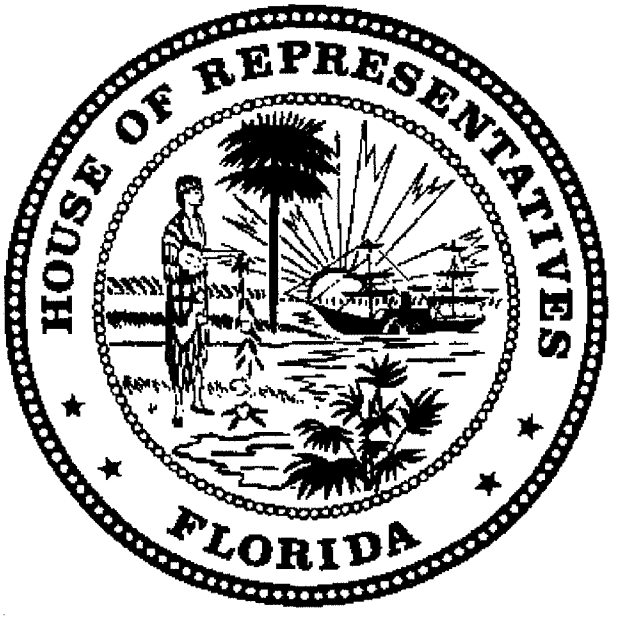


Health & Human Services Committee

Monday, March 14, 2011
12:30 PM
Morris Hall (17 HOB)

Dean Cannon
Speaker

Robert C. "Rob" Schenck
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Monday, March 14, 2011 12:30 pm
End Date and Time:	Monday, March 14, 2011 03:30 pm
Location:	Morris Hall (17 HOB)
Duration:	3.00 hrs

Workshop on the following:

PCB HHSC 11-01 Medicaid Managed Care
PCB HHSC 11-02 Medicaid

For your information, these two PCBs are available on the MyFloridaHouse.gov website under Committees, then all Proposed Committee Bills.

NOTICE FINALIZED on 03/10/2011 16:13 by Iseminger.Bobbye

Summary of PCBs

Summary of Medicaid Proposed Committee Bills

I. The House Medicaid proposal consists of two bills:

a. **PCB HHSC 11-01** creates a new part and numerous new sections of law in Chapter 409 that will be phased in over a 5-year period.

b. **PCB HHSC 11-02** 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 to prepare for the transition to managed care.

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

III. General provisions that apply across the Medicaid program:

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

b. **Plans eligible** 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 in 7 regions**.

    i. Each region will have a **minimum** and **maximum** number of plans

    ii. **Participation by one or two PSNs guaranteed**, provided there are responsive bidders, to ensure consumer choice and competition between different models of managed care (PSN vs. HMO).

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 the following factors:

    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. Pre-bid agreements with providers to meet network requirements.

    viii. Pre-bid agreements with select providers of essential services such as children's hospitals, medical school faculties, and trauma centers.

    ix. Comments submitted by providers related to a specific plan.

g. **Preference** will be given in the competitive selection process to plans which demonstrate:

   i. Signed contracts with primary and specialty physicians that meet specific standards.

   ii. Programs for recognizing patient centered **medical homes and accountable care organizations**.

   iii. Organizations that provide **greater economic benefit through employment of Floridians.**

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

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

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

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

   iii. **Region III -The West Central Florida Region:** Hillsborough, Hernando, Pasco, Pinellas, Polk.

   iv. **Region IV - Central Florida Region:** Brevard, Indian River, Lake, Marion, Orange, Osceola, Seminole, and Sumter.

   v. **Region V –Southwest Florida Region:** Charlotte, Collier, Desoto, Hardee, Highlands, Lee, Manatee and Sarasota.

   vi. **Region VI - Southeast Florida Region:** Broward, Glades, Hendry, Martin, Okeechobee, Palm Beach, St. Lucie.

   vii. **Region VII - South Florida Region:** Miami-Dade, Monroe.

i. **The number of plans per region are as follows:**

Medical/Long Term Care	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Total Statewide
Total Enrollees	209,392	398,583	528,116	457,797	244,295	458,655	544,244	2,841,062
Minimum plans	3	3	4	4	3	4	5	26
PSN plans if responsive	1	1	2	2	1	2	2	11
Maximum plans	3	6	8	7	3	7	9	43
DD plans Min – Max (1 PSN each)	2 – 3 (1 PSN)		2 - 3 (1 PSN)		2 – 4 (1 PSN)			6 – 10 (3 PSN)

**These numbers apply independently to the Managed Medical Assistance Program and the Long Term Care Managed Care Program*

Plan exceptions:

- Specialty plans which include no more than 10 percent of the region's enrollees are not subject to plan limits.
- Children's Medical Services is an eligible plan statewide and exempt from competitive procurement, but must meet other plan requirements.

j. Managed care plans will be held **accountable**:

i. AHCA will establish 5-year contracts with **no automatic 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. **A 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 1 month's capitation payments.

viii. **Specific requirements for enrollment, fair payment standards for PSNs, electronic claims submission, 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. **Achieved Savings Rebates** are included to incentivize management by the plans and to share savings between the plans and the state.

1. Like with a Medical Loss Ratio, administrative expenses are capped so the plans must spend their premium dollars on care or return the money to the state.

2. The plans will be paid an actuarially sound rate for their enrollees. If the plans manage the enrollees' care well and achieve a savings, they may keep a reasonable profit of up to 7%.

3. The plans can earn an additional 1% for demonstrating superior quality performance.

4. If the plans spend too little on quality care, the excess profits must be returned to the state.

IV. Specific provisions that apply to <u>managed medical assistance</u> – primary and acute care

a. **Implementation** shall begin January 1, 2013, with full implementation by **October 1, 2014**.

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 certain 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 establish programs to encourage and reward health behaviors.

d. **Plan Selection:**

i. AHCA will consider evidence of plan relationships with providers and give weight to signed contracts

ii. Preference will be given to plans that also provide long-term care services in the applicable region.

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

i. Plans are required to contract with Healthy Start Coalitions for coordination of care and improved outcomes for **pregnant women and infants**.

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

iii. **Florida Medical School Quality Network:**
AHCA shall contract with an organization representing medical schools and graduate medical education programs to improve clinical outcomes in all managed care plans.

iv. **Performance measurement:** plans must monitor quality and performance of providers with transparent metrics.

f. **Provider Networks:**

i. **Plans must develop and maintain provider networks to meet medical needs of enrollees**

ii. **Plans may** generally limit providers based on credentials, quality and price

iii. **Essential providers:** Plans must include in the network those providers classified by AHCA as essential unless alternative arrangements are approved. Providers may include:
- FQHCs
- Teaching hospitals
- Trauma Hospitals
- Hospitals greater than 25 miles from a similar service facility

iv. **Statewide essential providers:** Plans must also include in the network certain essential providers that are statewide resources including:
- Florida Medical Schools
- Regional Perinatal Intensive Care Centers
- Specialty Children's Hospitals

v. **Payments for essential providers** who do not contract with plans are specified and will vary based on certain conditions.

vi. After 12 months, essential **providers may be excluded** for failure to meet quality standards.

vii. Plans must offer contracts to each **home medical equipment and supplies provider** that meets certain criteria in the region.

g. **Intergovernmental Transfers Process**
i. Authorizes intergovernmental transfers (IGTs) as contributions to Medicaid within certain limits and time frames and requires local funding sources to designate participating providers.
ii. Directs the use of IGTs for certain programs and purposes.
iii. Authorizes an Access to Care Partnership as the means of implementing the Low Income Pool.
iv. Directs AHCA on the use of additional funds for tiered hospital rates, providing that all hospitals receive some increase and certain designated hospitals receive additional increases.

h. **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 **90-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, 2012, and be complete in all regions by October 1, 2013.

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. Benefits include traditional home and community based services for elders provided under a Medicaid waiver program.

e. 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 eligible plans for long-term care managed care.

iii. PACE plans are eligible but exempt from procurement.

iv. Eligible 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.

f. **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. Re-balancing of nursing home and home and community based care is expected each year until no more than 35% of enrollees receive nursing home care.

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.

g. Auto-assignments will 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 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. Nursing homes and plans may negotiate higher rates of payment for medically complex care.

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

j. **Technical Advisory Workgroup**

i. AHCA will establish a workgroup to assist in development of:
   1. Eligibility methodology
   2. Requirements for provider payment, prompt payment and claims processing
   3. Enrollment processes for individuals with pending eligibility

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

a. **Implementation** will begin January 1, 2015, and be complete in all regions by October 1, 2016.

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

iii. HMO's must be comprehensive plans already under contract in the region.

c. **Eligibility**

i. Criteria are the same as the current Medicaid waiver program and the program providing intermediate care for the developmentally disabled.

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

iii. New enrollees may be added when funds become available.

d. The **benefits** that will be required of participating plans are substantially the same as those currently offered.

e. To be **eligible**, a managed care plan must meet certain criteria:

i. Plans must have staff 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 offer a consumer-directed care program option to enrollees.

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

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. **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 facilities and intensive behavior residential habilitation facilities will be determined by AHCA.

g. Residents of Sunland Marianna and Tacachale 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. All plans statewide (both in reform areas and elsewhere) are required to **report encounter data**.

b. All Medicaid recipients statewide will be permitted to use their Medicaid premium to **purchase employment-based coverage**.

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

d. **AHCA is required to contract with prepaid dental plans until the Med**icaid Managed Medical Assistance program is fully implemented in all regions.

e. 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.

f. AHCA is directed to **implement a new methodology** for setting reimbursement rates for hospitals that is based on their actual allowable costs. The rates will be set annually, rather than adjusted though out the year, to provide certainty to the both the state and the hospitals.

g. The **Low Income Pool Council** will sunset on October 1, 2014, when the Managed Medical Assistance Program is fully implemented.

A bill to be entitled

An act relating to Medicaid managed care; providing an effective date.

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

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

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

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

provisions related to the department's responsibility for the determination of Medicaid eligibility.

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

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

(1) "Agency" means the Agency for Health Care Administration.

(2) "Aging network service provider" means a provider that participated in a home and community-based waiver administered by the Department of Elderly Affairs or the community care service system pursuant to s. 430.205, as of October 1, 2013.

(3) "Comprehensive long-term care plan" means a managed care plan that provides services described in s. 409.973 and also provides the services described in ss.409.980 or 409.988

(4) "Department" means the Department of Children and Families.

(5) "Developmental disability provider service network" means a provider service network, a controlling interest of which includes one or more entities licensed pursuant to s. 393.067 or s. 400.962 with 18 or more licensed beds and which owner or owners have at least 10 years experience serving this population.

(6) "Direct care management" means care management activities that involve direct interaction with Medicaid recipients.

(7) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized

under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(4)(d). For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391. For purposes of the long-term care managed care program, the term also includes entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans, and the Program for All-Inclusive Care for the Elderly.

(8) "Long-term care plan" means a managed care plan that provides the services described in s. 409.980 for the long-term care managed care program or the services described in s. 409.988 for the long-term care managed care program for persons with developmental disabilities.

(9) "Long term care provider service network" means a provider service network a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

(10) "Managed care plan" means an eligible plan under contract with the agency to provide services in the Medicaid program.

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

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

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

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

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

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

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

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

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and

regulations necessary to implement the program. Prior to seeking a waiver, the agency shall provide public notice and the opportunity for public comment and shall include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2) and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.

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

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

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

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

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

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

409.966 Eligible plans; selection.—

(1) ELIGIBLE PLANS.-Services in the Medicaid managed care program shall be provided by eligible plans. A provider service network must be capable of providing all covered services to a mandatory Medicaid managed care enrollee or may limit the

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

(2) ELIGIBLE PLAN SELECTION.-The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(3)(a). At least 30 days prior to issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county. The source of the data in the report shall include both historic fee-for-service claims and validated data from the Medicaid Encounter Data System. The report shall be made available in electronic form and shall delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. Separate and simultaneous procurements shall be conducted in each of the following regions:

(a) Region I, which shall consist of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,

Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties.

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

(c) Region III, which shall consist of Hernando, Hillsborough, Pasco, Pinellas, and Polk Counties.

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

(e) Region V, which shall consist of Charlotte, Collier, DeSoto, Hardee, Highlands, Lee, Manatee, and Sarasota Counties.

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

(g) Region VII, which shall consist of Dade and Monroe Counties.

(3) QUALITY SELECTION CRITERIA.-

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

1. Accreditation by the National Committee for Quality Assurance or another nationally recognized accrediting body.

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

3. Availability and accessibility of primary care and specialty physicians in the provider network.

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

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

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider. The agency shall give special weight to comments submitted by essential providers, as defined by the agency pursuant to s. 409.975(2).

(b) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive

and provide the best value to the state. Preference shall be given to plans which demonstrate the following:

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

2. Well-defined programs for recognizing patient-centered medical homes or accountable care organizations, and providing for increased compensation for recognized medical homes or accountable care organizations, as defined by the plan.

3. Greater net economic benefit to Florida compared to other bidders through employment of, or subcontracting with firms which employ, Floridians in order to accomplish the contract requirements. Contracts with such bidders shall specify performance measures to evaluate the plan's employment-based economic impact. Valuation of the net economic benefit shall not include employment of or subcontracts with providers.

(c) To ensure managed care plan participation in Region I, the agency shall award contracts in Region VII to each managed care plan selected in Region I, for such plans which submitted responsive bids in Region VII.

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate in more than one region and is selected in at least one region may not begin serving Medicaid recipients in any region for which it was selected until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the

agency may contract with other selected plans in the region not participating in the administrative challenge prior to resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

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

409.967 Managed care plan accountability.—

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

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

(a) Emergency services.—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider within 30 days after receipt of a

complete and correct claim. Plans must give providers of these services a specific explanation for each claim denied for being incomplete or incorrect. Providers shall have an opportunity to resubmit corrected claims for reconsideration within 30 days after receiving notice from the managed care plans of the claims being incomplete or incorrect. Payments for noncontracted emergency services and care shall be made at the rate the agency would pay for such services from the same provider. Claims from noncontracted providers shall be accepted by the managed care plan for at least 1 year after the date the services are provided.

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

the agency identifying the number of enrollees assigned to each primary care provider.

(c) Encounter data.—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic under-utilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

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

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

1. A provider credentialing system and ongoing provider monitoring;

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

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

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

5. Designation of a program integrity compliance officer.

(f) Grievance resolution.—Each managed care plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances from enrollees consistent

with the requirements of s. 641.511. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees. The agency shall maintain a process for provider service networks consistent with s. 408.7056.

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

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

(i) Electronic claims.-Managed care plans shall accept electronic claims in compliance with federal standards.

(j) Fair Payment.-Provider service networks must ensure that no network provider with a controlling interest in the network charges any Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(3) ACHIEVED SAVINGS REBATE.-

(a) The agency shall establish and the prepaid plans shall use a uniform method for annually reporting premium revenue,

medical and administrative costs, and income or losses, across all Florida Medicaid prepaid plan lines of business. The reports shall be due to the agency no more than 270 days after the conclusion of the reporting period and the agency may audit the reports. Achieved savings rebates will be due within 30 days of the reports. Except as provided in paragraph (b), the achieved savings rebate will be established by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

1. 100 percent of income up to and including 5 percent of revenue will be retained by the plan.

2. 50 percent of income above 5 percent and up to 9 percent will be retained by the plan, with the other 50 percent refunded to the state.

3. 100 percent of income above 9 percent of revenue will be refunded to the state.

(b) For any plan which meets or exceeds agency-defined quality measures in the reporting period, the achieved savings rebate will be established by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

1. 100 percent of income up to and including 6 percent of revenue will be retained by the plan.

2. 50 percent of income above 5 percent and up to 10 percent will be retained by the plan, with the other 50 percent refunded to the state.

3. 100 percent of income above 10 percent of revenue will be refunded to the state.

(c) The following shall not be included in calculating income to the plan:

1. Payment of achieved savings rebates

2. Any financial incentive payments made outside of the capitation rate

3. Any financial disincentive payments levied by the state or federal governments

4. Expenses associated with lobbying activities; and

5. Administrative, reinsurance, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

(d) Prepaid plans that incur a loss in the first contract year, may apply the full amount of the loss as an offset to income in the second contract year.

(e) If, after an audit or other reconciliation, the agency determines that a prepaid plan owes an additional rebate, the plan shall have 30 days after notification to make the payment. Upon failure to pay the rebate timely, the agency shall withhold future payments to the plan until the entire amount is recouped. If agency determines that a prepaid plan has made an overpayment, the agency shall return the overpayment within 30 days.

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

409.968 Managed care plan payment.—

(1) Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in s. 409.966. Payments shall be risk-adjusted rates based on

historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area, and the clinical risk profile of the recipients.

(2) Provider service networks may be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 5 years of its operation in a given region or until the contract year that begins on October 1, 2016, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of incurred but not reported claims within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days

after receipt of the reconciliation results. This reconciliation shall be considered final.

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

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

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

(2) CHOICE COUNSELING.—The agency shall provide choice counseling for Medicaid recipients. The agency may contract for the provision of choice counseling. Any such contract shall be with a vendor which employs Floridians to accomplish the contract requirements and shall be for a period of 5 years. The agency may renew a contract for an additional 5-year period; however, prior to renewal of the contract the agency shall hold at least one public meeting in each of the regions covered by the choice counseling vendor. The agency may extend the term of the contract to cover any delays in transition to a new contractor. Printed choice information and choice counseling shall be offered in the native or preferred language of the recipient, consistent with federal requirements. The manner and method of choice counseling shall be modified as necessary to

assure culturally competent, effective communication with people from diverse cultural backgrounds. The agency shall maintain a record of the recipients who receive such services, identifying the scope and method of the services provided. The agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

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

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

(c) An explanation of benefit limits.

