234 special weight to evidence of signed contracts with providers of
 1235 critical services pursuant to s. 409.982(2)(a)-(c).

1236 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—The
 1237 Program for All-Inclusive Care for the Elderly (PACE) is a
 1238 qualified plan for purposes of the long-term care managed care
 1239 program. Participation by PACE shall be pursuant to a contract
 1240 with the agency and not subject to the procurement requirements
 1241 or regional plan number limits of this section. PACE plans may
 1242 continue to provide services to individuals at such levels and
 1243 enrollment caps as authorized by the General Appropriations Act.

1244 Section 23. Section 409.982, Florida Statutes, is created
 1245 to read:

1246 409.982 Managed care plan accountability.—In addition to
 1247 the requirements of s. 409.967, plans and providers
 1248 participating in the long-term care managed care program shall
 1249 comply with the requirements of this section.

1250 (1) MEDICAL LOSS RATIO.—The agency shall establish and
 1251 plans shall use a uniform method of accounting and reporting

1252 long-term care service costs, direct care management costs, and
 1253 administrative costs. The agency shall evaluate plan spending
 1254 patterns beginning after the plan completes 2 full years of
 1255 operation and at least annually thereafter. The agency shall
 1256 implement the following thresholds and consequences of various
 1257 spending patterns:

1258 (a) Plans that spend less than 75 percent of Medicaid
 1259 premium revenue on long-term care services, including direct
 1260 care management as determined by the agency shall be excluded
 1261 from automatic enrollments and shall be required to pay back the
 1262 amount between actual spending and 85 percent of the Medicaid
 1263 premium revenue.

1264 (b) Plans that spend less than 85 percent of Medicaid
 1265 premium revenue on long-term care services, including direct
 1266 care management as determined by the agency shall be required to
 1267 pay back the amount of the difference between actual spending
 1268 and 85 percent of Medicaid premium revenue.

1269 (c) Plans that spend more than 92 percent of Medicaid
 1270 premium revenue on long-term care services, including direct
 1271 care management as determined by the agency, shall be evaluated
 1272 by the agency to determine whether higher expenditures are the
 1273 result of failures in care management.

1274 (d) Plans that spend 95 percent or more of Medicaid
 1275 premium revenue on long-term care services, including direct
 1276 care management as determined by the agency, and are determined
 1277 to be failing to appropriately manage care shall be excluded
 1278 from automatic enrollments.

1279 (2) PROVIDER NETWORKS.—Plans may limit the providers in

1280 their networks based on credentials, quality indicators, and
 1281 price. However, in the first contract period after a qualified
 1282 plan is selected in a region by the agency, the plan must offer
 1283 a network contract to the following providers in the region:

1284 (a) Nursing homes.

1285 (b) Hospices.

1286 (c) Aging network service providers that have previously
 1287 participated in home and community-based waivers serving elders
 1288 or community-service programs administered by the Department of
 1289 Elderly Affairs.

1290

1291 After 12 months of active participation in a plan's network, the
 1292 plan may exclude any of the providers named in this subsection
 1293 from the network for failure to meet quality or performance
 1294 criteria. If the plan excludes a provider from the plan, the
 1295 plan must provide written notice to all recipients who have
 1296 chosen that provider for care. The notice shall be provided at
 1297 least 30 days prior to the effective date of the exclusion.

1298 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1299 this subsection, providers may limit the plans they join.

1300 Nursing homes and hospices must participate in all qualified
 1301 plans selected by the agency in the region in which the provider
 1302 is located.

1303 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
 1304 quality and performance of each participating provider. At the
 1305 beginning of the contract period, each plan shall notify all its
 1306 network providers of the metrics used by the plan for evaluating

1307 the provider's performance and determining continued
 1308 participation in the network.

1309 (5) PROVIDER NETWORK STANDARDS.—The agency shall establish
 1310 and each plan must comply with specific standards for the
 1311 number, type, and regional distribution of providers in the
 1312 plan's network, which must include:

- 1313 (a) Adult day centers.
- 1314 (b) Adult family care homes.
- 1315 (c) Assisted living facilities.
- 1316 (d) Health care services pools.
- 1317 (e) Home health agencies.
- 1318 (f) Homemaker and companion services.
- 1319 (g) Hospices.
- 1320 (h) Community Care for the Elderly Lead Agencies.
- 1321 (i) Nurse registries.
- 1322 (j) Nursing homes.

1323 (6) PROVIDER PAYMENT.—Plans and providers shall negotiate
 1324 mutually acceptable rates, methods, and terms of payment. Plans
 1325 shall pay nursing homes an amount equal to the nursing facility-
 1326 specific payment rates set by the agency. Plans shall pay
 1327 hospice providers an amount equal to the per diem rate set by
 1328 the agency. For recipients residing in a nursing facility and
 1329 receiving hospice services, the plan shall pay the hospice
 1330 provider the per diem rate set by the agency minus the nursing
 1331 facility component and shall pay the nursing facility the
 1332 appropriate state rate.

1333 Section 24. Section 409.983, Florida Statutes, is created
 1334 to read:

1335 409.983 Managed care plan payment.—In addition to the
 1336 payment provisions of s. 409.968, the agency shall provide
 1337 payment to plans in the long-term care managed care program
 1338 pursuant to this section.

1339 (1) Prepaid payment rates for long-term care managed care
 1340 plans shall be negotiated between the agency and the qualified
 1341 plans as part of the procurement described in s. 409.966.

1342 (2) Payment rates for comprehensive long-term care plans
 1343 covering services described in s. 409.973 shall be combined with
 1344 rates for long-term care plans for services specified in s.
 1345 409.980.

1346 (3) Payment rates for plans shall reflect historic
 1347 utilization and spending for covered services projected forward
 1348 and adjusted to reflect the level of care profile for enrollees
 1349 of each plan. The payment shall be adjusted to provide an
 1350 incentive for reducing institutional placements and increasing
 1351 the utilization of home and community-based services.

1352 (4) The initial assessment of an enrollee's level of care
 1353 shall be made by the Comprehensive Assessment and Review for
 1354 Long-Term-Care Services (CARES) program, which shall assign the
 1355 recipient into one of the following levels of care:

1356 (a) Level of care 1 consists of recipients residing in
 1357 nursing homes or needing immediate placement in a nursing home.

1358 (b) Level of care 2 consists of recipients who require the
 1359 constant availability of routine medical and nursing treatment
 1360 and care, and require extensive health-related care and services
 1361 because of mental or physical incapacitation.

1362 (c) Level of care 3 consists of recipients who require the

1363 constant availability of routine medical and nursing treatment
 1364 and care, have a limited need for health-related care and
 1365 services, are mildly medically or physically incapacitated, and
 1366 have a priority score of 5 or above.

1367
 1368 The agency shall periodically adjust payment rates to account
 1369 for changes in the level of care profile for each plan based on
 1370 encounter data.

1371 (5) The incentive adjustment for reducing institutional
 1372 placements shall be modified in each successive rate period
 1373 during the contract in order to encourage a progressive
 1374 rebalancing of the spending distribution for institutional and
 1375 community services. The expected change toward more home and
 1376 community-based services shall be at least a 3 percent, up to a
 1377 5 percent, annual increase in the ratio of home and community-
 1378 based service expenditures compared to nursing facility
 1379 expenditures.

1380 (6) The agency shall establish nursing facility-specific
 1381 payment rates for each licensed nursing home based on facility
 1382 costs adjusted for inflation and other factors. Payments to
 1383 long-term care managed care plans shall be reconciled to
 1384 reimburse actual payments to nursing facilities.

1385 (7) The agency shall establish hospice payment rates.
 1386 Payments to long-term care managed care plans shall be
 1387 reconciled to reimburse actual payments to hospices.

1388 Section 25. Section 409.984, Florida Statutes, is created
 1389 to read:

1390 409.984 Choice counseling; enrollment.-

1391 (1) CHOICE COUNSELING.—Before contracting with a vendor to
 1392 provide choice counseling as authorized under s. 409.969, the
 1393 agency shall offer to contract with aging resource centers
 1394 established under s. 430.2053 for choice counseling services. If
 1395 the aging resource center is determined not to be the vendor
 1396 that provides choice counseling, the agency shall establish a
 1397 memorandum of understanding with the aging resource center to
 1398 coordinate staffing and collaborate with the choice counseling
 1399 vendor.

1400 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
 1401 enroll into a long-term care managed care plan those Medicaid
 1402 recipients who do not voluntarily choose a plan pursuant to s.
 1403 409.969. The agency shall automatically enroll recipients in
 1404 plans that meet or exceed the performance or quality standards
 1405 established pursuant to s. 409.967, and shall not automatically
 1406 enroll recipients in a plan that is deficient in those
 1407 performance or quality standards. The agency shall assign
 1408 individuals who are deemed dually eligible for Medicaid and
 1409 Medicare to a plan that provides both Medicaid and Medicare
 1410 services. The agency may not engage in practices that are
 1411 designed to favor one managed care plan over another. When
 1412 automatically enrolling recipients in plans, the agency shall
 1413 take into account the following criteria:

1414 (a) Whether the plan has sufficient network capacity to
 1415 meet the needs of the recipients.

1416 (b) Whether the recipient has previously received services
 1417 from one of the plan's home and community-based service
 1418 providers.

1419 (c) Whether the home and community-based providers in one
 1420 plan are more geographically accessible to the recipient's
 1421 residence than those in other plans.

1422 (3) Notwithstanding the provisions of s. 409.969(3)(c),
 1423 when a recipient is referred for hospice services, the recipient
 1424 shall have a 30-day period during which the recipient may select
 1425 to enroll in another plan to access the hospice provider of the
 1426 recipient's choice.

1427 Section 26. Section 409.985, Florida Statutes, is created
 1428 to read:

1429 409.985 Comprehensive Assessment and Review for Long-Term
 1430 Care Services (CARES) Program.-

1431 (1) The agency shall operate the Comprehensive Assessment
 1432 and Review for Long-Term Care Services (CARES) preadmission
 1433 screening program to ensure that only individuals whose
 1434 conditions require long-term care services are enrolled in the
 1435 long-term care managed care program.

1436 (2) The agency shall operate the CARES program through an
 1437 interagency agreement with the Department of Elderly Affairs.
 1438 The agency, in consultation with the Department of Elderly
 1439 Affairs, may contract for any function or activity of the CARES
 1440 program, including any function or activity required by 42
 1441 C.F.R. part 483.20, relating to preadmission screening and
 1442 review.

1443 (3) The CARES program shall determine if an individual
 1444 requires nursing facility care and, if the individual requires
 1445 such care, assign the individual to a level of care as described
 1446 in s. 409.983(4). For the purposes of the long-term care managed

1447 care program, "nursing facility care" means the individual:

1448 (a) Requires the constant availability of routine medical
 1449 and nursing treatment and care, and requires extensive health-
 1450 related care and services because of mental or physical
 1451 incapacitation; or

1452 (b) Requires the constant availability of routine medical
 1453 and nursing treatment and care, has a limited need for health-
 1454 related care and services, is mildly medically or physically
 1455 incapacitated, and has a priority score of 5 or above.

1456 (4) For individuals whose nursing home stay is initially
 1457 funded by Medicare and Medicare coverage is being terminated for
 1458 lack of progress towards rehabilitation, CARES staff shall
 1459 consult with the person making the determination of progress
 1460 toward rehabilitation to ensure that the recipient is not being
 1461 inappropriately disqualified from Medicare coverage. If, in
 1462 their professional judgment, CARES staff believes that a
 1463 Medicare beneficiary is still making progress toward
 1464 rehabilitation, they may assist the Medicare beneficiary with an
 1465 appeal of the disqualification from Medicare coverage. The use
 1466 of CARES teams to review Medicare denials for coverage under
 1467 this section is authorized only if it is determined that such
 1468 reviews qualify for federal matching funds through Medicaid. The
 1469 agency shall seek or amend federal waivers as necessary to
 1470 implement this section.

1471 Section 27. Section 409.986, Florida Statutes, is created
 1472 to read:

1473 409.986 Managed long-term care for persons with
 1474 developmental disabilities.—

1475 (1) Pursuant to s. 409.963, the agency is responsible for
 1476 administering the long-term care managed care program for
 1477 persons with developmental disabilities described in ss.
 1478 409.986-409.992, but may delegate specific duties and
 1479 responsibilities for the program to the Agency for Persons with
 1480 Disabilities and other state agencies. By January 1, 2014, the
 1481 agency shall begin implementation of statewide long-term care
 1482 managed care for persons with developmental disabilities, with
 1483 full implementation in all regions by October 1, 2015.

1484 (2) The agency shall make payments for long-term care for
 1485 persons with developmental disabilities, including home and
 1486 community-based services, using a managed care model. Unless
 1487 otherwise specified, the provisions of ss. 409.961-409.970 apply
 1488 to the long-term care managed care program for persons with
 1489 developmental disabilities.

1490 (3) The Agency for Persons with Disabilities shall assist
 1491 the agency to develop the specifications for use in the
 1492 invitations to negotiate and the model contract; determine
 1493 clinical eligibility for enrollment in long-term care plans for
 1494 persons with developmental disabilities; assist the agency to
 1495 monitor plan performance and measure quality; assist clients and
 1496 families to address complaints with the plans; facilitate
 1497 working relationships between plans and providers serving
 1498 persons with developmental disabilities; and perform other
 1499 functions specified in a memorandum of agreement.

1500 Section 28. Section 409.987, Florida Statutes, is created
 1501 to read:

1502 409.987 Eligibility.-

1503 (1) Medicaid recipients who meet all of the following
 1504 criteria are eligible to be enrolled in a developmental
 1505 disabilities comprehensive long-term care plan or developmental
 1506 disabilities long-term care plan:

1507 (a) Medicaid eligible pursuant to income and asset tests
 1508 in state and federal law.

1509 (b) A Florida resident who has a developmental disability
 1510 as defined in s. 393.063.

1511 (c) Meets the level of care need including:

1512 1. The recipient's intelligence quotient is 59 or less;

1513 2. The recipient's intelligence quotient is 60-69,

1514 inclusive, and the recipient has a secondary handicapping

1515 condition that includes cerebral palsy, spina bifida, Prader-

1516 Willi syndrome, epilepsy, or autism; or ambulation, sensory,

1517 chronic health, and behavioral problems;

1518 3. The recipient's intelligence quotient is 60-69,

1519 inclusive, and the recipient has severe functional limitations

1520 in at least three major life activities including self-care,

1521 learning, mobility, self-direction, understanding and use of

1522 language, and capacity for independent living; or

1523 4. The recipient is eligible under a primary disability of
 1524 autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.

1525 In addition, the condition must result in substantial functional

1526 limitations in three or more major life activities, including

1527 self-care, learning, mobility, self-direction, understanding and

1528 use of language, and capacity for independent living.

1529 (d) Meets the level of care need for services in an

1530 intermediate care facility for the developmentally disabled.

1531 (e) Is enrolled or has been offered enrollment in one of
 1532 the four tier waivers established in s. 393.0661(3) or the
 1533 recipient is a Medicaid-funded resident of a private
 1534 intermediate care facility for the developmentally disabled on
 1535 the date the managed long-term care plans for persons with
 1536 disabilities become available in the recipient's region or the
 1537 recipient has been offered enrollment in a developmental
 1538 disabilities comprehensive long-term care plan or developmental
 1539 disabilities long-term care plan.

1540 (2) Unless specifically exempted, all eligible persons
 1541 must be enrolled in a developmental disabilities comprehensive
 1542 long-term care plan or a developmental disabilities long-term
 1543 care plan. Medicaid recipients who are residents of a
 1544 developmental disability center, including Sunland Center in
 1545 Marianna and Tacachale Center in Gainesville, are exempt from
 1546 mandatory enrollment but may voluntarily enroll in a long-term
 1547 care plan.

1548 Section 29. Section 409.988, Florida Statutes, is created
 1549 to read:

1550 409.988 Benefits.-Managed care plans shall cover, at a
 1551 minimum, the services in this section. Plans may customize
 1552 benefit packages or offer additional benefits to meet the needs
 1553 of enrollees in the plan.

1554 (1) Intermediate care for the developmentally disabled.

1555 (2) Alternative residential services, including, but not
 1556 limited to:

1557 (a) Group homes and foster care homes licensed pursuant to
 1558 chapters 393 and 409.

1559 (b) Comprehensive transitional education programs licensed
 1560 pursuant to chapter 393.

1561 (c) Residential habilitation centers licensed pursuant to
 1562 chapter 393.

1563 (d) Assisted living facilities, and transitional living
 1564 facilities licensed pursuant to chapters 400 and 429.

1565 (3) Adult day training.

1566 (4) Behavior analysis services.

1567 (5) Companion services.

1568 (6) Consumable medical supplies.

1569 (7) Durable medical equipment and supplies.

1570 (8) Environmental accessibility adaptations.

1571 (9) In-home support services.

1572 (10) Therapies, including occupational, speech,
 1573 respiratory, and physical therapy.

1574 (11) Personal care assistance.

1575 (12) Residential habilitation services.

1576 (13) Intensive behavioral residential habilitation
 1577 services.

1578 (14) Behavior focus residential habilitation services.

1579 (15) Residential nursing services.

1580 (16) Respite care.

1581 (17) Case management.

1582 (18) Supported employment.

1583 (19) Supported living coaching.

1584 (20) Transportation.

1585 Section 30. Section 409.989, Florida Statutes, is created
 1586 to read:

1587 409.989 Qualified plans.—
 1588 (1) QUALIFIED PLANS.—Qualified plans that are a provider
 1589 service network or the Children's Medical Services Network
 1590 authorized under chapter 391 may be either developmental
 1591 disabilities long-term care plans that cover benefits pursuant
 1592 to s. 409.988, or developmental disabilities comprehensive long-
 1593 term care plans that cover benefits pursuant to ss. 409.973 and
 1594 409.988. Other qualified plans may only be developmental
 1595 disabilities comprehensive long-term care plans that cover
 1596 benefits pursuant to ss. 409.973 and 409.988.
 1597 (2) SPECIALTY PROVIDER SERVICE NETWORKS.—Provider service
 1598 networks targeted to serve persons with disabilities must
 1599 include one or more owners licensed pursuant to s. 393.067 or s.
 1600 400.962 and with at least 10 years experience in serving this
 1601 population.
 1602 (3) QUALIFIED PLAN SELECTION.—The agency shall select
 1603 qualified plans through the procurement described in s. 409.966.
 1604 The agency shall notice invitations to negotiate no later than
 1605 January 1, 2014.
 1606 (a) The agency shall procure two plans for Region I. At
 1607 least one plan shall be a provider service network, if any
 1608 submit a responsive bid.
 1609 (b) The agency shall procure at least two and no more than
 1610 five plans for Region II. At least one plan shall be a provider
 1611 service network, if any submit a responsive bid.
 1612 (c) The agency shall procure at least three plans and no
 1613 more than six plans for Region III. At least one plan shall be a
 1614 provider service network, if any submit a responsive bid.

1615 (d) The agency shall procure at least three plans and no
 1616 more than six plans for Region IV. At least one plan shall be a
 1617 provider service network if any submit a responsive bid.

1618 (e) The agency shall procure at least three plans and no
 1619 more than six plans for Region V. At least one plan shall be a
 1620 provider service network, if any submit a responsive bid.

1621 (f) The agency shall procure at least three plans and no
 1622 more than six plans for Region VI. At least one plan shall be a
 1623 provider service network, if any submit a responsive bid.

1624 If no provider service network submits a responsive bid, the
 1625 agency shall procure no more than one less than the maximum
 1626 number of qualified plans permitted in that region. Within 12
 1627 months after the initial invitation to negotiate, the agency
 1628 shall attempt to procure a qualified plan that is a provider
 1629 service network. The agency shall notice another invitation to
 1630 negotiate only with provider service networks in such region
 1631 where no provider service network has been selected.

1632 (4) QUALITY SELECTION CRITERIA.—In addition to the
 1633 criteria established in s. 409.966, the agency shall consider
 1634 the following factors in the selection of qualified plans:

1635 (a) Specialized staffing. Plan employment of executive
 1636 managers with expertise and experience in serving persons with
 1637 developmental disabilities.

1638 (b) Network qualifications. Plan establishment of a
 1639 network of service providers dispersed throughout the region and
 1640 in sufficient numbers to meet specific accessibility standards
 1641 established by the agency for specialty services for persons
 1642 with developmental disabilities.

1643 (c) Whether the plan has proposed to be a developmental
 1644 disabilities comprehensive long-term care plan and has a
 1645 contract to provide managed medical assistance services in the
 1646 same region. The agency shall exercise a preference for such
 1647 plans.

1648 (d) Whether the plan offers consumer-directed care
 1649 services to enrollees pursuant to s. 409.221. Consumer-directed
 1650 care services provide a flexible budget which is managed by
 1651 enrolled individuals and their families or representatives and
 1652 allows them to choose providers of services, determine provider
 1653 rates of payment and direct the delivery of services to best
 1654 meet their special long-term care needs. When all other factors
 1655 are equal among competing qualified plans, the agency shall
 1656 exercise a preference for such plans.

1657 (e) Evidence that a qualified plan has written agreements
 1658 or signed contracts or has made substantial progress in
 1659 establishing relationships with providers prior to the plan
 1660 submitting a response. The agency shall evaluate and give
 1661 special weight to evidence of signed contracts with providers of
 1662 critical services pursuant to s. 409.990(2)a)-(b).

1663 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's
 1664 Medical Services Network authorized under chapter 391 is a
 1665 qualified plan for purposes of the developmental disabilities
 1666 long-term care plans and developmental disabilities
 1667 comprehensive long-term care plans. Participation by the
 1668 Children's Medical Services Network shall be pursuant to a
 1669 single, statewide contract with the agency not subject to the
 1670 procurement requirements or regional plan number limits of this

1671 section. The Children's Medical Services Network must meet all
 1672 other plan requirements.

1673 Section 31. Section 409.990, Florida Statutes, is created
 1674 to read:

1675 409.990 Managed care plan accountability.—In addition to
 1676 the requirements of s. 409.967, qualified plans and providers
 1677 shall comply with the requirements of this section.

1678 (1) MEDICAL LOSS RATIO.—The agency shall establish and
 1679 plans shall use a uniform method of accounting and reporting
 1680 long-term care service costs, direct care management costs, and
 1681 administrative costs. The agency shall evaluate plan spending
 1682 patterns beginning after the plan completes 2 full years of
 1683 operation and at least annually thereafter. The agency shall
 1684 implement the following thresholds and consequences of various
 1685 spending patterns:

1686 (a) Plans that spend less than 75 percent of Medicaid
 1687 premium revenue on long-term care services, including direct
 1688 care management as determined by the agency shall be excluded
 1689 from automatic enrollments and shall be required to pay back the
 1690 amount between actual spending and 92 percent of the Medicaid
 1691 premium revenue.

1692 (b) Plans that spend less than 92 percent of Medicaid
 1693 premium revenue on long-term care services, including direct
 1694 care management as determined by the agency shall be required to
 1695 pay back the amount between actual spending and 92 percent of
 1696 the Medicaid premium revenue.

1697 (2) PROVIDER NETWORKS.—Plans may limit the providers in
 1698 their networks based on credentials, quality indicators, and

1699 price. However, in the first contract period after a qualified
 1700 plan is selected in a region by the agency, the plan must offer
 1701 a network contract to the following providers in the region:

1702 (a) Providers with licensed institutional care facilities
 1703 for the developmentally disabled.

1704 (b) Providers of alternative residential facilities
 1705 specified in s.409.988.

1706
 1707 After 12 months of active participation in a plan's network, the
 1708 plan may exclude any of the above-named providers from the
 1709 network for failure to meet quality or performance criteria. If
 1710 the plan excludes a provider from the plan, the plan must
 1711 provide written notice to all recipients who have chosen that
 1712 provider for care. The notice shall be issued at least 90 days
 1713 before the effective date of the exclusion.

1714 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1715 this subsection, providers may limit the plans they join.

1716 Licensed institutional care facilities for the developmentally
 1717 disabled with an active Medicaid provider agreement must agree
 1718 to participate in any qualified plan selected by the agency in
 1719 the region in which the provider is located.

1720 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
 1721 quality and performance of each participating provider. At the
 1722 beginning of the contract period, each plan shall notify all its
 1723 network providers of the metrics used by the plan for evaluating
 1724 the provider's performance and determining continued
 1725 participation in the network.

1726 (5) PROVIDER PAYMENT.—Plans and providers shall negotiate
 1727 mutually acceptable rates, methods, and terms of payment. Plans
 1728 shall pay intermediate care facilities for the developmentally
 1729 disabled an amount equal to the facility-specific payment rate
 1730 set by the agency.

1731 (6) CONSUMER AND FAMILY INVOLVEMENT.—Plans must establish
 1732 a family advisory committee to participate in program design and
 1733 oversight.

1734 Section 32. Section 409.991, Florida Statutes, is created
 1735 to read:

1736 409.991 Managed care plan payment.—In addition to the
 1737 payment provisions of s. 409.968, the agency shall provide
 1738 payment to developmental disabilities comprehensive long-term
 1739 care plans and developmental disabilities long-term care plans
 1740 pursuant to this section.

1741 (1) Prepaid payment rates shall be negotiated between the
 1742 agency and the qualified plans as part of the procurement
 1743 described in s. 409.966.

