Health Care Regulation Committee

(Revised)

Monday, December 5, 2005
2:00 - 4:45 PM
212 Knott Building

Allan G. Bense
Speaker

Rene Garcia
Chair

House of Representatives

Committee on Health Care Regulation

AGENDA

December 5, 2005
2:00 PM - 4:45 PM
212 Knott Building

I. Opening Remarks by Chair Garcia

II. Consideration of the following bill:

HB 3B – Medicaid by Rep. Benson

III. Closing Remarks by Chair Garcia

IV. Adjournment

210 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300 (850) 487-3771

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 3B Medicaid
SPONSOR(S): Benson
TIED BILLS: **IDEN./SIM. BILLS:** SB 2B

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Mitchell	Mitchell
2) Fiscal Council			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

In the 2005 Regular Session the Legislature passed CS/CS/SB 838 (Ch. 2005-60, L.O.F.), which establishes s. 409.91211, F.S., to give the Agency for Health Care Administration (AHCA) guidance and authority to seek a federal waiver to reform Medicaid, and specified the agency could not implement the waiver until it received authority from the Legislature. On October 3, 2005, AHCA submitted the waiver to the federal Centers for Medicare and Medicaid Services (CMS) for approval, following a year of negotiation with CMS. On October 19, 2005, the federal Centers for Medicare and Medicaid Services (CMS) approved Florida's Medicaid Reform waiver application with special terms and conditions.

HB 3B amends s. 409.91211, F.S., to give AHCA authority to implement Medicaid reform as required by CS/CS/SB 838 and in accordance with CMS special terms and conditions.

The bill provides an appropriation of $250,000, for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.

The effective date of the bill is upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government. The bill requires outsourcing of the administration of health care service delivery to managed care plans approved by the Agency for Health Care Administration.

B. EFFECT OF PROPOSED CHANGES:

HB 3B amends s. 409.91211, F.S., to give AHCA authority to implement the reform plan as established in the waiver application and federal terms and conditions for the waiver.

The bill:

- Requires Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.
- Modifies the name, composition, and mission of the existing Medicaid Disproportionate Share Council.
- Establishes Low Income Pool Council objectives for the distribution of LIP funds. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals.
- Allows current capitated, behavior health programs to continue in non-reform counties.
- Facilitates the establishment of PSNs by, removing the requirement that contracts for Provider Service Networks (PSNs) be competitively bid, so hospitals and other provider networks can be established to participate in Medicaid reform.
- Authorizes AHCA to begin implementing the Medicaid managed care pilot program in two sites, Broward and Duval Counties.
- Authorizes AHCA to seek options to make direct payments to state medical school hospitals and physicians.
- Requires PSNs to continue sharing savings with the state as PSNs transition to managed care reform plans.
- Allows the Department of Health's, Children's Medical Services Network, to become a reform plan.
- Establishes detailed measures that require quality assurance, patient satisfaction, and performance standard reporting by managed care reform plans.
- Establishes detailed standards for managed care plan compliance, including patient encounter reporting requirements.
- Establishes detailed requirements to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program.
- Requires AHCA to assign Medicaid recipients who are currently in a Medicaid managed care plan and who do not make a choice of a plan at the point of eligibility redetermination into the most appropriate reform plan operated by the recipient's current managed care organization.
- Requires AHCA to notify the Legislature before proposing any changes to the terms and conditions of the waiver.

- Requires the Office of Insurance Regulation to contract with an independent actuary for an annual review of the risk-adjusted rate methodology developed by AHCA for Medicaid reform plans and to report to the Legislature.
- Establishes a Joint Legislative Committee on Medicaid Reform Implementation for reviewing policy issues related to expansion.
- Establishes detailed requirements for readiness that must be met before expansion into other counties can be considered beginning in year two. At least two plans in the expansion area must meet readiness criteria.
- Removes the requirement of automatic assignment of Medicaid recipients in non-reform counties who do not make a choice of plans.
- Requires AHCA to report to the Legislature by April 1, 2006, on Low Income Pool methodology and other issues related to the special terms and conditions.
- Requires AHCA to submit all CMS required quarterly and annual progress reports to the Legislature.
- Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.
- Provides an appropriation of $250,000 for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.
- Provides an effective date of upon becoming law, so that AHCA can implement Medicaid Reform.

THE CURRENT SITUATION

Medicaid is the $15 billion state and federal program that provides health care to more than 2.1 million vulnerable, disabled, and elderly Floridians. According to AHCA, if Florida's Medicaid program continues to grow at its present rate, it would consume more than half of the state's budget by 2015.

Governor Bush's Proposal for Medicaid Reform

In 2004, Governor Bush proposed a major reform of Florida's Medicaid system, and the Agency for Health Care Administration (AHCA) began meeting with the federal Centers for Medicare and Medicaid Services (CMS) to develop concepts for the reform. The reform is referred to as a "waiver" because it seeks federal permission to waive certain federal requirements that govern the regular Medicaid program. The goals of the reform are to establish a new Medicaid system that achieves:

Patient Choice: Participants in reformed Medicaid plans will be able to choose among a variety of benefit packages. With the help of independent choice counselors they will choose the plan that best meets their needs. They will be able to earn credits for approved health-related expenses such as co-pays, over-the-counter medications, or eyeglasses, by meeting approved healthy lifestyle changes such as meeting all well baby checkups, losing weight, and smoking cessation.

Medicaid Marketplace Innovation: Provider groups will be able to design benefit plans that attract participants because of their benefit package, innovative care, convenient networks, and optional services. Competition among managed care plans will reduce fraud in Medicaid. Currently, Medicaid pays claims first and identifies fraud later. Under proposed reforms, capitated health plans have a financial incentive to aggressively guard against fraud.