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

(e) Managed care plan performance data.

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

except in cases in which immediate risk of permanent damage to the recipient's health is alleged.

(a) The managed care plan internal grievance process, when utilized, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the result of the grievance process is approval of an enrollee's request to disenroll, the agency is not required to make a determination in the case.

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

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

(d) On the first day of the next month after receiving notice from a recipient that the recipient has moved to another region, the agency shall automatically disenroll the recipient

582 from the managed care plan the recipient is currently enrolled
583 in and treat the recipient as if the recipient is a new Medicaid
584 enrollee. At that time, the recipient may choose another plan
585 pursuant to the enrollment process established in this section.
586 Section 11. Section 409.970, Florida Statutes, is created
587 to read:
588 409.970 State and Local Medicaid Partnerships.-
589 (1) INTERGOVERNMENTAL TRANSFERS. In addition to the
590 contributions required pursuant to s. 409.915, the agency may
591 accept voluntary transfers of local taxes and other qualified
592 revenue from counties, municipalities, and special taxing
593 districts. Such transfers must be contributed to advance the
594 general goals of the Florida Medicaid program without
595 restriction and must be executed pursuant to a contract between
596 the agency and the local funding source. Contracts executed
597 prior to October 31 shall result in contributions to Medicaid
598 for that same state fiscal year. Contracts executed between
599 November 1 and June 30 shall result in contributions for the
600 following state fiscal year. Based on the date of the signed
601 contracts, the agency shall allocate to the Low Income Pool the
602 first contributions received up to the limit established by
603 subsection (2). No more than 40 percent of the Low Income Pool
604 funding shall come from any single funding source.
605 Contributions in excess of the Low Income Pool shall be
606 allocated to the disproportionate share programs defined in s.
607 409.911(3) and s. 409.9113, and to hospital rates pursuant to
608 subsection (4). An attachment to the contract must designate
609 the Medicaid providers that ensure access to care for low income

and uninsured people within the applicable jurisdiction and which should be eligible for Low Income Pool funding. Eligible providers may include both hospitals and primary care providers.

(2) LOW INCOME POOL. The agency shall establish and maintain a Low Income Pool in a manner authorized by federal waiver. The Low Income Pool is created to compensate a network of providers designated pursuant to subsection (1). Funding of the Low Income Pool will be limited to the maximum amount permitted by federal waiver minus a percent specified in the General Appropriations Act. The Low Income Pool must be used to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement, paying for otherwise uncompensated care, and financing coverage for the uninsured. The Low Income Pool shall be distributed in periodic payments to the Access to Care Partnership throughout the fiscal year. Distribution of Low Income Pool funds to providers participating in the Access to Care Partnership may be made through capitated payments, fees for services, or contracts for specific deliverables. The agency shall delineate the distributions from the Low Income Pool in the contract with the Access to Care Partnership pursuant to subsection (3). Regardless of the method of distribution, providers participating in the Access to Care Partnership shall receive payments such that the aggregate benefit in the jurisdiction of each local funding source, as defined in subsection (1), equals the amount of the contribution plus a factor specified in the General Appropriations Act.

(3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract with a single organization representing all health care

facilities, programs, and providers supported with local taxes or certified public expenditures and designated pursuant to subsection (1). The contract shall provide for enhanced access to care for Medicaid, low-income, and uninsured Floridians. The partnership shall be responsible for an ongoing program of activities that provides needed, but uncovered or undercompensated, health services to Medicaid enrollees and persons receiving charity care, as defined in s. 409.911. Accountability for services rendered under this contract must be based on the number of unduplicated services provided to qualified beneficiaries, the total units of service provided to these persons, and the effectiveness of services provided as determined according to specific standards of care. The agency shall seek such plan amendments or waivers as may be necessary to authorize the implementation of the Low Income Pool as the Access to Care Partnership pursuant to this section.

(4) HOSPITAL RATE DISTRIBUTION.

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized by the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in 408.07(45), and specialty children's hospitals as defined in s. 395.002(28).

2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 11 percent of the hospital's

total inpatient days to Medicaid patients and are located in the jurisdiction of a local funding source pursuant to subsection (1).

3. Tier 3 hospitals include all community hospitals.

(b) When rates are increased pursuant to this section, the Total Tier Allocation (TTA) shall be allocated as follows:

Tier 1(T1A) = 0.50 x TTA;
Tier 2 (T2A) = 0.35 x TTA
Tier 3 (T3A) = 0.15 x TTA

The Tier allocation will be distributed as a percent increase to the hospital specific base rate (HSBR) established pursuant to s. 409.905(5)(c). The increase in each tier will be calculated according to the proportion of tier-specific allocation to the total estimated inpatient spending (TEIS) for all hospitals in each tier:

Tier 1 percent increase (T1PI) = T1A/Tier 1 total estimated inpatient spending (T1TEIS);

Tier 2 percent increase (T2PI) = T2A / Tier 2 total estimated inpatient spending (T2TEIS);

Tier 3 percent increase (T3PI) = T3A/ Tier 3 total estimated inpatient spending (T3TEIS);

The hospital specific tiered rate (HSTR) shall be calculated as follows:

For hospitals in Tier 3: HSTR = T3PI x HSBR

For hospitals in Tier 2: HSTR = (T3PI x HSBR) + (T2PI x HSBR)

For hospitals in Tier 1: HSTR = (T3PI x HSBR) + (T2PI x HSBR) + (T1PI x HSBR

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

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. By January 1, 2013, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all regions by October 1, 2014.

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

409.972 Mandatory and voluntary enrollment.—

(1) Persons eligible for the program known as "medically needy" pursuant to s. 409.904(2)(a) shall enroll in managed care plans. Medically needy recipients shall meet the share of cost by paying the plan premium, up to the share of cost amount, contingent upon federal approval.

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

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

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice, mental health treatment facilities as defined by s. 394.455(32).

(c) Persons eligible for refugee assistance.

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

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

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

409.973 Benefits.—

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

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

(e) Dental services.

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

(g) Emergency services.

(h) Family planning services and supplies.

(i) Healthy start services.

(j) Hearing services.

(k) Home health agency services.

(l) Hospice services.

(m) Hospital inpatient services.

(n) Hospital outpatient services.

(o) Laboratory and imaging services.

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

(q) Mental health services.

(r) Nursing care.

(s) Optical services and supplies.

(t) Optometrist services.

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

(v) Physician services.

(w) Podiatric services.

(x) Prescription drugs.

(y) Renal dialysis services.

(z) Respiratory equipment and supplies.

(aa) Rural health clinic services.

(bb) Substance abuse treatment services.

(cc) Transportation to access covered services.

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

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors.

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

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.-The agency shall select eligible plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2013.

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

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

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

(d) The agency shall procure at least four plans and no more than seven plans for Region IV. At least two plans shall be provider service networks if any two provider service networks submit responsive bids.

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

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

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

(g) The agency shall procure at least five plans and no more than nine plans for Region VII. At least two plans shall be provider service networks, if any two provider service network submit responsive bids.

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

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

(3) SPECIALTY PLANS.- Participation by specialty plans shall be subject to the procurement requirements and regional

plan number limits of this section. However, a specialty plan whose target population includes no more than 10 percent of the enrollees of that region shall not be subject to the regional plan number limits of this section.

(4) CHILDREN'S MEDICAL SERVICES NETWORK.- Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

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

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

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to 409.967(2)(b). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving

Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers;

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

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

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for one year or until an agreement is reached, whichever is first. Payments for services rendered by a non-participating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential

providers shall be attached to the contract between the agency and the plan. After one year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the non-participating essential service provider. If the alternative arrangement is approved by the agency, payments to non-participating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. If the alternative arrangement is not approved by the agency, payment to non-participating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools;

2. Regional perinatal intensive care centers as defined in s. 383.16(2); and,

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

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of non-participating

Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by a regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Payments to non-participating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

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

(d) Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan, and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency shall contract with a single organization representing medical schools and graduate medical education programs in Florida for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans.

The agency shall support these activities with certified public expenditures of general revenue appropriated to the participating medical schools and any earned federal matching funds, and shall seek any plan amendments or waivers necessary to comply with this subsection. To be eligible to participate in the quality network, a medical school must contract with each managed care plan in its region.

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

(4) MOMCARE NETWORK.—

(a) The agency shall contract with an administrative services organization representing all Healthy Start Coalitions providing risk appropriate care coordination and other services in accordance with a federal waiver and pursuant to s. 409.906. The contract shall require the network of coalitions to provide choice counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver. The agency shall evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. The agency shall support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

(b) Each managed care plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs. Each plan's programs and procedures shall include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with the agency and the MomCare Network.

(5) TRANSPORTATION.-Non-emergency transportation services shall be provided pursuant to a single, statewide contract between the agency and the Commission for Transportation Disadvantaged. The agency shall establish performance standards in the contract and shall evaluate the performance of the Commission for Transportation Disadvantaged.

(6) SCREENING RATE.—After the end of the second contract year, each managed care plan shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent of those recipients continuously enrolled for at least 8 months.

(7) PROVIDER PAYMENT.—Managed care plan and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. At a minimum, plans shall pay hospitals the Medicaid rate. Payments to hospitals shall not exceed 120 percent of the rate the agency would have paid on the first day of the contract

997 between the provider and the plan, unless specifically approved
998 by the agency. Payment rates may be updated periodically.
999 (8) MEDICALLY NEEDY ENROLLEES.—Each managed care plan
1000 shall accept any medically needy recipient who selects or is
1001 assigned to the plan and provide that recipient with continuous
1002 enrollment for 12 months. After the first month of qualifying as
1003 a medically needy recipient and enrolling in a plan, and
1004 contingent upon federal approval, the enrollee shall pay the
1005 plan a portion of the monthly premium equal to the enrollee's
1006 share of the cost as determined by the department. The agency
1007 shall pay the remainder of the monthly premium. Plans must
1008 provide a grace period of at least 90 days before disenrolling
1009 recipients who fail to pay their shares of the premium.
1010 Section 17. Section 409.976, Florida Statutes, is created
1011 to read:
1012 409.976 Managed care plan payment.—In addition to the
1013 payment provisions of s. 409.968, the agency shall provide
1014 payment to plans in the managed medical assistance program
1015 pursuant to this section.
1016 (1) Prepaid payment rates shall be negotiated between the
1017 agency and the eligible plans as part of the procurement
1018 described in s. 409.966.
1019 (2) The agency shall establish payment rates for statewide
1020 inpatient psychiatric programs. Payments to managed care plans
1021 shall be reconciled to reimburse actual payments to statewide
1022 inpatient psychiatric programs.
1023 Section 18. Section 409.977, Florida Statutes, is created
1024 to read:

409.977 Choice counseling and enrollment.—

(1) CHOICE COUNSELING.-In addition to the choice counseling information required by s. 409.969, the agency shall make available clear and easily understandable choice information to Medicaid recipients that includes information about cost sharing requirements of each managed care plan.

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

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

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

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

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

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

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.

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

program.

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

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

409.979 Eligibility.—

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

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

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

(2) Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 24 months without being re-evaluated for their need of nursing

facility care as defined in s. 409.985(3):

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

(b) The Aged and Disabled Adult Waiver.

(c) The Adult Day Health Care Waiver.

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

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

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

(g) The Channeling Services Waiver for Frail Elders.

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

409.980 Benefits.—Long term care plans shall cover, at a minimum, the following:

(1) Nursing facility care.

(2) Services provided in assisted living facilities.

(3) Hospice.

(4) Adult day care.

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

(5) Personal care.

(7) Home accessibility adaptation.

(9) Behavior management.

(9) Home delivered meals.

(10) Case management.

(11) Therapies:

(a) Occupational therapy

(b) Speech therapy

(c) Respiratory therapy

(d) Physical therapy.

(12) Intermittent and skilled nursing.

(13) Medication administration.

(14) Medication management.

(15) Nutritional assessment and risk reduction.

(16) Caregiver training.

(17) Respite care.

(18) Transportation.

(19) Personal emergency response system.

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

409.981 Eligible plans.—

(1) ELIGIBLE PLANS.— Provider service networks must be long-term care provider service networks. Other eligible plans may either be long-term care plans, or comprehensive long-term care plans.

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than July 1, 2012.

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

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

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

(d) The agency shall procure at least four plans and no more than seven plans for Region IV. At least two plans shall be provider service networks, if any two submit responsive bids.

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

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

(g) The agency shall procure at least five plans and no more than nine plans for Region VII. At least two plans shall be provider service networks, if any two submit responsive bids.

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

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

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

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

(c) Whether a plan is proposing to establish a comprehensive long-term care plan and whether the eligible plan has a contract to provide managed medical assistance services in the same region.

(d) Whether a plan offers consumer-directed care services to enrollees pursuant to s. 409.221.

(e) Whether a plan is proposing to provide home and community based services in addition to the minimum benefits required by s. 409.980.

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

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

409.982 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers

participating in the long-term care managed care program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price. For the period between October 1, 2013-September 30, 2014, each selected plan must offer a network contract to all the following providers in the region:

(a) Nursing homes.

(b) Hospices.

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

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

(2) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the managed care plans they join. Nursing homes and hospices which are enrolled Medicaid providers must participate in all eligible plans selected by the

agency in the region in which the provider is located.

(3) PERFORMANCE MEASUREMENT.—Each managed care plan shall monitor the quality and performance of each participating provider using measures adopted by and collected by the agency and any additional measures mutually agreed upon by the provider and the plan

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

(a) Adult day centers.

(b) Adult family care homes.

(c) Assisted living facilities.

(d) Health care services pools.

(e) Home health agencies.

(f) Homemaker and companion services.

(g) Hospices.

(h) Community Care for the Elderly Lead Agencies.

(i) Nurse registries.

(j) Nursing homes.

(5) PROVIDER PAYMENT.—Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay nursing homes an amount equal to the nursing facility-specific payment rates set by the agency; however, mutually acceptable higher rates may be negotiated for medically complex care. Plans shall pay hospice providers an amount equal to the per diem rate set by the agency. For recipients residing in a nursing facility and receiving hospice

services, the plan shall pay the hospice provider the per diem rate set by the agency minus the nursing facility component and shall pay the nursing facility the applicable state rate.

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

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

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

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

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

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

(a) Level of care 1 consists of recipients residing in or who must be placed in a nursing home.

(b) Level of care 2 consists of recipients at imminent risk of nursing home placement as evidenced by the need for the constant availability of routine medical and nursing treatment and care, and require extensive health-related care and services because of mental or physical incapacitation.

(c) Level of care 3 consists of recipients at imminent risk of nursing home placement as evidenced by the need for the constant availability of routine medical and nursing treatment and care, have a limited need for health-related care and services, are mildly medically or physically incapacitated

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

(5) The agency shall make an incentive adjustment in payment rates to encourage the increased utilization of home and community based services and a commensurate reduction of institutional placement. The incentive adjustment shall be modified in each successive rate period during the first contract period, as follows:

(a) a 2 percentage point shift in the first rate setting period;

(b) a 2 percentage point shift in the second rate setting period, as compared to the utilization mix at the end of the first rate setting period;

(c) a 3 percentage point shift in the third rate setting period, and in each subsequent rate setting period during the first contract period, as compared to the utilization mix at the

end of the immediately preceding rate setting period.

The incentive adjustment shall continue in subsequent contract periods, at a rate of 3 percentage points per year as compared to the utilization mix at the end of the immediately preceding rate setting period, until no more than 35 percent of the plan's enrollees are placed in institutional settings. The agency shall annually report to the Legislature the actual change in the utilization mix of home and community based services compared to institutional placements and provide a recommendation for utilization mix requirements for future contracts.

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

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

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

409.984 Choice counseling; enrollment.—

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

that provides choice counseling, the agency shall establish a memorandum of understanding with the aging resource center to coordinate staffing and collaborate with the choice counseling vendor. In addition to the requirements of s. 409.969, any contract to provide choice counseling for the long-term care managed care program shall provide that each recipient be given the option of having in-person choice counseling.

(2) AUTOMATIC ENROLLMENT.—The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, then the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as provided by this chapter, the agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall take into account the following criteria:

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

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

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

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

(4) CHOICE of RESIDENTIAL SETTING - When a recipient is referred for placement in a nursing home or assisted living facility, the plan shall inform the recipient of any facilities within the plan that have specific cultural or religious affiliations and, if requested by the recipient, make a reasonable effort to place the recipient in the facility of the recipient's choice.

Section 26. Section 409.9841. Florida Statutes is created to read:

409.9841 Long-term care managed care technical advisory workgroup.—

(1) Before August 1, 2011, the agency shall establish a technical advisory workgroup to assist in developing:

(a) the method of determining Medicaid eligibility pursuant to s. 409.985(3).

(b) the requirements for provider payments to nursing homes under s. 409.982(6).

(c) the requirements for prompt payments by plans to providers.

(d) uniform requirements for claims submissions and payments, including electronic funds transfers and claims processing.

(e) the process for enrollment of and payment for individuals pending determination of Medicaid eligibility.