1744 (2) Payment for developmental disabilities comprehensive
 1745 long-term care plans covering services pursuant to s. 409.973
 1746 shall be combined with payments for developmental disabilities
 1747 long-term care plans for services specified in s. 409.988.

1748 (3) Payment rates for plans covering service specified in
 1749 s. 409.988 shall be based on historical utilization and spending
 1750 for covered services projected forward and adjusted to reflect
 1751 the level of care profile of each plan's enrollees.

1752 (4) The Agency for Persons with Disabilities shall conduct
 1753 the initial assessment of an enrollee's level of care. The

1754 evaluation of level of care shall be based on assessment and
 1755 service utilization information from the most recent version of
 1756 the Questionnaire for Situational Information and encounter
 1757 data.

1758 (5) Payment rates for developmental disabilities long-term
 1759 care plans shall be classified into five levels of care to
 1760 account for variations in risk status and service needs among
 1761 enrollees.

1762 (a) Level of care 1 consists of individuals receiving
 1763 services in an intermediate care facility for the
 1764 developmentally disabled.

1765 (b) Level of care 2 consists of individuals with intensive
 1766 medical or adaptive needs and that are essential for avoiding
 1767 institutionalization, or who possess behavioral problems that
 1768 are exceptional in intensity, duration, or frequency and present
 1769 a substantial risk of harm to themselves or others.

1770 (c) Level of care 3 consists of individuals with service
 1771 needs, including a licensed residential facility and a moderate
 1772 level of support for standard residential habilitation services
 1773 or a minimal level of support for behavior focus residential
 1774 habilitation services, or individuals in supported living who
 1775 require more than 6 hours a day of in-home support services.

1776 (d) Level of care 4 consists of individuals requiring less
 1777 than moderate level of residential habilitation support in a
 1778 residential placement, or individuals in independent or
 1779 supported living situations, or who live in their family home.

1780 (e) Level of care 5 consists of individuals requiring
 1781 minimal support services while living in independent or

1782 supported living situations and individuals who live in their
 1783 family home.

1784
 1785 The agency shall periodically adjust payment rates to account
 1786 for changes in the level of care profile of each plan's
 1787 enrollees based on encounter data.

1788 (6) The agency shall establish intensive behavior
 1789 residential habilitation rates for providers approved by the
 1790 agency to provide this service. The agency shall also establish
 1791 intermediate care facility for the developmentally disabled-
 1792 specific payment rates for each licensed intermediate care
 1793 facility based on facility costs adjusted for inflation and
 1794 other factors. Payments to intermediate care facilities for the
 1795 developmentally disabled and providers of intensive behavior
 1796 residential habilitation service shall be reconciled to
 1797 reimburse the plan's actual payments to the facilities.

1798 Section 33. Section 409.992, Florida Statutes, is created
 1799 to read:

1800 409.992 Automatic enrollment.-

1801 (1) The agency shall automatically enroll into a
 1802 developmental disabilities comprehensive long-term care plan or
 1803 a developmental disabilities long-term care plan those Medicaid
 1804 recipients who do not voluntarily choose a plan pursuant to s.
 1805 409.969. The agency shall automatically enroll recipients in
 1806 plans that meet or exceed the performance or quality standards
 1807 established pursuant to s. 409.967, and shall not automatically
 1808 enroll recipients in a plan that is deficient in those
 1809 performance or quality standards. The agency shall assign

1810 individuals who are deemed dually eligible for Medicaid and
 1811 Medicare, to a plan that provides both Medicaid and Medicare
 1812 services. The agency may not engage in practices that are
 1813 designed to favor one managed care plan over another. When
 1814 automatically enrolling recipients in plans, the agency shall
 1815 take into account the following criteria:

1816 (a) Whether the plan has sufficient network capacity to
 1817 meet the needs of the recipients.

1818 (b) Whether the recipient has previously received services
 1819 from one of the plan's home and community-based service
 1820 providers.

1821 (c) Whether home and community-based providers in one plan
 1822 are more geographically accessible to the recipient's residence
 1823 than those in other plans.

1824 Section 34. This act shall take effect July 1, 2010.

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 393.0661, F.S.,
3 relating to the home and community-based services delivery
4 system for persons with developmental disabilities;
5 providing for an establishment of an iBudget demonstration
6 project by the Agency for Persons with Disabilities, in
7 consultation with the Agency for Health Care
8 Administration, in specified counties; providing for
9 allocation of funds; providing goals; providing for an
10 allocation algorithm and methodology for development of a
11 client's iBudget; providing for the seeking of federal
12 approval and waivers; providing for a transition to full
13 implementation; providing for inapplicability of certain
14 service limitations; providing for setting rates;
15 providing for client training and education; providing for
16 evaluation; requiring a report; requiring rulemaking;
17 requiring the Agency for Persons with Disabilities to
18 establish a transition plan for current Medicaid
19 recipients under certain circumstances; providing for
20 expiration of the section on a specified date; creating s.
21 400.0713, F.S.; requiring the Agency for Health Care
22 Administration to establish a nursing home licensure
23 workgroup; amending s. 408.040, F.S.; providing for
24 suspension of conditions precedent to the issuance of a
25 certificate of need for a nursing home, effective on a
26 specified date; amending s. 408.0435, F.S.; extending the
27 certificate-of-need moratorium for additional community
28 nursing home beds; designating ss. 409.016-409.803, F.S.,

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

57 Administration with respect to the development of a method
 58 for designating qualified plans as a medical home network;
 59 providing purposes and principles for creating medical
 60 home networks; providing criteria for designation of a
 61 qualified plan as a medical home network; providing agency
 62 duties with respect thereto; amending s. 409.91211, F.S.;

63 providing authority of the Agency for Health Care
 64 Administration to implement a managed care pilot program
 65 based on specified waiver authority with respect to the
 66 Medicaid reform program; continuing the existing pilot
 67 program in specified counties; requiring the agency to
 68 seek an extension of the waiver; providing for monthly
 69 reports; requiring approval of the Legislative Budget
 70 Commission for changes to specified terms and conditions ;
 71 providing for expansion of the managed care pilot program
 72 to Miami-Dade County; specifying managed care plans that
 73 are qualified to participate in the Medicaid managed care
 74 pilot program; providing requirements for qualified
 75 managed care plans; requiring the agency to develop and
 76 seek federal approval to implement methodologies to
 77 preserve intergovernmental transfers of funds and
 78 certified public expenditures from Miami-Dade County;
 79 requiring the agency to submit a plan and specified
 80 amendment to the Legislative Budget Commission; providing
 81 for a report; requiring Medicaid recipients in counties in
 82 which the managed care pilot program has been implemented
 83 to be enrolled in a qualified plan; providing a time limit
 84 for enrollment; requiring the agency to provide choice

85 | counseling; providing requirements with respect to choice
 86 | counseling information provided to Medicaid recipients;
 87 | providing for automatic enrollment of certain Medicaid
 88 | recipients; establishing criteria for automatic
 89 | enrollment; providing procedures and requirements with
 90 | respect to voluntary disenrollment of a recipient in a
 91 | qualified plan; providing for an enrollment period;
 92 | requiring qualified plans to establish a process for
 93 | review of and response to grievances of enrollees;
 94 | requiring qualified plans to submit quarterly reports;
 95 | specifying services to be covered by qualified plans;
 96 | authorizing qualified plans to offer specified
 97 | customizations, variances, and coverage for additional
 98 | services; requiring agency evaluation of proposed benefit
 99 | packages; requiring qualified plans to reimburse the
 100 | agency for the cost of specified enrollment changes;
 101 | providing for access to encounter data; requiring
 102 | participating plans to establish an incentive program to
 103 | reward healthy behaviors; requiring the agency to continue
 104 | budget-neutral adjustment of capitation rates for all
 105 | prepaid plans in existing managed care pilot program
 106 | counties; providing for transition to payment
 107 | methodologies for Miami-Dade County plans; providing a
 108 | phased schedule for risk-adjusted capitation rates;
 109 | providing for immediate risk adjustment of rates for plans
 110 | owned and operated by a public hospital in the county;
 111 | providing a method to ensure budget neutrality until all
 112 | rates in the county are risk-adjusted; requiring the

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

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

169 plans become available; providing for expiration thereof;
 170 amending s. 430.2053, F.S.; eliminating outdated
 171 provisions; providing additional duties of aging resource
 172 centers; providing an additional exception to direct
 173 services that may not be provided by an aging resource
 174 center; providing for the cessation of specified payments
 175 by the department as qualified plans become available;
 176 providing for a memorandum of understanding between the
 177 Agency for Health Care Administration and aging resource
 178 centers under certain circumstances; eliminating
 179 provisions requiring reports; amending s. 641.386, F.S.;
 180 conforming a cross-reference; repealing s. 430.701, F.S.,
 181 relating to legislative findings and intent and approval
 182 for action relating to provider enrollment levels;
 183 repealing s. 430.702, F.S., relating to the Long-Term Care
 184 Community Diversion Pilot Project Act; repealing s.
 185 430.703, F.S., relating to definitions; repealing s.
 186 430.7031, F.S., relating to nursing home transition
 187 program; repealing s. 430.704, F.S., relating to
 188 evaluation of long-term care through the pilot projects;
 189 repealing s. 430.705, F.S., relating to implementation of
 190 long-term care community diversion pilot projects;
 191 repealing s. 430.706, F.S., relating to quality of care;
 192 repealing s. 430.707, F.S., relating to contracts;
 193 repealing s. 430.708, F.S., relating to certificate of
 194 need; repealing s. 430.709, F.S., relating to reports and
 195 evaluations; renumbering ss. 409.9301, 409.942, 409.944,
 196 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.

197 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
 198 402.87, F.S., respectively; amending s. 443.111, F.S.;
 199 conforming a cross-reference; providing contingent
 200 effective dates.

201
 202 Be It Enacted by the Legislature of the State of Florida:

203
 204 Section 1. Section 393.0661, Florida Statutes, is amended
 205 to read:

206 393.0661 Home and community-based services delivery
 207 system; comprehensive redesign.—The Legislature finds that the
 208 home and community-based services delivery system for persons
 209 with developmental disabilities and the availability of
 210 appropriated funds are two of the critical elements in making
 211 services available. Therefore, it is the intent of the
 212 Legislature that the Agency for Persons with Disabilities shall
 213 develop and implement a comprehensive redesign of the system.

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

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

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

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

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

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

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

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

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

266 (d) Tier four is the family and supported living waiver
 267 and includes, but is not limited to, clients in independent or
 268 supported living situations and clients who live in their family
 269 home. Total annual expenditures under tier four may not exceed
 270 \$14,792 per client each year.

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

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

281 federal waiver programs administered by the agency as follows:

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

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

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

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

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

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

308 7. The agency shall conduct supplemental cost plan reviews

309 to verify the medical necessity of authorized services for plans
 310 that have increased by more than 8 percent during either of the
 311 2 preceding fiscal years.

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

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

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

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

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

336 (5) The geographic differential for Monroe County for

337 residential habilitation services shall be 20 percent.

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

365 condition or circumstance which results in a change of more than
 366 5 percent to his or her cost plan between July 1 and the date
 367 that a rebased cost plan would take effect pursuant to this
 368 subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

465
 466 However, the presence of an extraordinary need alone does not
 467 warrant an increase in the amount of funds allocated to a
 468 client's iBudget as determined by the algorithm.

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

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

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

500

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

582 (11) This section expires October 1, 2015.

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

585 400.0713 Nursing home licensure workgroup.—The agency
 586 shall establish a workgroup to develop a plan for licensure

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

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

591 408.040 Conditions and monitoring.-

592 (1)

593 (b) The agency may consider, in addition to the other
 594 criteria specified in s. 408.035, a statement of intent by the
 595 applicant that a specified percentage of the annual patient days
 596 at the facility will be utilized by patients eligible for care
 597 under Title XIX of the Social Security Act. Any certificate of
 598 need issued to a nursing home in reliance upon an applicant's
 599 statements that a specified percentage of annual patient days
 600 will be utilized by residents eligible for care under Title XIX
 601 of the Social Security Act must include a statement that such
 602 certification is a condition of issuance of the certificate of
 603 need. The certificate-of-need program shall notify the Medicaid
 604 program office and the Department of Elderly Affairs when it
 605 imposes conditions as authorized in this paragraph in an area in
 606 which a community diversion pilot project is implemented.

607 Effective July 1, 2011, the agency shall not consider, or impose
 608 conditions related to, patient day utilization by patients
 609 eligible for care under Title XIX the Social Security Act in
 610 making certificate-of-need determinations for nursing homes.

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

615 ~~recipients who are 60 years of age or older or dually eligible~~
 616 ~~for Medicare and Medicaid has been implemented under s.~~
 617 ~~409.912(5),~~ the nursing home may request a reduction in the
 618 percentage of annual patient days used by residents who are
 619 eligible for care under Title XIX of the Social Security Act,
 620 which is a condition of the nursing home's certificate of need.
 621 The agency shall automatically grant the nursing home's request
 622 if the reduction is not more than 15 percent of the nursing
 623 home's annual Medicaid-patient-days condition. A nursing home
 624 may submit only one request every 2 years for an automatic
 625 reduction. A requesting nursing home must notify the agency in
 626 writing at least 60 days in advance of its intent to reduce its
 627 annual Medicaid-patient-days condition by not more than 15
 628 percent. The agency must acknowledge the request in writing and
 629 must change its records to reflect the revised certificate-of-
 630 need condition. This paragraph expires June 30, 2011.

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

633 408.0435 Moratorium on nursing home certificates of need.—

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

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

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

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

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

651 409.907 Medicaid provider agreements.—The agency may make
 652 payments for medical assistance and related services rendered to
 653 Medicaid recipients only to an individual or entity who has a
 654 provider agreement in effect with the agency, who is performing
 655 services or supplying goods in accordance with federal, state,
 656 and local law, and who agrees that no person shall, on the
 657 grounds of handicap, race, color, or national origin, or for any
 658 other reason, be subjected to discrimination under any program
 659 or activity for which the provider receives payment from the
 660 agency.

661 (5) The agency:

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

670 (b) Is prohibited from demanding repayment from the

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

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

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

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

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

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

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

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

705
 706 This paragraph pertains solely to Medicare crossover-only
 707 providers. In order to become a standard Medicaid provider, the
 708 other requirements of this section and applicable rules must be
 709 met.

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

712 409.908 Reimbursement of Medicaid providers.—Subject to
 713 specific appropriations, the agency shall reimburse Medicaid
 714 providers, in accordance with state and federal law, according
 715 to methodologies set forth in the rules of the agency and in
 716 policy manuals and handbooks incorporated by reference therein.
 717 These methodologies may include fee schedules, reimbursement
 718 methods based on cost reporting, negotiated fees, competitive
 719 bidding pursuant to s. 287.057, and other mechanisms the agency
 720 considers efficient and effective for purchasing services or
 721 goods on behalf of recipients. If a provider is reimbursed based
 722 on cost reporting and submits a cost report late and that cost
 723 report would have been used to set a lower reimbursement rate
 724 for a rate semester, then the provider's rate for that semester
 725 shall be retroactively calculated using the new cost report, and
 726 full payment at the recalculated rate shall be effected

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

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

746 Section 10. Section 409.912, Florida Statutes, is amended
 747 to read:

748 409.912 Cost-effective purchasing of health care.—The
 749 agency shall purchase goods and services for Medicaid recipients
 750 in the most cost-effective manner consistent with the delivery
 751 of quality medical care. To ensure that medical services are
 752 effectively utilized, the agency may, in any case, require a
 753 confirmation or second physician's opinion of the correct
 754 diagnosis for purposes of authorizing future services under the

755 Medicaid program. This section does not restrict access to
 756 emergency services or poststabilization care services as defined
 757 in 42 C.F.R. part 438.114. Such confirmation or second opinion
 758 shall be rendered in a manner approved by the agency. The agency
 759 shall maximize the use of prepaid per capita and prepaid
 760 aggregate fixed-sum basis services when appropriate and other
 761 alternative service delivery and reimbursement methodologies,
 762 including competitive bidding pursuant to s. 287.057, designed
 763 to facilitate the cost-effective purchase of a case-managed
 764 continuum of care. The agency shall also require providers to
 765 minimize the exposure of recipients to the need for acute
 766 inpatient, custodial, and other institutional care and the
 767 inappropriate or unnecessary use of high-cost services. The
 768 agency shall contract with a vendor to monitor and evaluate the
 769 clinical practice patterns of providers in order to identify
 770 trends that are outside the normal practice patterns of a
 771 provider's professional peers or the national guidelines of a
 772 provider's professional association. The vendor must be able to
 773 provide information and counseling to a provider whose practice
 774 patterns are outside the norms, in consultation with the agency,
 775 to improve patient care and reduce inappropriate utilization.
 776 The agency may mandate prior authorization, drug therapy
 777 management, or disease management participation for certain
 778 populations of Medicaid beneficiaries, certain drug classes, or
 779 particular drugs to prevent fraud, abuse, overuse, and possible
 780 dangerous drug interactions. The Pharmaceutical and Therapeutics
 781 Committee shall make recommendations to the agency on drugs for
 782 which prior authorization is required. The agency shall inform

783 the Pharmaceutical and Therapeutics Committee of its decisions
 784 regarding drugs subject to prior authorization. The agency is
 785 authorized to limit the entities it contracts with or enrolls as
 786 Medicaid providers by developing a provider network through
 787 provider credentialing. The agency may competitively bid single-
 788 source-provider contracts if procurement of goods or services
 789 results in demonstrated cost savings to the state without
 790 limiting access to care. The agency may limit its network based
 791 on the assessment of beneficiary access to care, provider
 792 availability, provider quality standards, time and distance
 793 standards for access to care, the cultural competence of the
 794 provider network, demographic characteristics of Medicaid
 795 beneficiaries, practice and provider-to-beneficiary standards,
 796 appointment wait times, beneficiary use of services, provider
 797 turnover, provider profiling, provider licensure history,
 798 previous program integrity investigations and findings, peer
 799 review, provider Medicaid policy and billing compliance records,
 800 clinical and medical record audits, and other factors. Providers
 801 shall not be entitled to enrollment in the Medicaid provider
 802 network. The agency shall determine instances in which allowing
 803 Medicaid beneficiaries to purchase durable medical equipment and
 804 other goods is less expensive to the Medicaid program than long-
 805 term rental of the equipment or goods. The agency may establish
 806 rules to facilitate purchases in lieu of long-term rentals in
 807 order to protect against fraud and abuse in the Medicaid program
 808 as defined in s. 409.913. The agency may seek federal waivers
 809 necessary to administer these policies.

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

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

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

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

825 (4) The agency may contract with:

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

839 This paragraph expires October 1, 2013.

840 (b) An entity that is providing comprehensive behavioral
 841 health care services to certain Medicaid recipients through a
 842 capitated, prepaid arrangement pursuant to the federal waiver
 843 provided for by s. 409.905(5). Such entity must be licensed
 844 under chapter 624, chapter 636, or chapter 641, or authorized
 845 under paragraph (c) or paragraph (d), and must possess the
 846 clinical systems and operational competence to manage risk and
 847 provide comprehensive behavioral health care to Medicaid
 848 recipients. As used in this paragraph, the term "comprehensive
 849 behavioral health care services" means covered mental health and
 850 substance abuse treatment services that are available to
 851 Medicaid recipients. The secretary of the Department of Children
 852 and Family Services shall approve provisions of procurements
 853 related to children in the department's care or custody before
 854 enrolling such children in a prepaid behavioral health plan. Any
 855 contract awarded under this paragraph must be competitively
 856 procured. In developing the behavioral health care prepaid plan
 857 procurement document, the agency shall ensure that the
 858 procurement document requires the contractor to develop and
 859 implement a plan to ensure compliance with s. 394.4574 related
 860 to services provided to residents of licensed assisted living
 861 facilities that hold a limited mental health license. Except as
 862 provided in subparagraph 5. 8-, and except in counties where the
 863 Medicaid managed care pilot program is authorized pursuant to s.
 864 409.91211, the agency shall seek federal approval to contract
 865 with a single entity meeting these requirements to provide
 866 comprehensive behavioral health care services to all Medicaid

867 recipients not enrolled in a Medicaid managed care plan
 868 authorized under s. 409.91211, a provider service network as
 869 described in paragraph (d), or a Medicaid health maintenance
 870 organization in an AHCA area. In an AHCA area where the Medicaid
 871 managed care pilot program is authorized pursuant to s.
 872 409.91211 in one or more counties, the agency may procure a
 873 contract with a single entity to serve the remaining counties as
 874 an AHCA area or the remaining counties may be included with an
 875 adjacent AHCA area and are subject to this paragraph. Each
 876 entity must offer a sufficient choice of providers in its
 877 network to ensure recipient access to care and the opportunity
 878 to select a provider with whom they are satisfied. The network
 879 shall include all public mental health hospitals. To ensure
 880 unimpaired access to behavioral health care services by Medicaid
 881 recipients, all contracts issued pursuant to this paragraph must
 882 require 80 percent of the capitation paid to the managed care
 883 plan, including health maintenance organizations and capitated
 884 provider service networks, to be expended for the provision of
 885 behavioral health care services. If the managed care plan
 886 expends less than 80 percent of the capitation paid for the
 887 provision of behavioral health care services, the difference
 888 shall be returned to the agency. The agency shall provide the
 889 plan with a certification letter indicating the amount of
 890 capitation paid during each calendar year for behavioral health
 891 care services pursuant to this section. The agency may reimburse
 892 for substance abuse treatment services on a fee-for-service
 893 basis until the agency finds that adequate funds are available
 894 for capitated, prepaid arrangements.

895 1. ~~By January 1, 2001,~~ The agency shall modify the
 896 contracts with the entities providing comprehensive inpatient
 897 and outpatient mental health care services to Medicaid
 898 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
 899 Counties, to include substance abuse treatment services.

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

906 ~~2.3.~~ Except as provided in subparagraph ~~5. 8.,~~ by July 1,
 907 ~~2006,~~ the agency and the Department of Children and Family
 908 Services shall contract with managed care entities in each AHCA
 909 area except area 6 or arrange to provide comprehensive inpatient
 910 and outpatient mental health and substance abuse services
 911 through capitated prepaid arrangements to all Medicaid
 912 recipients who are eligible to participate in such plans under
 913 federal law and regulation. In AHCA areas where eligible
 914 individuals number less than 150,000, the agency shall contract
 915 with a single managed care plan to provide comprehensive
 916 behavioral health services to all recipients who are not
 917 enrolled in a Medicaid health maintenance organization, a
 918 provider service network as described in paragraph (d), or a
 919 Medicaid capitated managed care plan authorized under s.
 920 409.91211. The agency may contract with more than one
 921 comprehensive behavioral health provider to provide care to
 922 recipients who are not enrolled in a Medicaid capitated managed

923 | care plan authorized under s. 409.91211, a provider service
 924 | network as described in paragraph (d), or a Medicaid health
 925 | maintenance organization in AHCA areas where the eligible
 926 | population exceeds 150,000. In an AHCA area where the Medicaid
 927 | managed care pilot program is authorized pursuant to s.
 928 | 409.91211 in one or more counties, the agency may procure a
 929 | contract with a single entity to serve the remaining counties as
 930 | an AHCA area or the remaining counties may be included with an
 931 | adjacent AHCA area and shall be subject to this paragraph.
 932 | Contracts for comprehensive behavioral health providers awarded
 933 | pursuant to this section shall be competitively procured. Both
 934 | for-profit and not-for-profit corporations are eligible to
 935 | compete. Managed care plans contracting with the agency under
 936 | subsection (3) or paragraph (d), shall provide and receive
 937 | payment for the same comprehensive behavioral health benefits as
 938 | provided in AHCA rules, including handbooks incorporated by
 939 | reference. In AHCA area 11, the agency shall contract with at
 940 | least two comprehensive behavioral health care providers to
 941 | provide behavioral health care to recipients in that area who
 942 | are enrolled in, or assigned to, the MediPass program. One of
 943 | the behavioral health care contracts must be with the existing
 944 | provider service network pilot project, as described in
 945 | paragraph (d), for the purpose of demonstrating the cost-
 946 | effectiveness of the provision of quality mental health services
 947 | through a public hospital-operated managed care model. Payment
 948 | shall be at an agreed-upon capitated rate to ensure cost
 949 | savings. Of the recipients in area 11 who are assigned to
 950 | MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those

951 | MediPass-enrolled recipients shall be assigned to the existing
 952 | provider service network in area 11 for their behavioral care.

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

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

961 | ~~b. If the agency determines that the proposed capitation~~
 962 | ~~rate in any area is insufficient to provide appropriate~~
 963 | ~~services, the agency may adjust the capitation rate to ensure~~
 964 | ~~that care will be available. The agency and the department may~~
 965 | ~~use existing general revenue to address any additional required~~
 966 | ~~match but may not over-obligate existing funds on an annualized~~
 967 | ~~basis.~~

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

972 | 3.5. Children residing in a statewide inpatient
 973 | psychiatric program, or in a Department of Juvenile Justice or a
 974 | Department of Children and Family Services residential program
 975 | approved as a Medicaid behavioral health overlay services
 976 | provider may not be included in a behavioral health care prepaid
 977 | health plan or any other Medicaid managed care plan pursuant to
 978 | this paragraph.

