A bill to be entitled

An act relating to Medicaid; amending s. 409.907, F.S.; requiring Medicaid provider agreements to require the provider to fully comply with the agency's medical encounter data system; requiring the agency to annually submit a report that summarizes data regarding the agency's medical encounter data system; amending s. 409.908, F.S.; requiring the agency to adjust alternative health plan, health maintenance organization, and prepaid health plan capitation rates based on aggregate risk scores; providing for a two year limitation on risk score variance; requiring the agency to phase in the risk adjusted capitation rates over three years; requiring the Secretary of the agency to convene a technical advisory panel to advise the agency during the transition to risk adjusted capitation rates; amending s. 409.912, F.S.; authorizing the agency to contract with a federally qualified health center to provide comprehensive behavioral health care services through a capitated, prepaid arrangement; requiring the agency to integrate acute care and behavioral health services in the public hospital-operated managed care model; requiring an entity contracting on a prepaid or fixed-sum basis to meet the surplus requirements of health maintenance organizations; creating s. 409.91207, F.S.; requiring the agency to establish a medical home pilot project in Alachua, Hillsborough, Miami-Dade and Orange Counties; requiring each county to be served by at least one medical home

network consisting of specified entities; requiring each medical home network to provide specified services and comply with specified principals of operation; specifying procedures for enrollment of Medicaid recipients into a medical home network; requiring a medical home network to document capacity for coordinated systems of care; requiring medical home network services to be reimbursed based on Medicaid fee for service claims; authorizing specified enhanced benefits for entities participating in a medical home network; specifying that a medical home network is eligible for shared savings under certain circumstances; requiring a medical home network to maintain medical records and clinical data; requiring the agency to quarterly report on medical home network performance; requiring the agency to contract with the University of Florida for initial and final evaluations of the pilot project; amending s. 409.91211, F.S.; requiring a Medicaid provider who receives low income pool funds to serve Medicaid recipients regardless of the recipient's county of residence; extending the phasing in of risk adjusted capitated rates for provider service networks from three years to five years; amending s. 409.9122, F.S.; specifying that individuals currently enrolled in a disease management or specialized HIV/AIDS plan stay in their plan unless they opt out; providing for mandatory assignment of certain Medicaid recipients to a medical home network in Alachua, Hillsborough, Miami-Dade, and Orange counties who are eligible for managed care plan

enrollment; requiring the agency to convene a workgroup to evaluate the status and future viability of Medicaid managed care; requiring the agency to collect encounter data for services provided to patients enrolled in managed care plans; amending s. 409.9124, F.S.; requiring managed care rates to be based on a risk adjusted methodology; requiring the agency to submit an annual report regarding the financial condition and trends affecting Medicaid managed care plans; requiring the agency to designate a portion of the capitation rate of a managed care plan for enhanced benefits for plan enrollees; creating s. 409.9129, F.S.; requiring the agency to implement a monitored negotiation program for Medicaid providers and Medicaid managed care plans; specifying the circumstances under which assistance may be requested by either the plan or the provider; requiring three meetings between the provider and plan; requiring the agency to amend its contract with the provider and the plan under specified circumstances; providing an effective date.

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

Section 1. Paragraph (k) is added to subsection (3) of section 409.907, Florida Statutes, and subsection (13) of that section is created, to read:

409.907 Medicaid provider agreements.--The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a

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provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

(k) Fully comply with the agency's medical encounter data system.

(13) By January 1, 2010, and annually thereafter until full compliance is reached, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that summarizes data regarding the agency's medical encounter data system, including the number of participating plans, the level of compliance of each plan, and specific problem areas.

Section 2. Paragraphs (a) and (b) of subsection (4) of section 409.908, Florida Statutes, are created to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive

bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated, or competitively bid pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. The amount may not exceed the average amount

the agency determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility. The agency shall calculate capitation rates on a regional basis and~~, beginning September 1, 1995,~~ shall include age-band differentials in such calculations.