Better Care: Health plans can customize their benefit design to meet the needs of the target populations in the geographic areas they serve. The state will evaluate the benefits to ensure

they are actuarially equivalent to historical fee-for-service benefits and are sufficient to meet the needs of the targeted populations. Rates will be risk adjusted to create incentives for more prevention and identification of chronic illnesses.

Budget Predictability: According to the Agency for Health Care Administration, by moving to a managed and capitated system, the state expects to minimize budget fluctuations driven primarily by the current fee-for-service system and improve predictions of budget growth.

2004-2005 Legislative Action on Medicaid Reform

In the Fall of 2004, both the House and Senate established Select Committees on Medicaid Reform. The Select Committees conducted five public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. During the public hearings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, providers, health maintenance organization (HMO) representatives, advocacy groups, and other interested parties on ways to improve the Medicaid program.

CS/CS/SB 838 Authorization and Requirements to Pursue a Federal Waiver

In 2005, the Legislature passed CS/CS/SB 838, which creates s. 409.91211, F.S., to authorize AHCA to continue developing a plan to pilot the Governor's proposal for a capitated managed care system to replace the current fee-for-service Medicaid system. Requirements of SB 838 include:

Continued federal funding of supplemental payment mechanisms. The law specifies that the authorization was contingent on the attainment of:

- Federal approval to preserve the Upper Payment Limit (UPL) funding for hospitals, including a guarantee of a reasonable growth factor.
- A methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites.
- Provisions to preserve the state's ability to use Intergovernmental Transfers (IGT) as state match for federal funds.
- Provisions to protect the Disproportionate Share Hospital (DSH) program.

Components for the reform plan. The law requires AHCA to develop and recommend provisions for implementation of Medicaid reform pilot areas that include:

- Eligibility groups and two geographic areas for the pilot projects. The bill designates one pilot program in Broward County and one pilot program in Duval and surrounding Baker, Clay, and Nassau Counties. It allows the pilot in the Duval County area to be phased in over a 2-year period.
- Requirements that health care plans in Medicaid reform pilot areas include mandatory and optional Medicaid services listed in ss. 409.905 and 409.906, F.S.
- Standards and credentialing requirements for plans, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers.
- Actuarially sound, risk adjusted capitation rates for coverage of Medicaid recipients separated into comprehensive and catastrophic care premium components, and a method to phase in financial risk for approved provider service networks over a 3-year period, with stop-loss requirements.
- A system to help Medicaid recipients select a managed care plan that meets their needs. Requirements for mandatory enrollment in a capitated managed care network and locking a recipient into a health plan for 12 months, unless the recipient can demonstrate cause to justify a disenrollment, and provisions for disenrollment and selection of another plan within a certain timeframe.

- A system to monitor plan performance and the provision of services, and to detect and deter fraud and abuse by health plans, providers, and recipients, including underutilization and inappropriate denial of care.

Approval of an implementation plan. Section 409.91211, F.S, requires AHCA to develop an implementation plan to be submitted to the Legislature for approval before implementation of the reform, or if the Legislature is not in session, for approval by the Legislative Budget Commission.

Evaluation of the pilots. The Legislature also requires an independent evaluation of Medicaid reform for consideration of expansion beyond the pilot areas. The Office of Program Policy Analysis and Government Accountability (OPPAGA), in consultation with the Auditor General, will evaluate the two managed care pilot projects during the first 24 months of operation. The evaluation must contain cost savings estimates and quality measures, as well as explanations of any legal or administrative barriers to implementing the pilot projects. The evaluation must be included in a report to the Governor and the Legislature no later than June 30, 2008, for consideration of statewide expansion.

Legislature approval of expansion. No additional counties beyond those specified in s. 409.91211, F.S., may be included in the managed care pilot program without legislative authority.

Federal Approval of the Waiver

The Agency for Health Care Administration (AHCA) published the waiver application for public review on August 31, 2005, and formally submitted the waiver application to the federal government for approval on October 3, 2005.

The federal Centers for Medicaid and Medicare Services (CMS) approved the waiver for reform of Florida Medicaid on October 19, 2005. The waiver covers a 5-year period, from July 1, 2006, through June 30, 2011. Fundamental elements of the reform plan include:

Beneficiary Choice from among benefit packages. With the support of choice counselors, individuals will have the flexibility to choose from a variety of benefit packages and pick the plan that best meets their needs.

Plan Variety. In addition to traditional managed care organizations, new plans will be created from existing provider networks and organizations that wish to participate. Such entities include provider service networks, federally qualified health centers, federally qualified rural health clinics, county health departments, the Division of Children's Medical Services Network within the Department of Health; and other federally, state, or locally funded entities that serve the geographic areas within the pilot program.

Risk-Adjusted Premiums for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.

A Low-Income Pool (LIP) to be established and maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

An Employer-Sponsored Insurance (ESI) option to allow individuals to use their premiums to "opt out" of Medicaid and purchase insurance through their workplace.

Enhanced Benefits Accounts to provide incentives to Medicaid Reform enrollees for healthy behaviors that they can use to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins, etc.

Federal Terms and Conditions
In approving the waiver, CMS attached special terms and conditions (11-W-00206/4) that set forth in detail the nature, character, and extent of federal involvement in the reform, and Florida's obligations to CMS during the life of the waiver. The terms and conditions address 120 issues in 16 areas of the reform. They require detailed accountability. The terms and conditions require compliance with current Medicaid law, regulation, and policy. They spell out limits on the scope of change in some areas, and provide for broad flexibility in others. The areas addressed by the terms and conditions include:

- General Program and Reporting Requirements.
- Implementation of Florida Medicaid Reform.
- Eligibility, Enrollment, and Choice Counseling.
- Benefit Packages and Medicaid Reform Plans.
- Employer-Sponsored Insurance.
- The Enhanced Benefits Accounts Program.
- The Low Income Pool.
- Evaluation and Monitoring of Budget Neutrality.