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

990 | 4.7. Traditional community mental health providers under
 991 | contract with the Department of Children and Family Services
 992 | pursuant to part IV of chapter 394, child welfare providers
 993 | under contract with the Department of Children and Family
 994 | Services in areas 1 and 6, and inpatient mental health providers
 995 | licensed pursuant to chapter 395 must be offered an opportunity
 996 | to accept or decline a contract to participate in any provider
 997 | network for prepaid behavioral health services.

998 | 5.8. All Medicaid-eligible children, except children in
 999 | area 1 and children in Highlands County, Hardee County, Polk
 1000 | County, or Manatee County of area 6, that are open for child
 1001 | welfare services in the HomeSafeNet system, shall receive their
 1002 | behavioral health care services through a specialty prepaid plan
 1003 | operated by community-based lead agencies through a single
 1004 | agency or formal agreements among several agencies. The
 1005 | specialty prepaid plan must result in savings to the state
 1006 | comparable to savings achieved in other Medicaid managed care

1007 and prepaid programs. Such plan must provide mechanisms to
 1008 maximize state and local revenues. The specialty prepaid plan
 1009 shall be developed by the agency and the Department of Children
 1010 and Family Services. The agency may seek federal waivers to
 1011 implement this initiative. Medicaid-eligible children whose
 1012 cases are open for child welfare services in the HomeSafeNet
 1013 system and who reside in AHCA area 10 shall be enrolled in
 1014 capitated managed care plans that, in coordination with
 1015 available community-based care providers specified in s.
 1016 409.1671, provide sufficient medical, developmental, behavioral
 1017 and emotional services to meet the needs of these children. are
 1018 ~~exempt from the specialty prepaid plan upon the development of a~~
 1019 ~~service delivery mechanism for children who reside in area 10 as~~
 1020 ~~specified in s. 409.91211(3)(dd).~~

1021
 1022 This paragraph expires October 1, 2013.

1023 (c) A federally qualified health center or an entity owned
 1024 by one or more federally qualified health centers or an entity
 1025 owned by other migrant and community health centers receiving
 1026 non-Medicaid financial support from the Federal Government to
 1027 provide health care services on a prepaid or fixed-sum basis to
 1028 recipients. A federally qualified health center or an entity
 1029 that is owned by one or more federally qualified health centers
 1030 and is reimbursed by the agency on a prepaid basis is exempt
 1031 from parts I and III of chapter 641, but must comply with the
 1032 solvency requirements in s. 641.2261(2) and meet the appropriate
 1033 requirements governing financial reserve, quality assurance, and
 1034 patients' rights established by the agency. This paragraph

1035 expires October 1, 2013.

1036 (d)1. A provider service network may be reimbursed on a
 1037 fee-for-service or prepaid basis. Prepaid provider service
 1038 networks receive per-member per-month payments. Provider service
 1039 networks that do not choose to be prepaid plans shall receive
 1040 fee-for-service rates with a shared savings settlement. The fee-
 1041 for-service option shall be available to a provider service
 1042 network only for the first 5 years of the plan's operation in a
 1043 given region or until the contract year beginning October 1,
 1044 2015, whichever is later. The agency shall annually conduct cost
 1045 reconciliations to determine the amount of cost savings achieved
 1046 by fee-for-service provider service networks for the dates of
 1047 service in the period being reconciled. Only payments for
 1048 covered services for dates of service within the reconciliation
 1049 period and paid within 6 months after the last date of service
 1050 in the reconciliation period shall be included. The agency shall
 1051 perform the necessary adjustments for the inclusion of claims
 1052 incurred but not reported within the reconciliation for claims
 1053 that could be received and paid by the agency after the 6-month
 1054 claims processing time lag. The agency shall provide the results
 1055 of the reconciliations to the fee-for-service provider service
 1056 networks within 45 days after the end of the reconciliation
 1057 period. The fee-for-service provider service networks shall
 1058 review and provide written comments or a letter of concurrence
 1059 to the agency within 45 days after receipt of the reconciliation
 1060 results. This reconciliation shall be considered final.

1061 2. A provider service network which is reimbursed by the
 1062 agency on a prepaid basis shall be exempt from parts I and III

1063 of chapter 641, but must comply with the solvency requirements
 1064 in s. 641.2261(2) and meet appropriate financial reserve,
 1065 quality assurance, and patient rights requirements as
 1066 established by the agency.

1067 3. Medicaid recipients assigned to a provider service
 1068 network shall be chosen equally from those who would otherwise
 1069 have been assigned to prepaid plans and MediPass. The agency is
 1070 authorized to seek federal Medicaid waivers as necessary to
 1071 implement the provisions of this section. This subparagraph
 1072 expires October 1, 2013. ~~Any contract previously awarded to a~~
 1073 ~~provider service network operated by a hospital pursuant to this~~
 1074 ~~subsection shall remain in effect for a period of 3 years~~
 1075 ~~following the current contract expiration date, regardless of~~
 1076 ~~any contractual provisions to the contrary.~~

1077 4. A provider service network is a network established or
 1078 organized and operated by a health care provider, or group of
 1079 affiliated health care providers, including minority physician
 1080 networks and emergency room diversion programs that meet the
 1081 requirements of s. 409.91211, which provides a substantial
 1082 proportion of the health care items and services under a
 1083 contract directly through the provider or affiliated group of
 1084 providers and may make arrangements with physicians or other
 1085 health care professionals, health care institutions, or any
 1086 combination of such individuals or institutions to assume all or
 1087 part of the financial risk on a prospective basis for the
 1088 provision of basic health services by the physicians, by other
 1089 health professionals, or through the institutions. The health
 1090 care providers must have a controlling interest in the governing

1091 body of the provider service network organization.

1092 (e) An entity that provides only comprehensive behavioral
 1093 health care services to certain Medicaid recipients through an
 1094 administrative services organization agreement. Such an entity
 1095 must possess the clinical systems and operational competence to
 1096 provide comprehensive health care to Medicaid recipients. As
 1097 used in this paragraph, the term "comprehensive behavioral
 1098 health care services" means covered mental health and substance
 1099 abuse treatment services that are available to Medicaid
 1100 recipients. Any contract awarded under this paragraph must be
 1101 competitively procured. The agency must ensure that Medicaid
 1102 recipients have available the choice of at least two managed
 1103 care plans for their behavioral health care services. This
 1104 paragraph expires October 1, 2013.

1105 ~~(f) An entity that provides in-home physician services to~~
 1106 ~~test the cost-effectiveness of enhanced home-based medical care~~
 1107 ~~to Medicaid recipients with degenerative neurological diseases~~
 1108 ~~and other diseases or disabling conditions associated with high~~
 1109 ~~costs to Medicaid. The program shall be designed to serve very~~
 1110 ~~disabled persons and to reduce Medicaid reimbursed costs for~~
 1111 ~~inpatient, outpatient, and emergency department services. The~~
 1112 ~~agency shall contract with vendors on a risk-sharing basis.~~

1113 ~~(g) Children's provider networks that provide care~~
 1114 ~~coordination and care management for Medicaid-eligible pediatric~~
 1115 ~~patients, primary care, authorization of specialty care, and~~
 1116 ~~other urgent and emergency care through organized providers~~
 1117 ~~designed to service Medicaid eligibles under age 18 and~~
 1118 ~~pediatric emergency departments' diversion programs. The~~

1119 ~~networks shall provide after-hour operations, including evening~~
 1120 ~~and weekend hours, to promote, when appropriate, the use of the~~
 1121 ~~children's networks rather than hospital emergency departments.~~

1122 (f) ~~(h)~~ An entity authorized in s. 430.205 to contract with
 1123 the agency and the Department of Elderly Affairs to provide
 1124 health care and social services on a prepaid or fixed-sum basis
 1125 to elderly recipients. Such prepaid health care services
 1126 entities are exempt from the provisions of part I of chapter 641
 1127 for the first 3 years of operation. An entity recognized under
 1128 this paragraph that demonstrates to the satisfaction of the
 1129 Office of Insurance Regulation that it is backed by the full
 1130 faith and credit of one or more counties in which it operates
 1131 may be exempted from s. 641.225. This paragraph expires October
 1132 1, 2012.

1133 (g) ~~(i)~~ A Children's Medical Services Network, as defined
 1134 in s. 391.021. This paragraph expires October 1, 2013.

1135 ~~(5) The Agency for Health Care Administration, in~~
 1136 ~~partnership with the Department of Elderly Affairs, shall create~~
 1137 ~~an integrated, fixed-payment delivery program for Medicaid~~
 1138 ~~recipients who are 60 years of age or older or dually eligible~~
 1139 ~~for Medicare and Medicaid. The Agency for Health Care~~
 1140 ~~Administration shall implement the integrated program initially~~
 1141 ~~on a pilot basis in two areas of the state. The pilot areas~~
 1142 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
 1143 ~~Administration. Enrollment in the pilot areas shall be on a~~
 1144 ~~voluntary basis and in accordance with approved federal waivers~~
 1145 ~~and this section. The agency and its program contractors and~~
 1146 ~~providers shall not enroll any individual in the integrated~~

1147 | ~~program because the individual or the person legally responsible~~
 1148 | ~~for the individual fails to choose to enroll in the integrated~~
 1149 | ~~program. Enrollment in the integrated program shall be~~
 1150 | ~~exclusively by affirmative choice of the eligible individual or~~
 1151 | ~~by the person legally responsible for the individual. The~~
 1152 | ~~integrated program must transfer all Medicaid services for~~
 1153 | ~~eligible elderly individuals who choose to participate into an~~
 1154 | ~~integrated-care management model designed to serve Medicaid~~
 1155 | ~~recipients in the community. The integrated program must combine~~
 1156 | ~~all funding for Medicaid services provided to individuals who~~
 1157 | ~~are 60 years of age or older or dually eligible for Medicare and~~
 1158 | ~~Medicaid into the integrated program, including funds for~~
 1159 | ~~Medicaid home and community-based waiver services; all Medicaid~~
 1160 | ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
 1161 | ~~for Medicaid nursing home services unless the agency is able to~~
 1162 | ~~demonstrate how the integration of the funds will improve~~
 1163 | ~~coordinated care for these services in a less costly manner; and~~
 1164 | ~~Medicare coinsurance and deductibles for persons dually eligible~~
 1165 | ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~

1166 | ~~(a) Individuals who are 60 years of age or older or dually~~
 1167 | ~~eligible for Medicare and Medicaid and enrolled in the~~
 1168 | ~~developmental disabilities waiver program, the family and~~
 1169 | ~~supported-living waiver program, the project AIDS care waiver~~
 1170 | ~~program, the traumatic brain injury and spinal cord injury~~
 1171 | ~~waiver program, the consumer-directed care waiver program, and~~
 1172 | ~~the program of all-inclusive care for the elderly program, and~~
 1173 | ~~residents of institutional care facilities for the~~
 1174 | ~~developmentally disabled, must be excluded from the integrated~~

1175 ~~program.~~

1176 ~~(b) Managed care entities who meet or exceed the agency's~~

1177 ~~minimum standards are eligible to operate the integrated~~

1178 ~~program. Entities eligible to participate include managed care~~

1179 ~~organizations licensed under chapter 641, including entities~~

1180 ~~eligible to participate in the nursing home diversion program,~~

1181 ~~other qualified providers as defined in s. 430.703(7), community~~

1182 ~~care for the elderly lead agencies, and other state-certified~~

1183 ~~community service networks that meet comparable standards as~~

1184 ~~defined by the agency, in consultation with the Department of~~

1185 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~

1186 ~~financially solvent and able to take on financial risk for~~

1187 ~~managed care. Community service networks that are certified~~

1188 ~~pursuant to the comparable standards defined by the agency are~~

1189 ~~not required to be licensed under chapter 641. Managed care~~

1190 ~~entities who operate the integrated program shall be subject to~~

1191 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~

1192 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~

1193 ~~are 60 years of age or older, or both.~~

1194 ~~(c) The agency must ensure that the capitation-rate-~~

1195 ~~setting methodology for the integrated program is actuarially~~

1196 ~~sound and reflects the intent to provide quality care in the~~

1197 ~~least restrictive setting. The agency must also require~~

1198 ~~integrated-program providers to develop a credentialing system~~

1199 ~~for service providers and to contract with all Gold Seal nursing~~

1200 ~~homes, where feasible, and exclude, where feasible, chronically~~

1201 ~~poor-performing facilities and providers as defined by the~~

1202 ~~agency. The integrated program must develop and maintain an~~

1203 ~~informal provider grievance system that addresses provider~~
 1204 ~~payment and contract problems. The agency shall also establish a~~
 1205 ~~formal grievance system to address those issues that were not~~
 1206 ~~resolved through the informal grievance system. The integrated~~
 1207 ~~program must provide that if the recipient resides in a~~
 1208 ~~noncontracted residential facility licensed under chapter 400 or~~
 1209 ~~chapter 429 at the time of enrollment in the integrated program,~~
 1210 ~~the recipient must be permitted to continue to reside in the~~
 1211 ~~noncontracted facility as long as the recipient desires. The~~
 1212 ~~integrated program must also provide that, in the absence of a~~
 1213 ~~contract between the integrated-program provider and the~~
 1214 ~~residential facility licensed under chapter 400 or chapter 429,~~
 1215 ~~current Medicaid rates must prevail. The integrated-program~~
 1216 ~~provider must ensure that electronic nursing home claims that~~
 1217 ~~contain sufficient information for processing are paid within 10~~
 1218 ~~business days after receipt. Alternately, the integrated-program~~
 1219 ~~provider may establish a capitated payment mechanism to~~
 1220 ~~prospectively pay nursing homes at the beginning of each month.~~
 1221 ~~The agency and the Department of Elderly Affairs must jointly~~
 1222 ~~develop procedures to manage the services provided through the~~
 1223 ~~integrated program in order to ensure quality and recipient~~
 1224 ~~choice.~~

1225 ~~(d) The Office of Program Policy Analysis and Government~~
 1226 ~~Accountability, in consultation with the Auditor General, shall~~
 1227 ~~comprehensively evaluate the pilot project for the integrated,~~
 1228 ~~fixed-payment delivery program for Medicaid recipients created~~
 1229 ~~under this subsection. The evaluation shall begin as soon as~~
 1230 ~~Medicaid recipients are enrolled in the managed care pilot~~

1231 ~~program plans and shall continue for 24 months thereafter. The~~
 1232 ~~evaluation must include assessments of each managed care plan in~~
 1233 ~~the integrated program with regard to cost savings; consumer~~
 1234 ~~education, choice, and access to services; coordination of care;~~
 1235 ~~and quality of care. The evaluation must describe administrative~~
 1236 ~~or legal barriers to the implementation and operation of the~~
 1237 ~~pilot program and include recommendations regarding statewide~~
 1238 ~~expansion of the pilot program. The office shall submit its~~
 1239 ~~evaluation report to the Governor, the President of the Senate,~~
 1240 ~~and the Speaker of the House of Representatives no later than~~
 1241 ~~December 31, 2009.~~

1242 ~~(e) The agency may seek federal waivers or Medicaid state~~
 1243 ~~plan amendments and adopt rules as necessary to administer the~~
 1244 ~~integrated program. The agency may implement the approved~~
 1245 ~~federal waivers and other provisions as specified in this~~
 1246 ~~subsection.~~

1247 ~~(f) No later than December 31, 2007, the agency shall~~
 1248 ~~provide a report to the Governor, the President of the Senate,~~
 1249 ~~and the Speaker of the House of Representatives containing an~~
 1250 ~~analysis of the merits and challenges of seeking a waiver to~~
 1251 ~~implement a voluntary program that integrates payments and~~
 1252 ~~services for dually enrolled Medicare and Medicaid recipients~~
 1253 ~~who are 65 years of age or older.~~

1254 ~~(g) The implementation of the integrated, fixed-payment~~
 1255 ~~delivery program created under this subsection is subject to an~~
 1256 ~~appropriation in the General Appropriations Act.~~

1257 ~~(5)(6)~~ (5) The agency may contract with any public or private
 1258 entity otherwise authorized by this section on a prepaid or

1259 fixed-sum basis for the provision of health care services to
 1260 recipients. An entity may provide prepaid services to
 1261 recipients, either directly or through arrangements with other
 1262 entities, if each entity involved in providing services:
 1263 (a) Is organized primarily for the purpose of providing
 1264 health care or other services of the type regularly offered to
 1265 Medicaid recipients;
 1266 (b) Ensures that services meet the standards set by the
 1267 agency for quality, appropriateness, and timeliness;
 1268 (c) Makes provisions satisfactory to the agency for
 1269 insolvency protection and ensures that neither enrolled Medicaid
 1270 recipients nor the agency will be liable for the debts of the
 1271 entity;
 1272 (d) Submits to the agency, if a private entity, a
 1273 financial plan that the agency finds to be fiscally sound and
 1274 that provides for working capital in the form of cash or
 1275 equivalent liquid assets excluding revenues from Medicaid
 1276 premium payments equal to at least the first 3 months of
 1277 operating expenses or \$200,000, whichever is greater;
 1278 (e) Furnishes evidence satisfactory to the agency of
 1279 adequate liability insurance coverage or an adequate plan of
 1280 self-insurance to respond to claims for injuries arising out of
 1281 the furnishing of health care;
 1282 (f) Provides, through contract or otherwise, for periodic
 1283 review of its medical facilities and services, as required by
 1284 the agency; and
 1285 (g) Provides organizational, operational, financial, and
 1286 other information required by the agency.

1287
 1288 This subsection expires October 1, 2013.

1289 ~~(6)(7)~~ The agency may contract on a prepaid or fixed-sum
 1290 basis with any health insurer that:

1291 (a) Pays for health care services provided to enrolled
 1292 Medicaid recipients in exchange for a premium payment paid by
 1293 the agency;

1294 (b) Assumes the underwriting risk; and

1295 (c) Is organized and licensed under applicable provisions
 1296 of the Florida Insurance Code and is currently in good standing
 1297 with the Office of Insurance Regulation.

1298
 1299 This subsection expires October 1, 2013.

1300 ~~(7)(8)(a)~~ The agency may contract on a prepaid or fixed-
 1301 sum basis with an exclusive provider organization to provide
 1302 health care services to Medicaid recipients provided that the
 1303 exclusive provider organization meets applicable managed care
 1304 plan requirements in this section, ss. 409.9122, 409.9123,
 1305 409.9128, and 627.6472, and other applicable provisions of law.
 1306 This subsection expires October 1, 2013.

1307 ~~(b) For a period of no longer than 24 months after the~~
 1308 ~~effective date of this paragraph, when a member of an exclusive~~
 1309 ~~provider organization that is contracted by the agency to~~
 1310 ~~provide health care services to Medicaid recipients in rural~~
 1311 ~~areas without a health maintenance organization obtains services~~
 1312 ~~from a provider that participates in the Medicaid program in~~
 1313 ~~this state, the provider shall be paid in accordance with the~~
 1314 ~~appropriate fee schedule for services provided to eligible~~

1315 ~~Medicaid recipients. The agency may seek waiver authority to~~
 1316 ~~implement this paragraph.~~

1317 (8)~~(9)~~ The Agency for Health Care Administration may
 1318 provide cost-effective purchasing of chiropractic services on a
 1319 fee-for-service basis to Medicaid recipients through
 1320 arrangements with a statewide chiropractic preferred provider
 1321 organization incorporated in this state as a not-for-profit
 1322 corporation. The agency shall ensure that the benefit limits and
 1323 prior authorization requirements in the current Medicaid program
 1324 shall apply to the services provided by the chiropractic
 1325 preferred provider organization. This subsection expires October
 1326 1, 2013.

1327 (9)~~(10)~~ The agency shall not contract on a prepaid or
 1328 fixed-sum basis for Medicaid services with an entity which knows
 1329 or reasonably should know that any officer, director, agent,
 1330 managing employee, or owner of stock or beneficial interest in
 1331 excess of 5 percent common or preferred stock, or the entity
 1332 itself, has been found guilty of, regardless of adjudication, or
 1333 entered a plea of nolo contendere, or guilty, to:

1334 (a) Fraud;

1335 (b) Violation of federal or state antitrust statutes,
 1336 including those proscribing price fixing between competitors and
 1337 the allocation of customers among competitors;

1338 (c) Commission of a felony involving embezzlement, theft,
 1339 forgery, income tax evasion, bribery, falsification or
 1340 destruction of records, making false statements, receiving
 1341 stolen property, making false claims, or obstruction of justice;
 1342 or

1343 (d) Any crime in any jurisdiction which directly relates
 1344 to the provision of health services on a prepaid or fixed-sum
 1345 basis.

1346

1347 This subsection expires October 1, 2013.

1348 ~~(10)-(11)~~ The agency, after notifying the Legislature, may
 1349 apply for waivers of applicable federal laws and regulations as
 1350 necessary to implement more appropriate systems of health care
 1351 for Medicaid recipients and reduce the cost of the Medicaid
 1352 program to the state and federal governments and shall implement
 1353 such programs, after legislative approval, within a reasonable
 1354 period of time after federal approval. These programs must be
 1355 designed primarily to reduce the need for inpatient care,
 1356 custodial care and other long-term or institutional care, and
 1357 other high-cost services. Prior to seeking legislative approval
 1358 of such a waiver as authorized by this subsection, the agency
 1359 shall provide notice and an opportunity for public comment.
 1360 Notice shall be provided to all persons who have made requests
 1361 of the agency for advance notice and shall be published in the
 1362 Florida Administrative Weekly not less than 28 days prior to the
 1363 intended action. This subsection expires October 1, 2015.

1364 ~~(11)-(12)~~ The agency shall establish a postpayment
 1365 utilization control program designed to identify recipients who
 1366 may inappropriately overuse or underuse Medicaid services and
 1367 shall provide methods to correct such misuse. This subsection
 1368 expires October 1, 2013.

1369 ~~(12)-(13)~~ The agency shall develop and provide coordinated
 1370 systems of care for Medicaid recipients and may contract with

1371 public or private entities to develop and administer such
 1372 systems of care among public and private health care providers
 1373 in a given geographic area. This subsection expires October 1,
 1374 2013.

1375 (13)~~(14)~~~~(a)~~ The agency shall operate or contract for the
 1376 operation of utilization management and incentive systems
 1377 designed to encourage cost-effective use of services and to
 1378 eliminate services that are medically unnecessary. The agency
 1379 shall track Medicaid provider prescription and billing patterns
 1380 and evaluate them against Medicaid medical necessity criteria
 1381 and coverage and limitation guidelines adopted by rule. Medical
 1382 necessity determination requires that service be consistent with
 1383 symptoms or confirmed diagnosis of illness or injury under
 1384 treatment and not in excess of the patient's needs. The agency
 1385 shall conduct reviews of provider exceptions to peer group norms
 1386 and shall, using statistical methodologies, provider profiling,
 1387 and analysis of billing patterns, detect and investigate
 1388 abnormal or unusual increases in billing or payment of claims
 1389 for Medicaid services and medically unnecessary provision of
 1390 services. Providers that demonstrate a pattern of submitting
 1391 claims for medically unnecessary services shall be referred to
 1392 the Medicaid program integrity unit for investigation. In its
 1393 annual report, required in s. 409.913, the agency shall report
 1394 on its efforts to control overutilization as described in this
 1395 subsection ~~paragraph~~. This subsection expires October 1, 2013.

1396 ~~(b) The agency shall develop a procedure for determining~~
 1397 ~~whether health care providers and service vendors can provide~~
 1398 ~~the Medicaid program using a business case that demonstrates~~

1399 ~~whether a particular good or service can offset the cost of~~
 1400 ~~providing the good or service in an alternative setting or~~
 1401 ~~through other means and therefore should receive a higher~~
 1402 ~~reimbursement. The business case must include, but need not be~~
 1403 ~~limited to:~~

1404 ~~1. A detailed description of the good or service to be~~
 1405 ~~provided, a description and analysis of the agency's current~~
 1406 ~~performance of the service, and a rationale documenting how~~
 1407 ~~providing the service in an alternative setting would be in the~~
 1408 ~~best interest of the state, the agency, and its clients.~~

1409 ~~2. A cost-benefit analysis documenting the estimated~~
 1410 ~~specific direct and indirect costs, savings, performance~~
 1411 ~~improvements, risks, and qualitative and quantitative benefits~~
 1412 ~~involved in or resulting from providing the service. The cost-~~
 1413 ~~benefit analysis must include a detailed plan and timeline~~
 1414 ~~identifying all actions that must be implemented to realize~~
 1415 ~~expected benefits. The Secretary of Health Care Administration~~
 1416 ~~shall verify that all costs, savings, and benefits are valid and~~
 1417 ~~achievable.~~

1418 ~~(c) If the agency determines that the increased~~
 1419 ~~reimbursement is cost-effective, the agency shall recommend a~~
 1420 ~~change in the reimbursement schedule for that particular good or~~
 1421 ~~service. If, within 12 months after implementing any rate change~~
 1422 ~~under this procedure, the agency determines that costs were not~~
 1423 ~~offset by the increased reimbursement schedule, the agency may~~
 1424 ~~revert to the former reimbursement schedule for the particular~~
 1425 ~~good or service.~~

1426 (14)~~(15)~~(a) The agency shall operate the Comprehensive

1427 Assessment and Review for Long-Term Care Services (CARES)
 1428 nursing facility preadmission screening program to ensure that
 1429 Medicaid payment for nursing facility care is made only for
 1430 individuals whose conditions require such care and to ensure
 1431 that long-term care services are provided in the setting most
 1432 appropriate to the needs of the person and in the most
 1433 economical manner possible. The CARES program shall also ensure
 1434 that individuals participating in Medicaid home and community-
 1435 based waiver programs meet criteria for those programs,
 1436 consistent with approved federal waivers.