(2) The advisory workgroup must include, but is not limited to, representatives of providers and plans who could potentially participate in long-term care managed care. Members of the workgroup shall serve without compensation but are may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(3) This section is repealed on June 30, 2013.

Section 27. Section 409.985, Florida Statutes, is created to read:

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

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

(2) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly

Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and review.

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, "nursing facility care" means the individual:

(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24 hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professionals and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of mental or physical incapacitation by the individual; or

(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24 hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the

supervision of licensed nursing or other health professionals because the individual who is incapacitated mentally or physically; or

(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24 hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual who is mildly incapacitated mentally or physically.

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

Section 28. Section 409.986, Florida Statutes, is created to read:

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

(1) Pursuant to s. 409.963, the agency is responsible for administering the long-term care managed care program for persons with developmental disabilities described in ss. 409.986-409.992, but may delegate specific duties and responsibilities for the program to the Agency for Persons with Disabilities and other state agencies. By January 1,2015, the agency shall begin implementation of statewide long-term care managed care for persons with developmental disabilities, with full implementation in all regions by October 1, 2016.

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

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

Section 29. Section 409.987, Florida Statutes, is created to read:

409.987 Eligibility.—

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

(a) Medicaid eligible pursuant to s.409.904.

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

(c) Meets the level of care need including:

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

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

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

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

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

(e) Is enrolled in a home and community based Medicaid waiver established in chapter 393, or the Consumer Directed Care Plus program for persons with developmental disabilities under the Medicaid state plan or the recipient is a Medicaid-funded resident of a private intermediate care facility for the developmentally disabled on the date the managed long-term care plans for persons with disabilities become available in the recipient's region or the recipient has been offered enrollment in a comprehensive long-term care plan or long-term care plan.

1. The Agency for Persons with Disabilities shall make offers for enrollment to eligible individuals based on the waitlist prioritization in s.393.065(5) and subject to availability of funds. Prior to enrollment offers, the agency shall determine that sufficient funds exist to support additional enrollment into plans.

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

Section 30. Section 409.988, Florida Statutes, is created to read:

409.988 Benefits.-Managed care plans shall cover, at a minimum, the services in this section. Plans may customize

benefit packages or offer additional benefits to meet the needs of enrollees in the plan.

(1) Intermediate care for the developmentally disabled.

(2) Services in alternative residential settings, including, but not limited to:

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

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

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

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

(3) Adult day training.

(4) Behavior analysis services.

(5) Companion services.

(6) Consumable medical supplies.

(7) Durable medical equipment and supplies.

(8) Environmental accessibility adaptations.

(9) In-home support services.

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

(11) Personal care assistance.

(12) Residential habilitation services.

(13) Intensive behavioral residential habilitation services.

(14) Behavior focus residential habilitation services.

(15) Residential nursing services.

(16) Respite care.

(17) Case management.

(18) Supported employment.

(19) Supported living coaching.

(20) Transportation.

Section 31. Section 409.989, Florida Statutes, is created to read:

409.989 Qualified plans.—

(1) ELIGIBLE PLANS.—Provider service networks may be either long-term care plans or comprehensive long-term care plans. Other plans must be comprehensive long-term care plans and under contract to provide services pursuant to s. 409.973 or s. 409.980 in any of the regions which form the combined region as defined in this section.

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

(3) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2015

(a) The agency shall procure at least two plans and no more than three plans for services in combined Regions I and II. At least one plan shall be a provider service network, if any submit a responsive bid.

(b) The agency shall procure at least two plans and no more than three plans for services in combined Regions III and

IV. At least one plan shall be a provider service network, if any submit a responsive bid.

(c) The agency shall procure at least two plans and no more than four plans for services in combined Regions V, VI and VII. At least one plan shall be a provider service network, if any submit a responsive bid.

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

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

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

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

(c) Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall give preference to plans with evidence of signed contracts with providers listed in s. 409.990(2)(a)-(b).

(5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's Medical Services Network may provide either long-term care plans or comprehensive long-term care plans. Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements.

Section 32. Section 409.990, Florida Statutes, is created to read:

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

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

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

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

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

(3) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the managed care plans they join. Licensed institutional care facilities for the developmentally disabled and licensed residential settings providing Intensive Behavioral Residential Habilitation services with an active Medicaid provider agreement must agree to participate in any eligible plan selected by the agency

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

(5) PROVIDER PAYMENT.—Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay intermediate care facilities for the developmentally disabled and intensive behavior residential

habilitation providers an amount equal to the facility-specific payment rate set by the agency.

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

(7) Consumer-Directed Care. - Each managed care plan must offer consumer-directed care services to enrollees pursuant to s. 409.221.

Section 33. Section 409.991, Florida Statutes, is created to read:

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

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

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

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

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

service utilization information from the most recent version of the Questionnaire for Situational Information and encounter data.

(5) The agency shall assign enrollees of developmental disabilities long-term care plans into one of five levels of care to account for variations in risk status and service needs among enrollees.

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

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

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

(d) Level of care 4 consists of individuals requiring less than moderate level of residential habilitation support in a residential placement, or individuals in supported living who require 6 hours a day or less of in-home support service.

(e) Level of care 5 consists of individuals who do not receive in-home support service and need minimal support

services while living in independent or supported living situations or in their family home.

The agency shall periodically adjust aggregate payments to plans based on encounter data to account for variations in risk levels among plans' enrollees.

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

Section 34. Section 409.992, Florida Statutes, is created to read:

409.992 Automatic enrollment.—

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

services. The agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall take into account the following criteria:

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

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

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

Section 35. This act shall take effect July 1, 2011.

Section by Section
PCB HHSC 11-01

SECTION BY SECTION SUMMARY OF PCB HHSC-11-01
ESTABLISHMENT OF STATEWIDE MANAGED CARE PROGRAM

Section 1. s. 409.961 – 409.992, *Florida Statutes*

- Designates Sections 409.961 through 409.992 as part IV of chapter 409, entitled "Medicaid Managed Care."

Section 2. s. 409.961 *Statutory construction, applicability; rules*

- Technical provisions.

Section 3. s. 409.962 *Definitions*

- Defining terms used throughout this part.

Section 4. s. 409.963 *Single state agency*

- Establishes the Agency for Health Care Administration (AHCA) as single state agency for Medicaid program.
- Designates Department of Children and Families (DCF) to be responsible for eligibility determinations.
- Provides for Medicaid recipient consent to release medical records to be eligible for Medicaid.

Section 5. s. 409.964 *Managed care program; state plan; waivers.*

- Establishes the statewide, integrated managed care program for all covered Medicaid services, including long term care (LTC) services.
- Provides that AHCA must apply for and implement waivers of federal laws to implement the program.
- Provides that AHCA must obtain public feedback on the waiver program and included in the waiver application.

Section 6. s. 409.965 *Mandatory enrollment*

- Provides that all populations in the Medicaid program will enroll to receive services through the managed care program.
- Exceptions to enrollment include: women only eligible for family planning services or breast and cervical cancer screenings, and persons eligible for emergency Medicaid for aliens.

Section 7. s. 409.966 *Eligible plans; selection*

- Defines eligible plans to provide Medicaid managed care to include: health insurers, exclusive provider organizations, health maintenance organizations (HMOs), and provider service networks (PSNs).
- PSNs must be capable of providing all covered services to an enrollee, or limit services to enrollees based on a specific target population.
- PSNs can partner with an insurer or an HMO to meet the requirements of the Medicaid contract.
- AHCA will select a limited number of plans in 7 geographic regions throughout the state.
- AHCA will issue an invitation to negotiate (ITN) for plans wishing to participate.

The 7 geographic regions are:

- Region 1 = Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington
- Region II = Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, Union, and Volusia.
- Region III = Hernando, Hillsborough, Pasco, Pinellas, Polk.
- Region IV = Brevard, Lake, Indian River, Orange, Osceola, Seminole, Sumter, Marion.
- Region V = Charlotte, Collier, DeSoto, Hardee, Highlands, Lee, Manatee, Sarasota.
  Region VI = Broward, Glades, Hendry, Martin, Okeechobee, Palm Beach, St. Lucie.
- Region VII=Dade, Monroe.

- When selecting plans AHCA will consider accreditation, prior experience, adequate primary care and specialty physicians, community partnerships, commitment to quality improvement, offering of additional benefits, evidence of agreements with providers, and comments submitted by Medicaid providers of the same region to which the plan is applying.

- Preferences will be given to plans who demonstrate:
  - Signed contracts with an adequate number of primary care and specialty physicians.
  - Programs for recognizing and providing increased compensation for patient-centered medical homes or accountable care organizations
  - An economic benefit to Florida by employing Floridians.

- Provides that any plan that is awarded a contract in Region I will automatically be selected in Region VII, if the plan bids in both regions.

Section 8. s. 409.967 ***Managed care accountability***

- Managed care plans will be awarded 5-year contracts with no automatic renewals.
- The bill provides that AHCA will establish the contract requirements but the contract must include that plans :
  - pay for emergency services.
  - maintain an adequate number of providers.
  - comply with AHCA's Medicaid Encounter Data System.
  - meet performance standards established by AHCA.
  - establish quality improvement systems
  - establish a program integrity plan to reduce the incidence of fraud and abuse.
  - maintain internal grievance resolution process
  - provide for prompt payment on all electronically submitted claims.

- A provider with a controlling interest in a PSN may not charge a managed care plan more than they charge their own PSN for the same service.
- Penalties are established for reducing enrollment or withdrawing prior to the end of a contract

Section 9. s. 409.968 ***Managed care plan payment***

- Payment is based on historic utilization and spending data.
- PSNs may be prepaid plans or receive fee for service payments (FFS) for the first 3 years

Section 10. s. 409.969 ***Enrollment; choice counseling; automatic assignment; disenrollment***

- Enrollees will have a choice of all available plans.
- All enrollees will be offered choice counseling from vendor who employs Floridians.
- Recipients may disenroll from a plan within the first 90 days of enrollment; otherwise must remain for 12 months., unless there is good cause
- The managed care plan must have a grievance process.

Section 11. s. 409.970 ***State and Local Medicaid Partnerships***

- AHCA may accept contributions from counties, municipalities, and special taxing districts.
- AHCA will allocate the contributed local funds to the low income pool (LIP).
- Excess contributions will be allocated to the Disproportionate Share Program and to enhance hospital rates.
- The LIP will be used to compensate certain providers that serve low income and uninsured individuals.
- The Access to Care Partnership is created to implement the Low Income Pool.
- Additional contributions may be used to enhance hospital rates based on a 3 tiered system.

SPECIFIC PROVISIONS: MANAGED MEDICAL ASSISTANCE PROGRAM

Section 12. s. 409.971 ***Managed Medical Assistance Program***

- Primary and acute medical care will be provided through a managed care model by January 1, 2013 with full implementation in all regions by October 1, 2014.

Section 13. s. 409.972 ***Mandatory and voluntary enrollment***

- All Medicaid recipients not exempted must enroll in a managed care plan.
- Medically Needy must be enrolled in managed care.
- The following recipients are exempt and may enroll voluntarily:
  - Persons eligible for Medicaid with other creditable health care coverage.
  - Recipients in DJJ facilities.
  - Persons eligible for refugee assistance.
  - Recipients who are residents of Sunland or Tacachale.

Section 14. s. 409.973 ***Benefits***

- All mandatory and optional Medicaid benefits must be covered.
- Plans may customize benefits.
- Plans must establish a program to encourage and reward healthy behaviors.

Section 15. s. 409.974 *Eligible plans*

- AHCA will select a limited number of eligible plans in each region, including 1 or 2 PSNs, depending on the region.
- AHCA plan selection must consider certain factors, e.g. plans with written agreements, signed contracts, or substantial progress in establishing relationships with providers, and signed contracts with essential providers.
- Specialty Plans are not subject to plan limits if serving no more than 10 percent of the enrollees in that region
- Children's Medical Services Network (CMS) is not subject to procurement requirements or regional plan limits but must meet all other plan requirements.

Section 16. s. 409.975 *Managed care plan accountability*

- AHCA will establish a methodology to determine if the plan is managing care effectively. Plans not managing effectively will be required to pay a refund.

- Managed care plans must maintain provider networks that meet the medical needs of their enrollees. Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

- Essential Providers

    - Plans must include all essential providers in a region unless AHCA approves an alternative arrangement for services provided by essential providers. The bill establishes payment rates for non-contracted providers.

    - After 12 months, any essential providers may be excluded for failure to meet quality or performance standards. Plans must provide enrollees 30 day notice of the exclusion.

    - Plans must include all statewide essential providers in their networks. Statewide essential providers are: Florida medical schools, regional perinatal intenstive care centers, and specialty children's hospitals.

- Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region that meets certain criteria.

- Quality

    - Florida Medical Schools Quality Network-AHCA must contract with an organization representing medical schools to develop a program to improve clinical outcomes in all managed care plans.

    - Each managed care plan shall monitor the quality and performance of their providers and must notify them of the metrics used to measure performance.

    - AHCA shall contract with an organization representing all healthy start coalitions providing care coordination and other services to pregnant women and infants, in accordance with a federal waiver.

- Each managed care plan must receive an annual Early and Periodic Screening, Diagnosis, and Treatment Service (EPSDT) screening rate of at least 80 percent of recipients enrolled for at least 8 months.

- Managed care plans and hospitals must negotiate mutually acceptable rates and terms of payment. Hospitals must be paid the Medicaid rate at a minimum and payments to hospitals cannot exceed 120% of the agreed upon rate between AHCA and the plan.

- Medically Needy Enrollees-each managed care plan must accept any medically needy recipients who select or are assigned to that plan and provide continuous enrollment for 12 months. The medically needy enrollee will pay the plan an amount equal to their share of cost.

Section 17. s. 409.976 ***Managed care plan payment***

- Prepaid plan payments will be established through the negotiation process

- AHCA must establish payment rates for psychiatric programs and payments to the managed care plans for these services must reflect the established rate.

Section 18. s. 409.977 ***Choice counseling and enrollment***

- Choice counseling must be provided.

- Recipients that do not voluntarily choose a plan within 30 days will be automatically enrolled in a plan that meets or exceeds quality and performance standards. When a specialty plan is available that meets the enrollees' specific condition, they shall be enrolled in that plan.

- AHCA may also automatically enroll recipients based on the following other considerations:
  - Sufficient network capacity
  - Prior history between the enrollee and a primary care provider in that plan
  - Geographic accessibility

- Recipients may use Medicaid premiums for purchase of other coverage such as employer-sponsored coverage.

SPECIFIC PROVISIONS: LONG TERM MANAGED CARE PROGRAM

Section 19. s. 409.978 ***Long Term Managed Care Program***

- AHCA will administer the long-term managed care program but may delegate specific duties to the Department of Elder Affairs (DOEA). AHCA shall begin implementation of the statewide LTC managed care program by July, 1, 2012, with full implementation in all the regions by October 1, 2013.

- DOEA must assist AHCA in developing the ITN, determining eligibility, monitoring performance, assisting clients and families with complaints, facilitating relationships between the plans and applicable providers, and other agreed upon functions.

Section 20. s. 409.979 ***Eligibility***

- Eligible recipients for the long-term managed care program are:
  - Age 65 or older, and are clinically eligible based on need for nursing care,
  - or have a disability per federal standards

- Medicaid recipients currently receiving services in a nursing home or through other Medicaid waivers listed below are also eligible to participate in the LTC managed care program.
  - Assisted Living waiver
  - Aged & Disabled Adult waiver
  - Adult Day Health Care waiver
  - Consumer Directed Care waiver
  - PACE
  - Diversion
  - Channeling

Section 21. s. 409.980 ***Benefits***

- A specific list of established required benefits must be provided at a minimum by LTC managed care plans.

Section 22. s. 409.981 ***Eligible plans***

- Eligible plans for the LTC managed care program include: long term care PSNs, long term care plans, or comprehensive long term care plans.

- The agency shall select a limited number of eligible plans in each region, including at least 1 PSN per region if any two submit a responsive bid.

  Region I=3 plans
  Region II=3-6 plans
  Region III=4-8 plans
  Region IV=4-7 plans
  Region V=3 plans
  Region VI=4-7 plans
  Region VII=5-9 plans

- The following factors will be considered by AHCA when selecting a long term care plan:
  - Previous experience in serving aged and disabled persons requiring long term care.
  - Whether the plan has established an adequate provider network.
  - Whether a plan is proposing to establish a comprehensive long-term care plan and whether the plan has a contract to provide managed medical assistance services in the same region.
  - Whether a plan offers consumer-directed care services to enrollees.
  - Whether a plan proposes to provide home and community based services in addition to the minimum required benefits.

- Participation by the PACE program is pursuant to a contract with AHCA and is not subject to the procurement requirements or regional plan limits.

Section 23. s. 409.982. Managed Care Plan Accountability

- Plans may limit the providers in their networks based on credentials, quality, and price but must offer contracts to all of the following providers during the first year of operation:
  - Nursing homes
  - Hospices
  - Aging network providers

- After 12 months, any of these providers may be excluded for failure to meet quality or performance standards. The plan must provide written notice to all recipients of that provider 30 days prior to the exclusion.

- Providers may limit the managed care plans they participate in, however, nursing homes and hospices that are enrolled Medicaid providers must participate in all selected plans in the region where they are located.

- Managed care plans must monitor quality performance of participating providers through measures adopted and collected by AHCA, and any additional measures agreed upon between the plan and the provider.