(a) Beginning September 1, 2011, the agency shall begin a budget neutral adjustment of capitation rates based on aggregate risk scores for each plan's enrollees. During the first two years of the adjustment, the agency shall ensure that no plan has an aggregate risk score that varies by more than 10 percent from the aggregate weighted average for all plans. The risk adjusted capitation rates shall be phased in as follows:

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

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

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

(b) The Secretary of the agency shall convene a technical advisory panel to advise the agency in the area of risk adjusted rate setting during the transition to risk adjusted capitation rates described in paragraph (a). The panel shall include representatives of prepaid plans in counties not included in the demonstration sites under s. 409.91211(1). The panel shall advise the agency regarding:

1. The selection of a base year of encounter data to be used to set risk adjusted rates.

2. The completeness and accuracy of the encounter dataset.

3. The effect of risk adjusted rates on prepaid plans based on a review of a simulated rate setting process.

Section 3. Paragraph (b) of subsection (4) and subsection (17) of section 409.912, Florida Statutes, are amended to read:

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

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

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

(4) The agency may contract with:

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

children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require 80 percent of the capitation paid to the managed

care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the managed care plan with a certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

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

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

3. Except as provided in subparagraph 8., by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and

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

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

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

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

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

use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

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

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

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

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

Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

8. All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).

(17) An entity contracting on a prepaid or fixed-sum basis shall~~, in addition to meeting~~ meet the ~~any applicable statutory~~ surplus requirements of s. 641.225~~, also maintain at all times in the form of cash, investments that mature in less than 180 days allowable as admitted assets by the Office of Insurance~~

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~~Regulation, and restricted funds or deposits controlled by the agency or the Office of Insurance Regulation, a surplus amount equal to one-and-one-half times the entity's monthly Medicaid prepaid revenues. As used in this subsection, the term "surplus" means the entity's total assets minus total liabilities~~. If an entity's surplus falls below an amount equal to the surplus requirements of s. 641.225 ~~one-and-one-half times the entity's monthly Medicaid prepaid revenues~~, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and shall not renew the entity's contract until the required balance is achieved. ~~The requirements of this subsection do not apply:~~

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

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

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

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

Section 4. Section 409.91207, Florida Statutes, is created to read:

409.91207 Medical Home Pilot Project.--

(1) PURPOSE.--The agency shall establish pilot projects in Alachua, Hillsborough, Miami-Dade, and Orange counties to test

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the potential for coordinated and cost effective care in a fee for service environment and to compare performance of these pilot projects with other managed care models.

(2) ORGANIZATION.--Each pilot project shall be served by at least one medical home network, which shall consist of federally qualified health centers for primary care and disease management; primary care clinics owned or operated by medical schools or teaching hospitals for primary care and disease management; medical school faculty for specialty care; and hospitals that agree to participate in the pilot projects. A medical home network shall coordinate with other providers as necessary to ensure that Medicaid participants receive efficient and effective access to services specified in subsection (3).

(3) SERVICE CAPABILITIES.--A medical home network shall provide primary care, coordinated services to control chronic illnesses, pharmacy services, outpatient specialty physician services, and inpatient services.

(4) PRINCIPLES.--A medical home network shall modify the processes and patterns of health care service delivery by applying the following principles:

(a) A personal medical provider shall lead an interdisciplinary team of professionals who share the responsibility for ongoing care to a specific panel of patients.

(b) The personal medical provider shall identify the patient's health care needs and respond to those needs either through direct care or arrangements with other qualified providers.

(c) Care shall be coordinated or integrated across all areas of health service delivery.

(d) Information technology shall be integrated into delivery systems to enhance clinical performance and monitor patient outcomes.

(5) ENROLLMENT.--Each Medicaid recipient receiving primary care at a participating federally qualified health center or primary care clinic owned and operated by a medical school or teaching hospital shall be enrolled in the program if the recipient does not opt out of enrollment. Other Medicaid recipients shall be enrolled consistent with s. 409.9122(2)(e)1.

(6) ACCESS STANDARDS AND NETWORK ADEQUACY.--A medical home network shall document capacity for coordinated systems of care through written agreements among providers that establish arrangements for referral, access to medical records, and follow up care.

(7) FINANCING.--Services provided by a medical home network shall be reimbursed based on claims filed for Medicaid fee for service payments. In addition, the following entities participating in a medical home network shall be eligible to receive an enhanced payment:

(a) A Federally Qualified Health Center or primary care clinic owned and operated by a medical school or teaching hospital shall be eligible to receive enhanced primary care case management fees as authorized in the General Appropriations Act.