1437 (b) The agency shall operate the CARES program through an
 1438 interagency agreement with the Department of Elderly Affairs.
 1439 The agency, in consultation with the Department of Elderly
 1440 Affairs, may contract for any function or activity of the CARES
 1441 program, including any function or activity required by 42
 1442 C.F.R. part 483.20, relating to preadmission screening and
 1443 resident review.

1444 (c) Prior to making payment for nursing facility services
 1445 for a Medicaid recipient, the agency must verify that the
 1446 nursing facility preadmission screening program has determined
 1447 that the individual requires nursing facility care and that the
 1448 individual cannot be safely served in community-based programs.
 1449 The nursing facility preadmission screening program shall refer
 1450 a Medicaid recipient to a community-based program if the
 1451 individual could be safely served at a lower cost and the
 1452 recipient chooses to participate in such program. For
 1453 individuals whose nursing home stay is initially funded by
 1454 Medicare and Medicare coverage is being terminated for lack of

1455 progress towards rehabilitation, CARES staff shall consult with
 1456 the person making the determination of progress toward
 1457 rehabilitation to ensure that the recipient is not being
 1458 inappropriately disqualified from Medicare coverage. If, in
 1459 their professional judgment, CARES staff believes that a
 1460 Medicare beneficiary is still making progress toward
 1461 rehabilitation, they may assist the Medicare beneficiary with an
 1462 appeal of the disqualification from Medicare coverage. The use
 1463 of CARES teams to review Medicare denials for coverage under
 1464 this section is authorized only if it is determined that such
 1465 reviews qualify for federal matching funds through Medicaid. The
 1466 agency shall seek or amend federal waivers as necessary to
 1467 implement this section.

1468 (d) For the purpose of initiating immediate prescreening
 1469 and diversion assistance for individuals residing in nursing
 1470 homes and in order to make families aware of alternative long-
 1471 term care resources so that they may choose a more cost-
 1472 effective setting for long-term placement, CARES staff shall
 1473 conduct an assessment and review of a sample of individuals
 1474 whose nursing home stay is expected to exceed 20 days,
 1475 regardless of the initial funding source for the nursing home
 1476 placement. CARES staff shall provide counseling and referral
 1477 services to these individuals regarding choosing appropriate
 1478 long-term care alternatives. This paragraph does not apply to
 1479 continuing care facilities licensed under chapter 651 or to
 1480 retirement communities that provide a combination of nursing
 1481 home, independent living, and other long-term care services.

1482 (e) By January 15 of each year, the agency shall submit a

1483 | report to the Legislature describing the operations of the CARES
 1484 | program. The report must describe:

1485 | 1. Rate of diversion to community alternative programs;

1486 | 2. CARES program staffing needs to achieve additional
 1487 | diversions;

1488 | 3. Reasons the program is unable to place individuals in
 1489 | less restrictive settings when such individuals desired such
 1490 | services and could have been served in such settings;

1491 | 4. Barriers to appropriate placement, including barriers
 1492 | due to policies or operations of other agencies or state-funded
 1493 | programs; and

1494 | 5. Statutory changes necessary to ensure that individuals
 1495 | in need of long-term care services receive care in the least
 1496 | restrictive environment.

1497 | (f) The Department of Elderly Affairs shall track
 1498 | individuals over time who are assessed under the CARES program
 1499 | and who are diverted from nursing home placement. By January 15
 1500 | of each year, the department shall submit to the Legislature a
 1501 | longitudinal study of the individuals who are diverted from
 1502 | nursing home placement. The study must include:

1503 | 1. The demographic characteristics of the individuals
 1504 | assessed and diverted from nursing home placement, including,
 1505 | but not limited to, age, race, gender, frailty, caregiver
 1506 | status, living arrangements, and geographic location;

1507 | 2. A summary of community services provided to individuals
 1508 | for 1 year after assessment and diversion;

1509 | 3. A summary of inpatient hospital admissions for
 1510 | individuals who have been diverted; and

1511 4. A summary of the length of time between diversion and
 1512 subsequent entry into a nursing home or death.

1513 ~~(g) By July 1, 2005, the department and the Agency for~~
 1514 ~~Health Care Administration shall report to the President of the~~
 1515 ~~Senate and the Speaker of the House of Representatives regarding~~
 1516 ~~the impact to the state of modifying level-of-care criteria to~~
 1517 ~~eliminate the Intermediate II level of care.~~

1518

1519 This subsection expires October 1, 2012.

1520 (15)~~(16)~~(a) The agency shall identify health care
 1521 utilization and price patterns within the Medicaid program which
 1522 are not cost-effective or medically appropriate and assess the
 1523 effectiveness of new or alternate methods of providing and
 1524 monitoring service, and may implement such methods as it
 1525 considers appropriate. Such methods may include disease
 1526 management initiatives, an integrated and systematic approach
 1527 for managing the health care needs of recipients who are at risk
 1528 of or diagnosed with a specific disease by using best practices,
 1529 prevention strategies, clinical-practice improvement, clinical
 1530 interventions and protocols, outcomes research, information
 1531 technology, and other tools and resources to reduce overall
 1532 costs and improve measurable outcomes.

1533 (b) The responsibility of the agency under this subsection
 1534 shall include the development of capabilities to identify actual
 1535 and optimal practice patterns; patient and provider educational
 1536 initiatives; methods for determining patient compliance with
 1537 prescribed treatments; fraud, waste, and abuse prevention and
 1538 detection programs; and beneficiary case management programs.

1539 1. The practice pattern identification program shall
 1540 evaluate practitioner prescribing patterns based on national and
 1541 regional practice guidelines, comparing practitioners to their
 1542 peer groups. The agency and its Drug Utilization Review Board
 1543 shall consult with the Department of Health and a panel of
 1544 practicing health care professionals consisting of the
 1545 following: the Speaker of the House of Representatives and the
 1546 President of the Senate shall each appoint three physicians
 1547 licensed under chapter 458 or chapter 459; and the Governor
 1548 shall appoint two pharmacists licensed under chapter 465 and one
 1549 dentist licensed under chapter 466 who is an oral surgeon. Terms
 1550 of the panel members shall expire at the discretion of the
 1551 appointing official. The advisory panel shall be responsible for
 1552 evaluating treatment guidelines and recommending ways to
 1553 incorporate their use in the practice pattern identification
 1554 program. Practitioners who are prescribing inappropriately or
 1555 inefficiently, as determined by the agency, may have their
 1556 prescribing of certain drugs subject to prior authorization or
 1557 may be terminated from all participation in the Medicaid
 1558 program.

1559 2. The agency shall also develop educational interventions
 1560 designed to promote the proper use of medications by providers
 1561 and beneficiaries.

1562 3. The agency shall implement a pharmacy fraud, waste, and
 1563 abuse initiative that may include a surety bond or letter of
 1564 credit requirement for participating pharmacies, enhanced
 1565 provider auditing practices, the use of additional fraud and
 1566 abuse software, recipient management programs for beneficiaries

1567 | inappropriately using their benefits, and other steps that will
 1568 | eliminate provider and recipient fraud, waste, and abuse. The
 1569 | initiative shall address enforcement efforts to reduce the
 1570 | number and use of counterfeit prescriptions.

1571 | 4. By September 30, 2002, the agency shall contract with
 1572 | an entity in the state to implement a wireless handheld clinical
 1573 | pharmacology drug information database for practitioners. The
 1574 | initiative shall be designed to enhance the agency's efforts to
 1575 | reduce fraud, abuse, and errors in the prescription drug benefit
 1576 | program and to otherwise further the intent of this paragraph.

1577 | 5. By April 1, 2006, the agency shall contract with an
 1578 | entity to design a database of clinical utilization information
 1579 | or electronic medical records for Medicaid providers. This
 1580 | system must be web-based and allow providers to review on a
 1581 | real-time basis the utilization of Medicaid services, including,
 1582 | but not limited to, physician office visits, inpatient and
 1583 | outpatient hospitalizations, laboratory and pathology services,
 1584 | radiological and other imaging services, dental care, and
 1585 | patterns of dispensing prescription drugs in order to coordinate
 1586 | care and identify potential fraud and abuse.

1587 | 6. The agency may apply for any federal waivers needed to
 1588 | administer this paragraph.

1589 |
 1590 | This subsection expires October 1, 2013.

1591 | ~~(16)-(17)~~ An entity contracting on a prepaid or fixed-sum
 1592 | basis shall meet the surplus requirements of s. 641.225. If an
 1593 | entity's surplus falls below an amount equal to the surplus
 1594 | requirements of s. 641.225, the agency shall prohibit the entity

1595 from engaging in marketing and preenrollment activities, shall
 1596 cease to process new enrollments, and may not renew the entity's
 1597 contract until the required balance is achieved. The
 1598 requirements of this subsection do not apply:

1599 (a) Where a public entity agrees to fund any deficit
 1600 incurred by the contracting entity; or

1601 (b) Where the entity's performance and obligations are
 1602 guaranteed in writing by a guaranteeing organization which:

1603 1. Has been in operation for at least 5 years and has
 1604 assets in excess of \$50 million; or

1605 2. Submits a written guarantee acceptable to the agency
 1606 which is irrevocable during the term of the contracting entity's
 1607 contract with the agency and, upon termination of the contract,
 1608 until the agency receives proof of satisfaction of all
 1609 outstanding obligations incurred under the contract.

1610

1611 This subsection expires October 1, 2013.

1612 ~~(17)-(18)~~(a) The agency may require an entity contracting
 1613 on a prepaid or fixed-sum basis to establish a restricted
 1614 insolvency protection account with a federally guaranteed
 1615 financial institution licensed to do business in this state. The
 1616 entity shall deposit into that account 5 percent of the
 1617 capitation payments made by the agency each month until a
 1618 maximum total of 2 percent of the total current contract amount
 1619 is reached. The restricted insolvency protection account may be
 1620 drawn upon with the authorized signatures of two persons
 1621 designated by the entity and two representatives of the agency.
 1622 If the agency finds that the entity is insolvent, the agency may

1623 draw upon the account solely with the two authorized signatures
 1624 of representatives of the agency, and the funds may be disbursed
 1625 to meet financial obligations incurred by the entity under the
 1626 prepaid contract. If the contract is terminated, expired, or not
 1627 continued, the account balance must be released by the agency to
 1628 the entity upon receipt of proof of satisfaction of all
 1629 outstanding obligations incurred under this contract.

1630 (b) The agency may waive the insolvency protection account
 1631 requirement in writing when evidence is on file with the agency
 1632 of adequate insolvency insurance and reinsurance that will
 1633 protect enrollees if the entity becomes unable to meet its
 1634 obligations.

1635

1636 This subsection expires October 1, 2013.

1637 (18)~~(19)~~ An entity that contracts with the agency on a
 1638 prepaid or fixed-sum basis for the provision of Medicaid
 1639 services shall reimburse any hospital or physician that is
 1640 outside the entity's authorized geographic service area as
 1641 specified in its contract with the agency, and that provides
 1642 services authorized by the entity to its members, at a rate
 1643 negotiated with the hospital or physician for the provision of
 1644 services or according to the lesser of the following:

1645 (a) The usual and customary charges made to the general
 1646 public by the hospital or physician; or

1647 (b) The Florida Medicaid reimbursement rate established
 1648 for the hospital or physician.

1649

1650 This subsection expires October 1, 2013.

1651 ~~(19)~~~~(20)~~ When a merger or acquisition of a Medicaid
 1652 prepaid contractor has been approved by the Office of Insurance
 1653 Regulation pursuant to s. 628.4615, the agency shall approve the
 1654 assignment or transfer of the appropriate Medicaid prepaid
 1655 contract upon request of the surviving entity of the merger or
 1656 acquisition if the contractor and the other entity have been in
 1657 good standing with the agency for the most recent 12-month
 1658 period, unless the agency determines that the assignment or
 1659 transfer would be detrimental to the Medicaid recipients or the
 1660 Medicaid program. To be in good standing, an entity must not
 1661 have failed accreditation or committed any material violation of
 1662 the requirements of s. 641.52 and must meet the Medicaid
 1663 contract requirements. For purposes of this section, a merger or
 1664 acquisition means a change in controlling interest of an entity,
 1665 including an asset or stock purchase. This subsection expires
 1666 October 1, 2013.

1667 ~~(20)~~~~(21)~~ Any entity contracting with the agency pursuant
 1668 to this section to provide health care services to Medicaid
 1669 recipients is prohibited from engaging in any of the following
 1670 practices or activities:

1671 (a) Practices that are discriminatory, including, but not
 1672 limited to, attempts to discourage participation on the basis of
 1673 actual or perceived health status.

1674 (b) Activities that could mislead or confuse recipients,
 1675 or misrepresent the organization, its marketing representatives,
 1676 or the agency. Violations of this paragraph include, but are not
 1677 limited to:

1678 1. False or misleading claims that marketing

1679 representatives are employees or representatives of the state or
 1680 county, or of anyone other than the entity or the organization
 1681 by whom they are reimbursed.

1682 2. False or misleading claims that the entity is
 1683 recommended or endorsed by any state or county agency, or by any
 1684 other organization which has not certified its endorsement in
 1685 writing to the entity.

1686 3. False or misleading claims that the state or county
 1687 recommends that a Medicaid recipient enroll with an entity.

1688 4. Claims that a Medicaid recipient will lose benefits
 1689 under the Medicaid program, or any other health or welfare
 1690 benefits to which the recipient is legally entitled, if the
 1691 recipient does not enroll with the entity.

1692 (c) Granting or offering of any monetary or other valuable
 1693 consideration for enrollment, except as authorized by subsection
 1694 (23) ~~(24)~~.

1695 (d) Door-to-door solicitation of recipients who have not
 1696 contacted the entity or who have not invited the entity to make
 1697 a presentation.

1698 (e) Solicitation of Medicaid recipients by marketing
 1699 representatives stationed in state offices unless approved and
 1700 supervised by the agency or its agent and approved by the
 1701 affected state agency when solicitation occurs in an office of
 1702 the state agency. The agency shall ensure that marketing
 1703 representatives stationed in state offices shall market their
 1704 managed care plans to Medicaid recipients only in designated
 1705 areas and in such a way as to not interfere with the recipients'
 1706 activities in the state office.

1707 (f) Enrollment of Medicaid recipients.

1708

1709 This subsection expires October 1, 2013.

1710 ~~(21)(22)~~ The agency may impose a fine for a violation of
 1711 this section or the contract with the agency by a person or
 1712 entity that is under contract with the agency. With respect to
 1713 any nonwillful violation, such fine shall not exceed \$2,500 per
 1714 violation. In no event shall such fine exceed an aggregate
 1715 amount of \$10,000 for all nonwillful violations arising out of
 1716 the same action. With respect to any knowing and willful
 1717 violation of this section or the contract with the agency, the
 1718 agency may impose a fine upon the entity in an amount not to
 1719 exceed \$20,000 for each such violation. In no event shall such
 1720 fine exceed an aggregate amount of \$100,000 for all knowing and
 1721 willful violations arising out of the same action. This
 1722 subsection expires October 1, 2013.

1723 ~~(22)(23)~~ A health maintenance organization or a person or
 1724 entity exempt from chapter 641 that is under contract with the
 1725 agency for the provision of health care services to Medicaid
 1726 recipients may not use or distribute marketing materials used to
 1727 solicit Medicaid recipients, unless such materials have been
 1728 approved by the agency. The provisions of this subsection do not
 1729 apply to general advertising and marketing materials used by a
 1730 health maintenance organization to solicit both non-Medicaid
 1731 subscribers and Medicaid recipients. This subsection expires
 1732 October 1, 2013.

1733 ~~(23)(24)~~ Upon approval by the agency, health maintenance
 1734 organizations and persons or entities exempt from chapter 641

1735 that are under contract with the agency for the provision of
 1736 health care services to Medicaid recipients may be permitted
 1737 within the capitation rate to provide additional health benefits
 1738 that the agency has found are of high quality, are practicably
 1739 available, provide reasonable value to the recipient, and are
 1740 provided at no additional cost to the state. This subsection
 1741 expires October 1, 2013.

1742 (24)~~(25)~~ The agency shall utilize the statewide health
 1743 maintenance organization complaint hotline for the purpose of
 1744 investigating and resolving Medicaid and prepaid health plan
 1745 complaints, maintaining a record of complaints and confirmed
 1746 problems, and receiving disenrollment requests made by
 1747 recipients. This subsection expires October 1, 2013.

1748 (25)~~(26)~~ The agency shall require the publication of the
 1749 health maintenance organization's and the prepaid health plan's
 1750 consumer services telephone numbers and the "800" telephone
 1751 number of the statewide health maintenance organization
 1752 complaint hotline on each Medicaid identification card issued by
 1753 a health maintenance organization or prepaid health plan
 1754 contracting with the agency to serve Medicaid recipients and on
 1755 each subscriber handbook issued to a Medicaid recipient. This
 1756 subsection expires October 1, 2013.

1757 (26)~~(27)~~ The agency shall establish a health care quality
 1758 improvement system for those entities contracting with the
 1759 agency pursuant to this section, incorporating all the standards
 1760 and guidelines developed by the Medicaid Bureau of the Health
 1761 Care Financing Administration as a part of the quality assurance
 1762 reform initiative. The system shall include, but need not be

- 1763 | limited to, the following:
- 1764 | (a) Guidelines for internal quality assurance programs,
- 1765 | including standards for:
- 1766 | 1. Written quality assurance program descriptions.
- 1767 | 2. Responsibilities of the governing body for monitoring,
- 1768 | evaluating, and making improvements to care.
- 1769 | 3. An active quality assurance committee.
- 1770 | 4. Quality assurance program supervision.
- 1771 | 5. Requiring the program to have adequate resources to
- 1772 | effectively carry out its specified activities.
- 1773 | 6. Provider participation in the quality assurance
- 1774 | program.
- 1775 | 7. Delegation of quality assurance program activities.
- 1776 | 8. Credentialing and recredentialing.
- 1777 | 9. Enrollee rights and responsibilities.
- 1778 | 10. Availability and accessibility to services and care.
- 1779 | 11. Ambulatory care facilities.
- 1780 | 12. Accessibility and availability of medical records, as
- 1781 | well as proper recordkeeping and process for record review.
- 1782 | 13. Utilization review.
- 1783 | 14. A continuity of care system.
- 1784 | 15. Quality assurance program documentation.
- 1785 | 16. Coordination of quality assurance activity with other
- 1786 | management activity.
- 1787 | 17. Delivering care to pregnant women and infants; to
- 1788 | elderly and disabled recipients, especially those who are at
- 1789 | risk of institutional placement; to persons with developmental
- 1790 | disabilities; and to adults who have chronic, high-cost medical

1791 conditions.

1792 (b) Guidelines which require the entities to conduct
 1793 quality-of-care studies which:

1794 1. Target specific conditions and specific health service
 1795 delivery issues for focused monitoring and evaluation.

1796 2. Use clinical care standards or practice guidelines to
 1797 objectively evaluate the care the entity delivers or fails to
 1798 deliver for the targeted clinical conditions and health services
 1799 delivery issues.

1800 3. Use quality indicators derived from the clinical care
 1801 standards or practice guidelines to screen and monitor care and
 1802 services delivered.

1803 (c) Guidelines for external quality review of each
 1804 contractor which require: focused studies of patterns of care;
 1805 individual care review in specific situations; and followup
 1806 activities on previous pattern-of-care study findings and
 1807 individual-care-review findings. In designing the external
 1808 quality review function and determining how it is to operate as
 1809 part of the state's overall quality improvement system, the
 1810 agency shall construct its external quality review organization
 1811 and entity contracts to address each of the following:

1812 1. Delineating the role of the external quality review
 1813 organization.

1814 2. Length of the external quality review organization
 1815 contract with the state.

1816 3. Participation of the contracting entities in designing
 1817 external quality review organization review activities.

1818 4. Potential variation in the type of clinical conditions

1819 and health services delivery issues to be studied at each plan.

1820 5. Determining the number of focused pattern-of-care
1821 studies to be conducted for each plan.

1822 6. Methods for implementing focused studies.

1823 7. Individual care review.

1824 8. Followup activities.

1825

1826 This subsection expires October 1, 2015.

1827 (27)~~(28)~~ In order to ensure that children receive health
1828 care services for which an entity has already been compensated,
1829 an entity contracting with the agency pursuant to this section
1830 shall achieve an annual Early and Periodic Screening, Diagnosis,
1831 and Treatment (EPSDT) Service screening rate of at least 60
1832 percent for those recipients continuously enrolled for at least
1833 8 months. The agency shall develop a method by which the EPSDT
1834 screening rate shall be calculated. For any entity which does
1835 not achieve the annual 60 percent rate, the entity must submit a
1836 corrective action plan for the agency's approval. If the entity
1837 does not meet the standard established in the corrective action
1838 plan during the specified timeframe, the agency is authorized to
1839 impose appropriate contract sanctions. At least annually, the
1840 agency shall publicly release the EPSDT Services screening rates
1841 of each entity it has contracted with on a prepaid basis to
1842 serve Medicaid recipients. This subsection expires October 1,
1843 2013.

1844 (28)~~(29)~~ The agency shall perform enrollments and
1845 disenrollments for Medicaid recipients who are eligible for
1846 MediPass or managed care plans. Notwithstanding the prohibition

1847 contained in paragraph ~~(20)-(21)~~(f), managed care plans may
 1848 perform preenrollments of Medicaid recipients under the
 1849 supervision of the agency or its agents. For the purposes of
 1850 this section, "preenrollment" means the provision of marketing
 1851 and educational materials to a Medicaid recipient and assistance
 1852 in completing the application forms, but shall not include
 1853 actual enrollment into a managed care plan. An application for
 1854 enrollment shall not be deemed complete until the agency or its
 1855 agent verifies that the recipient made an informed, voluntary
 1856 choice. The agency, in cooperation with the Department of
 1857 Children and Family Services, may test new marketing initiatives
 1858 to inform Medicaid recipients about their managed care options
 1859 at selected sites. The agency shall report to the Legislature on
 1860 the effectiveness of such initiatives. The agency may contract
 1861 with a third party to perform managed care plan and MediPass
 1862 enrollment and disenrollment services for Medicaid recipients
 1863 and is authorized to adopt rules to implement such services. The
 1864 agency may adjust the capitation rate only to cover the costs of
 1865 a third-party enrollment and disenrollment contract, and for
 1866 agency supervision and management of the managed care plan
 1867 enrollment and disenrollment contract. This subsection expires
 1868 October 1, 2013.

1869 ~~(29)-(30)~~ Any lists of providers made available to Medicaid
 1870 recipients, MediPass enrollees, or managed care plan enrollees
 1871 shall be arranged alphabetically showing the provider's name and
 1872 specialty and, separately, by specialty in alphabetical order.
 1873 This subsection expires October 1, 2013.

1874 ~~(30)-(31)~~ The agency shall establish an enhanced managed

1875 care quality assurance oversight function, to include at least
 1876 the following components:

1877 (a) At least quarterly analysis and followup, including
 1878 sanctions as appropriate, of managed care participant
 1879 utilization of services.

1880 (b) At least quarterly analysis and followup, including
 1881 sanctions as appropriate, of quality findings of the Medicaid
 1882 peer review organization and other external quality assurance
 1883 programs.

1884 (c) At least quarterly analysis and followup, including
 1885 sanctions as appropriate, of the fiscal viability of managed
 1886 care plans.

1887 (d) At least quarterly analysis and followup, including
 1888 sanctions as appropriate, of managed care participant
 1889 satisfaction and disenrollment surveys.

1890 (e) The agency shall conduct regular and ongoing Medicaid
 1891 recipient satisfaction surveys.

1892
 1893 The analyses and followup activities conducted by the agency
 1894 under its enhanced managed care quality assurance oversight
 1895 function shall not duplicate the activities of accreditation
 1896 reviewers for entities regulated under part III of chapter 641,
 1897 but may include a review of the finding of such reviewers. This
 1898 subsection expires October 1, 2013.

1899 (31)~~(32)~~ Each managed care plan that is under contract
 1900 with the agency to provide health care services to Medicaid
 1901 recipients shall annually conduct a background check with the
 1902 Florida Department of Law Enforcement of all persons with

1903 ownership interest of 5 percent or more or executive management
 1904 responsibility for the managed care plan and shall submit to the
 1905 agency information concerning any such person who has been found
 1906 guilty of, regardless of adjudication, or has entered a plea of
 1907 nolo contendere or guilty to, any of the offenses listed in s.
 1908 435.03. This subsection expires October 1, 2013.

1909 (32)~~(33)~~ The agency shall, by rule, develop a process
 1910 whereby a Medicaid managed care plan enrollee who wishes to
 1911 enter hospice care may be disenrolled from the managed care plan
 1912 within 24 hours after contacting the agency regarding such
 1913 request. The agency rule shall include a methodology for the
 1914 agency to recoup managed care plan payments on a pro rata basis
 1915 if payment has been made for the enrollment month when
 1916 disenrollment occurs. This subsection expires October 1, 2013.