- AHCA must establish specific standards for the number, type and regional distribution of the following providers in the plan's network:
  - Adult day care
  - Adult family care homes
  - ALFs
  - Health care services pools
  - HHAs
  - Homemaker/Companion organizations
  - Hospices
  - Lead agencies
  - Nurse registries
  - Nursing homes

- Plans must negotiate acceptable rates with providers. However, nursing homes shall be paid rates established by AHCA but mutually acceptable higher rates can be negotiated for medically complex care. Hospices will be paid per diem rates established by AHCA.

Section 24. s. 409.983 *Managed Care Plan Payment*

- Prepaid plans will receive per member, per month (PMPM) payments negotiated through the bidding process and adjusted for risk.

- In comprehensive LTC plans, payment rates for standard Medicaid benefits will be blended with payment rates for the required minimum LTC benefits.

- Calculation of rates must be based on historic use and spending and adjusted to reflect the necessary level of care for enrollees in each plan. Payment must be adjusted to provide an incentive for reducing institutional placements and increasing home and community-based services.

- The Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will make the initial assessment to determine the recipient's level of care.
  Level 1: residing in or who must be placed in a nursing home.
  Level 2: imminent risk of nursing home placement evidenced by the need for constant availability of routine care with extensive need for health related services
  Level 3: imminent risk of nursing home placement evidenced by the need for constant availability of routine care with limited need for health related services

- AHCA must adjust payment rates periodically to account for changes in required level of care.

- Rates will be adjusted to create an incentive for plans to increase use of home and community based services over institutional care. The rates will continue to adjust to incentivize the shift from institutional care to home and community based care until no more than 35% of any LTC plan's enrollees are placed in institutional care settings.

- Nursing home and hospice rates are by AHCA.

Section 25. s. 409.984 *Choice Counseling and enrollment*

- Choice counseling must be offered to enrollees. Before AHCA contracts with a vendor to provide choice counseling, they must offer a contract for such services to Aging Resource Centers (ARCs). Each recipient must be given the opportunity for "in person" choice counseling.

- Recipients that do not choose a plan will be automatically enrolled in a plan that meets or exceeds performance and quality standards.

- Individuals who are dually eligible for Medicaid and Medicare shall be automatially enrolled in the plan that currently provides Medicare services to those individuals.

- AHCA shall also take the following conditions into consideration when making automatic enrollments:
  - Network capacity
  - Prior relationships with home and community based providers
  - Geographic accessibility

- Individuals referred for hospice services have 30 days in which they may select another plan to access the hospice provider of their choice.

- Recipients referred for nursing home or assisted living facility placement shall be informed of facilities within the plan that have specific cultural or religious and affiliations and if the recipient chooses, a reasonable effort must be made to place the recipient in the facility they choose.

Section 26. s. 409.9841 ***Long-term care managed care technical advisory workgroup***

- AHCA shall develop a workgroup to assist in developing eligibility determinations and payment methods for the long-term care managed care program.

- The workgroup must include representatives of providers and plans who would participate in LTC managed care.

Section 27. s. 409.985 ***CARES***

- CARES will ensure that only individuals whose conditions require LTC are enrolled in the LTC managed care program.

- CARES will determine clinical eligibility and level of care for nursing facility care and will give consideration to the recipient's access to community or other resources.

- CARES will determine if there is progress towards rehabilitation for individuals whose nursing home stay is initially funded by Medicare and Medicare coverage was terminated for lack of progress towards rehabilitation. CARES may assist the recipient in appealing the termination of Medicare.

SPECIFIC PROVISIONS: LONG-TERM CARE MANAGED CARE PROGRAM FOR PERSONS WITH DEVLEOPMENTAL DISABILITIES

Section 28. s. 409.986 ***Managed Long-Term Care for Persons with Developmental Disabilities***

- AHCA will administer the long-term managed care program for persons with developmental disabilities (DD) but may delegate specific duties to the Agency for Persons with Disabilities (APD).

- AHCA shall begin implementation of the statewide LTC managed care program for persons with DD by January, 1, 2015, with full implementation in all the regions by October 1, 2016.

- APD must assist AHCA in developing the ITN, determining eligibility, monitoring performance, assisting clients and families with complaints, facilitating relationships between the plans and applicable providers, and any other agreed upon functions.

Section 29. s. 409.987 ***Eligibility***

- To be eligible recipients must meet the following:
  - Financially eligible based on Medicaid income and asset tests
  - Have a developmental disability as defined in statute
  - Meets a certain level of care need
  - Be in an intermediate care facility for the developmentally disabled (ICF/DD)
  - Be enrolled in the Home and Community-Based Waiver program for persons with developmental disabilities, in the Consumer Directed Care (CDC) Plus program for persons with developmental disabilities, or in a private intermediate care facility for the developmentally disabled.

- APD shall make offers of enrollment to eligible individuals who are on the waitlist, if funding is available.

- Residents of Sunland and Tacachale are exempt from enrollment but may voluntarily enroll.

Section 30. s. 409.988. ***Benefits***

- A specific list of benefits is provided and must be covered at a minimum

- Plans may customize or add additional benefits

Section 31. s. 409.989 ***Eligible plans***

- Only provider service networks and CMS network plans may provide long term care plans for persons with DD. Other eligible plans may only provide comprehensive plans. Comprehensive plans must already be under contract as a managed care plan in the applicable region.

- PSNs wishing to participate in the LTC DD managed care plan must include at least 1 owner licensed to operate a DD facility or an ICF/DD, and has at least 10 years' experience serving the DD population.

- A limited number of plans will be selected. DD long-term care plans will be procured in 3 combined regions. One PSN must be selected in each region.

Region I & II=2-3 plans
Region III & IV=2-3 plans
Region V, VI, & VII=2-4 plans

- The following factors will be considered by AHCA when selecting a LTC plan for DD:
  - Employment of staff that have expertise and experience serving individuals with a developmental disability
  - A sufficient number of DD providers in the network.
  - Written agreements, signed contracts, or has made substantial progress in establishing relationships with providers

- The CMS Network Plan for children is an eligible plan and not subject to competitive procurement or regional plan limits, but must meet all other plan requirements.

Section 32. s. 409.990 ***Managed Care Plan Accountability***

- Plans may limit the providers in their networks based on credentials, quality, and price but must offer contracts to all of the following applicable providers during the first contract period:
  - Intermediate care facilities for the developmentally disabled (ICF/DDs)
  - Alternate residential facilities (such as: group homes, foster homes etc.)

- Certain providers: ICF/DDs and intensive behavior residential habilitation providers must agree to participate in the LTC plans for DD.

- After 12 months, any of these providers may be excluded for failure to meet quality or performance standards. Plans must provide enrollees 30 day notice of the exclusion.

- Plans must measure provider quality and performance. The plans must inform the providers of the methods that will be used to evaluate their performance.

- Plans and providers will negotiate acceptable payment rates. However, payments to ICF/DDs and intensive behavioral residential habilitation service providers must be made at the rates set by AHCA.

- Plans must establish a family advisory committee to participate in the program design and development of the DD plans.

- Plans must provide a consumer directed care option to all enrollees.

Section 33. s. 409.991 *Managed Care Plan Payment*

- Prepaid plans will receive per member, per month (PMPM) payments negotiated through the bidding process and adjusted for risk.

- In comprehensive LTC plans, payment rates for medical assistance benefits will be blended with payment rates for LTC benefits.

- Calculation of rates must be based on historic use and spending and adjusted to reflect the necessary level of care for enrollees in each plan.

- APD assessments are used to initially determine the level of care. AHCA will assign enrollees in the LTC DD plan into one of 5 levels of care.

- AHCA must adjust payment rates periodically to account for changes in risk levels among enrollees.

Section 34. s. 409.992 *Automatic Enrollment*

- The agency will automatically enroll recipients into a plan that meets or exceeds performance and quality standards.

- AHCA shall also take the following conditions into consideration when making automatic enrollments:
    - Network capacity
    - Prior relationships with home and community based providers
    - Geographic accessibility

Section 35. *Effective date*

- The effective date is July 1, 2011

A bill to be entitled

An act relating to Medicaid; amending s. 393.0661, F.S.; requiring the Agency for Persons with Disabilities to establish a transition plan for current Medicaid recipients under certain circumstances; providing for expiration of the section on a specified date; amending s. 393.0662, F.S.; requiring the Agency for Persons with Disabilities to complete the transition for current Medicaid recipients to the i-budget by a certain date; requiring the agency to develop a transition plan for current Medicaid recipients to qualities managed care plans; providing for expiration of the section on a specified date; amending s. 408.040, F.S.; providing for suspension of conditions precedent to the issuance of a certificate of need for a nursing home, effective on a specified date; amending s. 408.0435, F.S.; extending the certificate-of-need moratorium for additional community nursing home beds; designating ss. 409.016-409.803, F.S., as pt. I of ch. 409, F.S., and entitling the part "Social and Economic Assistance"; designating ss. 409.810-409.821, F.S., as pt. II of ch. 409, F.S., and entitling the part "Kidcare"; designating ss. 409.901-409.9205, F.S., as part III of ch. 409, F.S., and entitling the part "Medicaid"; amending s. 409.905, F.S.; providing that the Agency for Health Care Administration shall set reimbursements rates for hospitals providing Medicaid services based on allowable cost reporting from the hospitals; providing the methodology for the rate calculation and adjustments;

providing that the rates shall be subject to certain limits or ceilings; providing that limits or ceilings may be provided in the General Appropriations Act; amending s. 409.911, F.S.; providing for expiration of the Medicaid Low Income Pool Council; amending s. 409.912, F.S.; providing payment requirements for provider service networks; providing for the expiration of various provisions of the section on specified dates to conform to the reorganization of Medicaid managed care; requiring the Agency for Health Care Administration to contract on a prepaid or fixed-sum basis with certain prepaid dental health plans; requiring Medicaid-eligible children with open child welfare cases who reside in AHCA area 10 to be enrolled in specified capitated managed care plans; eliminating obsolete provisions and updating provisions within the section; amending ss. 409.91195 and 409.91196, F.S.; conforming cross-references; repealing s. 409.91207, F.S.; relating to the medical home pilot project; repealing s. 409.91211, F.S.; relating to the Medicaid managed care pilot program; amending s. 409.9122, F.S.; eliminating outdated provisions; providing for the expiration of various provisions of the section on specified dates to conform to the reorganization of Medicaid managed care; requiring the Agency for Health Care Administration to develop a process to enable any recipient with access to employer sponsored coverage to opt out of eligible plans in the Medicaid program; requiring the agency, contingent on federal approval, to

enable recipients with access to other coverage or related products providing access to specified health care services to opt out of eligible plans in the Medicaid program; requiring the agency to maintain and operate the Medicaid Encounter Data System; requiring the agency to conduct a review of encounter data and publish the results of the review prior to adjusting rates for prepaid plans; requiring the agency to establish a designated payment for specified Medicare Advantage Special Needs members; authorizing the agency to develop a designated payment for Medicaid-only covered services for which the state is responsible; requiring the agency to establish, and managed care plans to use, a uniform method of accounting for and reporting of medical and nonmedical costs; authorizing the Agency for Health Care Administration to create exceptions to mandatory enrollment in managed care under specified circumstances; providing that the agency shall contract with a provider service network to function as a third party administrator and managing entity for the MediPass program; providing contract provisions; providing for the expiration of the section on a specified date; amending s. 430.04, F.S.; eliminating outdated provisions; requiring the Department of Elderly Affairs to develop a transition plan for specified elder and disabled adults receiving long-term care Medicaid services when eligible plans become available; providing for expiration thereof; amending s. 430.2053, F.S.; eliminating outdated provisions; providing additional duties of aging resource

centers; providing an additional exception to direct services that may not be provided by an aging resource center; providing for the cessation of specified payments by the department as eligible plans become available; providing for a memorandum of understanding between the Agency for Health Care Administration and aging resource centers under certain circumstances; eliminating provisions requiring reports; amending s. 641.386, F.S.; conforming a cross-reference; repealing s. 430.701, F.S., relating to legislative findings and intent and approval for action relating to provider enrollment levels; repealing s. 430.702, F.S., relating to the Long-Term Care Community Diversion Pilot Project Act; repealing s. 430.703, F.S., relating to definitions; repealing s. 430.7031, F.S., relating to nursing home transition program; repealing s. 430.704, F.S., relating to evaluation of long-term care through the pilot projects; repealing s. 430.705, F.S., relating to implementation of long-term care community diversion pilot projects; repealing s. 430.706, F.S., relating to quality of care; repealing s. 430.707, F.S., relating to contracts; repealing s. 430.708, F.S., relating to certificate of need; repealing s. 430.709, F.S., relating to reports and evaluations; renumbering ss. 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S., as ss. 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and 402.87, F.S., respectively; amending s. 443.111, F.S.;

conforming a cross-reference; providing contingent effective dates.

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

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

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

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

(a) The agency shall use an assessment instrument that the agency deems to be reliable and valid, including, but not limited to, the Department of Children and Family Services' Individual Cost Guidelines or the agency's Questionnaire for Situational Information. The agency may contract with an

external vendor or may use support coordinators to complete client assessments if it develops sufficient safeguards and training to ensure ongoing inter-rater reliability.

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

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

(3) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval and implement a four-tiered waiver system to serve eligible clients through the developmental disabilities and family and supported living waivers. The agency shall assign all clients receiving services through the developmental disabilities waiver to a tier based on the Department of Children and Family Services' Individual Cost Guidelines, the agency's Questionnaire for Situational Information, or another such assessment instrument deemed to be valid and reliable by the agency; client characteristics, including, but not limited to, age; and other appropriate assessment methods.

(a) Tier one is limited to clients who have service needs

that cannot be met in tier two, three, or four for intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others. Total annual expenditures under tier one may not exceed $150,000 per client each year, provided that expenditures for clients in tier one with a documented medical necessity requiring intensive behavioral residential habilitation services, intensive behavioral residential habilitation services with medical needs, or special medical home care, as provided in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, are not subject to the $150,000 limit on annual expenditures.

(b) Tier two is limited to clients whose service needs include a licensed residential facility and who are authorized to receive a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or clients in supported living who receive more than 6 hours a day of in-home support services. Total annual expenditures under tier two may not exceed $53,625 per client each year.

(c) Tier three includes, but is not limited to, clients requiring residential placements, clients in independent or supported living situations, and clients who live in their family home. Total annual expenditures under tier three may not exceed $34,125 per client each year.

(d) Tier four includes individuals who were enrolled in the family and supported living waiver on July 1, 2007, who

shall be assigned to this tier without the assessments required by this section. Tier four also includes, but is not limited to, clients in independent or supported living situations and clients who live in their family home. Total annual expenditures under tier four may not exceed $14,422 per client each year.

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

(f) The agency shall seek federal waivers and amend contracts as necessary to make changes to services defined in federal waiver programs administered by the agency as follows:

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

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

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

4. Residential habilitation services are limited to 8

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

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

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

7. The agency shall conduct supplemental cost plan reviews to verify the medical necessity of authorized services for plans that have increased by more than 8 percent during either of the 2 preceding fiscal years.

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

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

may be reassessed during this year in order to determine the necessity for a change in their support plan.

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

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

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

(5) The geographic differential for Monroe County for residential habilitation services shall be 20 percent.

(6) Effective January 1, 2010, and except as otherwise provided in this section, a client served by the home and community-based services waiver or the family and supported living waiver funded through the agency shall have his or her cost plan adjusted to reflect the amount of expenditures for the previous state fiscal year plus 5 percent if such amount is less than the client's existing cost plan. The agency shall use actual paid claims for services provided during the previous fiscal year that are submitted by October 31 to calculate the revised cost plan amount. If the client was not served for the entire previous state fiscal year or there was any single change in the cost plan amount of more than 5 percent during the

previous state fiscal year, the agency shall set the cost plan amount at an estimated annualized expenditure amount plus 5 percent. The agency shall estimate the annualized expenditure amount by calculating the average of monthly expenditures, beginning in the fourth month after the client enrolled, interrupted services are resumed, or the cost plan was changed by more than 5 percent and ending on August 31, 2009, and multiplying the average by 12. In order to determine whether a client was not served for the entire year, the agency shall include any interruption of a waiver-funded service or services lasting at least 18 days. If at least 3 months of actual expenditure data are not available to estimate annualized expenditures, the agency may not rebase a cost plan pursuant to this subsection. The agency may not rebase the cost plan of any client who experiences a significant change in recipient condition or circumstance which results in a change of more than 5 percent to his or her cost plan between July 1 and the date that a rebased cost plan would take effect pursuant to this subsection.

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

(8) The Agency for Persons with Disabilities shall submit quarterly status reports to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor regarding the financial status of home and community-based services, including the number of enrolled individuals who are receiving services through one or more programs; the number of individuals who have requested services who are not enrolled but who are receiving services through one or more programs, with a description indicating the programs from which the individual is receiving services; the number of individuals who have refused an offer of services but who choose to remain on the list of individuals waiting for services; the number of individuals who have requested services but who are receiving no services; a frequency distribution indicating the length of time individuals have been waiting for services; and information concerning the actual and projected costs compared to the amount of the appropriation available to the program and any projected surpluses or deficits. If at any time an analysis by the agency, in consultation with the Agency for Health Care Administration, indicates that the cost of services is expected to exceed the amount appropriated, the agency shall submit a plan in accordance with subsection (7) to the Executive Office of the Governor, the chair of the Senate Ways and Means Committee or its successor, and the chair of the House Fiscal Council or its successor to remain within the amount appropriated. The agency shall work with the Agency for Health Care Administration to implement the plan so as to remain within the appropriation.