The terms and conditions require federal approval of amendments to the waiver before Florida can add dual eligible, hospice, and medically needy groups to the reform; and before any program or budget changes can be made to: eligibility, enrollment, benefits, employer-sponsored insurance, implementation, the Low Income Pool, Federal Financial Participation (FFP), sources of the non-Federal share, and budget neutrality.

C. SECTION DIRECTORY:

Section 1. Amends s. 641.2261(2), F.S., to require Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.

Section 2. Amends s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver.

Section 3. Amends s. 409.912, F.S., to allow current capitated, behavior health programs to continue in non-reform counties, and remove the requirement that contracts for Provider Service Networks (PSNs) be competitively bid.

Section 4. Amends s. 409.91211, F.S., to authorize AHCA to begin implementing the Medicaid managed care pilot program in two pilot sites (Broward and Duval Counties per CS/CS/SB 838, 2005). The bill specifies additional requirements related to PSN cost sharing, quality assurance, encounter data, fraud and abuse, and continuity of care; and it makes technical changes to conform to requirements of the federal waiver.

Section 5. Creates s. 409.91212, F.S., to allow Medicaid reform to expand to other counties after the beginning of year two, if detailed criteria for readiness are met.

Section 6. Amends s. 409.9122, F.S., to remove the requirement of automatic assignment into Medipass of Medicaid recipients in non-reform counties who do not make a choice of plans.

Section 7. Requires AHCA to report to the Legislature by April 1, 2006, on the Low Income Pool methodology and other issues related to the federal terms and conditions requirements of the waiver.

Section 8. Requires AHCA to submit all CMS required quarterly and annual reports to the Legislature.

Section 9. Creates s. 11.72, F.S., to establish a Joint Legislative Committee on Medicaid Reform Implementation to review policy issues related to expansion of the Medicaid managed pilot program and make recommendations regarding the extent readiness criteria are met.

Section 10. Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.

Section 11. Amends s. 216.346, F.S., to allow contracts between state agencies and state colleges and universities to charge a reasonable overhead.

Section 12. Provides an appropriation of $250,000, for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.

Section 13. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Comments below.

2. Expenditures:

   See Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Administration Costs

The Agency for Health Care Administration has requested $15 million ($7.5 million General Revenue) of nonrecurring funds for the administration of Medicaid reform in its Fiscal Year 2006-2007 Legislative Budget Request. The request is for the following funds.

Choice Counseling
General Revenue Fund $3,250,000
Administrative Trust Fund $3,250,000

Plan Evaluation/Satisfaction Survey
General Revenue Fund $250,000
Administrative Trust Fund $250,000

Premium Development
General Revenue Fund $1,000,000
Administrative Trust Fund $1,000,000

Enhanced Benefit Accounts
General Revenue Fund $1,500,000
Administrative Trust Fund $1,500,000

Management of Employer Sponsored Insurance
General Revenue Fund $1,000,000
Administrative Trust Fund $1,000,000

Infrastructure & System Modification
General Revenue Fund $500,000
Administrative Trust Fund $500,000

For subsequent years, the agency states that the projects will increase in cost as the capitated managed care pilot program expands into Baker, Clay, and Nassau counties.

Medicaid Reform Benefit Costs

The agency's Florida Medicaid Reform Implementation Plan dated November 28, 2005, compares the costs of Medicaid benefits without Medicaid reform to the costs of Medicaid benefits with Medicaid reform. The comparison is below.

Benefit Costs	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Without reform	$8,005,381,618	$9,074,633,163	$10,317,423,381	$11,763,265,977	$13,446,859,984
With reform	$7,814,617,174	8,747,049,308	$9,823,408,828	$11,067,673,309	$12,507,991,943
Difference	$190,764,444	$327,583,855	$494,014,553	$695,592,668	$938,868,041

The $190.7 million in savings shown above for Fiscal Year 2006-2007 is for statewide expenditures. According to the agency, the fiscal impact of moving recipients into Medicaid reform plans in only Duval and Broward counties is indeterminate at this time.

Rate Review

This bill authorizes one full-time equivalent position and appropriates $250,000 from the General Revenue Fund for Fiscal Year 2006-2007 for the annual review of the Medicaid managed care pilot program's risk-adjusted rate setting methodology.

Assignment of Recipients to Managed Care

The bill changes the assignment of undecided enrollees. Although an estimate of the fiscal impact of this policy decision is not available at this time, an estimate provided by the agency at an impact

conference during the 2005 session showed that moving all non-institutionalized SSI-eligible beneficiaries into a health maintenance organization would result in savings of more than $71 million ($13.2 million General Revenue).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to Medicaid; amending s. 641.2261, F.S.;
3 revising the applicability of solvency requirements to
4 include Medicaid provider service networks and updating a
5 reference; amending s. 409.911, F.S.; renaming the
6 Medicaid Disproportionate Share Council; providing for
7 appointment of council members; providing responsibilities
8 of the council; amending s. 409.912, F.S.; providing an
9 exception from certain contract procurement requirements
10 for specified Medicaid managed care pilot programs and
11 Medicaid health maintenance organizations; deleting the
12 competitive procurement requirement for provider service
13 networks; requiring provider service networks to comply
14 with the solvency requirements in s. 641.2261, F.S.;
15 updating a reference; amending s. 409.91211, F.S.;
16 providing for distribution of upper payment limit,
17 hospital disproportionate share program, and low income
18 pool funds; providing legislative intent with respect to
19 distribution of said funds; providing for implementation
20 of the powers, duties, and responsibilities of the Agency
21 for Health Care Administration with respect to the pilot
22 program; including the Division of Children's Medical
23 Services Network within the Department of Health in a list
24 of state-authorized pilot programs; requiring the agency
25 to develop a data reporting system; requiring the agency
26 to implement procedures to minimize fraud and abuse;
27 providing that certain Medicaid and Supplemental Security
28 Income recipients are exempt from s. 409.9122, F.S.;