1917 (33)~~(34)~~ The agency and entities that contract with the
 1918 agency to provide health care services to Medicaid recipients
 1919 under this section or ss. 409.91211 and 409.9122 must comply
 1920 with the provisions of s. 641.513 in providing emergency
 1921 services and care to Medicaid recipients and MediPass
 1922 recipients. Where feasible, safe, and cost-effective, the agency
 1923 shall encourage hospitals, emergency medical services providers,
 1924 and other public and private health care providers to work
 1925 together in their local communities to enter into agreements or
 1926 arrangements to ensure access to alternatives to emergency
 1927 services and care for those Medicaid recipients who need
 1928 nonemergent care. The agency shall coordinate with hospitals,
 1929 emergency medical services providers, private health plans,
 1930 capitated managed care networks as established in s. 409.91211,

1931 and other public and private health care providers to implement
 1932 the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
 1933 and 641.31097 to develop and implement emergency department
 1934 diversion programs for Medicaid recipients. This subsection
 1935 expires October 1, 2013.

1936 (34)-(35) All entities providing health care services to
 1937 Medicaid recipients shall make available, and encourage all
 1938 pregnant women and mothers with infants to receive, and provide
 1939 documentation in the medical records to reflect, the following:

1940 (a) Healthy Start prenatal or infant screening.

1941 (b) Healthy Start care coordination, when screening or
 1942 other factors indicate need.

1943 (c) Healthy Start enhanced services in accordance with the
 1944 prenatal or infant screening results.

1945 (d) Immunizations in accordance with recommendations of
 1946 the Advisory Committee on Immunization Practices of the United
 1947 States Public Health Service and the American Academy of
 1948 Pediatrics, as appropriate.

1949 (e) Counseling and services for family planning to all
 1950 women and their partners.

1951 (f) A scheduled postpartum visit for the purpose of
 1952 voluntary family planning, to include discussion of all methods
 1953 of contraception, as appropriate.

1954 (g) Referral to the Special Supplemental Nutrition Program
 1955 for Women, Infants, and Children (WIC).

1956

1957 This subsection expires October 1, 2013.

1958 (35)-(36) Any entity that provides Medicaid prepaid health

1959 plan services shall ensure the appropriate coordination of
 1960 health care services with an assisted living facility in cases
 1961 where a Medicaid recipient is both a member of the entity's
 1962 prepaid health plan and a resident of the assisted living
 1963 facility. If the entity is at risk for Medicaid targeted case
 1964 management and behavioral health services, the entity shall
 1965 inform the assisted living facility of the procedures to follow
 1966 should an emergent condition arise. This subsection expires
 1967 October 1, 2013.

1968 ~~(37) The agency may seek and implement federal waivers~~
 1969 ~~necessary to provide for cost-effective purchasing of home~~
 1970 ~~health services, private duty nursing services, transportation,~~
 1971 ~~independent laboratory services, and durable medical equipment~~
 1972 ~~and supplies through competitive bidding pursuant to s. 287.057.~~
 1973 ~~The agency may request appropriate waivers from the federal~~
 1974 ~~Health Care Financing Administration in order to competitively~~
 1975 ~~bid such services. The agency may exclude providers not selected~~
 1976 ~~through the bidding process from the Medicaid provider network.~~

1977 (36)~~(38)~~ The agency shall enter into agreements with not-
 1978 for-profit organizations based in this state for the purpose of
 1979 providing vision screening. This subsection expires October 1,
 1980 2013.

1981 (37)~~(39)~~(a) The agency shall implement a Medicaid
 1982 prescribed-drug spending-control program that includes the
 1983 following components:

- 1984 1. A Medicaid preferred drug list, which shall be a
- 1985 listing of cost-effective therapeutic options recommended by the
- 1986 Medicaid Pharmacy and Therapeutics Committee established

1987 pursuant to s. 409.91195 and adopted by the agency for each
 1988 therapeutic class on the preferred drug list. At the discretion
 1989 of the committee, and when feasible, the preferred drug list
 1990 should include at least two products in a therapeutic class. The
 1991 agency may post the preferred drug list and updates to the
 1992 preferred drug list on an Internet website without following the
 1993 rulemaking procedures of chapter 120. Antiretroviral agents are
 1994 excluded from the preferred drug list. The agency shall also
 1995 limit the amount of a prescribed drug dispensed to no more than
 1996 a 34-day supply unless the drug products' smallest marketed
 1997 package is greater than a 34-day supply, or the drug is
 1998 determined by the agency to be a maintenance drug in which case
 1999 a 100-day maximum supply may be authorized. The agency is
 2000 authorized to seek any federal waivers necessary to implement
 2001 these cost-control programs and to continue participation in the
 2002 federal Medicaid rebate program, or alternatively to negotiate
 2003 state-only manufacturer rebates. The agency may adopt rules to
 2004 implement this subparagraph. The agency shall continue to
 2005 provide unlimited contraceptive drugs and items. The agency must
 2006 establish procedures to ensure that:

2007 a. There is a response to a request for prior consultation
 2008 by telephone or other telecommunication device within 24 hours
 2009 after receipt of a request for prior consultation; and

2010 b. A 72-hour supply of the drug prescribed is provided in
 2011 an emergency or when the agency does not provide a response
 2012 within 24 hours as required by sub-subparagraph a.

2013 2. Reimbursement to pharmacies for Medicaid prescribed
 2014 drugs shall be set at the lesser of: the average wholesale price

2015 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
 2016 plus 4.75 percent, the federal upper limit (FUL), the state
 2017 maximum allowable cost (SMAC), or the usual and customary (UAC)
 2018 charge billed by the provider.

2019 3. The agency shall develop and implement a process for
 2020 managing the drug therapies of Medicaid recipients who are using
 2021 significant numbers of prescribed drugs each month. The
 2022 management process may include, but is not limited to,
 2023 comprehensive, physician-directed medical-record reviews, claims
 2024 analyses, and case evaluations to determine the medical
 2025 necessity and appropriateness of a patient's treatment plan and
 2026 drug therapies. The agency may contract with a private
 2027 organization to provide drug-program-management services. The
 2028 Medicaid drug benefit management program shall include
 2029 initiatives to manage drug therapies for HIV/AIDS patients,
 2030 patients using 20 or more unique prescriptions in a 180-day
 2031 period, and the top 1,000 patients in annual spending. The
 2032 agency shall enroll any Medicaid recipient in the drug benefit
 2033 management program if he or she meets the specifications of this
 2034 provision and is not enrolled in a Medicaid health maintenance
 2035 organization.

2036 4. The agency may limit the size of its pharmacy network
 2037 based on need, competitive bidding, price negotiations,
 2038 credentialing, or similar criteria. The agency shall give
 2039 special consideration to rural areas in determining the size and
 2040 location of pharmacies included in the Medicaid pharmacy
 2041 network. A pharmacy credentialing process may include criteria
 2042 such as a pharmacy's full-service status, location, size,

2043 patient educational programs, patient consultation, disease
 2044 management services, and other characteristics. The agency may
 2045 impose a moratorium on Medicaid pharmacy enrollment when it is
 2046 determined that it has a sufficient number of Medicaid-
 2047 participating providers. The agency must allow dispensing
 2048 practitioners to participate as a part of the Medicaid pharmacy
 2049 network regardless of the practitioner's proximity to any other
 2050 entity that is dispensing prescription drugs under the Medicaid
 2051 program. A dispensing practitioner must meet all credentialing
 2052 requirements applicable to his or her practice, as determined by
 2053 the agency.

2054 5. The agency shall develop and implement a program that
 2055 requires Medicaid practitioners who prescribe drugs to use a
 2056 counterfeit-proof prescription pad for Medicaid prescriptions.
 2057 The agency shall require the use of standardized counterfeit-
 2058 proof prescription pads by Medicaid-participating prescribers or
 2059 prescribers who write prescriptions for Medicaid recipients. The
 2060 agency may implement the program in targeted geographic areas or
 2061 statewide.

2062 6. The agency may enter into arrangements that require
 2063 manufacturers of generic drugs prescribed to Medicaid recipients
 2064 to provide rebates of at least 15.1 percent of the average
 2065 manufacturer price for the manufacturer's generic products.
 2066 These arrangements shall require that if a generic-drug
 2067 manufacturer pays federal rebates for Medicaid-reimbursed drugs
 2068 at a level below 15.1 percent, the manufacturer must provide a
 2069 supplemental rebate to the state in an amount necessary to
 2070 achieve a 15.1-percent rebate level.

2071 7. The agency may establish a preferred drug list as
 2072 described in this subsection, and, pursuant to the establishment
 2073 of such preferred drug list, it is authorized to negotiate
 2074 supplemental rebates from manufacturers that are in addition to
 2075 those required by Title XIX of the Social Security Act and at no
 2076 less than 14 percent of the average manufacturer price as
 2077 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
 2078 the federal or supplemental rebate, or both, equals or exceeds
 2079 29 percent. There is no upper limit on the supplemental rebates
 2080 the agency may negotiate. The agency may determine that specific
 2081 products, brand-name or generic, are competitive at lower rebate
 2082 percentages. Agreement to pay the minimum supplemental rebate
 2083 percentage will guarantee a manufacturer that the Medicaid
 2084 Pharmaceutical and Therapeutics Committee will consider a
 2085 product for inclusion on the preferred drug list. However, a
 2086 pharmaceutical manufacturer is not guaranteed placement on the
 2087 preferred drug list by simply paying the minimum supplemental
 2088 rebate. Agency decisions will be made on the clinical efficacy
 2089 of a drug and recommendations of the Medicaid Pharmaceutical and
 2090 Therapeutics Committee, as well as the price of competing
 2091 products minus federal and state rebates. The agency is
 2092 authorized to contract with an outside agency or contractor to
 2093 conduct negotiations for supplemental rebates. For the purposes
 2094 of this section, the term "supplemental rebates" means cash
 2095 rebates. Effective July 1, 2004, value-added programs as a
 2096 substitution for supplemental rebates are prohibited. The agency
 2097 is authorized to seek any federal waivers to implement this
 2098 initiative.

2099 8. The Agency for Health Care Administration shall expand
 2100 home delivery of pharmacy products. To assist Medicaid patients
 2101 in securing their prescriptions and reduce program costs, the
 2102 agency shall expand its current mail-order-pharmacy diabetes-
 2103 supply program to include all generic and brand-name drugs used
 2104 by Medicaid patients with diabetes. Medicaid recipients in the
 2105 current program may obtain nondiabetes drugs on a voluntary
 2106 basis. This initiative is limited to the geographic area covered
 2107 by the current contract. The agency may seek and implement any
 2108 federal waivers necessary to implement this subparagraph.

2109 9. The agency shall limit to one dose per month any drug
 2110 prescribed to treat erectile dysfunction.

2111 10.a. The agency may implement a Medicaid behavioral drug
 2112 management system. The agency may contract with a vendor that
 2113 has experience in operating behavioral drug management systems
 2114 to implement this program. The agency is authorized to seek
 2115 federal waivers to implement this program.

2116 b. The agency, in conjunction with the Department of
 2117 Children and Family Services, may implement the Medicaid
 2118 behavioral drug management system that is designed to improve
 2119 the quality of care and behavioral health prescribing practices
 2120 based on best practice guidelines, improve patient adherence to
 2121 medication plans, reduce clinical risk, and lower prescribed
 2122 drug costs and the rate of inappropriate spending on Medicaid
 2123 behavioral drugs. The program may include the following
 2124 elements:

2125 (I) Provide for the development and adoption of best
 2126 practice guidelines for behavioral health-related drugs such as

2127 antipsychotics, antidepressants, and medications for treating
 2128 bipolar disorders and other behavioral conditions; translate
 2129 them into practice; review behavioral health prescribers and
 2130 compare their prescribing patterns to a number of indicators
 2131 that are based on national standards; and determine deviations
 2132 from best practice guidelines.

2133 (II) Implement processes for providing feedback to and
 2134 educating prescribers using best practice educational materials
 2135 and peer-to-peer consultation.

2136 (III) Assess Medicaid beneficiaries who are outliers in
 2137 their use of behavioral health drugs with regard to the numbers
 2138 and types of drugs taken, drug dosages, combination drug
 2139 therapies, and other indicators of improper use of behavioral
 2140 health drugs.

2141 (IV) Alert prescribers to patients who fail to refill
 2142 prescriptions in a timely fashion, are prescribed multiple same-
 2143 class behavioral health drugs, and may have other potential
 2144 medication problems.

2145 (V) Track spending trends for behavioral health drugs and
 2146 deviation from best practice guidelines.

2147 (VI) Use educational and technological approaches to
 2148 promote best practices, educate consumers, and train prescribers
 2149 in the use of practice guidelines.

2150 (VII) Disseminate electronic and published materials.

2151 (VIII) Hold statewide and regional conferences.

2152 (IX) Implement a disease management program with a model
 2153 quality-based medication component for severely mentally ill
 2154 individuals and emotionally disturbed children who are high

2155 users of care.

2156 11.a. The agency shall implement a Medicaid prescription
 2157 drug management system. The agency may contract with a vendor
 2158 that has experience in operating prescription drug management
 2159 systems in order to implement this system. Any management system
 2160 that is implemented in accordance with this subparagraph must
 2161 rely on cooperation between physicians and pharmacists to
 2162 determine appropriate practice patterns and clinical guidelines
 2163 to improve the prescribing, dispensing, and use of drugs in the
 2164 Medicaid program. The agency may seek federal waivers to
 2165 implement this program.

2166 b. The drug management system must be designed to improve
 2167 the quality of care and prescribing practices based on best
 2168 practice guidelines, improve patient adherence to medication
 2169 plans, reduce clinical risk, and lower prescribed drug costs and
 2170 the rate of inappropriate spending on Medicaid prescription
 2171 drugs. The program must:

2172 (I) Provide for the development and adoption of best
 2173 practice guidelines for the prescribing and use of drugs in the
 2174 Medicaid program, including translating best practice guidelines
 2175 into practice; reviewing prescriber patterns and comparing them
 2176 to indicators that are based on national standards and practice
 2177 patterns of clinical peers in their community, statewide, and
 2178 nationally; and determine deviations from best practice
 2179 guidelines.

2180 (II) Implement processes for providing feedback to and
 2181 educating prescribers using best practice educational materials
 2182 and peer-to-peer consultation.

2183 (III) Assess Medicaid recipients who are outliers in their
 2184 use of a single or multiple prescription drugs with regard to
 2185 the numbers and types of drugs taken, drug dosages, combination
 2186 drug therapies, and other indicators of improper use of
 2187 prescription drugs.

2188 (IV) Alert prescribers to patients who fail to refill
 2189 prescriptions in a timely fashion, are prescribed multiple drugs
 2190 that may be redundant or contraindicated, or may have other
 2191 potential medication problems.

2192 (V) Track spending trends for prescription drugs and
 2193 deviation from best practice guidelines.

2194 (VI) Use educational and technological approaches to
 2195 promote best practices, educate consumers, and train prescribers
 2196 in the use of practice guidelines.

2197 (VII) Disseminate electronic and published materials.

2198 (VIII) Hold statewide and regional conferences.

2199 (IX) Implement disease management programs in cooperation
 2200 with physicians and pharmacists, along with a model quality-
 2201 based medication component for individuals having chronic
 2202 medical conditions.

2203 12. The agency is authorized to contract for drug rebate
 2204 administration, including, but not limited to, calculating
 2205 rebate amounts, invoicing manufacturers, negotiating disputes
 2206 with manufacturers, and maintaining a database of rebate
 2207 collections.

2208 13. The agency may specify the preferred daily dosing form
 2209 or strength for the purpose of promoting best practices with
 2210 regard to the prescribing of certain drugs as specified in the

2211 General Appropriations Act and ensuring cost-effective
 2212 prescribing practices.

2213 14. The agency may require prior authorization for
 2214 Medicaid-covered prescribed drugs. The agency may, but is not
 2215 required to, prior-authorize the use of a product:

- 2216 a. For an indication not approved in labeling;
- 2217 b. To comply with certain clinical guidelines; or
- 2218 c. If the product has the potential for overuse, misuse,
 2219 or abuse.

2220
 2221 The agency may require the prescribing professional to provide
 2222 information about the rationale and supporting medical evidence
 2223 for the use of a drug. The agency may post prior authorization
 2224 criteria and protocol and updates to the list of drugs that are
 2225 subject to prior authorization on an Internet website without
 2226 amending its rule or engaging in additional rulemaking.

2227 15. The agency, in conjunction with the Pharmaceutical and
 2228 Therapeutics Committee, may require age-related prior
 2229 authorizations for certain prescribed drugs. The agency may
 2230 preauthorize the use of a drug for a recipient who may not meet
 2231 the age requirement or may exceed the length of therapy for use
 2232 of this product as recommended by the manufacturer and approved
 2233 by the Food and Drug Administration. Prior authorization may
 2234 require the prescribing professional to provide information
 2235 about the rationale and supporting medical evidence for the use
 2236 of a drug.

2237 16. The agency shall implement a step-therapy prior
 2238 authorization approval process for medications excluded from the

2239 preferred drug list. Medications listed on the preferred drug
 2240 list must be used within the previous 12 months prior to the
 2241 alternative medications that are not listed. The step-therapy
 2242 prior authorization may require the prescriber to use the
 2243 medications of a similar drug class or for a similar medical
 2244 indication unless contraindicated in the Food and Drug
 2245 Administration labeling. The trial period between the specified
 2246 steps may vary according to the medical indication. The step-
 2247 therapy approval process shall be developed in accordance with
 2248 the committee as stated in s. 409.91195(7) and (8). A drug
 2249 product may be approved without meeting the step-therapy prior
 2250 authorization criteria if the prescribing physician provides the
 2251 agency with additional written medical or clinical documentation
 2252 that the product is medically necessary because:

2253 a. There is not a drug on the preferred drug list to treat
 2254 the disease or medical condition which is an acceptable clinical
 2255 alternative;

2256 b. The alternatives have been ineffective in the treatment
 2257 of the beneficiary's disease; or

2258 c. Based on historic evidence and known characteristics of
 2259 the patient and the drug, the drug is likely to be ineffective,
 2260 or the number of doses have been ineffective.

2261
 2262 The agency shall work with the physician to determine the best
 2263 alternative for the patient. The agency may adopt rules waiving
 2264 the requirements for written clinical documentation for specific
 2265 drugs in limited clinical situations.

2266 17. The agency shall implement a return and reuse program

2267 for drugs dispensed by pharmacies to institutional recipients,
 2268 which includes payment of a \$5 restocking fee for the
 2269 implementation and operation of the program. The return and
 2270 reuse program shall be implemented electronically and in a
 2271 manner that promotes efficiency. The program must permit a
 2272 pharmacy to exclude drugs from the program if it is not
 2273 practical or cost-effective for the drug to be included and must
 2274 provide for the return to inventory of drugs that cannot be
 2275 credited or returned in a cost-effective manner. The agency
 2276 shall determine if the program has reduced the amount of
 2277 Medicaid prescription drugs which are destroyed on an annual
 2278 basis and if there are additional ways to ensure more
 2279 prescription drugs are not destroyed which could safely be
 2280 reused. The agency's conclusion and recommendations shall be
 2281 reported to the Legislature by December 1, 2005.

2282 (b) The agency shall implement this subsection to the
 2283 extent that funds are appropriated to administer the Medicaid
 2284 prescribed-drug spending-control program. The agency may
 2285 contract all or any part of this program to private
 2286 organizations.

2287 (c) The agency shall submit quarterly reports to the
 2288 Governor, the President of the Senate, and the Speaker of the
 2289 House of Representatives which must include, but need not be
 2290 limited to, the progress made in implementing this subsection
 2291 and its effect on Medicaid prescribed-drug expenditures.

2292 (38)~~(40)~~ Notwithstanding the provisions of chapter 287,
 2293 the agency may, at its discretion, renew a contract or contracts
 2294 for fiscal intermediary services one or more times for such

2295 periods as the agency may decide; however, all such renewals may
 2296 not combine to exceed a total period longer than the term of the
 2297 original contract.

2298 (39)~~(41)~~ The agency shall provide for the development of a
 2299 demonstration project by establishment in Miami-Dade County of a
 2300 long-term-care facility licensed pursuant to chapter 395 to
 2301 improve access to health care for a predominantly minority,
 2302 medically underserved, and medically complex population and to
 2303 evaluate alternatives to nursing home care and general acute
 2304 care for such population. Such project is to be located in a
 2305 health care condominium and colocated with licensed facilities
 2306 providing a continuum of care. The establishment of this project
 2307 is not subject to the provisions of s. 408.036 or s. 408.039.
 2308 This subsection expires October 1, 2012.

2309 ~~(42) The agency shall develop and implement a utilization~~
 2310 ~~management program for Medicaid-eligible recipients for the~~
 2311 ~~management of occupational, physical, respiratory, and speech~~
 2312 ~~therapies. The agency shall establish a utilization program that~~
 2313 ~~may require prior authorization in order to ensure medically~~
 2314 ~~necessary and cost-effective treatments. The program shall be~~
 2315 ~~operated in accordance with a federally approved waiver program~~
 2316 ~~or state plan amendment. The agency may seek a federal waiver or~~
 2317 ~~state plan amendment to implement this program. The agency may~~
 2318 ~~also competitively procure these services from an outside vendor~~
 2319 ~~on a regional or statewide basis.~~

2320 (40)~~(43)~~ The agency shall ~~may~~ contract on a prepaid or
 2321 fixed-sum basis with appropriately licensed prepaid dental
 2322 health plans to provide dental services. This subsection expires

2323 October 1, 2013.

2324 ~~(41)-(44)~~ The Agency for Health Care Administration shall
 2325 ensure that any Medicaid managed care plan as defined in s.
 2326 409.9122(2)(f), whether paid on a capitated basis or a shared
 2327 savings basis, is cost-effective. For purposes of this
 2328 subsection, the term "cost-effective" means that a network's
 2329 per-member, per-month costs to the state, including, but not
 2330 limited to, fee-for-service costs, administrative costs, and
 2331 case-management fees, if any, must be no greater than the
 2332 state's costs associated with contracts for Medicaid services
 2333 established under subsection (3), which may be adjusted for
 2334 health status. The agency shall conduct actuarially sound
 2335 adjustments for health status in order to ensure such cost-
 2336 effectiveness and shall publish the results on its Internet
 2337 website and submit the results annually to the Governor, the
 2338 President of the Senate, and the Speaker of the House of
 2339 Representatives no later than December 31 of each year.
 2340 Contracts established pursuant to this subsection which are not
 2341 cost-effective may not be renewed. This subsection expires
 2342 October 1, 2013.

2343 ~~(42)-(45)~~ Subject to the availability of funds, the agency
 2344 shall mandate a recipient's participation in a provider lock-in
 2345 program, when appropriate, if a recipient is found by the agency
 2346 to have used Medicaid goods or services at a frequency or amount
 2347 not medically necessary, limiting the receipt of goods or
 2348 services to medically necessary providers after the 21-day
 2349 appeal process has ended, for a period of not less than 1 year.
 2350 The lock-in programs shall include, but are not limited to,

2351 pharmacies, medical doctors, and infusion clinics. The
 2352 limitation does not apply to emergency services and care
 2353 provided to the recipient in a hospital emergency department.
 2354 The agency shall seek any federal waivers necessary to implement
 2355 this subsection. The agency shall adopt any rules necessary to
 2356 comply with or administer this subsection. This subsection
 2357 expires October 1, 2013.

2358 (43)~~(46)~~ The agency shall seek a federal waiver for
 2359 permission to terminate the eligibility of a Medicaid recipient
 2360 who has been found to have committed fraud, through judicial or
 2361 administrative determination, two times in a period of 5 years.

2362 ~~(47) The agency shall conduct a study of available~~
 2363 ~~electronic systems for the purpose of verifying the identity and~~
 2364 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
 2365 ~~to the Legislature a plan to implement an electronic~~
 2366 ~~verification system for Medicaid recipients by January 31, 2005.~~

2367 (44)~~(48)~~(a) A provider is not entitled to enrollment in
 2368 the Medicaid provider network. The agency may implement a
 2369 Medicaid fee-for-service provider network controls, including,
 2370 but not limited to, competitive procurement and provider
 2371 credentialing. If a credentialing process is used, the agency
 2372 may limit its provider network based upon the following
 2373 considerations: beneficiary access to care, provider
 2374 availability, provider quality standards and quality assurance
 2375 processes, cultural competency, demographic characteristics of
 2376 beneficiaries, practice standards, service wait times, provider
 2377 turnover, provider licensure and accreditation history, program
 2378 integrity history, peer review, Medicaid policy and billing

2379 compliance records, clinical and medical record audit findings,
 2380 and such other areas that are considered necessary by the agency
 2381 to ensure the integrity of the program.

2382 (b) The agency shall limit its network of durable medical
 2383 equipment and medical supply providers. For dates of service
 2384 after January 1, 2009, the agency shall limit payment for
 2385 durable medical equipment and supplies to providers that meet
 2386 all the requirements of this paragraph.

2387 1. Providers must be accredited by a Centers for Medicare
 2388 and Medicaid Services deemed accreditation organization for
 2389 suppliers of durable medical equipment, prosthetics, orthotics,
 2390 and supplies. The provider must maintain accreditation and is
 2391 subject to unannounced reviews by the accrediting organization.