(b) A medical school shall be eligible to receive enhanced payments through the supplemental physician payment program

utilizing such certified funds as identified in the General Appropriations Act.

(c) An outpatient primary or specialty clinic shall be eligible to bill Medicaid for facility costs, in addition to professional services.

(d) A hospital shall be eligible to receive supplemental Medicaid payments through the Low Income Pool, as authorized by the General Appropriations Act, and shall receive exempt fee-for-service rates.

(8) SHARED SAVINGS.--The agency shall analyze spending for enrolled medical home network patients compared to capitation rates that would have been paid for the same population in the same region during the same year. The agency shall report the results of this comparison as part of the Social Services Estimating Conference. Each medical home network that achieves savings equal to the prepaid health plan area discount factor is eligible for an appropriation of the shared savings. When the savings exceed the area discount factor, the medical home network shall be eligible for an appropriation of the full amount of the excess savings. To the extent possible, savings shared with the Medical Home Network shall be distributed as bonus payments for quality performance.

(9) QUALITY ASSURANCE AND ACCOUNTABILITY.--A medical home network shall maintain medical records and clinical data as necessary to assess the utilization, cost, and outcome of services provided to enrollees.

(10) EVALUATION.--The agency shall report medical home network performance on a quarterly basis. The agency shall

contract with the University of Florida to comprehensively evaluate the pilot projects created under this section, including a comparison of the medical home network to other models of managed care. An initial evaluation shall cover a 24 month period beginning with the implementation of the pilot projects in all pilot counties. A final evaluation shall cover a 60 month period beginning with the implementation of the pilot projects in all pilot counties. The initial evaluation shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2012. The final evaluation shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2015.

Section 5. Paragraph (b) of subsection (1) and paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, are amended to read:

409.91211 Medicaid managed care pilot program.--

(1)

(b) This waiver authority is contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites, provisions to preserve the state's ability to use intergovernmental transfers, and provisions to protect the disproportionate share program authorized pursuant to this chapter. Upon completion of the evaluation conducted under s. 3, ch. 2005-133, Laws of Florida, the agency may request statewide

expansion of the demonstration projects. Statewide phase-in to additional counties shall be contingent upon review and approval by the Legislature. Under the upper-payment-limit program, or the low-income pool as implemented by the Agency for Health Care Administration pursuant to federal waiver, the state matching funds required for the program shall be provided by local governmental entities through intergovernmental transfers in accordance with published federal statutes and regulations. The Agency for Health Care Administration shall distribute upper-payment-limit, disproportionate share hospital, and low-income pool funds according to published federal statutes, regulations, and waivers and the low-income pool methodology approved by the federal Centers for Medicare and Medicaid Services. A provider who receives low income pool funds shall serve Medicaid recipients regardless of their Florida county of residence and shall not restrict access to care based on residency in a Florida county other than the one in which the provider is located.

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

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks over a 5-year ~~3-year~~ period. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall be converted to

a risk-adjusted capitated rate no later than the beginning of the sixth ~~fourth~~ year of operation, and may be converted earlier at the option of the provider service network. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

Section 6. Paragraph (e) of subsection (2) and subsection (7) of section 409.9122, Florida Statutes, are amended, and subsection (15) is created, to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. Enrolled Medicaid recipients who have a known diagnosis consistent with HIV/AIDS shall be offered the opportunity to change plans on a staggered basis; however, these individuals shall remain in their current disease management or specialized HIV/AIDS plan, unless they actively choose to opt out of that plan. In counties that have two or more managed care plans, a recipient already enrolled in MediPass who fails to make a choice during the annual period shall be assigned to a managed care plan if he or she is eligible for enrollment in the managed care plan. The agency shall apply for a state plan amendment or federal waiver

authority, if necessary, to implement the provisions of this paragraph. All newly eligible Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan. If the SSI recipient has an ongoing relationship with a managed care plan, the agency shall assign the recipient to that managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

1. Notwithstanding this paragraph and paragraph (f), a Medicaid recipient who resides in Alachua, Hillsborough, Miami-Dade, or Orange county, who is eligible for managed care plan enrollment and subject to mandatory assignment because the recipient failed to make a choice, shall be assigned by the agency to a medical home network operated pursuant to s. 409.91207 until an enrollment of 65 percent in medical home networks and 35 percent in managed care plans, of all those eligible to choose managed care, is achieved. In making these assignments, the agency shall consider the capability of the networks to meet patient needs. Thereafter, assignment of Medicaid recipients shall continue in accordance with paragraph (f).