29 authorizing the agency to assign certain Medicaid
30 recipients to reform plans; authorizing the agency to
31 implement the provisions of the waiver approved by Centers
32 for Medicare and Medicaid Services and requiring the
33 agency to notify the Legislature prior to seeking federal
34 approval of modifications to said terms and conditions;
35 requiring an annual review by the Office of Insurance
36 Regulation of the pilot program's rate setting
37 methodology; requiring a report to the Legislature;
38 defining the term "capitated managed care plan"; creating
39 s. 409.91212, F.S.; authorizing the agency to expand the
40 Medicaid reform demonstration program; providing readiness
41 criteria; providing for public meetings; requiring notice
42 of intent to expand the demonstration program; requiring
43 the agency to request a hearing by the Joint Legislative
44 Committee on Medicaid Reform Implementation; authorizing
45 the agency to request certain budget transfers; amending
46 s. 409.9122, F.S.; revising provisions relating to
47 assignment of certain Medicaid recipients to managed care
48 plans; requiring the agency to submit reports to the
49 Legislature; specifying content of reports; creating s.
50 11.72, F.S.; creating the Joint Legislative Committee on
51 Medicaid Reform Implementation; providing for membership,
52 powers, and duties; providing for conflict between
53 specified provisions of ch. 409, F.S., and requiring a
54 report by the agency pertaining thereto; amending s.
55 216.346, F.S.; revising provisions relating to contracts

56 between state agencies; providing an appropriation;
57 providing an effective date.
58
59 Be It Enacted by the Legislature of the State of Florida:
60
61 Section 1. Section 641.2261, Florida Statutes, is amended
62 to read:
63 641.2261 Application of federal solvency requirements to
64 provider-sponsored organizations and Medicaid provider service
65 networks.--
66 (1) The solvency requirements of ss. 1855 and 1856 of the
67 Balanced Budget Act of 1997 and 42 C.F.R. s. 422.350, subpart H,
68 ~~rules adopted by the Secretary of the United States Department~~
69 ~~of Health and Human Services~~ apply to a health maintenance
70 organization that is a provider-sponsored organization rather
71 than the solvency requirements of this part. However, if the
72 provider-sponsored organization does not meet the solvency
73 requirements of this part, the organization is limited to the
74 issuance of Medicare+Choice plans to eligible individuals. For
75 the purposes of this section, the terms "Medicare+Choice plans,"
76 "provider-sponsored organizations," and "solvency requirements"
77 have the same meaning as defined in the federal act and federal
78 rules and regulations.
79 (2) The solvency requirements of 42 C.F.R. s. 422.350,
80 subpart H, and the solvency requirements established in the
81 approved federal waiver pursuant to chapter 409 apply to a
82 Medicaid provider service network rather than the solvency
83 requirements of this part.

84 Section 2. Subsection (9) of section 409.911, Florida
85 Statutes, is amended to read:
86 409.911 Disproportionate share program.--Subject to
87 specific allocations established within the General
88 Appropriations Act and any limitations established pursuant to
89 chapter 216, the agency shall distribute, pursuant to this
90 section, moneys to hospitals providing a disproportionate share
91 of Medicaid or charity care services by making quarterly
92 Medicaid payments as required. Notwithstanding the provisions of
93 s. 409.915, counties are exempt from contributing toward the
94 cost of this special reimbursement for hospitals serving a
95 disproportionate share of low-income patients.
96 (9) The Agency for Health Care Administration shall create
97 a Medicaid Low Income Pool ~~Disproportionate Share~~ Council. The
98 Low Income Pool Council shall consist of 17 members, including
99 three representatives of statutory teaching hospitals, three
100 representatives of public hospitals, three representatives of
101 nonprofit hospitals, three representatives of for-profit
102 hospitals, two representatives of rural hospitals, two
103 representatives of units of local government which contribute
104 funding, and one representative from the Department of Health.
105 The council shall have the following responsibilities:
106 (a) Make recommendations on the financing of the upper
107 payment limit program, the hospital disproportionate share
108 program, or the low income pool as implemented by the agency
109 pursuant to federal waiver and on the distribution of funds.

110 (b) Advise the agency on the development of the low income
111 pool plan required by the Centers for Medicare and Medicaid
112 Services pursuant to the Medicaid reform waiver.
113 (c) Advise the agency on the distribution of hospital
114 funds used to adjust inpatient hospital rates and rebase rates
115 or otherwise exempt hospitals from reimbursement limits as
116 financed by intergovernmental transfers.
117 ~~(a) The purpose of the council is to study and make~~
118 ~~recommendations regarding:~~
119 ~~1. The formula for the regular disproportionate share~~
120 ~~program and alternative financing options.~~
121 ~~2. Enhanced Medicaid funding through the Special Medicaid~~
122 ~~Payment program.~~
123 ~~3. The federal status of the upper-payment-limit funding~~
124 ~~option and how this option may be used to promote health care~~
125 ~~initiatives determined by the council to be state health care~~
126 ~~priorities.~~
127 ~~(b) The council shall include representatives of the~~
128 ~~Executive Office of the Governor and of the agency;~~
129 ~~representatives from teaching, public, private nonprofit,~~
130 ~~private for-profit, and family practice teaching hospitals; and~~
131 ~~representatives from other groups as needed.~~
132 (d) ~~(c) The council shall~~ Submit its findings and
133 recommendations to the Governor and the Legislature no later
134 than February 1 of each year.
135 Section 3. Paragraphs (b) and (d) of subsection (4) of
136 section 409.912, Florida Statutes, are amended to read:

137 409.912 Cost-effective purchasing of health care.--The
138 agency shall purchase goods and services for Medicaid recipients
139 in the most cost-effective manner consistent with the delivery
140 of quality medical care. To ensure that medical services are
141 effectively utilized, the agency may, in any case, require a
142 confirmation or second physician's opinion of the correct
143 diagnosis for purposes of authorizing future services under the
144 Medicaid program. This section does not restrict access to
145 emergency services or poststabilization care services as defined
146 in 42 C.F.R. part 438.114. Such confirmation or second opinion
147 shall be rendered in a manner approved by the agency. The agency
148 shall maximize the use of prepaid per capita and prepaid
149 aggregate fixed-sum basis services when appropriate and other
150 alternative service delivery and reimbursement methodologies,
151 including competitive bidding pursuant to s. 287.057, designed
152 to facilitate the cost-effective purchase of a case-managed
153 continuum of care. The agency shall also require providers to
154 minimize the exposure of recipients to the need for acute
155 inpatient, custodial, and other institutional care and the
156 inappropriate or unnecessary use of high-cost services. The
157 agency shall contract with a vendor to monitor and evaluate the
158 clinical practice patterns of providers in order to identify
159 trends that are outside the normal practice patterns of a
160 provider's professional peers or the national guidelines of a
161 provider's professional association. The vendor must be able to
162 provide information and counseling to a provider whose practice
163 patterns are outside the norms, in consultation with the agency,
164 to improve patient care and reduce inappropriate utilization.

165 The agency may mandate prior authorization, drug therapy
166 management, or disease management participation for certain
167 populations of Medicaid beneficiaries, certain drug classes, or
168 particular drugs to prevent fraud, abuse, overuse, and possible
169 dangerous drug interactions. The Pharmaceutical and Therapeutics
170 Committee shall make recommendations to the agency on drugs for
171 which prior authorization is required. The agency shall inform
172 the Pharmaceutical and Therapeutics Committee of its decisions
173 regarding drugs subject to prior authorization. The agency is
174 authorized to limit the entities it contracts with or enrolls as
175 Medicaid providers by developing a provider network through
176 provider credentialing. The agency may competitively bid single-
177 source-provider contracts if procurement of goods or services
178 results in demonstrated cost savings to the state without
179 limiting access to care. The agency may limit its network based
180 on the assessment of beneficiary access to care, provider
181 availability, provider quality standards, time and distance
182 standards for access to care, the cultural competence of the
183 provider network, demographic characteristics of Medicaid
184 beneficiaries, practice and provider-to-beneficiary standards,
185 appointment wait times, beneficiary use of services, provider
186 turnover, provider profiling, provider licensure history,
187 previous program integrity investigations and findings, peer
188 review, provider Medicaid policy and billing compliance records,
189 clinical and medical record audits, and other factors. Providers
190 shall not be entitled to enrollment in the Medicaid provider
191 network. The agency shall determine instances in which allowing
192 Medicaid beneficiaries to purchase durable medical equipment and

193 other goods is less expensive to the Medicaid program than long-
194 term rental of the equipment or goods. The agency may establish
195 rules to facilitate purchases in lieu of long-term rentals in
196 order to protect against fraud and abuse in the Medicaid program
197 as defined in s. 409.913. The agency may seek federal waivers
198 necessary to administer these policies.
199 (4) The agency may contract with:
200 (b) An entity that is providing comprehensive behavioral
201 health care services to certain Medicaid recipients through a
202 capitated, prepaid arrangement pursuant to the federal waiver
203 provided for by s. 409.905(5). Such an entity must be licensed
204 under chapter 624, chapter 636, or chapter 641 and must possess
205 the clinical systems and operational competence to manage risk
206 and provide comprehensive behavioral health care to Medicaid
207 recipients. As used in this paragraph, the term "comprehensive
208 behavioral health care services" means covered mental health and
209 substance abuse treatment services that are available to
210 Medicaid recipients. The secretary of the Department of Children
211 and Family Services shall approve provisions of procurements
212 related to children in the department's care or custody prior to
213 enrolling such children in a prepaid behavioral health plan. Any
214 contract awarded under this paragraph must be competitively
215 procured. In developing the behavioral health care prepaid plan
216 procurement document, the agency shall ensure that the
217 procurement document requires the contractor to develop and
218 implement a plan to ensure compliance with s. 394.4574 related
219 to services provided to residents of licensed assisted living
220 facilities that hold a limited mental health license. Except as

221 provided in subparagraph 8. and except in counties where the
222 Medicaid managed care pilot program is authorized under s.
223 409.91211, the agency shall seek federal approval to contract
224 with a single entity meeting these requirements to provide
225 comprehensive behavioral health care services to all Medicaid
226 recipients not enrolled in a Medicaid capitated managed care
227 plan authorized under s. 409.91211 or a Medicaid health
228 maintenance organization ~~plan~~ in an AHCA area. In an AHCA area
229 where the Medicaid managed care pilot program is authorized
230 under s. 409.91211 in one or more counties, the agency may
231 procure a contract with a single entity to serve the remaining
232 counties as an AHCA area or the remaining counties may be
233 included with an adjacent AHCA area and shall be subject to this
234 paragraph. Each entity must offer sufficient choice of providers
235 in its network to ensure recipient access to care and the
236 opportunity to select a provider with whom they are satisfied.
237 The network shall include all public mental health hospitals. To
238 ensure unimpaired access to behavioral health care services by
239 Medicaid recipients, all contracts issued pursuant to this
240 paragraph shall require 80 percent of the capitation paid to the
241 managed care plan, including health maintenance organizations,
242 to be expended for the provision of behavioral health care
243 services. In the event the managed care plan expends less than
244 80 percent of the capitation paid pursuant to this paragraph for
245 the provision of behavioral health care services, the difference
246 shall be returned to the agency. The agency shall provide the
247 managed care plan with a certification letter indicating the
248 amount of capitation paid during each calendar year for the