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

(10) This section expires October 1, 2016.

Section 2. Section 393.0662, Florida Statutes, is amended to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget. Therefore, the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, develop and implement a comprehensive redesign of the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(1) The agency shall establish an individual budget,

referred to as an iBudget, for each individual served by the home and community-based services Medicaid waiver program. The funds appropriated to the agency shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. The iBudget system shall be designed to provide for: enhanced client choice within a specified service package; appropriate assessment strategies; an efficient consumer budgeting and billing process that includes reconciliation and monitoring components; a redefined role for support coordinators that avoids potential conflicts of interest; a flexible and streamlined service review process; and a methodology and process that ensures the equitable allocation of available funds to each client based on the client's level of need, as determined by the variables in the allocation algorithm.

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

(b) The allocation methodology shall provide the algorithm that determines the amount of funds allocated to a client's iBudget. The agency may approve an increase in the amount of

funds allocated, as determined by the algorithm, based on the client having one or more of the following needs that cannot be accommodated within the funding as determined by the algorithm and having no other resources, supports, or services available to meet the need:

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

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

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

c. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a medical condition existing simultaneously but independently with another medical condition in a patient; or

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

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

2. A significant need for one-time or temporary support or

services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term "temporary" means a period of fewer than 12 continuous months. However, the presence of such significant need for one-time or temporary supports or services alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

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

amount of funds allocated to a client's iBudget as determined by the algorithm.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for adjustments required pursuant to this paragraph and may use the services of an independent actuary in determining the amount of the portions to be reserved.

(c) A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided pursuant to paragraph (b). A client's annual expenditures for home and community-based services Medicaid waiver services may not exceed the limits of his or her iBudget. The total of all clients' projected annual iBudget expenditures may not exceed the agency's appropriation for waiver services.

(2) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval to amend current waivers, request a new waiver, and amend contracts as necessary to implement the iBudget system to serve eligible, enrolled clients through the home and community-based services Medicaid waiver program and the Consumer-Directed Care Plus Program.

(3) The agency shall transition all eligible, enrolled clients to the iBudget system. The agency may gradually phase in the iBudget system and must complete the phase in by January 1, 2015.

(a) While the agency phases in the iBudget system, the agency may continue to serve eligible, enrolled clients under

the four-tiered waiver system established under s. 393.065 while those clients await transitioning to the iBudget system.

(b) The agency shall design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to the iBudget system.

(4) A client must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may be available to the client before using funds from his or her iBudget to pay for support and services.

(5) The service limitations in s. 393.0661(3)(f)1., 2., and 3. do not apply to the iBudget system.

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

(7) The agency shall ensure that clients and caregivers have access to training and education to inform them about the iBudget system and enhance their ability for self-direction. Such training shall be offered in a variety of formats and at a minimum shall address the policies and processes of the iBudget system; the roles and responsibilities of consumers, caregivers,

waiver support coordinators, providers, and the agency; information available to help the client make decisions regarding the iBudget system; and examples of support and resources available in the community.

(8) The agency shall collect data to evaluate the implementation and outcomes of the iBudget system.

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

(10) The agency shall develop a transition plan for recipients who are receiving services through the ibudget system at the time eligible managed care plans are available in each recipient's region defined in s. 409.989 to enroll those recipients in eligible plans.

(11) This section expires October 1, 2016.

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

408.040 Conditions and monitoring.—

(1)

(b) The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent by the applicant that a specified percentage of the annual patient days at the facility will be utilized by patients eligible for care

under Title XIX of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that a specified percentage of annual patient days will be utilized by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph in an area in which a community diversion pilot project is implemented. Effective July 1, 2012, the agency shall not consider, or impose conditions related to, patient day utilization by patients eligible for care under Title XIX the Social Security Act in making certificate-of-need determinations for nursing homes.

(d) If a nursing home is located in a county in which a long-term care community diversion pilot project has been implemented under s. 430.705 ~~or in a county in which an integrated, fixed-payment delivery program for Medicaid recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid has been implemented under s. 409.912(5),~~ the nursing home may request a reduction in the percentage of annual patient days used by residents who are eligible for care under Title XIX of the Social Security Act, which is a condition of the nursing home's certificate of need. The agency shall automatically grant the nursing home's request if the reduction is not more than 15 percent of the nursing home's annual Medicaid-patient-days condition. A nursing home may submit only one request every 2 years for an automatic

reduction. A requesting nursing home must notify the agency in writing at least 60 days in advance of its intent to reduce its annual Medicaid-patient-days condition by not more than 15 percent. The agency must acknowledge the request in writing and must change its records to reflect the revised certificate-of-need condition. This paragraph expires June 30, 2011.

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

408.0435 Moratorium on nursing home certificates of need.—

(1) Notwithstanding the establishment of need as provided for in this chapter, a certificate of need for additional community nursing home beds may not be approved by the agency until after Medicaid managed care is implemented statewide pursuant to ss. 409.961-409.992, or October 1, 2016, whichever is earlier ~~July 1, 2011.~~

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

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

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

Section 8. Paragraph (c) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the

state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(c) The agency shall implement a methodology for establishing base reimbursements rates for each hospital based on allowable costs, as defined by the agency. Rates shall be calculated annually and become effect at the start of each state fiscal year based on the most recent complete and accurate cost report submitted by each hospital. The rates shall be effective on July 1 of each year. No adjustments will be made to the

rates after September 30 of the state fiscal year in which the rate is effective. Errors in cost reporting or calculation of rates discovered after September 30 must be reconciled in a subsequent rate period. Hospital rates shall be subject to such limits or ceilings as many be established in law or described in the agency's hospital reimbursement plan. Specific exemptions to the limits or ceilings may be provide in the General Appropriations Act.

~~The agency shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:~~

~~1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995;~~

~~2. The hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or~~

~~3. The hospital is located in a county that has six or fewer general acute care hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.~~

~~By October 1 of each year, the agency must provide estimated costs for any adjustment in a hospital inpatient per diem rate to the Executive Office of the Governor, the House of~~

~~Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.~~

Section 9. Subsection (10) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(10) The Agency for Health Care Administration shall create a Medicaid Low-Income Pool Council by July 1, 2006. The Low-Income Pool Council shall consist of 24 members, including 2 members appointed by the President of the Senate, 2 members appointed by the Speaker of the House of Representatives, 3 representatives of statutory teaching hospitals, 3 representatives of public hospitals, 3 representatives of nonprofit hospitals, 3 representatives of for-profit hospitals, 2 representatives of rural hospitals, 2 representatives of units of local government which contribute funding, 1 representative

of family practice teaching hospitals, 1 representative of federally qualified health centers, 1 representative from the Department of Health, and 1 nonvoting representative of the Agency for Health Care Administration who shall serve as chair of the council. Except for a full-time employee of a public entity, an individual who qualifies as a lobbyist under s. 11.045 or s. 112.3215 may not serve as a member of the council. Of the members appointed by the Senate President, only one shall be a physician. Of the members appointed by the Speaker of the House of Representatives, only one shall be a physician. The physician member appointed by the Senate President and the physician member appointed by the Speaker of the House of Representatives must be physicians who routinely take calls in a trauma center, as defined in s. 395.4001, or a hospital emergency department. The council shall:

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

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

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

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

year.

This subsection expires October 1, 2014.

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

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

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

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

(1) The agency shall work with the Department of Children and Family Services to ensure access of children and families in the child protection system to needed and appropriate mental health and substance abuse services. This subsection expires October 1, 2014.

(2) The agency may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920. This subsection expires October 1, 2016.

(3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.

(4) The agency may contract with:

(a) An entity that provides no prepaid health care

services other than Medicaid services under contract with the agency and which is owned and operated by a county, county health department, or county-owned and operated hospital to provide health care services on a prepaid or fixed-sum basis to recipients, which entity may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services entities must be licensed under parts I and III of chapter 641. An entity recognized under this paragraph which demonstrates to the satisfaction of the Office of Insurance Regulation of the Financial Services Commission that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225. This paragraph expires October 1, 2014.

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

contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 5.~~8.~~, and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care

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

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

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

2. ~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1, 2006,~~ the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services

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

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

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

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

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

~~basis.~~

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

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

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

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

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

5. ~~8.~~ All Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency may seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 shall be enrolled in capitated managed care plans that, in coordination with available community-based care providers specified in s. 409.1671, provide sufficient medical, developmental, behavioral and emotional services to meet the needs of these children. ~~are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd).~~

This paragraph expires October 1, 2014.

(c) A federally qualified health center or an entity owned by one or more federally qualified health centers or an entity owned by other migrant and community health centers receiving non-Medicaid financial support from the Federal Government to provide health care services on a prepaid or fixed-sum basis to recipients. A federally qualified health center or an entity that is owned by one or more federally qualified health centers and is reimbursed by the agency on a prepaid basis is exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet the appropriate requirements governing financial reserve, quality assurance, and patients' rights established by the agency. This paragraph expires October 1, 2014.

(d) 1. A provider service network may be reimbursed on a fee-for-service or prepaid basis. Prepaid provider service networks receive per-member per-month payments. Provider service networks that do not choose to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 5 years of the plan's operation in a given region or until the contract year beginning October 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall

perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.

2. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

3. Medicaid recipients assigned to a provider service network shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. This subparagraph expires October 1, 2014. ~~Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary.~~

4. A provider service network is a network established or organized and operated by a health care provider, or group of

affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(e) An entity that provides only comprehensive behavioral health care services to certain Medicaid recipients through an administrative services organization agreement. Such an entity must possess the clinical systems and operational competence to provide comprehensive health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. Any contract awarded under this paragraph must be competitively procured. The agency must ensure that Medicaid recipients have available the choice of at least two managed care plans for their behavioral health care services. This paragraph expires October 1, 2014.

~~(f) An entity that provides in-home physician services to test the cost-effectiveness of enhanced home-based medical care~~

~~to Medicaid recipients with degenerative neurological diseases and other diseases or disabling conditions associated with high costs to Medicaid. The program shall be designed to serve very disabled persons and to reduce Medicaid reimbursed costs for inpatient, outpatient, and emergency department services. The agency shall contract with vendors on a risk-sharing basis.~~

~~(g) Children's provider networks that provide care coordination and care management for Medicaid-eligible pediatric patients, primary care, authorization of specialty care, and other urgent and emergency care through organized providers designed to service Medicaid eligibles under age 18 and pediatric emergency departments' diversion programs. The networks shall provide after-hour operations, including evening and weekend hours, to promote, when appropriate, the use of the children's networks rather than hospital emergency departments.~~

(f) ~~(h)~~ An entity authorized in s. 430.205 to contract with the agency and the Department of Elderly Affairs to provide health care and social services on a prepaid or fixed-sum basis to elderly recipients. Such prepaid health care services entities are exempt from the provisions of part I of chapter 641 for the first 3 years of operation. An entity recognized under this paragraph that demonstrates to the satisfaction of the Office of Insurance Regulation that it is backed by the full faith and credit of one or more counties in which it operates may be exempted from s. 641.225. This paragraph expires October 1, 2013.

(g) ~~(i)~~ A Children's Medical Services Network, as defined in s. 391.021. This paragraph expires October 1, 2014.

~~(5) The Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery program for Medicaid recipients who are 60 years of age or older or dually eligible for Medicare and Medicaid. The Agency for Health Care Administration shall implement the integrated program initially on a pilot basis in two areas of the state. The pilot areas shall be Area 7 and Area 11 of the Agency for Health Care Administration. Enrollment in the pilot areas shall be on a voluntary basis and in accordance with approved federal waivers and this section. The agency and its program contractors and providers shall not enroll any individual in the integrated program because the individual or the person legally responsible for the individual fails to choose to enroll in the integrated program. Enrollment in the integrated program shall be exclusively by affirmative choice of the eligible individual or by the person legally responsible for the individual. The integrated program must transfer all Medicaid services for eligible elderly individuals who choose to participate into an integrated-care management model designed to serve Medicaid recipients in the community. The integrated program must combine all funding for Medicaid services provided to individuals who are 60 years of age or older or dually eligible for Medicare and Medicaid into the integrated program, including funds for Medicaid home and community-based waiver services; all Medicaid services authorized in ss. 409.905 and 409.906, excluding funds for Medicaid nursing home services unless the agency is able to demonstrate how the integration of the funds will improve~~

~~coordinated care for these services in a less costly manner; and Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).~~

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

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

~~s. 408.7056. Eligible entities shall choose to serve enrollees who are dually eligible for Medicare and Medicaid, enrollees who are 60 years of age or older, or both.~~

~~(c) The agency must ensure that the capitation-rate-setting methodology for the integrated program is actuarially sound and reflects the intent to provide quality care in the least restrictive setting. The agency must also require integrated-program providers to develop a credentialing system for service providers and to contract with all Gold Seal nursing homes, where feasible, and exclude, where feasible, chronically poor-performing facilities and providers as defined by the agency. The integrated program must develop and maintain an informal provider grievance system that addresses provider payment and contract problems. The agency shall also establish a formal grievance system to address those issues that were not resolved through the informal grievance system. The integrated program must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 400 or chapter 429 at the time of enrollment in the integrated program, the recipient must be permitted to continue to reside in the noncontracted facility as long as the recipient desires. The integrated program must also provide that, in the absence of a contract between the integrated-program provider and the residential facility licensed under chapter 400 or chapter 429, current Medicaid rates must prevail. The integrated-program provider must ensure that electronic nursing home claims that contain sufficient information for processing are paid within 10 business days after receipt. Alternately, the integrated-program

~~provider may establish a capitated payment mechanism to prospectively pay nursing homes at the beginning of each month. The agency and the Department of Elderly Affairs must jointly develop procedures to manage the services provided through the integrated program in order to ensure quality and recipient choice.~~

~~(d) The Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the pilot project for the integrated, fixed-payment delivery program for Medicaid recipients created under this subsection. The evaluation shall begin as soon as Medicaid recipients are enrolled in the managed care pilot program plans and shall continue for 24 months thereafter. The evaluation must include assessments of each managed care plan in the integrated program with regard to cost savings; consumer education, choice, and access to services; coordination of care; and quality of care. The evaluation must describe administrative or legal barriers to the implementation and operation of the pilot program and include recommendations regarding statewide expansion of the pilot program. The office shall submit its evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2009.~~

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

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

(5) ~~(6)~~ The agency may contract with any public or private entity otherwise authorized by this section on a prepaid or fixed-sum basis for the provision of health care services to recipients. An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

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

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

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

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

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

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

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

This subsection expires October 1, 2014.

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

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

(b) Assumes the underwriting risk; and

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

This subsection expires October 1, 2014.

(7) ~~(8)(a)~~ The agency may contract on a prepaid or fixed-sum basis with an exclusive provider organization to provide health care services to Medicaid recipients provided that the exclusive provider organization meets applicable managed care plan requirements in this section, ss. 409.9122, 409.9123, 409.9128, and 627.6472, and other applicable provisions of law. This subsection expires October 1, 2014.

~~(b) For a period of no longer than 24 months after the~~

~~effective date of this paragraph, when a member of an exclusive provider organization that is contracted by the agency to provide health care services to Medicaid recipients in rural areas without a health maintenance organization obtains services from a provider that participates in the Medicaid program in this state, the provider shall be paid in accordance with the appropriate fee schedule for services provided to eligible Medicaid recipients. The agency may seek waiver authority to implement this paragraph.~~

(8) ~~(9)~~ The Agency for Health Care Administration may provide cost-effective purchasing of chiropractic services on a fee-for-service basis to Medicaid recipients through arrangements with a statewide chiropractic preferred provider organization incorporated in this state as a not-for-profit corporation. The agency shall ensure that the benefit limits and prior authorization requirements in the current Medicaid program shall apply to the services provided by the chiropractic preferred provider organization. This subsection expires October 1, 2014.

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

(a) Fraud;

(b) Violation of federal or state antitrust statutes,

including those proscribing price fixing between competitors and the allocation of customers among competitors;

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

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

This subsection expires October 1, 2014.

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

intended action. This subsection expires October 1, 2016.

(11) ~~(12)~~ The agency shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse. This subsection expires October 1, 2014.

(12) ~~(13)~~ The agency shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area. This subsection expires October 1, 2014.

(13) ~~(14)(a)~~ The agency shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use of services and to eliminate services that are medically unnecessary. The agency shall track Medicaid provider prescription and billing patterns and evaluate them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule. Medical necessity determination requires that service be consistent with symptoms or confirmed diagnosis of illness or injury under treatment and not in excess of the patient's needs. The agency shall conduct reviews of provider exceptions to peer group norms and shall, using statistical methodologies, provider profiling, and analysis of billing patterns, detect and investigate abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services. Providers that demonstrate a pattern of submitting

claims for medically unnecessary services shall be referred to the Medicaid program integrity unit for investigation. In its annual report, required in s. 409.913, the agency shall report on its efforts to control overutilization as described in this subsection ~~paragraph~~. This subsection expires October 1, 2014.