2392 2. Providers must provide the services or supplies
 2393 directly to the Medicaid recipient or caregiver at the provider
 2394 location or recipient's residence or send the supplies directly
 2395 to the recipient's residence with receipt of mailed delivery.
 2396 Subcontracting or consignment of the service or supply to a
 2397 third party is prohibited.

2398 3. Notwithstanding subparagraph 2., a durable medical
 2399 equipment provider may store nebulizers at a physician's office
 2400 for the purpose of having the physician's staff issue the
 2401 equipment if it meets all of the following conditions:

2402 a. The physician must document the medical necessity and
 2403 need to prevent further deterioration of the patient's
 2404 respiratory status by the timely delivery of the nebulizer in
 2405 the physician's office.

2406 b. The durable medical equipment provider must have

2407 written documentation of the competency and training by a
 2408 Florida-licensed registered respiratory therapist of any durable
 2409 medical equipment staff who participate in the training of
 2410 physician office staff for the use of nebulizers, including
 2411 cleaning, warranty, and special needs of patients.

2412 c. The physician's office must have documented the
 2413 training and competency of any staff member who initiates the
 2414 delivery of nebulizers to patients. The durable medical
 2415 equipment provider must maintain copies of all physician office
 2416 training.

2417 d. The physician's office must maintain inventory records
 2418 of stored nebulizers, including documentation of the durable
 2419 medical equipment provider source.

2420 e. A physician contracted with a Medicaid durable medical
 2421 equipment provider may not have a financial relationship with
 2422 that provider or receive any financial gain from the delivery of
 2423 nebulizers to patients.

2424 4. Providers must have a physical business location and a
 2425 functional landline business phone. The location must be within
 2426 the state or not more than 50 miles from the Florida state line.
 2427 The agency may make exceptions for providers of durable medical
 2428 equipment or supplies not otherwise available from other
 2429 enrolled providers located within the state.

2430 5. Physical business locations must be clearly identified
 2431 as a business that furnishes durable medical equipment or
 2432 medical supplies by signage that can be read from 20 feet away.
 2433 The location must be readily accessible to the public during
 2434 normal, posted business hours and must operate no less than 5

2435 | hours per day and no less than 5 days per week, with the
 2436 | exception of scheduled and posted holidays. The location may not
 2437 | be located within or at the same numbered street address as
 2438 | another enrolled Medicaid durable medical equipment or medical
 2439 | supply provider or as an enrolled Medicaid pharmacy that is also
 2440 | enrolled as a durable medical equipment provider. A licensed
 2441 | orthotist or prosthetist that provides only orthotic or
 2442 | prosthetic devices as a Medicaid durable medical equipment
 2443 | provider is exempt from the provisions in this paragraph.

2444 | 6. Providers must maintain a stock of durable medical
 2445 | equipment and medical supplies on site that is readily available
 2446 | to meet the needs of the durable medical equipment business
 2447 | location's customers.

2448 | 7. Providers must provide a surety bond of \$50,000 for
 2449 | each provider location, up to a maximum of 5 bonds statewide or
 2450 | an aggregate bond of \$250,000 statewide, as identified by
 2451 | Federal Employer Identification Number. Providers who post a
 2452 | statewide or an aggregate bond must identify all of their
 2453 | locations in any Medicaid durable medical equipment and medical
 2454 | supply provider enrollment application or bond renewal. Each
 2455 | provider location's surety bond must be renewed annually and the
 2456 | provider must submit proof of renewal even if the original bond
 2457 | is a continuous bond. A licensed orthotist or prosthetist that
 2458 | provides only orthotic or prosthetic devices as a Medicaid
 2459 | durable medical equipment provider is exempt from the provisions
 2460 | in this paragraph.

2461 | 8. Providers must obtain a level 2 background screening,
 2462 | as provided under s. 435.04, for each provider employee in

2463 direct contact with or providing direct services to recipients
 2464 of durable medical equipment and medical supplies in their
 2465 homes. This requirement includes, but is not limited to, repair
 2466 and service technicians, fitters, and delivery staff. The
 2467 provider shall pay for the cost of the background screening.

2468 9. The following providers are exempt from the
 2469 requirements of subparagraphs 1. and 7.:

2470 a. Durable medical equipment providers owned and operated
 2471 by a government entity.

2472 b. Durable medical equipment providers that are operating
 2473 within a pharmacy that is currently enrolled as a Medicaid
 2474 pharmacy provider.

2475 c. Active, Medicaid-enrolled orthopedic physician groups,
 2476 primarily owned by physicians, which provide only orthotic and
 2477 prosthetic devices.

2478 (45)~~(49)~~ The agency shall contract with established
 2479 minority physician networks that provide services to
 2480 historically underserved minority patients. The networks must
 2481 provide cost-effective Medicaid services, comply with the
 2482 requirements to be a MediPass provider, and provide their
 2483 primary care physicians with access to data and other management
 2484 tools necessary to assist them in ensuring the appropriate use
 2485 of services, including inpatient hospital services and
 2486 pharmaceuticals.

2487 (a) The agency shall provide for the development and
 2488 expansion of minority physician networks in each service area to
 2489 provide services to Medicaid recipients who are eligible to
 2490 participate under federal law and rules.

2491 (b) The agency shall reimburse each minority physician
 2492 network as a fee-for-service provider, including the case
 2493 management fee for primary care, if any, or as a capitated rate
 2494 provider for Medicaid services. Any savings shall be shared with
 2495 the minority physician networks pursuant to the contract.

2496 (c) For purposes of this subsection, the term "cost-
 2497 effective" means that a network's per-member, per-month costs to
 2498 the state, including, but not limited to, fee-for-service costs,
 2499 administrative costs, and case-management fees, if any, must be
 2500 no greater than the state's costs associated with contracts for
 2501 Medicaid services established under subsection (3), which shall
 2502 be actuarially adjusted for case mix, model, and service area.
 2503 The agency shall conduct actuarially sound audits adjusted for
 2504 case mix and model in order to ensure such cost-effectiveness
 2505 and shall publish the audit results on its Internet website and
 2506 submit the audit results annually to the Governor, the President
 2507 of the Senate, and the Speaker of the House of Representatives
 2508 no later than December 31. Contracts established pursuant to
 2509 this subsection which are not cost-effective may not be renewed.

2510 (d) The agency may apply for any federal waivers needed to
 2511 implement this subsection.

2512

2513 This subsection expires October 1, 2013.

2514 ~~(46)(50)~~ To the extent permitted by federal law and as
 2515 allowed under s. 409.906, the agency shall provide reimbursement
 2516 for emergency mental health care services for Medicaid
 2517 recipients in crisis stabilization facilities licensed under s.
 2518 394.875 as long as those services are less expensive than the

2519 same services provided in a hospital setting.

2520 ~~(47)~~(51) The agency shall work with the Agency for Persons
 2521 with Disabilities to develop a home and community-based waiver
 2522 to serve children and adults who are diagnosed with familial
 2523 dysautonomia or Riley-Day syndrome caused by a mutation of the
 2524 IKBKAP gene on chromosome 9. The agency shall seek federal
 2525 waiver approval and implement the approved waiver subject to the
 2526 availability of funds and any limitations provided in the
 2527 General Appropriations Act. The agency may adopt rules to
 2528 implement this waiver program.

2529 ~~(48)~~(52) The agency shall implement a program of all-
 2530 inclusive care for children. The program of all-inclusive care
 2531 for children shall be established to provide in-home hospice-
 2532 like support services to children diagnosed with a life-
 2533 threatening illness and enrolled in the Children's Medical
 2534 Services network to reduce hospitalizations as appropriate. The
 2535 agency, in consultation with the Department of Health, may
 2536 implement the program of all-inclusive care for children after
 2537 obtaining approval from the Centers for Medicare and Medicaid
 2538 Services.

2539 ~~(49)~~(53) Before seeking an amendment to the state plan for
 2540 purposes of implementing programs authorized by the Deficit
 2541 Reduction Act of 2005, the agency shall notify the Legislature.

2542 Section 11. Subsection (4) of section 409.91195, Florida
 2543 Statutes, is amended to read:

2544 409.91195 Medicaid Pharmaceutical and Therapeutics
 2545 Committee.—There is created a Medicaid Pharmaceutical and
 2546 Therapeutics Committee within the agency for the purpose of

2547 developing a Medicaid preferred drug list.

2548 (4) Upon recommendation of the committee, the agency shall
 2549 adopt a preferred drug list as described in s. 409.912(37)~~(39)~~.
 2550 To the extent feasible, the committee shall review all drug
 2551 classes included on the preferred drug list every 12 months, and
 2552 may recommend additions to and deletions from the preferred drug
 2553 list, such that the preferred drug list provides for medically
 2554 appropriate drug therapies for Medicaid patients which achieve
 2555 cost savings contained in the General Appropriations Act.

2556 Section 12. Subsection (1) of section 409.91196, Florida
 2557 Statutes, is amended to read:

2558 409.91196 Supplemental rebate agreements; public records
 2559 and public meetings exemption.—

2560 (1) The rebate amount, percent of rebate, manufacturer's
 2561 pricing, and supplemental rebate, and other trade secrets as
 2562 defined in s. 688.002 that the agency has identified for use in
 2563 negotiations, held by the Agency for Health Care Administration
 2564 under s. 409.912(37)~~(39)~~(a)7. are confidential and exempt from
 2565 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

2566 Section 13. Section 409.91207, Florida Statutes, is
 2567 amended to read:

2568 (Substantial rewording of section. See s. 409.91207,
 2569 F.S., for present text.)
 2570 409.91207 Medical homes.—

2571 (1) AUTHORITY.—The agency shall develop a method for
 2572 designating qualified plans as a medical home network.

2573 (2) PURPOSE AND PRINCIPLES.—Medical home networks foster
 2574 and support coordinated and effective primary care through case

2575 management, support to primary care providers, supplemental
 2576 services, and dissemination of best practices. Medical home
 2577 networks target patients with chronic illnesses and frequent
 2578 service utilization in order to coordinate services, provide
 2579 disease management and patient education, and improve quality of
 2580 care. In addition to primary care, medical home networks are
 2581 able to provide or arrange for pharmacy, outpatient diagnostic,
 2582 and specialty physician services and coordinate with inpatient
 2583 facilities and rehabilitative service providers.

2584 (3) DESIGNATION.—A qualified plan may request agency
 2585 designation as a medical home network if the plan is accredited
 2586 as a medical home network by the National Committee for Quality
 2587 Assurance or:

2588 (a) The plan establishes a method for its enrollees to
 2589 choose to participate as medical home patients and select a
 2590 primary care provider that is certified as a medical home.

2591 (b) At least 85 percent of the primary care providers in a
 2592 medical home network are certified by the qualified plan as
 2593 having the following service capabilities:

2594 1. Supply all medically necessary primary and preventive
 2595 services and provide all scheduled immunizations.

2596 2. Organize clinical data in electronic form using a
 2597 patient-centered charting system.

2598 3. Maintain and update a patient's medication list and
 2599 review all medications during each office visit.

2600 4. Maintain a system to track diagnostic tests and provide
 2601 followup services regarding test results.

2602 5. Maintain a system to track referrals, including self-

- 2603 | referrals by members.
- 2604 | 6. Supply care coordination and continuity of care through
- 2605 | proactive contact with members and encourage family
- 2606 | participation in care.
- 2607 | 7. Supply education and support using various materials
- 2608 | and processes appropriate for individual patient needs.
- 2609 | 8. Communicate electronically.
- 2610 | 9. Supply voice-to-voice telephone coverage to medical
- 2611 | home patients 24 hours per day, 7 days per week, to enable
- 2612 | medical home patients to speak to a licensed health care
- 2613 | professional who triages and forwards calls, as appropriate.
- 2614 | 10. Maintain an office schedule of at least 30 scheduled
- 2615 | hours per week.
- 2616 | 11. Use scheduling processes to promote continuity with
- 2617 | clinicians, including providing care for walk-in, routine, and
- 2618 | urgent care visits.
- 2619 | 12. Implement and document behavioral health and substance
- 2620 | abuse screening procedures and make referrals as needed.
- 2621 | 13. Use data to identify and track patients' health and
- 2622 | service use patterns.
- 2623 | 14. Coordinate care and followup for patients receiving
- 2624 | services in inpatient and outpatient facilities.
- 2625 | 15. Implement processes to promote access to care and
- 2626 | member communication.
- 2627 | 16. Maintain electronic medical records.
- 2628 | 17. Develop a health care team that provides ongoing
- 2629 | support, oversight, and guidance for all medical care received
- 2630 | by the patient and documents contact with specialists and other

2631 health care providers caring for the patient.
 2632 18. Supply postvisit followup care for patients.
 2633 19. Implement specific evidence-based clinical practice
 2634 guidelines for preventive and chronic care.
 2635 20. Implement a medication reconciliation procedure to
 2636 avoid interactions or duplications.
 2637 21. Use personalized screening, brief intervention, and
 2638 referral to treatment procedures for appropriate patients
 2639 requiring specialty treatment.
 2640 22. Offer at least 4 hours per week of after-hours care to
 2641 patients.
 2642 23. Use health assessment tools to identify patient needs
 2643 and risks.
 2644 (c) The qualified plan offers support services to its
 2645 primary care providers, including:
 2646 1. Case management, outreach, care coordination, and other
 2647 targeted support services for medical home patients.
 2648 2. Ongoing assessment of spending and service utilization
 2649 by all medical home network patients.
 2650 3. Periodic evaluation of patient outcomes.
 2651 4. Coordination with inpatient facilities, behavioral
 2652 health, and rehabilitative service providers.
 2653 5. Establishing specific methods to manage pharmacy and
 2654 behavioral health services.
 2655 6. Paying primary care providers. It is the intent of the
 2656 Legislature that the savings that result from the implementation
 2657 of the medical home network model be used to enable Medicaid
 2658 fees to physicians participating in medical home networks to be

2659 equivalent to 100 percent of Medicare rates as soon as possible.

2660 (4) AGENCY DUTIES.—The agency shall:

2661 (a) Maintain a record of qualified plans designated as
 2662 medical home networks.

2663 (b) Develop a standard form to be used by the qualified
 2664 plans to certify to the agency that they meet the necessary
 2665 service and primary care provider support capabilities to be
 2666 designated a medical home.

2667 Section 14. Section 409.91211, Florida Statutes, is
 2668 amended to read:

2669 (Substantial rewording of section. See s. 409.91211,
 2670 F.S., for present text.)

2671 409.91211.—Medicaid managed care pilot program.—

2672 (1) AUTHORITY.—The agency is authorized to implement a
 2673 managed care pilot program based on the Section 1115 waiver
 2674 approved by the Centers for Medicare and Medicaid Services on
 2675 October 19, 2005, including continued operation of the program
 2676 in Baker, Broward, Clay, Duval, and Nassau Counties. The managed
 2677 care pilot program shall be consistent with the provisions of
 2678 this section, subject to federal approval.

2679 (2) EXTENSION.—No later than July 1, 2010, the agency
 2680 shall begin the process of requesting an extension of the
 2681 Section 1115 waiver. The agency shall report at least monthly to
 2682 the Legislature on progress in negotiating for the extension of
 2683 the waiver. Changes to the terms and conditions relating to the
 2684 low-income pool must be approved by the Legislative Budget
 2685 Commission.

2686 (3) EXPANSION.—The agency shall expand the managed care
 2687 pilot program to Miami-Dade County in a manner that enrolls all
 2688 eligible recipients in qualified plan commencing January 1,
 2689 2012, but no later than October 1, 2012.

2690 (4) QUALIFIED PLANS.—Managed care plans qualified to
 2691 participate in the Medicaid managed care pilot program include
 2692 health insurers authorized under chapter 624, exclusive provider
 2693 organizations authorized under chapter 627, health maintenance
 2694 organizations authorized under chapter 641, the Children's
 2695 Medical Services Network under chapter 391, and provider service
 2696 networks authorized pursuant to s. 409.912(4)(d).

2697 (5) PLAN REQUIREMENTS.—The agency shall apply the
 2698 following requirements to all qualified plans:

2699 (a) Prepaid rates shall be risk adjusted pursuant to
 2700 subsection (17).

2701 (b) All Medicaid recipients shall be offered the
 2702 opportunity to use their Medicaid premium to pay for the
 2703 recipient's share of cost pursuant to s. 409.9122(13).

2704 (6) INTERGOVERNMENTAL TRANSFERS.—In order to preserve
 2705 intergovernmental transfers of funds from Miami-Dade County, the
 2706 agency shall develop methodologies, including, but not limited
 2707 to, a supplemental capitation rate, risk pool, or incentive
 2708 payments, which may be paid to prepaid plans or plans owned and
 2709 operated by providers that contract with safety net providers,
 2710 trauma hospitals, children's hospitals, and statutory teaching
 2711 hospitals. In order to preserve certified public expenditures
 2712 from Miami-Dade County, the agency shall seek federal approval
 2713 to implement a methodology that allows supplemental payments to

2714 | be made directly to physicians employed by or under contract
 2715 | with a medical school in Florida in recognition of the costs
 2716 | associated with graduate medical education or their teaching
 2717 | mission. Alternatively, the agency may develop additional
 2718 | methodologies including, but not limited to, methodologies
 2719 | mentioned above, as well as capitated rates that exclude
 2720 | payments made to these physicians so that they may be paid
 2721 | directly. Once methodologies and payment mechanisms are
 2722 | approved, the agency shall submit the plan for preserving
 2723 | intergovernmental transfers and certified public expenditures to
 2724 | the Legislative Budget Commission. After the assignment and
 2725 | enrollment of all mandatory eligible persons in Miami-Dade
 2726 | County into managed care plans, an amendment shall be submitted
 2727 | to the Legislative Budget Commission requesting authority for
 2728 | the transfer of sufficient funds from appropriate line items
 2729 | within the Grants and Donations Trust Fund and the Medical Care
 2730 | Trust Fund within the Agency for Health Care Administration in
 2731 | the General Appropriations Act to the line item for Prepaid
 2732 | Health Plans within the General Appropriations Act. The agency
 2733 | shall submit a report to the Legislature regarding how the
 2734 | developed and approved methodologies and payment mechanisms may
 2735 | be applied to other counties in the state pursuant to managed
 2736 | care payments under s. 409.968.

2737 | (7) ENROLLMENT.—All Medicaid recipients in the counties in
 2738 | which the managed care pilot program has been implemented shall
 2739 | be enrolled in a qualified plan. Each recipient shall have a
 2740 | choice of plans and may select any plan unless that plan is
 2741 | restricted by contract to a specific population that does not

2742 include the recipient. Medicaid recipients shall have 30 days in
 2743 which to make a choice of plans. All recipients shall be offered
 2744 choice counseling services in accordance with this section.

2745 (8) CHOICE COUNSELING.—The agency shall provide choice
 2746 counseling and may contract for the provision of choice
 2747 counseling services. Choice counseling shall be provided in the
 2748 native or preferred language of the recipient, consistent with
 2749 federal requirements. The agency shall maintain a record of the
 2750 recipients who receive such services, identifying the scope and
 2751 method of the services provided. The agency shall make available
 2752 clear and easily understandable choice information to Medicaid
 2753 recipients that includes:

2754 (a) An explanation that each recipient has the right to
 2755 choose a qualified plan at the time of enrollment in Medicaid
 2756 and again at regular intervals set by the agency and that, if a
 2757 recipient does not choose a qualified plan, the agency will
 2758 assign the recipient to a qualified plan according to the
 2759 criteria specified in this section.

2760 (b) A list and description of the benefits provided in
 2761 each plan.

2762 (c) Information about earning credits in the plan's
 2763 enhanced benefit program.

2764 (d) An explanation of benefit limits.

2765 (e) Information about cost-sharing requirements of each
 2766 plan.

2767 (f) A current list of providers participating in the
 2768 network, including location and contact information.

2769 (g) Plan performance data.

2770 | (9) AUTOMATIC ENROLLMENT.—The agency shall automatically
 2771 | enroll Medicaid recipients who do not voluntarily choose a
 2772 | managed care plan. Enrollment shall be distributed among all
 2773 | qualified plans. When automatically enrolling recipients, the
 2774 | agency shall take into account the following criteria:

2775 | (a) The plan has sufficient network capacity to meet the
 2776 | needs of the recipients.

2777 | (b) The recipient has previously received services from
 2778 | one of the plan's primary care providers.

2779 | (c) Primary care providers in one plan are more
 2780 | geographically accessible to the recipient's residence.

2781 |
 2782 | The agency may not engage in practices that are designed to
 2783 | favor one qualified plan over another.

2784 | (10) DISENROLLMENT.—After a recipient has selected and
 2785 | enrolled in a qualified plan, the recipient shall have 90 days
 2786 | to voluntarily disenroll and select another qualified plan.
 2787 | After 90 days, further changes may be made only for good cause.
 2788 | "Good cause" includes, but is not limited to, poor quality of
 2789 | care, lack of access to necessary specialty services, an
 2790 | unreasonable delay or denial of service, or fraudulent
 2791 | enrollment. The agency must make a determination as to whether
 2792 | cause exists. However, the agency may require a recipient to use
 2793 | the qualified plan's grievance process prior to the agency's
 2794 | determination of cause, except in cases in which immediate risk
 2795 | of permanent damage to the recipient's health is alleged. The
 2796 | agency must make a determination and take final action on a
 2797 | recipient's request so that disenrollment occurs no later than

2798 the first day of the second month after the month the request
 2799 was made. If the agency fails to act within the specified
 2800 timeframe, the recipient's request to disenroll is deemed to be
 2801 approved as of the date agency action was required. Recipients
 2802 who disagree with the agency's finding that cause does not exist
 2803 for disenrollment shall be advised of their right to pursue a
 2804 Medicaid fair hearing to dispute the agency's finding.

2805 (11) ENROLLMENT PERIOD.—Medicaid recipients enrolled in a
 2806 qualified plan after the 90-day period shall remain in the plan
 2807 for 12 months. After 12 months, the recipient may select another
 2808 plan. However, nothing shall prevent a Medicaid recipient from
 2809 changing primary care providers within the qualified plan during
 2810 the 12-month period.

2811 (12) GRIEVANCES.—Each qualified plan shall establish an
 2812 internal process for reviewing and responding to grievances from
 2813 enrollees. The contract shall specify timeframes for submission,
 2814 plan response, and resolution. Grievances not resolved by a
 2815 plan's internal process shall be submitted to the Subscriber
 2816 Assistance Panel pursuant to s. 408.7056. Each plan shall submit
 2817 quarterly reports on the number, description, and outcome of
 2818 grievances filed by enrollees. The agency shall establish a
 2819 similar process for provider service networks.

2820 (13) BENEFITS.—Qualified plans operating in the Medicaid
 2821 managed care pilot program shall cover the services specified in
 2822 ss. 409.905 and 409.906, emergency services provided under s.
 2823 409.9128, and such other services as the plan may offer. Plans
 2824 may customize benefit packages for nonpregnant adults, vary
 2825 cost-sharing provisions, and provide coverage for additional

2826 services. The agency shall evaluate the proposed benefit
 2827 packages to ensure services are sufficient to meet the needs of
 2828 the plans' enrollees and to verify actuarial equivalence.

2829 (14) PENALTIES.—Qualified plans that reduce enrollment
 2830 levels or leave a county where the managed care pilot program
 2831 has been implemented shall reimburse the agency for the cost of
 2832 enrollment changes, including the cost of additional choice
 2833 counseling services. When more than one qualified plan leaves a
 2834 county at the same time, costs shall be shared by the plans
 2835 proportionate to their enrollments.

2836 (15) ACCESS TO DATA.—The agency shall make encounter data
 2837 available to those plans accepting enrollees who are assigned to
 2838 them from other plans leaving a county where the managed care
 2839 pilot program has been implemented.

2840 (16) ENHANCED BENEFITS.—Each plan operating in the managed
 2841 care pilot program shall establish an incentive program that
 2842 rewards specific healthy behaviors with credits in a flexible
 2843 spending account pursuant to s. 409.9122(14).

2844 (17) PAYMENTS TO MANAGED CARE PLANS.—

2845 (a) The agency shall continue the budget-neutral
 2846 adjustment of capitation rates for all prepaid plans in existing
 2847 managed care pilot program counties.

2848 (b) Beginning September 1, 2010, the agency shall begin a
 2849 budget-neutral adjustment of capitation rates for all prepaid
 2850 plans in Miami-Dade County. The adjustment to capitation rates
 2851 shall be based on aggregate risk scores for each prepaid plan's
 2852 enrollees. During the first 2 years of the adjustment, the
 2853 agency shall ensure that no plan has an aggregate risk score

2854 that varies by more than 10 percent from the aggregate weighted
 2855 average for all plans. Except as otherwise provided in this
 2856 paragraph, the risk adjusted capitation rates shall be phased in
 2857 as follows:

2858 1. In the first fiscal year, 75 percent of the capitation
 2859 rate shall be based on the current methodology and 25 percent
 2860 shall be based on the risk-adjusted rate methodology.

2861 2. In the second fiscal year, 50 percent of the capitation
 2862 rate shall be based on the current methodology and 50 percent
 2863 shall be based on the risk-adjusted methodology.

2864 3. In the third fiscal year, the risk-adjusted capitation
 2865 methodology shall be fully implemented.