249 provision of behavioral health care services pursuant to this
250 section. The agency may reimburse for substance abuse treatment
251 services on a fee-for-service basis until the agency finds that
252 adequate funds are available for capitated, prepaid
253 arrangements.
254 1. By January 1, 2001, the agency shall modify the
255 contracts with the entities providing comprehensive inpatient
256 and outpatient mental health care services to Medicaid
257 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
258 Counties, to include substance abuse treatment services.
259 2. By July 1, 2003, the agency and the Department of
260 Children and Family Services shall execute a written agreement
261 that requires collaboration and joint development of all policy,
262 budgets, procurement documents, contracts, and monitoring plans
263 that have an impact on the state and Medicaid community mental
264 health and targeted case management programs.
265 3. Except as provided in subparagraph 8., by July 1, 2006,
266 the agency and the Department of Children and Family Services
267 shall contract with managed care entities in each AHCA area
268 except area 6 or arrange to provide comprehensive inpatient and
269 outpatient mental health and substance abuse services through
270 capitated prepaid arrangements to all Medicaid recipients who
271 are eligible to participate in such plans under federal law and
272 regulation. In AHCA areas where eligible individuals number less
273 than 150,000, the agency shall contract with a single managed
274 care plan to provide comprehensive behavioral health services to
275 all recipients who are not enrolled in a Medicaid health
276 maintenance organization <u>or a Medicaid capitated managed care</u>

277 plan authorized under s. 409.91211. The agency may contract with
278 more than one comprehensive behavioral health provider to
279 provide care to recipients who are not enrolled in a Medicaid
280 health maintenance organization or a Medicaid capitated managed
281 care plan authorized under s. 409.91211 in AHCA areas where the
282 eligible population exceeds 150,000. In an AHCA area where the
283 Medicaid managed care pilot program is authorized under s.
284 409.91211 in one or more counties, the agency may procure a
285 contract with a single entity to serve the remaining counties as
286 an AHCA area or the remaining counties may be included with an
287 adjacent AHCA area and shall be subject to this paragraph.
288 Contracts for comprehensive behavioral health providers awarded
289 pursuant to this section shall be competitively procured. Both
290 for-profit and not-for-profit corporations shall be eligible to
291 compete. Managed care plans contracting with the agency under
292 subsection (3) shall provide and receive payment for the same
293 comprehensive behavioral health benefits as provided in AHCA
294 rules, including handbooks incorporated by reference. In AHCA
295 area 11, the agency shall contract with at least two
296 comprehensive behavioral health care providers to provide
297 behavioral health care to recipients in that area who are
298 enrolled in, or assigned to, the MediPass program. One of the
299 behavioral health care contracts shall be with the existing
300 provider service network pilot project, as described in
301 paragraph (d), for the purpose of demonstrating the cost-
302 effectiveness of the provision of quality mental health services
303 through a public hospital-operated managed care model. Payment
304 shall be at an agreed-upon capitated rate to ensure cost

305 savings. ~~Of the recipients in area 11 who are assigned to~~
306 ~~MediPass under the provisions of s. 409.9122(2)(k),~~ A minimum of
307 50,000 ~~of those~~ MediPass-enrolled recipients shall be assigned
308 to the existing provider service network in area 11 for their
309 behavioral care.
310 4. By October 1, 2003, the agency and the department shall
311 submit a plan to the Governor, the President of the Senate, and
312 the Speaker of the House of Representatives which provides for
313 the full implementation of capitated prepaid behavioral health
314 care in all areas of the state.
315 a. Implementation shall begin in 2003 in those AHCA areas
316 of the state where the agency is able to establish sufficient
317 capitation rates.
318 b. If the agency determines that the proposed capitation
319 rate in any area is insufficient to provide appropriate
320 services, the agency may adjust the capitation rate to ensure
321 that care will be available. The agency and the department may
322 use existing general revenue to address any additional required
323 match but may not over-obligate existing funds on an annualized
324 basis.
325 c. Subject to any limitations provided for in the General
326 Appropriations Act, the agency, in compliance with appropriate
327 federal authorization, shall develop policies and procedures
328 that allow for certification of local and state funds.
329 5. Children residing in a statewide inpatient psychiatric
330 program, or in a Department of Juvenile Justice or a Department
331 of Children and Family Services residential program approved as
332 a Medicaid behavioral health overlay services provider shall not

333 be included in a behavioral health care prepaid health plan or
334 any other Medicaid managed care plan pursuant to this paragraph.
335 6. In converting to a prepaid system of delivery, the
336 agency shall in its procurement document require an entity
337 providing only comprehensive behavioral health care services to
338 prevent the displacement of indigent care patients by enrollees
339 in the Medicaid prepaid health plan providing behavioral health
340 care services from facilities receiving state funding to provide
341 indigent behavioral health care, to facilities licensed under
342 chapter 395 which do not receive state funding for indigent
343 behavioral health care, or reimburse the unsubsidized facility
344 for the cost of behavioral health care provided to the displaced
345 indigent care patient.
346 7. Traditional community mental health providers under
347 contract with the Department of Children and Family Services
348 pursuant to part IV of chapter 394, child welfare providers
349 under contract with the Department of Children and Family
350 Services in areas 1 and 6, and inpatient mental health providers
351 licensed pursuant to chapter 395 must be offered an opportunity
352 to accept or decline a contract to participate in any provider
353 network for prepaid behavioral health services.
354 8. For fiscal year 2004-2005, all Medicaid eligible
355 children, except children in areas 1 and 6, whose cases are open
356 for child welfare services in the HomeSafeNet system, shall be
357 enrolled in MediPass or in Medicaid fee-for-service and all
358 their behavioral health care services including inpatient,
359 outpatient psychiatric, community mental health, and case
360 management shall be reimbursed on a fee-for-service basis.