~~(b) The agency shall develop a procedure for determining whether health care providers and service vendors can provide the Medicaid program using a business case that demonstrates whether a particular good or service can offset the cost of providing the good or service in an alternative setting or through other means and therefore should receive a higher reimbursement. The business case must include, but need not be limited to:~~

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

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

~~(c) If the agency determines that the increased~~

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

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

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

(c) Prior to making payment for nursing facility services for a Medicaid recipient, the agency must verify that the nursing facility preadmission screening program has determined

that the individual requires nursing facility care and that the individual cannot be safely served in community-based programs. The nursing facility preadmission screening program shall refer a Medicaid recipient to a community-based program if the individual could be safely served at a lower cost and the recipient chooses to participate in such program. For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage is being terminated for lack of progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believes that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

(d) For the purpose of initiating immediate prescreening and diversion assistance for individuals residing in nursing homes and in order to make families aware of alternative long-term care resources so that they may choose a more cost-effective setting for long-term placement, CARES staff shall conduct an assessment and review of a sample of individuals whose nursing home stay is expected to exceed 20 days,

regardless of the initial funding source for the nursing home placement. CARES staff shall provide counseling and referral services to these individuals regarding choosing appropriate long-term care alternatives. This paragraph does not apply to continuing care facilities licensed under chapter 651 or to retirement communities that provide a combination of nursing home, independent living, and other long-term care services.

(e) By January 15 of each year, the agency shall submit a report to the Legislature describing the operations of the CARES program. The report must describe:

1. Rate of diversion to community alternative programs;

2. CARES program staffing needs to achieve additional diversions;

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

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

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

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

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

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

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

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

This subsection expires October 1, 2013.

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

(b) The responsibility of the agency under this subsection shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational

initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs.

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

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

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of

credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other steps that will eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

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

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

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

This subsection expires October 1, 2014.

(16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum

basis shall meet the surplus requirements of s. 641.225. If an entity's surplus falls below an amount equal to the surplus requirements of s. 641.225, the agency shall prohibit the entity from engaging in marketing and preenrollment activities, shall cease to process new enrollments, and may not renew the entity's contract until the required balance is achieved. The requirements of this subsection do not apply:

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

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

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

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

This subsection expires October 1, 2014.

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

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

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

This subsection expires October 1, 2014.

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

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

(b) The Florida Medicaid reimbursement rate established

for the hospital or physician.

This subsection expires October 1, 2014.

(19) ~~(20)~~ When a merger or acquisition of a Medicaid prepaid contractor has been approved by the Office of Insurance Regulation pursuant to s. 628.4615, the agency shall approve the assignment or transfer of the appropriate Medicaid prepaid contract upon request of the surviving entity of the merger or acquisition if the contractor and the other entity have been in good standing with the agency for the most recent 12-month period, unless the agency determines that the assignment or transfer would be detrimental to the Medicaid recipients or the Medicaid program. To be in good standing, an entity must not have failed accreditation or committed any material violation of the requirements of s. 641.52 and must meet the Medicaid contract requirements. For purposes of this section, a merger or acquisition means a change in controlling interest of an entity, including an asset or stock purchase. This subsection expires October 1, 2014.

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

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

(b) Activities that could mislead or confuse recipients, or misrepresent the organization, its marketing representatives,

or the agency. Violations of this paragraph include, but are not limited to:

1. False or misleading claims that marketing representatives are employees or representatives of the state or county, or of anyone other than the entity or the organization by whom they are reimbursed.

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

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

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

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

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

(e) Solicitation of Medicaid recipients by marketing representatives stationed in state offices unless approved and supervised by the agency or its agent and approved by the affected state agency when solicitation occurs in an office of the state agency. The agency shall ensure that marketing representatives stationed in state offices shall market their

managed care plans to Medicaid recipients only in designated areas and in such a way as to not interfere with the recipients' activities in the state office.

(f) Enrollment of Medicaid recipients.

This subsection expires October 1, 2014.

(21) ~~(22)~~ The agency may impose a fine for a violation of this section or the contract with the agency by a person or entity that is under contract with the agency. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of this section or the contract with the agency, the agency may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action. This subsection expires October 1, 2014.

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

October 1, 2014.

(23) ~~(24)~~ Upon approval by the agency, health maintenance organizations and persons or entities exempt from chapter 641 that are under contract with the agency for the provision of health care services to Medicaid recipients may be permitted within the capitation rate to provide additional health benefits that the agency has found are of high quality, are practicably available, provide reasonable value to the recipient, and are provided at no additional cost to the state. This subsection expires October 1, 2014.

(24) ~~(25)~~ The agency shall utilize the statewide health maintenance organization complaint hotline for the purpose of investigating and resolving Medicaid and prepaid health plan complaints, maintaining a record of complaints and confirmed problems, and receiving disenrollment requests made by recipients. This subsection expires October 1, 2014.

(25) ~~(26)~~ The agency shall require the publication of the health maintenance organization's and the prepaid health plan's consumer services telephone numbers and the "800" telephone number of the statewide health maintenance organization complaint hotline on each Medicaid identification card issued by a health maintenance organization or prepaid health plan contracting with the agency to serve Medicaid recipients and on each subscriber handbook issued to a Medicaid recipient. This subsection expires October 1, 2014.

(26) ~~(27)~~ The agency shall establish a health care quality improvement system for those entities contracting with the

agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as a part of the quality assurance reform initiative. The system shall include, but need not be limited to, the following:

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

1. Written quality assurance program descriptions.

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

3. An active quality assurance committee.

4. Quality assurance program supervision.

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

6. Provider participation in the quality assurance program.

7. Delegation of quality assurance program activities.

8. Credentialing and recredentialing.

9. Enrollee rights and responsibilities.

10. Availability and accessibility to services and care.

11. Ambulatory care facilities.

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

13. Utilization review.

14. A continuity of care system.

15. Quality assurance program documentation.

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

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

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

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

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

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

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

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

2. Length of the external quality review organization

contract with the state.

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

4. Potential variation in the type of clinical conditions and health services delivery issues to be studied at each plan.

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

6. Methods for implementing focused studies.

7. Individual care review.

8. Followup activities.

This subsection expires October 1, 2016.

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

2014.

(28) ~~(29)~~ The agency shall perform enrollments and disenrollments for Medicaid recipients who are eligible for MediPass or managed care plans. Notwithstanding the prohibition contained in paragraph (21)(f), managed care plans may perform preenrollments of Medicaid recipients under the supervision of the agency or its agents. For the purposes of this section, the term "preenrollment" means the provision of marketing and educational materials to a Medicaid recipient and assistance in completing the application forms, but does not include actual enrollment into a managed care plan. An application for enrollment may not be deemed complete until the agency or its agent verifies that the recipient made an informed, voluntary choice. The agency, in cooperation with the Department of Children and Family Services, may test new marketing initiatives to inform Medicaid recipients about their managed care options at selected sites. The agency may contract with a third party to perform managed care plan and MediPass enrollment and disenrollment services for Medicaid recipients and may adopt rules to administer such services. The agency may adjust the capitation rate only to cover the costs of a third-party enrollment and disenrollment contract, and for agency supervision and management of the managed care plan enrollment and disenrollment contract. This subsection expires October 1, 2014.

(29) ~~(30)~~ Any lists of providers made available to Medicaid recipients, MediPass enrollees, or managed care plan enrollees shall be arranged alphabetically showing the

provider's name and specialty and, separately, by specialty in alphabetical order. This subsection expires October 1, 2014.

(30) ~~(31)~~ The agency shall establish an enhanced managed care quality assurance oversight function, to include at least the following components:

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

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

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

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

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

The analyses and followup activities conducted by the agency under its enhanced managed care quality assurance oversight function shall not duplicate the activities of accreditation reviewers for entities regulated under part III of chapter 641, but may include a review of the finding of such reviewers. This subsection expires October 1, 2014.

(31) ~~(32)~~ Each managed care plan that is under contract

with the agency to provide health care services to Medicaid recipients shall annually conduct a background check with the Department of Law Enforcement of all persons with ownership interest of 5 percent or more or executive management responsibility for the managed care plan and shall submit to the agency information concerning any such person who has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any of the offenses listed in s. 435.04. This subsection expires October 1, 2014.

(32) ~~(33)~~ The agency shall, by rule, develop a process whereby a Medicaid managed care plan enrollee who wishes to enter hospice care may be disenrolled from the managed care plan within 24 hours after contacting the agency regarding such request. The agency rule shall include a methodology for the agency to recoup managed care plan payments on a pro rata basis if payment has been made for the enrollment month when disenrollment occurs. This subsection expires October 1, 2014.

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

nonemergent care. The agency shall coordinate with hospitals, emergency medical services providers, private health plans, capitated managed care networks as established in s. 409.91211, and other public and private health care providers to implement the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405, and 641.31097 to develop and implement emergency department diversion programs for Medicaid recipients. This subsection expires October 1, 2014.

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

(a) Healthy Start prenatal or infant screening.

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

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

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

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

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

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

This subsection expires October 1, 2014.

(35) ~~(36)~~ Any entity that provides Medicaid prepaid health plan services shall ensure the appropriate coordination of health care services with an assisted living facility in cases where a Medicaid recipient is both a member of the entity's prepaid health plan and a resident of the assisted living facility. If the entity is at risk for Medicaid targeted case management and behavioral health services, the entity shall inform the assisted living facility of the procedures to follow should an emergent condition arise. This subsection expires October 1, 2014.

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

(36) ~~(38)~~ The agency shall enter into agreements with not-for-profit organizations based in this state for the purpose of providing vision screening. This subsection expires October 1, 2014.

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

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

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

b. A 72-hour supply of the drug prescribed is provided in an emergency or when the agency does not provide a response

within 24 hours as required by sub-subparagraph a.

2. Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

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

4. The agency may limit the size of its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria. The agency shall give special consideration to rural areas in determining the size and

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

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

6. The agency may enter into arrangements that require manufacturers of generic drugs prescribed to Medicaid recipients to provide rebates of at least 15.1 percent of the average manufacturer price for the manufacturer's generic products. These arrangements shall require that if a generic-drug manufacturer pays federal rebates for Medicaid-reimbursed drugs

at a level below 15.1 percent, the manufacturer must provide a supplemental rebate to the state in an amount necessary to achieve a 15.1-percent rebate level.

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

substitution for supplemental rebates are prohibited. The agency is authorized to seek any federal waivers to implement this initiative.

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

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

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

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

elements:

(I) Provide for the development and adoption of best practice guidelines for behavioral health-related drugs such as antipsychotics, antidepressants, and medications for treating bipolar disorders and other behavioral conditions; translate them into practice; review behavioral health prescribers and compare their prescribing patterns to a number of indicators that are based on national standards; and determine deviations from best practice guidelines.

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

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

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

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

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

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

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

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

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

(VII) Disseminate electronic and published materials.

(VIII) Hold statewide and regional conferences.

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

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

13. The agency may specify the preferred daily dosing form or strength for the purpose of promoting best practices with regard to the prescribing of certain drugs as specified in the General Appropriations Act and ensuring cost-effective prescribing practices.

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

a. For an indication not approved in labeling;

b. To comply with certain clinical guidelines; or

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

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

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

of a drug.

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

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

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

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

The agency shall work with the physician to determine the best alternative for the patient. The agency may adopt rules waiving

the requirements for written clinical documentation for specific drugs in limited clinical situations.

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

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

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

(38) ~~(40)~~ Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew a contract or contracts for fiscal intermediary services one or more times for such periods as the agency may decide; however, all such renewals may not combine to exceed a total period longer than the term of the original contract.

(39) ~~(41)~~ The agency shall provide for the development of a demonstration project by establishment in Miami-Dade County of a long-term-care facility licensed pursuant to chapter 395 to improve access to health care for a predominantly minority, medically underserved, and medically complex population and to evaluate alternatives to nursing home care and general acute care for such population. Such project is to be located in a health care condominium and colocated with licensed facilities providing a continuum of care. The establishment of this project is not subject to the provisions of s. 408.036 or s. 408.039. This subsection expires October 1, 2013.

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

(40) ~~(43)~~ The agency shall ~~may~~ contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This subsection expires October 1, 2014.

(41) ~~(44)~~ The Agency for Health Care Administration shall ensure that any Medicaid managed care plan as defined in s. 409.9122(2)(f), whether paid on a capitated basis or a shared savings basis, is cost-effective. For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which may be adjusted for health status. The agency shall conduct actuarially sound adjustments for health status in order to ensure such cost-effectiveness and shall annually publish the results on its Internet website. Contracts established pursuant to this subsection which are not cost-effective may not be renewed. This subsection expires October 1, 2014.

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

pharmacies, medical doctors, and infusion clinics. The limitation does not apply to emergency services and care provided to the recipient in a hospital emergency department. The agency shall seek any federal waivers necessary to implement this subsection. The agency shall adopt any rules necessary to comply with or administer this subsection. This subsection expires October 1, 2014.

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

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

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

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

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

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

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

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

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

b. The durable medical equipment provider must have

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

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

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

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

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

5. Physical business locations must be clearly identified as a business that furnishes durable medical equipment or medical supplies by signage that can be read from 20 feet away. The location must be readily accessible to the public during normal, posted business hours and must operate at least 5 hours

per day and at least 5 days per week, with the exception of scheduled and posted holidays. The location may not be located within or at the same numbered street address as another enrolled Medicaid durable medical equipment or medical supply provider or as an enrolled Medicaid pharmacy that is also enrolled as a durable medical equipment provider. A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider is exempt from this paragraph.

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

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

8. Providers must obtain a level 2 background screening, in accordance with chapter 435 and s. 408.809, for each provider

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

9. The following providers are exempt from subparagraphs 1. and 7.:

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

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

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

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

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

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

(c) For purposes of this subsection, the term "cost-effective" means that a network's per-member, per-month costs to the state, including, but not limited to, fee-for-service costs, administrative costs, and case-management fees, if any, must be no greater than the state's costs associated with contracts for Medicaid services established under subsection (3), which shall be actuarially adjusted for case mix, model, and service area. The agency shall conduct actuarially sound audits adjusted for case mix and model in order to ensure such cost-effectiveness and shall annually publish the audit results on its Internet website. Contracts established pursuant to this subsection which are not cost-effective may not be renewed.

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

This subsection expires October 1, 2014.

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

(47) ~~(51)~~ The agency shall work with the Agency for

Persons with Disabilities to develop a home and community-based waiver to serve children and adults who are diagnosed with familial dysautonomia or Riley-Day syndrome caused by a mutation of the IKBKAP gene on chromosome 9. The agency shall seek federal waiver approval and implement the approved waiver subject to the availability of funds and any limitations provided in the General Appropriations Act. The agency may adopt rules to implement this waiver program.

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

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

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

409.91195 Medicaid Pharmaceutical and Therapeutics Committee.—There is created a Medicaid Pharmaceutical and Therapeutics Committee within the agency for the purpose of developing a Medicaid preferred drug list.

(4) Upon recommendation of the committee, the agency shall

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

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

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

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

Section 13. Section 409.91207, Florida Statutes, is repealed.

Section 14. Section 409.91211, Florida Statutes, is repealed.

Section 15. Section 409.9122, Florida Statutes, is amended to read:

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

(1) It is the intent of the Legislature that the MediPass program be cost-effective, provide quality health care, and

improve access to health services, and that the program be statewide. This subsection expires October 1, 2014.

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. Upon enrollment, individuals will be able to change their managed care option during the 90-day opt out period required by federal Medicaid regulations. The agency is authorized to seek the necessary Medicaid state plan amendment to implement this policy. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Centers for Medicare and Medicaid Services.

~~The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a~~

~~managed care plan or MediPass.~~ School districts participating in the certified school match program pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid, subject to the limitations of s. 1011.70(1), for a Medicaid-eligible child participating in the services as authorized in s. 1011.70, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts regarding the coordinated provision of services authorized under s. 1011.70. County health departments delivering school-based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid-eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.

(b) A Medicaid recipient shall not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

(c) Medicaid recipients shall have a choice of managed

care plans or MediPass. The Agency for Health Care Administration, the Department of Health, the Department of Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each Medicaid recipient receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care, including MediPass.

2. Provides information on the comparative performance of managed care plans and MediPass in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care plan and MediPass in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their managed care coverage at the time they first enroll in Medicaid and again at regular intervals set by the agency. However, if a recipient does not choose a managed care plan or MediPass, the agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass.

(d) The agency shall develop a mechanism for providing information to Medicaid recipients for the purpose of making a managed care plan or MediPass selection. Examples of such mechanisms may include, but not be limited to, interactive

information systems, mailings, and mass marketing materials. Managed care plans and MediPass providers are prohibited from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans or MediPass providers.

(e) Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 30 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

(f) If a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients eligible for managed care plan enrollment who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of

35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, ~~including children, and who would be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g),~~ Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be operated economically. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making

assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

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

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

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(i) After a recipient has made his or her selection or has

been enrolled in a managed care plan or MediPass, the recipient shall have 90 days to exercise the opportunity to voluntarily disenroll and select another managed care plan or MediPass. After 90 days, no further changes may be made except for good cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when utilized, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree

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

(j) The agency shall apply for a federal waiver from the Centers for Medicare and Medicaid Services to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.

(k) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. For purposes of this paragraph, when referring to assignment, the term

"managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

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

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

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

5. The agency has authority to make mandatory assignments based on quality of service and performance of managed care plans.

(l) Notwithstanding the provisions of chapter 287, the agency may, at its discretion, renew cost-effective contracts for choice counseling services once or more for such periods as the agency may decide. However, all such renewals may not combine to exceed a total period longer than the term of the original contract.