2. For purposes of subparagraph 1., the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act

(7) The agency shall convene a workgroup to evaluate the current status and future viability of Medicaid managed care. The workgroup shall complete a report by January 1, 2010 that considers the following issues~~investigate the feasibility of developing managed care plan and MediPass options for the following groups of Medicaid recipients~~:

(a) The performance of managed care plans in achieving access to care, quality services, and cost containment.~~Pregnant women and infants.~~

(b) The effect of recent changes to payment rates for managed care plans.~~Elderly and disabled recipients, especially those who are at risk of nursing home placement.~~

(c) The status of contractual relationships between managed care plans and providers, especially providers critically necessary for compliance with network adequacy standards.~~Persons with developmental disabilities.~~

(d) The availability of other models for managed care that may improve performance, assure stability, and contain costs in the future. ~~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.~~

(15) The agency shall collect encounter data in conformity with s. 409.91211(2)(p)4. on services provided to patients enrolled in managed care plans.

Section 7. Subsections (1), (4), and (6) of section 409.9124, Florida Statutes, are amended to read:

409.9124 Managed care reimbursement.--The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(1) Final managed care rates shall be published annually prior to September 1 of each year, based on methodology that:

(d) Is risk adjusted in accordance with s. 409.908(4).

(4) The agency shall quarterly examine the financial condition of each managed care plan, and its performance in serving Medicaid patients, and shall utilize examinations performed by the Office of Insurance Regulation wherever possible. No later than January 1, 2010, and at least annually thereafter, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the financial condition and trends affecting Medicaid managed care plans in order to assess the viability of these plans, identify any specific risks to future performance, and recommend any changes necessary to ensuring a resilient and effective managed care program that meets the needs of Medicaid participants.

(6) The agency shall designate a portion that shall not exceed two percent of the capitation rate for use by the managed care plan in financing enhanced benefits for their enrollees as rewards for healthy behaviors specified by the agency as qualifications for earning enhanced benefits. Enhanced benefits shall consist of an amount or type of health and related services not normally covered by the managed care plan.~~For the 2005-2006 fiscal year only, the agency shall make an additional adjustment in calculating the capitation payments to prepaid health plans, excluding prepaid mental health plans. This adjustment must result in an increase of 2.8 percent in the average per-member, per-month rate paid to prepaid health plans, excluding prepaid mental health plans, which are funded from Specific Appropriations 225 and 226 in the 2005-2006 General Appropriations Act.~~

Section 8. Section 409.9129, Florida Statutes, is created to read:

409.9129 Monitored negotiations of managed care contracts.--

(1) The agency shall implement a monitored negotiation program for Medicaid providers and Medicaid managed care plans to facilitate contracting arrangements that preserve recipients' access to needed medical services. The program shall be used only when requested by one or more parties to the negotiation and only when a contract between the plan and the provider is necessary for the plan to meet network adequacy standards.

(2) When assistance is requested by either the managed care plan or the provider when contract negotiations are at an

impasse, the agency shall notify the involved parties of the request for assistance and convene three meetings that shall be attended by both parties.

(a) In the first meeting, each party shall describe the status of the negotiations held prior to the agency's involvement.

(b) In the second meeting, the party who requested the agency's assistance shall make an offer that is different from its last offer.

(c) In the third meeting, the second party shall make an offer that is different from its last offer.

(3) After these meetings are completed, and if the two offers do not result in an agreement between the parties, the agency shall amend its contract with both parties in a manner consistent with one of the following options:

(a) The managed care plan shall pay the provider at a rate equal to 90 percent of the Medicaid fee-for-service paid to the provider by the agency on July 1 of the contract year; or,

(b) The agency shall reimburse the provider on a fee for service basis for the managed care plan's enrollees who receive services from the provider. The agency shall recoup from the managed care plan an amount equal to 110 percent of these fees for service payments to the provider at the end of the contract year.

Section 9. This act shall take effect July 1, 2009.