361 Beginning July 1, 2005, such children, who are open for child
362 welfare services in the HomeSafeNet system, shall receive their
363 behavioral health care services through a specialty prepaid plan
364 operated by community-based lead agencies either through a
365 single agency or formal agreements among several agencies. The
366 specialty prepaid plan must result in savings to the state
367 comparable to savings achieved in other Medicaid managed care
368 and prepaid programs. Such plan must provide mechanisms to
369 maximize state and local revenues. The specialty prepaid plan
370 shall be developed by the agency and the Department of Children
371 and Family Services. The agency is authorized to seek any
372 federal waivers to implement this initiative.
373 (d) A provider service network which may be reimbursed on
374 a fee-for-service or prepaid basis. A provider service network
375 which is reimbursed by the agency on a prepaid basis shall be
376 exempt from parts I and III of chapter 641, but must comply with
377 the solvency requirements in s. 641.2261(2) and meet appropriate
378 financial reserve, quality assurance, and patient rights
379 requirements as established by the agency. ~~The agency shall~~
380 ~~award contracts on a competitive bid basis and shall select~~
381 ~~bidders based upon price and quality of care.~~ Medicaid
382 recipients assigned to a provider service network ~~demonstration~~
383 ~~project~~ shall be chosen equally from those who would otherwise
384 have been assigned to prepaid plans and MediPass. The agency is
385 authorized to seek federal Medicaid waivers as necessary to
386 implement the provisions of this section. Any contract
387 previously awarded to a provider service network operated by a
388 hospital pursuant to this subsection shall remain in effect for

389 a period of 3 years following the current contract expiration
390 date, regardless of any contractual provisions to the contrary.
391 A provider service network is a network established or organized
392 and operated by a health care provider, or group of affiliated
393 health care providers, which provides a substantial proportion
394 of the health care items and services under a contract directly
395 through the provider or affiliated group of providers and may
396 make arrangements with physicians or other health care
397 professionals, health care institutions, or any combination of
398 such individuals or institutions to assume all or part of the
399 financial risk on a prospective basis for the provision of basic
400 health services by the physicians, by other health
401 professionals, or through the institutions. The health care
402 providers must have a controlling interest in the governing body
403 of the provider service network organization.
404 Section 4. Section 409.91211, Florida Statutes, is amended
405 to read:
406 409.91211 Medicaid managed care pilot program.--
407 (1)(a) The agency is authorized to seek experimental,
408 pilot, or demonstration project waivers, pursuant to s. 1115 of
409 the Social Security Act, to create a statewide initiative to
410 provide for a more efficient and effective service delivery
411 system that enhances quality of care and client outcomes in the
412 Florida Medicaid program pursuant to this section. Phase one of
413 the demonstration shall be implemented in two geographic areas.
414 One demonstration site shall include only Broward County. A
415 second demonstration site shall initially include Duval County
416 and shall be expanded to include Baker, Clay, and Nassau

417 Counties within 1 year after the Duval County program becomes
418 operational. This waiver authority is contingent upon federal
419 approval to preserve the upper-payment-limit funding mechanism
420 for hospitals, including a guarantee of a reasonable growth
421 factor, a methodology to allow the use of a portion of these
422 funds to serve as a risk pool for demonstration sites,
423 provisions to preserve the state's ability to use
424 intergovernmental transfers, and provisions to protect the
425 disproportionate share program authorized pursuant to this
426 chapter. Under the upper payment limit program, the hospital
427 disproportionate share program, or the low income pool as
428 implemented by the agency pursuant to federal waiver, the state
429 matching funds required for the program shall be provided by the
430 state and by local governmental entities through
431 intergovernmental transfers. The agency shall distribute funds
432 from the upper payment limit program, the hospital
433 disproportionate share program, and the low income pool
434 according to federal regulations and waivers and the low income
435 pool methodology approved by the Centers for Medicare and
436 Medicaid Services. ~~Upon completion of the evaluation conducted~~
437 ~~under s. 3, ch. 2005-133, Laws of Florida, the agency may~~
438 ~~request statewide expansion of the demonstration projects.~~
439 ~~Statewide phase-in to additional counties shall be contingent~~
440 ~~upon review and approval by the Legislature.~~
441 (b) It is the intent of the Legislature that the low
442 income pool plan required by the terms and conditions of the
443 Medicaid reform waiver and submitted to the Centers for Medicare

444 and Medicaid Services propose the distribution of the program
445 funds in paragraph (a) based on the following objectives:
446 1. Ensure a broad and fair distribution of available funds
447 based on the access provided by Medicaid participating
448 hospitals, regardless of their ownership status, through their
449 delivery of inpatient or outpatient care for Medicaid
450 beneficiaries and uninsured and underinsured individuals.
451 2. Ensure accessible emergency inpatient and outpatient
452 care for Medicaid beneficiaries and uninsured and underinsured
453 individuals.
454 3. Enhance primary, preventive, and other ambulatory care
455 coverages for uninsured individuals.
456 4. Promote teaching and specialty hospital programs.
457 5. Promote the stability and viability of statutorily
458 defined rural hospitals and hospitals that serve as sole
459 community hospitals.
460 6. Recognize the extent of hospital uncompensated care
461 costs.
462 7. Maintain and enhance essential community hospital care.
463 8. Maintain incentives for local governmental entities to
464 contribute to the cost of uncompensated care.
465 9. Promote measures to avoid preventable hospitalizations.
466 10. Account for hospital efficiency.
467 11. Contribute to a community's overall health system.
468 (2) The Legislature intends for the capitated managed care
469 pilot program to:
470 (a) Provide recipients in Medicaid fee-for-service or the
471 MediPass program a comprehensive and coordinated capitated