2772
2773 This subsection expires October 1, 2014.
2774 (3)(a) The agency shall establish quality-of-care
2775 standards for managed care plans. These standards shall be based
2776 upon, but are not limited to:
2777 1. Compliance with the accreditation requirements as
2778 provided in s. 641.512.
2779 2. Compliance with Early and Periodic Screening,
2780 Diagnosis, and Treatment screening requirements.
2781 3. The percentage of voluntary disenrollments.
2782 4. Immunization rates.
2783 5. Standards of the National Committee for Quality
2784 Assurance and other approved accrediting bodies.
2785 6. Recommendations of other authoritative bodies.
2786 7. Specific requirements of the Medicaid program, or
2787 standards designed to specifically assist the unique needs of
2788 Medicaid recipients.
2789 8. Compliance with the health quality improvement system
2790 as established by the agency, which incorporates standards and
2791 guidelines developed by the Medicaid Bureau of the Health Care
2792 Financing Administration as part of the quality assurance reform
2793 initiative.
2794 (b) For the MediPass program, the agency shall establish
2795 standards which are based upon, but are not limited to:
2796 1. Quality-of-care standards which are comparable to those
2797 required of managed care plans.
2798 2. Credentialing standards for MediPass providers.
2799 3. Compliance with Early and Periodic Screening,

Diagnosis, and Treatment screening requirements.

4. Immunization rates.

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

This subsection expires October 1, 2014.

(4)(a) Each female recipient may select as her primary care provider an obstetrician/gynecologist who has agreed to participate as a MediPass primary care case manager.

(b) The agency shall establish a complaints and grievance process to assist Medicaid recipients enrolled in the MediPass program to resolve complaints and grievances. The agency shall investigate reports of quality-of-care grievances which remain unresolved to the satisfaction of the enrollee.

This subsection expires October 1, 2014.

(5)(a) The agency shall work cooperatively with the Social Security Administration to identify beneficiaries who are jointly eligible for Medicare and Medicaid and shall develop cooperative programs to encourage these beneficiaries to enroll in a Medicare participating health maintenance organization or prepaid health plans.

(b) The agency shall work cooperatively with the Department of Elderly Affairs to assess the potential cost-effectiveness of providing MediPass to beneficiaries who are jointly eligible for Medicare and Medicaid on a voluntary choice basis. If the agency determines that enrollment of these

beneficiaries in MediPass has the potential for being cost-effective for the state, the agency shall offer MediPass to these beneficiaries on a voluntary choice basis in the counties where MediPass operates.

This subsection expires October 1, 2014.

(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, 2014.

~~(7) The agency shall investigate the feasibility of developing managed care plan and MediPass options for the following groups of Medicaid recipients:~~

~~(a) Pregnant women and infants.~~

~~(b) Elderly and disabled recipients, especially those who are at risk of nursing home placement.~~

~~(c) Persons with developmental disabilities.~~

~~(d) Qualified Medicare beneficiaries.~~

~~(e) Adults who have chronic, high-cost medical conditions.~~

~~(f) Adults and children who have mental health problems.~~

~~(g) Other recipients for whom managed care plans and~~

~~MediPass offer the opportunity of more cost-effective care and greater access to qualified providers.~~

~~(8)(a) The agency shall encourage the development of public and private partnerships to foster the growth of health maintenance organizations and prepaid health plans that will provide high-quality health care to Medicaid recipients.~~

~~(b) Subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216, the agency is authorized to enter into contracts with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid prepaid health plans.~~

~~1. The agency may contract with disproportionate share hospitals, county health departments, federally initiated or federally funded community health centers, and counties that operate either a hospital or a community clinic.~~

~~2. A contract may not be for more than $100,000 per year, and no contract may be extended with any particular provider for more than 2 years. The contract is intended only as seed or development funding and requires a commitment from the interested party.~~

~~3. A contract must require participation by at least one community health clinic and one disproportionate share hospital.~~

(7) ~~(9)~~(a) The agency shall develop and implement a comprehensive plan to ensure that recipients are adequately informed of their choices and rights under all Medicaid managed care programs and that Medicaid managed care programs meet acceptable standards of quality in patient care, patient

satisfaction, and financial solvency.

(b) The agency shall provide adequate means for informing patients of their choice and rights under a managed care plan at the time of eligibility determination.

(c) The agency shall require managed care plans and MediPass providers to demonstrate and document plans and activities, as defined by rule, including outreach and followup, undertaken to ensure that Medicaid recipients receive the health care service to which they are entitled.

This subsection expires October 1, 2014.

(8) ~~(10)~~ The agency shall consult with Medicaid consumers and their representatives on an ongoing basis regarding measurements of patient satisfaction, procedures for resolving patient grievances, standards for ensuring quality of care, mechanisms for providing patient access to services, and policies affecting patient care. This subsection expires October 1, 2014.

(9) ~~(11)~~ The agency may extend eligibility for Medicaid recipients enrolled in licensed and accredited health maintenance organizations for the duration of the enrollment period or for 6 months, whichever is earlier, provided the agency certifies that such an offer will not increase state expenditures. This subsection expires October 1, 2013.

(10) ~~(12)~~ A managed care plan that has a Medicaid contract shall at least annually review each primary care physician's active patient load and shall ensure that additional Medicaid recipients are not assigned to physicians who have a total

active patient load of more than 3,000 patients. As used in this subsection, the term "active patient" means a patient who is seen by the same primary care physician, or by a physician assistant or advanced registered nurse practitioner under the supervision of the primary care physician, at least three times within a calendar year. Each primary care physician shall annually certify to the managed care plan whether or not his or her patient load exceeds the limits established under this subsection and the managed care plan shall accept such certification on face value as compliance with this subsection. The agency shall accept the managed care plan's representations that it is in compliance with this subsection based on the certification of its primary care physicians, unless the agency has an objective indication that access to primary care is being compromised, such as receiving complaints or grievances relating to access to care. If the agency determines that an objective indication exists that access to primary care is being compromised, it may verify the patient load certifications submitted by the managed care plan's primary care physicians and that the managed care plan is not assigning Medicaid recipients to primary care physicians who have an active patient load of more than 3,000 patients. This subsection expires October 1, 2014.

~~(13) Effective July 1, 2003, the agency shall adjust the enrollee assignment process of Medicaid managed prepaid health plans for those Medicaid managed prepaid plans operating in Miami-Dade County which have executed a contract with the agency for a minimum of 8 consecutive years in order for the Medicaid~~

~~managed prepaid plan to maintain a minimum enrollment level of 15,000 members per month. When assigning enrollees pursuant to this subsection, the agency shall give priority to providers that initially qualified under this subsection until such providers reach and maintain an enrollment level of 15,000 members per month. A prepaid health plan that has a statewide Medicaid enrollment of 25,000 or more members is not eligible for enrollee assignments under this subsection.~~

(11) ~~(14)~~ The agency shall include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including, but not limited to, upper payment limit or disproportionate share hospital payments, made to qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval or state plan amendment as needed to implement this adjustment.

(12) The agency shall develop a process to enable any recipient with access to employer sponsored health care coverage to opt out of all eligible plans in the Medicaid program and to use Medicaid financial assistance to pay for the recipient's share of cost in any such employer-sponsored coverage. Contingent on federal approval, the agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any plan or product available pursuant to the Florida Health Choices Program or any health exchange, to opt out. The amount of financial assistance provided for each

recipient shall not exceed the amount of the Medicaid premium that would have been paid to a plan for that recipient.

(13) The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Florida Medicaid recipients enrolled in prepaid managed care plans.

(a) Prepaid managed care plans shall submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid managed care plans must certify that the data reported is accurate and complete.

(b) The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic under-utilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

(14) The agency may establish a per-member per-month payment for Medicare Advantage Special Needs members that are also eligible for Medicaid as a mechanism for meeting the

state's cost sharing obligation. The agency may also develop a per-member per-month payment for Medicaid only covered services for which the state is responsible. The agency shall develop a mechanism to ensure that such per-member per-month payment enhances the value to the state and enrolled members by limiting cost sharing, enhancing the scope of Medicare supplemental benefits that are equal to or greater than Medicaid coverage for select services, and improving care coordination.

(15) The agency shall establish, and managed care plans shall use, a uniform method of accounting for and reporting medical and nonmedical costs. The agency shall make such information available to the public.

(16) The agency may, on a case-by-case basis, exempt a recipient from mandatory enrollment in a managed care plan when the recipient has a unique, time-limited disease or condition-related circumstance and managed care enrollment will interfere with ongoing care because the recipient's provider does not participate in the managed care plans available in the recipient's area.

(17) The agency shall contract with a single provider service network to function as a third party administrator and managing entity for the MediPass program in all counties with less two prepaid plans. The contractor may earn an administrative fee, provided that fee is less than any savings determined by the reconciliation process pursuant to s. 409.912(4)(d)(1). This subsection shall expire October 1, 2014 or upon full implementation of the managed medical assistance program whichever is sooner.

Section 16. Subsection (15) of section 430.04, Florida Statutes, is amended to read:

430.04 Duties and responsibilities of the Department of Elderly Affairs.—The Department of Elderly Affairs shall:

(15) Administer all Medicaid waivers and programs relating to elders and their appropriations. The waivers include, but are not limited to:

~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as established in s. 430.502(7), (8), and (9).~~

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

(b) ~~(c)~~ The Aged and Disabled Adult Waiver.

(c) ~~(d)~~ The Adult Day Health Care Waiver.

(d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined in s. 409.221.

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

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

(g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.

The department shall develop a transition plan for recipients receiving services in long-term care Medicaid waivers for elders or disabled adults on the date eligible plans become available in each recipient's region defined in s. 409.981(2) to enroll those recipients in eligible plans. This subsection expires October 1, 2013.

Section 17. Section 430.2053, Florida Statutes, is amended to read:

430.2053 Aging resource centers.—

(1) The department, in consultation with the Agency for Health Care Administration and the Department of Children and Family Services, shall develop pilot projects for aging resource centers. ~~By October 31, 2004, the department, in consultation with the agency and the Department of Children and Family Services, shall develop an implementation plan for aging resource centers and submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The plan must include qualifications for designation as a center, the functions to be performed by each center, and a process for determining that a current area agency on aging is ready to assume the functions of an aging resource center.~~

~~(2) Each area agency on aging shall develop, in consultation with the existing community care for the elderly lead agencies within their planning and service areas, a proposal that describes the process the area agency on aging intends to undertake to transition to an aging resource center prior to July 1, 2005, and that describes the area agency's compliance with the requirements of this section. The proposals must be submitted to the department prior to December 31, 2004. The department shall evaluate all proposals for readiness and, prior to March 1, 2005, shall select three area agencies on aging which meet the requirements of this section to begin the transition to aging resource centers. Those area agencies on~~

~~aging which are not selected to begin the transition to aging resource centers shall, in consultation with the department and the existing community care for the elderly lead agencies within their planning and service areas, amend their proposals as necessary and resubmit them to the department prior to July 1, 2005. The department may transition additional area agencies to aging resource centers as it determines that area agencies are in compliance with the requirements of this section.~~

~~(3) The Auditor General and the Office of Program Policy Analysis and Government Accountability (OPPAGA) shall jointly review and assess the department's process for determining an area agency's readiness to transition to an aging resource center.~~

~~(a) The review must, at a minimum, address the appropriateness of the department's criteria for selection of an area agency to transition to an aging resource center, the instruments applied, the degree to which the department accurately determined each area agency's compliance with the readiness criteria, the quality of the technical assistance provided by the department to an area agency in correcting any weaknesses identified in the readiness assessment, and the degree to which each area agency overcame any identified weaknesses.~~

~~(b) Reports of these reviews must be submitted to the appropriate substantive and appropriations committees in the Senate and the House of Representatives on March 1 and September 1 of each year until full transition to aging resource centers has been accomplished statewide, except that the first report~~

~~must be submitted by February 1, 2005, and must address all readiness activities undertaken through December 31, 2004. The perspectives of all participants in this review process must be included in each report.~~

(2) ~~(4)~~ The purposes of an aging resource center shall be:

(a) To provide Florida's elders and their families with a locally focused, coordinated approach to integrating information and referral for all available services for elders with the eligibility determination entities for state and federally funded long-term-care services.

(b) To provide for easier access to long-term-care services by Florida's elders and their families by creating multiple access points to the long-term-care network that flow through one established entity with wide community recognition.

(3) ~~(5)~~ The duties of an aging resource center are to:

(a) Develop referral agreements with local community service organizations, such as senior centers, existing elder service providers, volunteer associations, and other similar organizations, to better assist clients who do not need or do not wish to enroll in programs funded by the department or the agency. The referral agreements must also include a protocol, developed and approved by the department, which provides specific actions that an aging resource center and local community service organizations must take when an elder or an elder's representative seeking information on long-term-care services contacts a local community service organization prior to contacting the aging resource center. The protocol shall be

designed to ensure that elders and their families are able to access information and services in the most efficient and least cumbersome manner possible.

(b) Provide an initial screening of all clients who request long-term-care services to determine whether the person would be most appropriately served through any combination of federally funded programs, state-funded programs, locally funded or community volunteer programs, or private funding for services.

(c) Determine eligibility for the programs and services listed in subsection (9) ~~(11)~~ for persons residing within the geographic area served by the aging resource center and determine a priority ranking for services which is based upon the potential recipient's frailty level and likelihood of institutional placement without such services.

(d) Manage the availability of financial resources for the programs and services listed in subsection (11) for persons residing within the geographic area served by the aging resource center.

(e) When financial resources become available, refer a client to the most appropriate entity to begin receiving services. The aging resource center shall make referrals to lead agencies for service provision that ensure that individuals who are vulnerable adults in need of services pursuant to s. 415.104(3)(b), or who are victims of abuse, neglect, or exploitation in need of immediate services to prevent further harm and are referred by the adult protective services program, are given primary consideration for receiving community-care-

for-the-elderly services in compliance with the requirements of s. 430.205(5)(a) and that other referrals for services are in compliance with s. 430.205(5)(b).

(f) Convene a work group to advise in the planning, implementation, and evaluation of the aging resource center. The work group shall be comprised of representatives of local service providers, Alzheimer's Association chapters, housing authorities, social service organizations, advocacy groups, representatives of clients receiving services through the aging resource center, and any other persons or groups as determined by the department. The aging resource center, in consultation with the work group, must develop annual program improvement plans that shall be submitted to the department for consideration. The department shall review each annual improvement plan and make recommendations on how to implement the components of the plan.

(g) Enhance the existing area agency on aging in each planning and service area by integrating, either physically or virtually, the staff and services of the area agency on aging with the staff of the department's local CARES Medicaid ~~nursing home~~ preadmission screening unit and a sufficient number of staff from the Department of Children and Family Services' Economic Self-Sufficiency Unit necessary to determine the financial eligibility for all persons age 60 and older residing within the area served by the aging resource center that are seeking Medicaid services, Supplemental Security Income, and food assistance.

(h) Assist clients who request long-term care services in

being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program as eligible plans become available in each of the regions pursuant to s. 409.981(2).

(i) Provide choice counseling for the Medicaid long-term care managed care program by integrating, either physically or virtually, choice counseling staff and services as eligible plans become available in each of the regions pursuant to s. 409.981(2). Pursuant to s. 409.984(1), the agency may contract directly with the aging resource center to provide choice counseling services or may contract with another vendor if the aging resource center does not choose to provide such services.

(j) Assist Medicaid recipients enrolled in the Medicaid long-term care managed care program with informally resolving grievances with a managed care network and assist Medicaid recipients in accessing the managed care network's formal grievance process as eligible plans become available in each of the regions defined in s. 409.981(2).

(4) ~~(6)~~ The department shall select the entities to become aging resource centers based on each entity's readiness and ability to perform the duties listed in subsection (3) ~~(5)~~ and the entity's:

(a) Expertise in the needs of each target population the center proposes to serve and a thorough knowledge of the providers that serve these populations.

(b) Strong connections to service providers, volunteer agencies, and community institutions.

(c) Expertise in information and referral activities.

(d) Knowledge of long-term-care resources, including

resources designed to provide services in the least restrictive setting.

(e) Financial solvency and stability.

(f) Ability to collect, monitor, and analyze data in a timely and accurate manner, along with systems that meet the department's standards.

(g) Commitment to adequate staffing by qualified personnel to effectively perform all functions.

(h) Ability to meet all performance standards established by the department.

(5) ~~(7)~~ The aging resource center shall have a governing body which shall be the same entity described in s. 20.41(7), and an executive director who may be the same person as described in s. 20.41(7). The governing body shall annually evaluate the performance of the executive director.

(6) ~~(8)~~ The aging resource center may not be a provider of direct services other than choice counseling as eligible plans become available in each of the regions defined in s. 409.981(2), information and referral services, and screening.

(7) ~~(9)~~ The aging resource center must agree to allow the department to review any financial information the department determines is necessary for monitoring or reporting purposes, including financial relationships.

(8) ~~(10)~~ The duties and responsibilities of the community care for the elderly lead agencies within each area served by an aging resource center shall be to:

(a) Develop strong community partnerships to maximize the use of community resources for the purpose of assisting elders

to remain in their community settings for as long as it is safely possible.

(b) Conduct comprehensive assessments of clients that have been determined eligible and develop a care plan consistent with established protocols that ensures that the unique needs of each client are met.

(9) ~~(11)~~ The services to be administered through the aging resource center shall include those funded by the following programs:

(a) Community care for the elderly.

(b) Home care for the elderly.

(c) Contracted services.

(d) Alzheimer's disease initiative.

(e) Aged and disabled adult Medicaid waiver. This paragraph expires October 1, 2013.