2866
 2867 The rates for plans owned and operated by a public hospital
 2868 shall be risk-adjusted immediately. In order to meet the
 2869 requirements of budget neutrality, and until such time as all
 2870 rates in the county are risk-adjusted, the rate differential is
 2871 contingent on the nonfederal share being provided through grants
 2872 and donations from allowable nonstate sources. The agency shall
 2873 submit an amendment to the Legislative Budget Commission
 2874 requesting authority for such payments.

2875 (c) During this period, the agency shall establish a
 2876 technical advisory panel to obtain input from the prepaid plans
 2877 affected by the transition to risk adjusted rates.

2878 (18) LOW-INCOME POOL.—Funds from a low-income pool shall
 2879 be distributed in accordance with the terms and conditions of
 2880 the 1115 waiver and in a manner authorized by the General

2881 Appropriations Act. The distribution of funds is intended for
 2882 the following purposes:
 2883 (a) Assure a broad and fair distribution of available
 2884 funds based on the access provided by Medicaid participating
 2885 hospitals, regardless of their ownership status, through their
 2886 delivery of inpatient or outpatient care for Medicaid
 2887 beneficiaries and uninsured and underinsured individuals;
 2888 (b) Assure accessible emergency inpatient and outpatient
 2889 care for Medicaid beneficiaries and uninsured and underinsured
 2890 individuals;
 2891 (c) Enhance primary, preventive, and other ambulatory care
 2892 coverages for uninsured individuals;
 2893 (d) Promote teaching and specialty hospital programs;
 2894 (e) Promote the stability and viability of statutorily
 2895 defined rural hospitals and hospitals that serve as sole
 2896 community hospitals;
 2897 (f) Recognize the extent of hospital uncompensated care
 2898 costs;
 2899 (g) Maintain and enhance essential community hospital
 2900 care;
 2901 (h) Maintain incentives for local governmental entities to
 2902 contribute to the cost of uncompensated care;
 2903 (i) Promote measures to avoid preventable
 2904 hospitalizations;
 2905 (j) Account for hospital efficiency; and
 2906 (k) Contribute to a community's overall health system.
 2907 (19) ENCOUNTER DATA.—The agency shall maintain and operate
 2908 the Medicaid Encounter Data System pursuant to s. 409.9122(15).

2909 (20) EVALUATION.—The agency shall contract with the
 2910 University of Florida to complete a comprehensive evaluation of
 2911 the managed care pilot program. The evaluation shall include an
 2912 assessment of patient satisfaction, changes in benefits and
 2913 coverage, implementation and impact of enhanced benefits, access
 2914 to care and service utilization by enrolled recipients, and
 2915 costs per enrollee. The agency shall establish an initiative to
 2916 improve recipient access to information about plan performance.
 2917 The agency shall publish on its Internet website information on
 2918 plan performance, including, but not limited to, results of plan
 2919 enrollee satisfaction surveys, data reported pursuant to s.
 2920 409.9122(17), and information on recipient grievances. The
 2921 website shall be user-friendly and shall provide an opportunity
 2922 for recipients to give web-based feedback on plans. Plans shall
 2923 advise recipients of the information available on the agency's
 2924 website and how to access it in the initial enrollment
 2925 materials. The agency shall evaluate the initiative to determine
 2926 whether it improves recipient access to information.

2927 Section 15. Section 409.9122, Florida Statutes, is amended
 2928 to read:

2929 409.9122 Mandatory Medicaid managed care enrollment;
 2930 programs and procedures.—

2931 (1) It is the intent of the Legislature that the MediPass
 2932 program be cost-effective, provide quality health care, and
 2933 improve access to health services, and that the program be
 2934 statewide. This subsection expires October 1, 2013.

2935 (2) (a) The agency shall enroll in a managed care plan or
 2936 MediPass all Medicaid recipients, except those Medicaid

2937 recipients who are: in an institution; enrolled in the Medicaid
 2938 medically needy program; or eligible for both Medicaid and
 2939 Medicare. Upon enrollment, individuals will be able to change
 2940 their managed care option during the 90-day opt out period
 2941 required by federal Medicaid regulations. The agency is
 2942 authorized to seek the necessary Medicaid state plan amendment
 2943 to implement this policy. However, to the extent permitted by
 2944 federal law, the agency may enroll in a managed care plan or
 2945 MediPass a Medicaid recipient who is exempt from mandatory
 2946 managed care enrollment, provided that:

2947 1. The recipient's decision to enroll in a managed care
 2948 plan or MediPass is voluntary;

2949 2. If the recipient chooses to enroll in a managed care
 2950 plan, the agency has determined that the managed care plan
 2951 provides specific programs and services which address the
 2952 special health needs of the recipient; and

2953 3. The agency receives any necessary waivers from the
 2954 federal Centers for Medicare and Medicaid Services.

2955
 2956 ~~The agency shall develop rules to establish policies by which~~
 2957 ~~exceptions to the mandatory managed care enrollment requirement~~
 2958 ~~may be made on a case-by-case basis. The rules shall include the~~
 2959 ~~specific criteria to be applied when making a determination as~~
 2960 ~~to whether to exempt a recipient from mandatory enrollment in a~~
 2961 ~~managed care plan or MediPass.~~ School districts participating in
 2962 the certified school match program pursuant to ss. 409.908(21)
 2963 and 1011.70 shall be reimbursed by Medicaid, subject to the
 2964 limitations of s. 1011.70(1), for a Medicaid-eligible child

2965 participating in the services as authorized in s. 1011.70, as
 2966 provided for in s. 409.9071, regardless of whether the child is
 2967 enrolled in MediPass or a managed care plan. Managed care plans
 2968 shall make a good faith effort to execute agreements with school
 2969 districts regarding the coordinated provision of services
 2970 authorized under s. 1011.70. County health departments
 2971 delivering school-based services pursuant to ss. 381.0056 and
 2972 381.0057 shall be reimbursed by Medicaid for the federal share
 2973 for a Medicaid-eligible child who receives Medicaid-covered
 2974 services in a school setting, regardless of whether the child is
 2975 enrolled in MediPass or a managed care plan. Managed care plans
 2976 shall make a good faith effort to execute agreements with county
 2977 health departments regarding the coordinated provision of
 2978 services to a Medicaid-eligible child. To ensure continuity of
 2979 care for Medicaid patients, the agency, the Department of
 2980 Health, and the Department of Education shall develop procedures
 2981 for ensuring that a student's managed care plan or MediPass
 2982 provider receives information relating to services provided in
 2983 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

2984 (b) A Medicaid recipient shall not be enrolled in or
 2985 assigned to a managed care plan or MediPass unless the managed
 2986 care plan or MediPass has complied with the quality-of-care
 2987 standards specified in paragraphs (3)(a) and (b), respectively.

2988 (c) Medicaid recipients shall have a choice of managed
 2989 care plans or MediPass. The Agency for Health Care
 2990 Administration, the Department of Health, the Department of
 2991 Children and Family Services, and the Department of Elderly
 2992 Affairs shall cooperate to ensure that each Medicaid recipient

2993 receives clear and easily understandable information that meets
 2994 the following requirements:

2995 1. Explains the concept of managed care, including
 2996 MediPass.

2997 2. Provides information on the comparative performance of
 2998 managed care plans and MediPass in the areas of quality,
 2999 credentialing, preventive health programs, network size and
 3000 availability, and patient satisfaction.

3001 3. Explains where additional information on each managed
 3002 care plan and MediPass in the recipient's area can be obtained.

3003 4. Explains that recipients have the right to choose their
 3004 managed care coverage at the time they first enroll in Medicaid
 3005 and again at regular intervals set by the agency. However, if a
 3006 recipient does not choose a managed care plan or MediPass, the
 3007 agency will assign the recipient to a managed care plan or
 3008 MediPass according to the criteria specified in this section.

3009 5. Explains the recipient's right to complain, file a
 3010 grievance, or change managed care plans or MediPass providers if
 3011 the recipient is not satisfied with the managed care plan or
 3012 MediPass.

3013 (d) The agency shall develop a mechanism for providing
 3014 information to Medicaid recipients for the purpose of making a
 3015 managed care plan or MediPass selection. Examples of such
 3016 mechanisms may include, but not be limited to, interactive
 3017 information systems, mailings, and mass marketing materials.
 3018 Managed care plans and MediPass providers are prohibited from
 3019 providing inducements to Medicaid recipients to select their
 3020 plans or from prejudicing Medicaid recipients against other

3021 managed care plans or MediPass providers.

3022 (e) Medicaid recipients who are already enrolled in a
 3023 managed care plan or MediPass shall be offered the opportunity
 3024 to change managed care plans or MediPass providers on a
 3025 staggered basis, as defined by the agency. All Medicaid
 3026 recipients shall have 30 days in which to make a choice of
 3027 managed care plans or MediPass providers. Those Medicaid
 3028 recipients who do not make a choice shall be assigned in
 3029 accordance with paragraph (f). To facilitate continuity of care,
 3030 for a Medicaid recipient who is also a recipient of Supplemental
 3031 Security Income (SSI), prior to assigning the SSI recipient to a
 3032 managed care plan or MediPass, the agency shall determine
 3033 whether the SSI recipient has an ongoing relationship with a
 3034 MediPass provider or managed care plan, and if so, the agency
 3035 shall assign the SSI recipient to that MediPass provider or
 3036 managed care plan. Those SSI recipients who do not have such a
 3037 provider relationship shall be assigned to a managed care plan
 3038 or MediPass provider in accordance with paragraph (f).

3039 (f) If a Medicaid recipient does not choose a managed care
 3040 plan or MediPass provider, the agency shall assign the Medicaid
 3041 recipient to a managed care plan or MediPass provider. Medicaid
 3042 recipients eligible for managed care plan enrollment who are
 3043 subject to mandatory assignment but who fail to make a choice
 3044 shall be assigned to managed care plans until an enrollment of
 3045 35 percent in MediPass and 65 percent in managed care plans, of
 3046 all those eligible to choose managed care, is achieved. Once
 3047 this enrollment is achieved, the assignments shall be divided in
 3048 order to maintain an enrollment in MediPass and managed care

3049 plans which is in a 35 percent and 65 percent proportion,
 3050 respectively. Thereafter, assignment of Medicaid recipients who
 3051 fail to make a choice shall be based proportionally on the
 3052 preferences of recipients who have made a choice in the previous
 3053 period. Such proportions shall be revised at least quarterly to
 3054 reflect an update of the preferences of Medicaid recipients. The
 3055 agency shall disproportionately assign Medicaid-eligible
 3056 recipients who are required to but have failed to make a choice
 3057 of managed care plan or MediPass, ~~including children, and who~~
 3058 ~~would be assigned to the MediPass program to children's networks~~
 3059 ~~as described in s. 409.912(4)(g),~~ Children's Medical Services
 3060 Network as defined in s. 391.021, exclusive provider
 3061 organizations, provider service networks, minority physician
 3062 networks, and pediatric emergency department diversion programs
 3063 authorized by this chapter or the General Appropriations Act, in
 3064 such manner as the agency deems appropriate, until the agency
 3065 has determined that the networks and programs have sufficient
 3066 numbers to be operated economically. For purposes of this
 3067 paragraph, when referring to assignment, the term "managed care
 3068 plans" includes health maintenance organizations, exclusive
 3069 provider organizations, provider service networks, minority
 3070 physician networks, Children's Medical Services Network, and
 3071 pediatric emergency department diversion programs authorized by
 3072 this chapter or the General Appropriations Act. When making
 3073 assignments, the agency shall take into account the following
 3074 criteria:
 3075 1. A managed care plan has sufficient network capacity to
 3076 meet the need of members.

3077 2. The managed care plan or MediPass has previously
 3078 enrolled the recipient as a member, or one of the managed care
 3079 plan's primary care providers or MediPass providers has
 3080 previously provided health care to the recipient.

3081 3. The agency has knowledge that the member has previously
 3082 expressed a preference for a particular managed care plan or
 3083 MediPass provider as indicated by Medicaid fee-for-service
 3084 claims data, but has failed to make a choice.

3085 4. The managed care plan's or MediPass primary care
 3086 providers are geographically accessible to the recipient's
 3087 residence.

3088 (g) When more than one managed care plan or MediPass
 3089 provider meets the criteria specified in paragraph (f), the
 3090 agency shall make recipient assignments consecutively by family
 3091 unit.

3092 (h) The agency may not engage in practices that are
 3093 designed to favor one managed care plan over another or that are
 3094 designed to influence Medicaid recipients to enroll in MediPass
 3095 rather than in a managed care plan or to enroll in a managed
 3096 care plan rather than in MediPass. This subsection does not
 3097 prohibit the agency from reporting on the performance of
 3098 MediPass or any managed care plan, as measured by performance
 3099 criteria developed by the agency.

3100 (i) After a recipient has made his or her selection or has
 3101 been enrolled in a managed care plan or MediPass, the recipient
 3102 shall have 90 days to exercise the opportunity to voluntarily
 3103 disenroll and select another managed care plan or MediPass.
 3104 After 90 days, no further changes may be made except for good

3105 cause. Good cause includes, but is not limited to, poor quality
 3106 of care, lack of access to necessary specialty services, an
 3107 unreasonable delay or denial of service, or fraudulent
 3108 enrollment. The agency shall develop criteria for good cause
 3109 disenrollment for chronically ill and disabled populations who
 3110 are assigned to managed care plans if more appropriate care is
 3111 available through the MediPass program. The agency must make a
 3112 determination as to whether cause exists. However, the agency
 3113 may require a recipient to use the managed care plan's or
 3114 MediPass grievance process prior to the agency's determination
 3115 of cause, except in cases in which immediate risk of permanent
 3116 damage to the recipient's health is alleged. The grievance
 3117 process, when utilized, must be completed in time to permit the
 3118 recipient to disenroll by the first day of the second month
 3119 after the month the disenrollment request was made. If the
 3120 managed care plan or MediPass, as a result of the grievance
 3121 process, approves an enrollee's request to disenroll, the agency
 3122 is not required to make a determination in the case. The agency
 3123 must make a determination and take final action on a recipient's
 3124 request so that disenrollment occurs no later than the first day
 3125 of the second month after the month the request was made. If the
 3126 agency fails to act within the specified timeframe, the
 3127 recipient's request to disenroll is deemed to be approved as of
 3128 the date agency action was required. Recipients who disagree
 3129 with the agency's finding that cause does not exist for
 3130 disenrollment shall be advised of their right to pursue a
 3131 Medicaid fair hearing to dispute the agency's finding.

3132 (j) The agency shall apply for a federal waiver from the

3133 Centers for Medicare and Medicaid Services to lock eligible
 3134 Medicaid recipients into a managed care plan or MediPass for 12
 3135 months after an open enrollment period. After 12 months'
 3136 enrollment, a recipient may select another managed care plan or
 3137 MediPass provider. However, nothing shall prevent a Medicaid
 3138 recipient from changing primary care providers within the
 3139 managed care plan or MediPass program during the 12-month
 3140 period.

3141 (k) When a Medicaid recipient does not choose a managed
 3142 care plan or MediPass provider, the agency shall assign the
 3143 Medicaid recipient to a managed care plan, except in those
 3144 counties in which there are fewer than two managed care plans
 3145 accepting Medicaid enrollees, in which case assignment shall be
 3146 to a managed care plan or a MediPass provider. Medicaid
 3147 recipients in counties with fewer than two managed care plans
 3148 accepting Medicaid enrollees who are subject to mandatory
 3149 assignment but who fail to make a choice shall be assigned to
 3150 managed care plans until an enrollment of 35 percent in MediPass
 3151 and 65 percent in managed care plans, of all those eligible to
 3152 choose managed care, is achieved. Once that enrollment is
 3153 achieved, the assignments shall be divided in order to maintain
 3154 an enrollment in MediPass and managed care plans which is in a
 3155 35 percent and 65 percent proportion, respectively. For purposes
 3156 of this paragraph, when referring to assignment, the term
 3157 "managed care plans" includes exclusive provider organizations,
 3158 provider service networks, Children's Medical Services Network,
 3159 minority physician networks, and pediatric emergency department
 3160 diversion programs authorized by this chapter or the General

3161 Appropriations Act. When making assignments, the agency shall
 3162 take into account the following criteria:

3163 1. A managed care plan has sufficient network capacity to
 3164 meet the need of members.

3165 2. The managed care plan or MediPass has previously
 3166 enrolled the recipient as a member, or one of the managed care
 3167 plan's primary care providers or MediPass providers has
 3168 previously provided health care to the recipient.

3169 3. The agency has knowledge that the member has previously
 3170 expressed a preference for a particular managed care plan or
 3171 MediPass provider as indicated by Medicaid fee-for-service
 3172 claims data, but has failed to make a choice.

3173 4. The managed care plan's or MediPass primary care
 3174 providers are geographically accessible to the recipient's
 3175 residence.

3176 5. The agency has authority to make mandatory assignments
 3177 based on quality of service and performance of managed care
 3178 plans.

3179 (1) Notwithstanding the provisions of chapter 287, the
 3180 agency may, at its discretion, renew cost-effective contracts
 3181 for choice counseling services once or more for such periods as
 3182 the agency may decide. However, all such renewals may not
 3183 combine to exceed a total period longer than the term of the
 3184 original contract.

3185
 3186 This subsection expires October 1, 2013.

3187 (3) (a) The agency shall establish quality-of-care
 3188 standards for managed care plans. These standards shall be based

3189 upon, but are not limited to:

3190 1. Compliance with the accreditation requirements as
3191 provided in s. 641.512.

3192 2. Compliance with Early and Periodic Screening,
3193 Diagnosis, and Treatment screening requirements.

3194 3. The percentage of voluntary disenrollments.

3195 4. Immunization rates.

3196 5. Standards of the National Committee for Quality
3197 Assurance and other approved accrediting bodies.

3198 6. Recommendations of other authoritative bodies.

3199 7. Specific requirements of the Medicaid program, or
3200 standards designed to specifically assist the unique needs of
3201 Medicaid recipients.

3202 8. Compliance with the health quality improvement system
3203 as established by the agency, which incorporates standards and
3204 guidelines developed by the Medicaid Bureau of the Health Care
3205 Financing Administration as part of the quality assurance reform
3206 initiative.

3207 (b) For the MediPass program, the agency shall establish
3208 standards which are based upon, but are not limited to:

3209 1. Quality-of-care standards which are comparable to those
3210 required of managed care plans.

3211 2. Credentialing standards for MediPass providers.

3212 3. Compliance with Early and Periodic Screening,
3213 Diagnosis, and Treatment screening requirements.

3214 4. Immunization rates.

3215 5. Specific requirements of the Medicaid program, or
3216 standards designed to specifically assist the unique needs of

3217 Medicaid recipients.

3218

3219 This subsection expires October 1, 2013.

3220 (4) (a) Each female recipient may select as her primary
 3221 care provider an obstetrician/gynecologist who has agreed to
 3222 participate as a MediPass primary care case manager.

3223 (b) The agency shall establish a complaints and grievance
 3224 process to assist Medicaid recipients enrolled in the MediPass
 3225 program to resolve complaints and grievances. The agency shall
 3226 investigate reports of quality-of-care grievances which remain
 3227 unresolved to the satisfaction of the enrollee.

3228

3229 This subsection expires October 1, 2013.

3230 (5) (a) The agency shall work cooperatively with the Social
 3231 Security Administration to identify beneficiaries who are
 3232 jointly eligible for Medicare and Medicaid and shall develop
 3233 cooperative programs to encourage these beneficiaries to enroll
 3234 in a Medicare participating health maintenance organization or
 3235 prepaid health plans.

3236 (b) The agency shall work cooperatively with the
 3237 Department of Elderly Affairs to assess the potential cost-
 3238 effectiveness of providing MediPass to beneficiaries who are
 3239 jointly eligible for Medicare and Medicaid on a voluntary choice
 3240 basis. If the agency determines that enrollment of these
 3241 beneficiaries in MediPass has the potential for being cost-
 3242 effective for the state, the agency shall offer MediPass to
 3243 these beneficiaries on a voluntary choice basis in the counties
 3244 where MediPass operates.

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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~~

3273 ~~maintenance organizations and prepaid health plans that will~~
 3274 ~~provide high-quality health care to Medicaid recipients.~~

3275 ~~(b) Subject to the availability of moneys and any~~
 3276 ~~limitations established by the General Appropriations Act or~~
 3277 ~~chapter 216, the agency is authorized to enter into contracts~~
 3278 ~~with traditional providers of health care to low-income persons~~
 3279 ~~to assist such providers with the technical aspects of~~
 3280 ~~cooperatively developing Medicaid prepaid health plans.~~

3281 ~~1. The agency may contract with disproportionate share~~
 3282 ~~hospitals, county health departments, federally initiated or~~
 3283 ~~federally funded community health centers, and counties that~~
 3284 ~~operate either a hospital or a community clinic.~~

3285 ~~2. A contract may not be for more than \$100,000 per year,~~
 3286 ~~and no contract may be extended with any particular provider for~~
 3287 ~~more than 2 years. The contract is intended only as seed or~~
 3288 ~~development funding and requires a commitment from the~~
 3289 ~~interested party.~~

3290 ~~3. A contract must require participation by at least one~~
 3291 ~~community health clinic and one disproportionate share hospital.~~

3292 (7)(9)(a) The agency shall develop and implement a
 3293 comprehensive plan to ensure that recipients are adequately
 3294 informed of their choices and rights under all Medicaid managed
 3295 care programs and that Medicaid managed care programs meet
 3296 acceptable standards of quality in patient care, patient
 3297 satisfaction, and financial solvency.

3298 (b) The agency shall provide adequate means for informing
 3299 patients of their choice and rights under a managed care plan at
 3300 the time of eligibility determination.

3301 (c) The agency shall require managed care plans and
 3302 MediPass providers to demonstrate and document plans and
 3303 activities, as defined by rule, including outreach and followup,
 3304 undertaken to ensure that Medicaid recipients receive the health
 3305 care service to which they are entitled.

3306

3307 This subsection expires October 1, 2013.

3308 ~~(8)-(10)~~ The agency shall consult with Medicaid consumers
 3309 and their representatives on an ongoing basis regarding
 3310 measurements of patient satisfaction, procedures for resolving
 3311 patient grievances, standards for ensuring quality of care,
 3312 mechanisms for providing patient access to services, and
 3313 policies affecting patient care. This subsection expires October
 3314 1, 2013.

3315 ~~(9)-(11)~~ The agency may extend eligibility for Medicaid
 3316 recipients enrolled in licensed and accredited health
 3317 maintenance organizations for the duration of the enrollment
 3318 period or for 6 months, whichever is earlier, provided the
 3319 agency certifies that such an offer will not increase state
 3320 expenditures. This subsection expires October 1, 2013.

3321 ~~(10)-(12)~~ A managed care plan that has a Medicaid contract
 3322 shall at least annually review each primary care physician's
 3323 active patient load and shall ensure that additional Medicaid
 3324 recipients are not assigned to physicians who have a total
 3325 active patient load of more than 3,000 patients. As used in this
 3326 subsection, the term "active patient" means a patient who is
 3327 seen by the same primary care physician, or by a physician
 3328 assistant or advanced registered nurse practitioner under the

3329 supervision of the primary care physician, at least three times
 3330 within a calendar year. Each primary care physician shall
 3331 annually certify to the managed care plan whether or not his or
 3332 her patient load exceeds the limits established under this
 3333 subsection and the managed care plan shall accept such
 3334 certification on face value as compliance with this subsection.
 3335 The agency shall accept the managed care plan's representations
 3336 that it is in compliance with this subsection based on the
 3337 certification of its primary care physicians, unless the agency
 3338 has an objective indication that access to primary care is being
 3339 compromised, such as receiving complaints or grievances relating
 3340 to access to care. If the agency determines that an objective
 3341 indication exists that access to primary care is being
 3342 compromised, it may verify the patient load certifications
 3343 submitted by the managed care plan's primary care physicians and
 3344 that the managed care plan is not assigning Medicaid recipients
 3345 to primary care physicians who have an active patient load of
 3346 more than 3,000 patients. This subsection expires October 1,
 3347 2013.

3348 ~~(13) Effective July 1, 2003, the agency shall adjust the~~
 3349 ~~enrollee assignment process of Medicaid managed prepaid health~~
 3350 ~~plans for those Medicaid managed prepaid plans operating in~~
 3351 ~~Miami-Dade County which have executed a contract with the agency~~
 3352 ~~for a minimum of 8 consecutive years in order for the Medicaid~~
 3353 ~~managed prepaid plan to maintain a minimum enrollment level of~~
 3354 ~~15,000 members per month. When assigning enrollees pursuant to~~
 3355 ~~this subsection, the agency shall give priority to providers~~
 3356 ~~that initially qualified under this subsection until such~~

3357 ~~providers reach and maintain an enrollment level of 15,000~~
 3358 ~~members per month. A prepaid health plan that has a statewide~~
 3359 ~~Medicaid enrollment of 25,000 or more members is not eligible~~
 3360 ~~for enrollee assignments under this subsection.~~

3361 (11)~~(14)~~ The agency shall include in its calculation of
 3362 the hospital inpatient component of a Medicaid health
 3363 maintenance organization's capitation rate any special payments,
 3364 including, but not limited to, upper payment limit or
 3365 disproportionate share hospital payments, made to qualifying
 3366 hospitals through the fee-for-service program. The agency may
 3367 seek federal waiver approval or state plan amendment as needed
 3368 to implement this adjustment.