(f) Assisted living for the frail elderly Medicaid waiver. This paragraph expires October 1, 2013.

(g) Older Americans Act.

(10) ~~(12)~~ The department shall, prior to designation of an aging resource center, develop by rule operational and quality assurance standards and outcome measures to ensure that clients receiving services through all long-term-care programs administered through an aging resource center are receiving the appropriate care they require and that contractors and subcontractors are adhering to the terms of their contracts and are acting in the best interests of the clients they are serving, consistent with the intent of the Legislature to reduce the use of and cost of nursing home care. The department shall

by rule provide operating procedures for aging resource centers, which shall include:

(a) Minimum standards for financial operation, including audit procedures.

(b) Procedures for monitoring and sanctioning of service providers.

(c) Minimum standards for technology utilized by the aging resource center.

(d) Minimum staff requirements which shall ensure that the aging resource center employs sufficient quality and quantity of staff to adequately meet the needs of the elders residing within the area served by the aging resource center.

(e) Minimum accessibility standards, including hours of operation.

(f) Minimum oversight standards for the governing body of the aging resource center to ensure its continuous involvement in, and accountability for, all matters related to the development, implementation, staffing, administration, and operations of the aging resource center.

(g) Minimum education and experience requirements for executive directors and other executive staff positions of aging resource centers.

(h) Minimum requirements regarding any executive staff positions that the aging resource center must employ and minimum requirements that a candidate must meet in order to be eligible for appointment to such positions.

(11) ~~(13)~~ In an area in which the department has designated an area agency on aging as an aging resource center,

the department and the agency shall not make payments for the services listed in subsection (9) ~~(11)~~ and the Long-Term Care Community Diversion Project for such persons who were not screened and enrolled through the aging resource center. The department shall cease making payments for recipients in eligible plans as eligible plans become available in each of the regions defined in s. 409.981(2).

(12) ~~(14)~~ Each aging resource center shall enter into a memorandum of understanding with the department for collaboration with the CARES unit staff. The memorandum of understanding shall outline the staff person responsible for each function and shall provide the staffing levels necessary to carry out the functions of the aging resource center.

(13) ~~(15)~~ Each aging resource center shall enter into a memorandum of understanding with the Department of Children and Family Services for collaboration with the Economic Self-Sufficiency Unit staff. The memorandum of understanding shall outline which staff persons are responsible for which functions and shall provide the staffing levels necessary to carry out the functions of the aging resource center.

(14) As eligible plans become available in each of the regions defined in s. 409.981(2), if an aging resource center does not contract with the agency to provide Medicaid long-term care managed care choice counseling pursuant to s. 409.984(1), the aging resource center shall enter into a memorandum of understanding with the agency to coordinate staffing and collaborate with the choice counseling vendor. The memorandum of understanding shall identify the staff responsible for each

function and shall provide the staffing levels necessary to carry out the functions of the aging resource center.

(15) ~~(16)~~ If any of the state activities described in this section are outsourced, either in part or in whole, the contract executing the outsourcing shall mandate that the contractor or its subcontractors shall, either physically or virtually, execute the provisions of the memorandum of understanding instead of the state entity whose function the contractor or subcontractor now performs.

(16) ~~(17)~~ In order to be eligible to begin transitioning to an aging resource center, an area agency on aging board must ensure that the area agency on aging which it oversees meets all of the minimum requirements set by law and in rule.

~~(18) The department shall monitor the three initial projects for aging resource centers and report on the progress of those projects to the Governor, the President of the Senate, and the Speaker of the House of Representatives by June 30, 2005. The report must include an evaluation of the implementation process.~~

(17) ~~(19)~~(a) Once an aging resource center is operational, the department, in consultation with the agency, may develop capitation rates for any of the programs administered through the aging resource center. Capitation rates for programs shall be based on the historical cost experience of the state in providing those same services to the population age 60 or older residing within each area served by an aging resource center. Each capitated rate may vary by geographic area as determined by the department.

(b) The department and the agency may determine for each area served by an aging resource center whether it is appropriate, consistent with federal and state laws and regulations, to develop and pay separate capitated rates for each program administered through the aging resource center or to develop and pay capitated rates for service packages which include more than one program or service administered through the aging resource center.

(c) Once capitation rates have been developed and certified as actuarially sound, the department and the agency may pay service providers the capitated rates for services when appropriate.

(d) The department, in consultation with the agency, shall annually reevaluate and recertify the capitation rates, adjusting forward to account for inflation, programmatic changes.

~~(20) The department, in consultation with the agency, shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by December 1, 2006, a report addressing the feasibility of administering the following services through aging resource centers beginning July 1, 2007:~~

~~(a) Medicaid nursing home services.~~

~~(b) Medicaid transportation services.~~

~~(c) Medicaid hospice care services.~~

~~(d) Medicaid intermediate care services.~~

~~(e) Medicaid prescribed drug services.~~

~~(f) Medicaid assistive care services.~~

~~(g) Any other long-term-care program or Medicaid service.~~

(18) ~~(21)~~ This section shall not be construed to allow an aging resource center to restrict, manage, or impede the local fundraising activities of service providers.

Section 18. Subsection (4) of section 641.386, Florida Statutes, is amended to read:

641.386 Agent licensing and appointment required; exceptions.—

(4) All agents and health maintenance organizations shall comply with and be subject to the applicable provisions of ss. 641.309 and 409.912 (20) ~~(21)~~, and all companies and entities appointing agents shall comply with s. 626.451, when marketing for any health maintenance organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

Section 19. Effective October 1, 2013, sections 430.701, 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707, 430.708, and 430.709 Florida Statutes, are repealed.

Section 20. Sections 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and 402.87, Florida Statutes, respectively.

Section 21. Paragraph (a) of subsection (1) of section 443.111, Florida Statutes, is amended to read:

443.111 Payment of benefits.—

(1) MANNER OF PAYMENT.—Benefits are payable from the fund in accordance with rules adopted by the Agency for Workforce Innovation, subject to the following requirements:

(a) Benefits are payable by mail or electronically. Notwithstanding s. 402.84(4) ~~s. 409.942(4)~~, the agency may develop a system for the payment of benefits by electronic funds transfer, including, but not limited to, debit cards, electronic payment cards, or any other means of electronic payment that the agency deems to be commercially viable or cost-effective. Commodities or services related to the development of such a system shall be procured by competitive solicitation, unless they are purchased from a state term contract pursuant to s. 287.056. The agency shall adopt rules necessary to administer the system.

Section 22. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2011, if PCB HHSC 11-01 or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.

SECTION-BY-SECTION SUMMARY OF PCB HHSC 11-02
MODIFICATION OF EXISTING MEDICAID STATUTES

Section 1:

- Amends s. 393.0661, F.S., relating to home and community-based services delivery system by the Agency for Persons with Disabilities
- Requires APD to establish a transition plan for recipient enrolled in one of the four tier waivers to long term care (LTC) managed care plans for persons with developmental disabilities once those plans are implemented in each of the regions pursuant to the statewide Medicaid managed care PCB
- Repeals this section of law effective October 1, 2016, the final implementation date for all developmentally disabled (DD) long-term care plans statewide

Section 2:

- Amends s. 393.0662, F.S., to provide that APD must complete the phase in of the ibudget by January 1, 2015
- Requires APD to establish a transition plan for recipients receiving services through the ibudget system to long term care (LTC) managed care plans for persons with developmental disabilities once those plans are implemented in each of the regions pursuant to the statewide Medicaid managed care PCB
- Repeals this section of law effective October 1, 2016, the final implementation date for all DD long-term care plans statewide

Section 3:

- Amends s. 408.040, F.S., relating to conditions and monitoring for nursing homes requiring certificates of need (CON) by suspending CON Medicaid utilization maintenance requirements effective July 1, 2012, when ITNs will be issued for the LTC managed care program

Section 4:

- Amends s. 408.0435, F.S., relating to moratorium on nursing home certificates of need
- Extends the nursing home CON moratorium until after Medicaid managed care is implemented statewide or October 1, 2016, whichever is earlier

Sections 5-7:

- Divides existing statutory sections in Chapter 409 into 3 parts:
- Part I of Chapter 409, will be titled "Social and Economic Assistance," and encompass ss. 409.016 – 409.803, F.S.
- Part II of Chapter 409, will be titled "Kidcare," and encompasses ss. 409.810 – 409.821, F.S.

- Part III of Chapter 409, will be titled "Medicaid," and encompasses ss. 409.901 – 409.9025, F.S.

Section 8:

- Amends s. 409.905 (5), F.S, relating the purchasing of Medicaid medical services.
- Provides that agency shall implement a methodology for establishing base reimbursements rates for hospitals based on allowable costs, as defined by the agency.

Section 9:

- Amends s. 409.911, F.S., to sunset the Low Income Pool Council effective October 1, 2014, when the Managed Medical Assistance program becomes effective statewide

Section 10:

- Amends s. 409.912, F.S., relating to cost-effective purchasing of health care
- Repeals outdated provisions
- Repeals other provisions on a date certain – pursuant to the full implementation deadline of applicable statewide Medicaid managed care programs
- The availability of the fee-for-service option for PSNs is limited to 5 years or October 1, 2014, whichever is later
- Medicaid-eligible children receiving child welfare services in the HomeSafeNet system and who reside in AHCA area 10 can continue to be enrolled in capitated managed care plans. This restates current law in this section instead of by cross-reference and preserves plan availability
- Requires AHCA to contract with prepaid dental plans until the Managed Medical Assistance program is implemented statewide pursuant to PCB HHSC 11-01
- Directs AHCA to contract with a PSN to serve as a managing entity for Medipass until implementation of Managed Medical Assistance

Section 11:

- Amends s. 409.91195, F.S. relating to Medicaid Pharmaceutical and Therapeutics Committee in order to conform a cross reference

Section 12:

- Amends s. 409.91196, F.S., relating to supplemental rebate agreements; public records and public meetings in order to conform a cross reference

Section 13:

- Repeals s. 409.91207, F.S., relating to the medical homes pilot project

- The pilot project was never implemented and is being replaced with the Managed Medical Assistance program

Section 14:

- Repeals s. 409.91211, F.S., relating to Medicaid managed care pilot program (Medicaid Reform) effective October 1, 2014, when it is replaced with the Managed Medical Assistance program

Section 15:

- Amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment; programs and procedures
- Repeals outdated provisions
- Repeals other provisions on a date certain – pursuant to the full implementation deadline of applicable statewide Medicaid managed care programs
- Creates opt-out option for Medicaid recipients, which allows recipients to use their Medicaid funds to purchase employer-sponsored health coverage or coverage that may be offered through state programs – Florida Health Choice Program or health insurance exchanges
- Requires encounter data be reported by all prepaid plans statewide.
- Creates immediate authority to establish payments for dual eligible Medicaid recipients enrolled in Medicare Advantage plans. This will help facilitate the transition into statewide managed long-term care
- Establishes reporting requirements for medical and non-medical expenses for all plans and requires such information to be made public
- Allows the agency to exempt on a case-by-case basis a recipient from managed care enrollment when the individual has a unique, time-limit disease or condition and the transition to managed care could interfere with treatment.

Section 16:

- Amends s. 430.04, F.S., relating to duties and responsibilities of the Department of Elderly Affairs
- Requires the Department to transition waiver recipients to LTC managed care plans pursuant to the LTC managed care program as it is implemented in each of the regions
- Repeals the Department of Elder Affairs' authority to administer long-term care waivers for elders on October 1, 2013, when LTC managed care is fully implemented in all regions

Section 17:

- Amends s. 430.2053, F.S., relating to aging resource centers
- Repeals outdated provisions

- Repeals other provisions on a date certain – pursuant to the full implementation deadline of statewide Medicaid LTC managed care
- Requires aging resource centers to provide choice counseling for new long-term care managed care plans
- Establishes requirements for Aging Resource Centers to assist recipients in the LTC managed care program as plans become available in the regions by:

    - Evaluating recipients for eligibility
    - Providing choice counseling services, if they choose to contract with AHCA for these services or entering into a Memorandum of Understanding with AHCA to coordinate staffing in collaboration with the choice counseling vendor
    - Assisting recipients with accessing formal grievance processes and resolving informal grievances

Section 18:

- Amends s. 641.386, F.S., relating to HMO agent licensing to conform a cross reference

Section 19:

- Repeals ss. 430.701, 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707, 430.708, and 430.709, relating to the Long-Term Care Community Diversion Pilot Project Act on October 1, 2013, which is subsequent to implementation of LTC managed care in all regions

Section 20:

- Transfers certain existing provisions of Chapter 409, F.S., to Chapter 402, F.S.

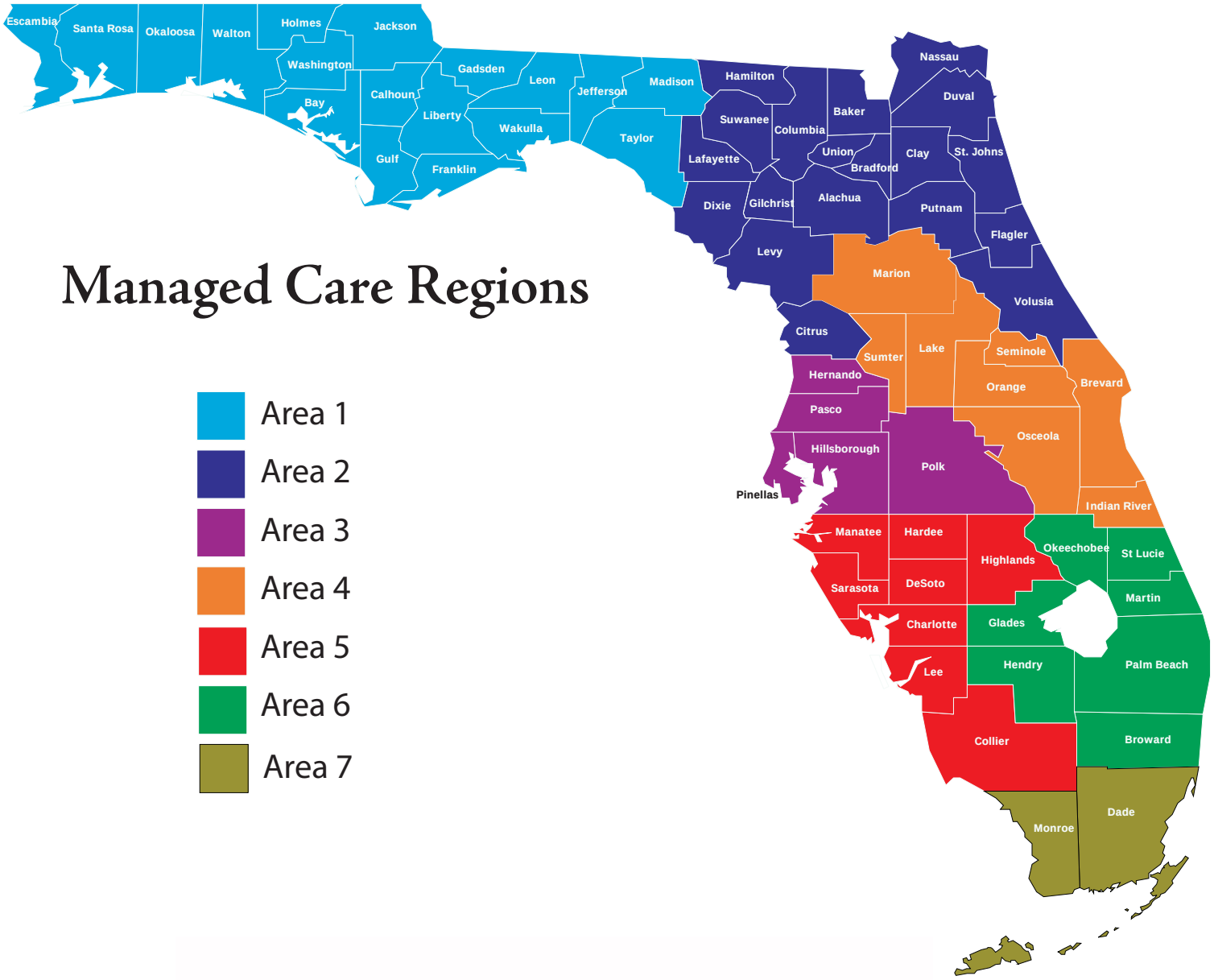
Section 21:

- Amends s. 443.111 relating to payment of benefits to conform a cross reference

Section 22:

- Provides for an effective date that is contingent upon PCB HHSC 11-01 or similar legislation passing this session, or during an extension thereof, and becoming law

Managed Care Regions



Medical and Long Term Care Plans*	**Region I**	**Region II**	**Region III**	**Region IV**	**Region V**	**Region VI**	**Region VII**	**Statewide Totals**
Total Enrollees	**209,392**	**398,583**	**528,116**	**457,797**	**244,295**	**458,655**	544,224	2,841,062
Minimum plans	**3**	**3**	**4**	**4**	**3**	**4**	5	26
PSN plans if responsive	**1**	**1**	2	**2**	**1**	**2**	2	11
Maximum plans	**3**	**6**	**8**	**7**	**3**	**7**	9	43
DD plans	Combined Region I & II		Combined Region III & IV		Combined Region V, VI & VII			
	2-3 including 1 PSN		2-3 including 1 PSN		2-4 including 1 PSN			6-10 including 3 PSNs

**These numbers apply independently to the Managed Medical Assistance Program and the Long Term Care Managed Care Program.*