3369 (12) (a) Beginning September 1, 2010, the agency shall
 3370 begin a budget-neutral adjustment of capitation rates for all
 3371 Medicaid prepaid plans in the state. The adjustment to
 3372 capitation rates shall be based on aggregate risk scores for
 3373 each prepaid plan's enrollees. During the first 2 years of the
 3374 adjustment, the agency shall ensure that no plan has an
 3375 aggregate risk score that varies more than 10 percent from the
 3376 aggregate weighted average for all plans. The risk adjusted
 3377 capitation rates shall be phased in as follows:

3378 1. In the first fiscal year, 75 percent of the capitation
 3379 rate shall be based on the current methodology and 25 percent
 3380 shall be based on the risk-adjusted rate methodology.

3381 2. In the second fiscal year, 50 percent of the capitation
 3382 rate shall be based on the current methodology and 50 percent
 3383 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.

3411 (b) Enhanced benefits offered by a qualified plan shall be
 3412 structured to provide greater incentives for those diseases
 3413 linked with lifestyle and conditions or behaviors associated
 3414 with avoidable utilization of high-cost services.

3415 (c) To fund these credits, each plan must maintain a
 3416 reserve account in an amount up to 2 percent of the plan's
 3417 Medicaid premium revenue or benchmark premium revenue in the
 3418 case of provider service networks based on an actuarial
 3419 assessment of the value of the enhanced benefit program.

3420 (15) The agency shall maintain and operate the Medicaid
 3421 Encounter Data System to collect, process, store, and report on
 3422 covered services provided to all Florida Medicaid recipients
 3423 enrolled in prepaid managed care plans. Prepaid managed care
 3424 plans shall submit encounter data electronically in a format
 3425 that complies with the Health Insurance Portability and
 3426 Accountability Act provisions for electronic claims and in
 3427 accordance with deadlines established by the agency. Prepaid
 3428 managed care plans must certify that the data reported is
 3429 accurate and complete. The agency is responsible for validating
 3430 the data submitted by the plans. Prior to utilizing validated
 3431 encounter data to adjust rates for prepaid plans, the agency
 3432 shall conduct a review to ensure adequate encounter data is
 3433 available to establish actuarially sound rates. The review shall
 3434 include a simulated rate-setting exercise, followed by an
 3435 evaluation by independent actuaries and consideration of
 3436 comments from the plans. The agency shall publish the results of
 3437 the review on its website at least 30 days prior to adjusting
 3438 rates.

3439 (16) The agency may establish a per-member per-month
 3440 payment for Medicare Advantage Special Needs members that are
 3441 also eligible for Medicaid as a mechanism for meeting the
 3442 state's cost sharing obligation. The agency may also develop a
 3443 per-member per-month payment for Medicaid only covered services
 3444 for which the state is responsible. The agency shall develop a
 3445 mechanism to ensure that such per-member per-month payment
 3446 enhances the value to the state and enrolled members by limiting
 3447 cost sharing, enhancing the scope of Medicare supplemental
 3448 benefits that are equal to or greater than Medicaid coverage for
 3449 select services, and improving care coordination.

3450 (17) The agency shall establish, and managed care plans
 3451 shall use, a uniform method of accounting for and reporting
 3452 medical and nonmedical costs. The agency shall make such
 3453 information available to the public.

3454 (18) Effective October 1, 2013, school districts
 3455 participating in the certified school match program pursuant to
 3456 ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid,
 3457 subject to the limitations of s. 1011.70(1), for a Medicaid-
 3458 eligible child participating in the services as authorized in s.
 3459 1011.70, as provided for in s. 409.9071. Managed care plans
 3460 shall make a good faith effort to execute agreements with school
 3461 districts regarding the coordinated provision of services
 3462 authorized under s. 1011.70 and county health departments
 3463 delivering school-based services pursuant to ss. 381.0056 and
 3464 381.0057. To ensure continuity of care for Medicaid patients,
 3465 the agency, the Department of Health, and the Department of
 3466 Education shall develop procedures for ensuring that a student's

3467 managed care plan receives information relating to services
 3468 provided in accordance with ss. 381.0056, 381.0057, 409.9071,
 3469 and 1011.70.

3470 (19) The agency may, on a case-by-case basis, exempt a
 3471 recipient from mandatory enrollment in a managed care plan when
 3472 the recipient has a unique, time-limited disease or condition-
 3473 related circumstance and managed care enrollment will interfere
 3474 with ongoing care because the recipient's provider does not
 3475 participate in the managed care plans available in the
 3476 recipient's area.

3477 Section 16. Subsection (18) of section 430.04, Florida
 3478 Statutes, is amended to read:

3479 430.04 Duties and responsibilities of the Department of
 3480 Elderly Affairs.—The Department of Elderly Affairs shall:

3481 (18) Administer all Medicaid waivers and programs relating
 3482 to elders and their appropriations. The waivers include, but are
 3483 not limited to:

3484 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
 3485 ~~established in s. 430.502(7), (8), and (9).~~

3486 (a)-(b) The Assisted Living for the Frail Elderly Waiver.

3487 (b)-(c) The Aged and Disabled Adult Waiver.

3488 (c)-(d) The Adult Day Health Care Waiver.

3489 (d)-(e) The Consumer-Directed Care Plus Program as defined
 3490 in s. 409.221.

3491 (e)-(f) The Program of All-inclusive Care for the Elderly.

3492 (f)-(g) The Long-Term Care Community-Based Diversion Pilot
 3493 Project as described in s. 430.705.

3494 (g)-(h) The Channeling Services Waiver for Frail Elders.

3495
 3496 The department shall develop a transition plan for recipients
 3497 receiving services in long-term care Medicaid waivers for elders
 3498 or disabled adults on the date qualified plans become available
 3499 in each recipient's region pursuant to s. 409.981(2) to enroll
 3500 those recipients in qualified plans. This subsection expires
 3501 October 1, 2012.

3502 Section 17. Section 430.2053, Florida Statutes, is amended
 3503 to read:

3504 430.2053 Aging resource centers.—

3505 (1) The department, in consultation with the Agency for
 3506 Health Care Administration and the Department of Children and
 3507 Family Services, shall develop pilot projects for aging resource
 3508 centers. ~~By October 31, 2004, the department, in consultation~~
 3509 ~~with the agency and the Department of Children and Family~~
 3510 ~~Services, shall develop an implementation plan for aging~~
 3511 ~~resource centers and submit the plan to the Governor, the~~
 3512 ~~President of the Senate, and the Speaker of the House of~~
 3513 ~~Representatives. The plan must include qualifications for~~
 3514 ~~designation as a center, the functions to be performed by each~~
 3515 ~~center, and a process for determining that a current area agency~~
 3516 ~~on aging is ready to assume the functions of an aging resource~~
 3517 ~~center.~~

3518 ~~(2) Each area agency on aging shall develop, in~~
 3519 ~~consultation with the existing community care for the elderly~~
 3520 ~~lead agencies within their planning and service areas, a~~
 3521 ~~proposal that describes the process the area agency on aging~~
 3522 ~~intends to undertake to transition to an aging resource center~~

3523 ~~prior to July 1, 2005, and that describes the area agency's~~
 3524 ~~compliance with the requirements of this section. The proposals~~
 3525 ~~must be submitted to the department prior to December 31, 2004.~~
 3526 ~~The department shall evaluate all proposals for readiness and,~~
 3527 ~~prior to March 1, 2005, shall select three area agencies on~~
 3528 ~~aging which meet the requirements of this section to begin the~~
 3529 ~~transition to aging resource centers. Those area agencies on~~
 3530 ~~aging which are not selected to begin the transition to aging~~
 3531 ~~resource centers shall, in consultation with the department and~~
 3532 ~~the existing community care for the elderly lead agencies within~~
 3533 ~~their planning and service areas, amend their proposals as~~
 3534 ~~necessary and resubmit them to the department prior to July 1,~~
 3535 ~~2005. The department may transition additional area agencies to~~
 3536 ~~aging resource centers as it determines that area agencies are~~
 3537 ~~in compliance with the requirements of this section.~~

3538 ~~(3) The Auditor General and the Office of Program Policy~~
 3539 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
 3540 ~~review and assess the department's process for determining an~~
 3541 ~~area agency's readiness to transition to an aging resource~~
 3542 ~~center.~~

3543 ~~(a) The review must, at a minimum, address the~~
 3544 ~~appropriateness of the department's criteria for selection of an~~
 3545 ~~area agency to transition to an aging resource center, the~~
 3546 ~~instruments applied, the degree to which the department~~
 3547 ~~accurately determined each area agency's compliance with the~~
 3548 ~~readiness criteria, the quality of the technical assistance~~
 3549 ~~provided by the department to an area agency in correcting any~~
 3550 ~~weaknesses identified in the readiness assessment, and the~~

3551 ~~degree to which each area agency overcame any identified~~
 3552 ~~weaknesses.~~

3553 ~~(b) Reports of these reviews must be submitted to the~~
 3554 ~~appropriate substantive and appropriations committees in the~~
 3555 ~~Senate and the House of Representatives on March 1 and September~~
 3556 ~~1 of each year until full transition to aging resource centers~~
 3557 ~~has been accomplished statewide, except that the first report~~
 3558 ~~must be submitted by February 1, 2005, and must address all~~
 3559 ~~readiness activities undertaken through December 31, 2004. The~~
 3560 ~~perspectives of all participants in this review process must be~~
 3561 ~~included in each report.~~

3562 (2)~~(4)~~ The purposes of an aging resource center shall be:

3563 (a) To provide Florida's elders and their families with a
 3564 locally focused, coordinated approach to integrating information
 3565 and referral for all available services for elders with the
 3566 eligibility determination entities for state and federally
 3567 funded long-term-care services.

3568 (b) To provide for easier access to long-term-care
 3569 services by Florida's elders and their families by creating
 3570 multiple access points to the long-term-care network that flow
 3571 through one established entity with wide community recognition.

3572 (3)~~(5)~~ The duties of an aging resource center are to:

3573 (a) Develop referral agreements with local community
 3574 service organizations, such as senior centers, existing elder
 3575 service providers, volunteer associations, and other similar
 3576 organizations, to better assist clients who do not need or do
 3577 not wish to enroll in programs funded by the department or the
 3578 agency. The referral agreements must also include a protocol,

3579 developed and approved by the department, which provides
 3580 specific actions that an aging resource center and local
 3581 community service organizations must take when an elder or an
 3582 elder's representative seeking information on long-term-care
 3583 services contacts a local community service organization prior
 3584 to contacting the aging resource center. The protocol shall be
 3585 designed to ensure that elders and their families are able to
 3586 access information and services in the most efficient and least
 3587 cumbersome manner possible.

3588 (b) Provide an initial screening of all clients who
 3589 request long-term-care services to determine whether the person
 3590 would be most appropriately served through any combination of
 3591 federally funded programs, state-funded programs, locally funded
 3592 or community volunteer programs, or private funding for
 3593 services.

3594 (c) Determine eligibility for the programs and services
 3595 listed in subsection (9) ~~(11)~~ for persons residing within the
 3596 geographic area served by the aging resource center and
 3597 determine a priority ranking for services which is based upon
 3598 the potential recipient's frailty level and likelihood of
 3599 institutional placement without such services.

3600 (d) Manage the availability of financial resources for the
 3601 programs and services listed in subsection (9) ~~(11)~~ for persons
 3602 residing within the geographic area served by the aging resource
 3603 center.

3604 (e) When financial resources become available, refer a
 3605 client to the most appropriate entity to begin receiving
 3606 services. The aging resource center shall make referrals to lead

3607 agencies for service provision that ensure that individuals who
 3608 are vulnerable adults in need of services pursuant to s.
 3609 415.104(3)(b), or who are victims of abuse, neglect, or
 3610 exploitation in need of immediate services to prevent further
 3611 harm and are referred by the adult protective services program,
 3612 are given primary consideration for receiving community-care-
 3613 for-the-elderly services in compliance with the requirements of
 3614 s. 430.205(5)(a) and that other referrals for services are in
 3615 compliance with s. 430.205(5)(b).

3616 (f) Convene a work group to advise in the planning,
 3617 implementation, and evaluation of the aging resource center. The
 3618 work group shall be comprised of representatives of local
 3619 service providers, Alzheimer's Association chapters, housing
 3620 authorities, social service organizations, advocacy groups,
 3621 representatives of clients receiving services through the aging
 3622 resource center, and any other persons or groups as determined
 3623 by the department. The aging resource center, in consultation
 3624 with the work group, must develop annual program improvement
 3625 plans that shall be submitted to the department for
 3626 consideration. The department shall review each annual
 3627 improvement plan and make recommendations on how to implement
 3628 the components of the plan.

3629 (g) Enhance the existing area agency on aging in each
 3630 planning and service area by integrating, either physically or
 3631 virtually, the staff and services of the area agency on aging
 3632 with the staff of the department's local CARES Medicaid ~~nursing~~
 3633 ~~home~~ preadmission screening unit and a sufficient number of
 3634 staff from the Department of Children and Family Services'

3635 Economic Self-Sufficiency Unit necessary to determine the
 3636 financial eligibility for all persons age 60 and older residing
 3637 within the area served by the aging resource center that are
 3638 seeking Medicaid services, Supplemental Security Income, and
 3639 food stamps.

3640 (h) Assist clients who request long-term care services in
 3641 being evaluated for eligibility for enrollment in the Medicaid
 3642 long-term care managed care program as qualified plans become
 3643 available in each of the regions pursuant to s. 409.981(2).

3644 (i) Provide choice counseling for the Medicaid long-term
 3645 care managed care program by integrating, either physically or
 3646 virtually, choice counseling staff and services as qualified
 3647 plans become available in each of the regions pursuant to s.
 3648 409.981(2). Pursuant to s. 409.984(1), the agency may contract
 3649 directly with the aging resource center to provide choice
 3650 counseling services or may contract with another vendor if the
 3651 aging resource center does not choose to provide such services.

3652 (j) Assist Medicaid recipients enrolled in the Medicaid
 3653 long-term care managed care program with informally resolving
 3654 grievances with a managed care network and assist Medicaid
 3655 recipients in accessing the managed care network's formal
 3656 grievance process as qualified plans become available in each of
 3657 the regions pursuant to s. 409.981(2).

3658 (4)-(6) The department shall select the entities to become
 3659 aging resource centers based on each entity's readiness and
 3660 ability to perform the duties listed in subsection (3) ~~(5)~~ and
 3661 the entity's:

3662 (a) Expertise in the needs of each target population the

3663 center proposes to serve and a thorough knowledge of the
 3664 providers that serve these populations.

3665 (b) Strong connections to service providers, volunteer
 3666 agencies, and community institutions.

3667 (c) Expertise in information and referral activities.

3668 (d) Knowledge of long-term-care resources, including
 3669 resources designed to provide services in the least restrictive
 3670 setting.

3671 (e) Financial solvency and stability.

3672 (f) Ability to collect, monitor, and analyze data in a
 3673 timely and accurate manner, along with systems that meet the
 3674 department's standards.

3675 (g) Commitment to adequate staffing by qualified personnel
 3676 to effectively perform all functions.

3677 (h) Ability to meet all performance standards established
 3678 by the department.

3679 ~~(5)(7)~~ The aging resource center shall have a governing
 3680 body which shall be the same entity described in s. 20.41(7),
 3681 and an executive director who may be the same person as
 3682 described in s. 20.41(7). The governing body shall annually
 3683 evaluate the performance of the executive director.

3684 ~~(6)(8)~~ The aging resource center may not be a provider of
 3685 direct services other than choice counseling as qualified plans
 3686 become available in each of the regions pursuant to s.
 3687 409.981(2), information and referral services, and screening.

3688 ~~(7)(9)~~ The aging resource center must agree to allow the
 3689 department to review any financial information the department
 3690 determines is necessary for monitoring or reporting purposes,

3691 including financial relationships.

3692 ~~(8)-(10)~~ The duties and responsibilities of the community
 3693 care for the elderly lead agencies within each area served by an
 3694 aging resource center shall be to:

3695 (a) Develop strong community partnerships to maximize the
 3696 use of community resources for the purpose of assisting elders
 3697 to remain in their community settings for as long as it is
 3698 safely possible.

3699 (b) Conduct comprehensive assessments of clients that have
 3700 been determined eligible and develop a care plan consistent with
 3701 established protocols that ensures that the unique needs of each
 3702 client are met.

3703 ~~(9)-(11)~~ The services to be administered through the aging
 3704 resource center shall include those funded by the following
 3705 programs:

3706 (a) Community care for the elderly.

3707 (b) Home care for the elderly.

3708 (c) Contracted services.

3709 (d) Alzheimer's disease initiative.

3710 (e) Aged and disabled adult Medicaid waiver. This
 3711 paragraph expires October 1, 2012.

3712 (f) Assisted living for the frail elderly Medicaid waiver.
 3713 This paragraph expires October 1, 2012.

3714 (g) Older Americans Act.

3715 ~~(10)-(12)~~ The department shall, prior to designation of an
 3716 aging resource center, develop by rule operational and quality
 3717 assurance standards and outcome measures to ensure that clients
 3718 receiving services through all long-term-care programs

3719 administered through an aging resource center are receiving the
 3720 appropriate care they require and that contractors and
 3721 subcontractors are adhering to the terms of their contracts and
 3722 are acting in the best interests of the clients they are
 3723 serving, consistent with the intent of the Legislature to reduce
 3724 the use of and cost of nursing home care. The department shall
 3725 by rule provide operating procedures for aging resource centers,
 3726 which shall include:

3727 (a) Minimum standards for financial operation, including
 3728 audit procedures.

3729 (b) Procedures for monitoring and sanctioning of service
 3730 providers.

3731 (c) Minimum standards for technology utilized by the aging
 3732 resource center.

3733 (d) Minimum staff requirements which shall ensure that the
 3734 aging resource center employs sufficient quality and quantity of
 3735 staff to adequately meet the needs of the elders residing within
 3736 the area served by the aging resource center.

3737 (e) Minimum accessibility standards, including hours of
 3738 operation.

3739 (f) Minimum oversight standards for the governing body of
 3740 the aging resource center to ensure its continuous involvement
 3741 in, and accountability for, all matters related to the
 3742 development, implementation, staffing, administration, and
 3743 operations of the aging resource center.

3744 (g) Minimum education and experience requirements for
 3745 executive directors and other executive staff positions of aging
 3746 resource centers.

3747 (h) Minimum requirements regarding any executive staff
 3748 positions that the aging resource center must employ and minimum
 3749 requirements that a candidate must meet in order to be eligible
 3750 for appointment to such positions.

3751 ~~(11)-(13)~~ In an area in which the department has designated
 3752 an area agency on aging as an aging resource center, the
 3753 department and the agency shall not make payments for the
 3754 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
 3755 Community Diversion Project for such persons who were not
 3756 screened and enrolled through the aging resource center. The
 3757 department shall cease making payments for recipients in
 3758 qualified plans as qualified plans become available in each of
 3759 the regions pursuant to s. 409.981(2).

3760 ~~(12)-(14)~~ Each aging resource center shall enter into a
 3761 memorandum of understanding with the department for
 3762 collaboration with the CARES unit staff. The memorandum of
 3763 understanding shall outline the staff person responsible for
 3764 each function and shall provide the staffing levels necessary to
 3765 carry out the functions of the aging resource center.

3766 ~~(13)-(15)~~ Each aging resource center shall enter into a
 3767 memorandum of understanding with the Department of Children and
 3768 Family Services for collaboration with the Economic Self-
 3769 Sufficiency Unit staff. The memorandum of understanding shall
 3770 outline which staff persons are responsible for which functions
 3771 and shall provide the staffing levels necessary to carry out the
 3772 functions of the aging resource center.

3773 (14) As qualified plans become available in each of the
 3774 regions pursuant to s. 409.981(2), if an aging resource center

3775 does not contract with the agency to provide Medicaid long-term
 3776 care managed care choice counseling pursuant to s. 409.984(1),
 3777 the aging resource center shall enter into a memorandum of
 3778 understanding with the agency to coordinate staffing and
 3779 collaborate with the choice counseling vendor. The memorandum of
 3780 understanding shall identify the staff responsible for each
 3781 function and shall provide the staffing levels necessary to
 3782 carry out the functions of the aging resource center.

3783 ~~(15)-(16)~~ If any of the state activities described in this
 3784 section are outsourced, either in part or in whole, the contract
 3785 executing the outsourcing shall mandate that the contractor or
 3786 its subcontractors shall, either physically or virtually,
 3787 execute the provisions of the memorandum of understanding
 3788 instead of the state entity whose function the contractor or
 3789 subcontractor now performs.

3790 ~~(16)-(17)~~ In order to be eligible to begin transitioning to
 3791 an aging resource center, an area agency on aging board must
 3792 ensure that the area agency on aging which it oversees meets all
 3793 of the minimum requirements set by law and in rule.

3794 ~~(18) The department shall monitor the three initial~~
 3795 ~~projects for aging resource centers and report on the progress~~
 3796 ~~of those projects to the Governor, the President of the Senate,~~
 3797 ~~and the Speaker of the House of Representatives by June 30,~~
 3798 ~~2005. The report must include an evaluation of the~~
 3799 ~~implementation process.~~

3800 ~~(17)-(19)~~ (a) Once an aging resource center is operational,
 3801 the department, in consultation with the agency, may develop
 3802 capitation rates for any of the programs administered through

3803 the aging resource center. Capitation rates for programs shall
 3804 be based on the historical cost experience of the state in
 3805 providing those same services to the population age 60 or older
 3806 residing within each area served by an aging resource center.
 3807 Each capitated rate may vary by geographic area as determined by
 3808 the department.

3809 (b) The department and the agency may determine for each
 3810 area served by an aging resource center whether it is
 3811 appropriate, consistent with federal and state laws and
 3812 regulations, to develop and pay separate capitated rates for
 3813 each program administered through the aging resource center or
 3814 to develop and pay capitated rates for service packages which
 3815 include more than one program or service administered through
 3816 the aging resource center.

3817 (c) Once capitation rates have been developed and
 3818 certified as actuarially sound, the department and the agency
 3819 may pay service providers the capitated rates for services when
 3820 appropriate.

3821 (d) The department, in consultation with the agency, shall
 3822 annually reevaluate and recertify the capitation rates,
 3823 adjusting forward to account for inflation, programmatic
 3824 changes.

3825 ~~(20) The department, in consultation with the agency,~~
 3826 ~~shall submit to the Governor, the President of the Senate, and~~
 3827 ~~the Speaker of the House of Representatives, by December 1,~~
 3828 ~~2006, a report addressing the feasibility of administering the~~
 3829 ~~following services through aging resource centers beginning July~~
 3830 ~~1, 2007:~~

- 3831 ~~(a) Medicaid nursing home services.~~
- 3832 ~~(b) Medicaid transportation services.~~
- 3833 ~~(c) Medicaid hospice care services.~~
- 3834 ~~(d) Medicaid intermediate care services.~~
- 3835 ~~(e) Medicaid prescribed drug services.~~
- 3836 ~~(f) Medicaid assistive care services.~~
- 3837 ~~(g) Any other long-term care program or Medicaid service.~~

3838 (18)~~(21)~~ This section shall not be construed to allow an
 3839 aging resource center to restrict, manage, or impede the local
 3840 fundraising activities of service providers.

3841 Section 18. Subsection (4) of section 641.386, Florida
 3842 Statutes, is amended to read:

3843 641.386 Agent licensing and appointment required;
 3844 exceptions.—

3845 (4) All agents and health maintenance organizations shall
 3846 comply with and be subject to the applicable provisions of ss.
 3847 641.309 and 409.912(20)~~(21)~~, and all companies and entities
 3848 appointing agents shall comply with s. 626.451, when marketing
 3849 for any health maintenance organization licensed pursuant to
 3850 this part, including those organizations under contract with the
 3851 Agency for Health Care Administration to provide health care
 3852 services to Medicaid recipients or any private entity providing
 3853 health care services to Medicaid recipients pursuant to a
 3854 prepaid health plan contract with the Agency for Health Care
 3855 Administration.

3856 Section 19. Effective October 1, 2012, sections 430.701,
 3857 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,
 3858 430.708, and 430.709 Florida Statutes, are repealed.

3859 Section 20. Sections 409.9301, 409.942, 409.944, 409.945,
 3860 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered
 3861 as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
 3862 402.87, Florida Statutes, respectively.

3863 Section 21. Paragraph (a) of subsection (1) of section
 3864 443.111, Florida Statutes, is amended to read:

3865 443.111 Payment of benefits.—

3866 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
 3867 in accordance with rules adopted by the Agency for Workforce
 3868 Innovation, subject to the following requirements:

3869 (a) Benefits are payable by mail or electronically.
 3870 Notwithstanding s. 402.82(4) ~~409.942(4)~~, The agency may develop
 3871 a system for the payment of benefits by electronic funds
 3872 transfer, including, but not limited to, debit cards, electronic
 3873 payment cards, or any other means of electronic payment that the
 3874 agency deems to be commercially viable or cost-effective.
 3875 Commodities or services related to the development of such a
 3876 system shall be procured by competitive solicitation, unless
 3877 they are purchased from a state term contract pursuant to s.
 3878 287.056. The agency shall adopt rules necessary to administer
 3879 the system.

3880 Section 22. Except as otherwise expressly provided in this
 3881 act, this act shall take effect July 1, 2010, if HB 7223 or
 3882 similar legislation is adopted in the same legislative session
 3883 or an extension thereof and becomes law.