472 managed care system for all health care services specified in
473 ss. 409.905 and 409.906.
474 (b) Stabilize Medicaid expenditures under the pilot
475 program compared to Medicaid expenditures in the pilot area for
476 the 3 years before implementation of the pilot program, while
477 ensuring:
478 1. Consumer education and choice.
479 2. Access to medically necessary services.
480 3. Coordination of preventative, acute, and long-term
481 care.
482 4. Reductions in unnecessary service utilization.
483 (c) Provide an opportunity to evaluate the feasibility of
484 statewide implementation of capitated managed care networks as a
485 replacement for the current Medicaid fee-for-service and
486 MediPass systems.
487 (3) The agency shall have the following powers, duties,
488 and responsibilities with respect to the ~~development of a~~ pilot
489 program:
490 (a) To implement ~~develop and recommend~~ a system to deliver
491 all mandatory services specified in s. 409.905 and optional
492 services specified in s. 409.906, as approved by the Centers for
493 Medicare and Medicaid Services and the Legislature in the waiver
494 pursuant to this section. Services to recipients under plan
495 benefits shall include emergency services provided under s.
496 409.9128.
497 (b) To implement a pilot program that includes ~~recommend~~
498 Medicaid eligibility categories~~, from those~~ specified in ss.

499 409.903 and 409.904 as authorized in an approved federal waiver~~,~~
500 ~~which shall be included in the pilot program~~.
501 (c) To implement ~~determine and recommend how to design~~ the
502 managed care pilot program that maximizes ~~in order to take~~
503 ~~maximum advantage of~~ all available state and federal funds,
504 including those obtained through intergovernmental transfers,
505 the low income pool, supplemental Medicaid payments ~~upper-~~
506 ~~payment-level funding systems~~, and the disproportionate share
507 program. Within the parameters allowed by federal statute and
508 rule, the agency is authorized to seek options for making direct
509 payments to hospitals and physicians employed by or under
510 contract with the state's medical schools for the costs
511 associated with graduate medical education under Medicaid
512 reform.
513 (d) To implement ~~determine and recommend~~ actuarially
514 sound, risk-adjusted capitation rates for Medicaid recipients in
515 the pilot program which ~~can be separated to~~ cover comprehensive
516 care, enhanced services, and catastrophic care.
517 (e) To implement ~~determine and recommend~~ policies and
518 guidelines for phasing in financial risk for approved provider
519 service networks over a 3-year period. These policies and
520 guidelines shall include an option for a provider service
521 network to be paid ~~to pay~~ fee-for-service rates. For any
522 provider service network established in a managed care pilot
523 area, the option to be paid fee-for-service rates shall include
524 a savings-settlement mechanism that is consistent with s.
525 409.912(44) ~~that may include a savings-settlement option for at~~
526 ~~least 2 years~~. This model shall ~~may~~ be converted to a risk-

527 adjusted capitated rate no later than the beginning of the
528 fourth ~~in the third~~ year of operation and may be converted
529 earlier at the option of the provider service network. Federally
530 qualified health centers may be offered an opportunity to accept
531 or decline a contract to participate in any provider network for
532 prepaid primary care services.
533 (f) To implement ~~determine and recommend provisions~~
534 ~~related to~~ stop-loss requirements and the transfer of excess
535 cost to catastrophic coverage that accommodates the risks
536 associated with the development of the pilot program.
537 (g) To ~~determine and~~ recommend a process to be used by the
538 Social Services Estimating Conference to determine and validate
539 the rate of growth of the per-member costs of providing Medicaid
540 services under the managed care pilot program.
541 (h) To implement ~~determine and recommend~~ program standards
542 and credentialing requirements for capitated managed care
543 networks to participate in the pilot program, including those
544 related to fiscal solvency, quality of care, and adequacy of
545 access to health care providers. It is the intent of the
546 Legislature that, to the extent possible, any pilot program
547 authorized by the state under this section include any federally
548 qualified health center, any federally qualified rural health
549 clinic, county health department, the Division of Children's
550 Medical Services Network within the Department of Health, or any
551 other federally, state, or locally funded entity that serves the
552 geographic areas within the boundaries of the pilot program that
553 requests to participate. This paragraph does not relieve an
554 entity that qualifies as a capitated managed care network under

555 this section from any other licensure or regulatory requirements
556 contained in state or federal law which would otherwise apply to
557 the entity. The standards and credentialing requirements shall
558 be based upon, but are not limited to:
559 1. Compliance with the accreditation requirements as
560 provided in s. 641.512.
561 2. Compliance with early and periodic screening,
562 diagnosis, and treatment screening requirements under federal
563 law.
564 3. The percentage of voluntary disenrollments.
565 4. Immunization rates.
566 5. Standards of the National Committee for Quality
567 Assurance and other approved accrediting bodies.
568 6. Recommendations of other authoritative bodies.
569 7. Specific requirements of the Medicaid program, or
570 standards designed to specifically meet the unique needs of
571 Medicaid recipients.
572 8. Compliance with the health quality improvement system
573 as established by the agency, which incorporates standards and
574 guidelines developed by the Centers for Medicare and Medicaid
575 Services as part of the quality assurance reform initiative.
576 9. The network's infrastructure capacity to manage
577 financial transactions, recordkeeping, data collection, and
578 other administrative functions.
579 10. The network's ability to submit any financial,
580 programmatic, or patient-encounter data or other information
581 required by the agency to determine the actual services provided
582 and the cost of administering the plan.

583 (i) To implement ~~develop and recommend~~ a mechanism for
584 providing information to Medicaid recipients for the purpose of
585 selecting a capitated managed care plan. For each plan available
586 to a recipient, the agency, at a minimum, shall ensure that the
587 recipient is provided with:
588 1. A list and description of the benefits provided.
589 2. Information about cost sharing.
590 3. Plan performance data, if available.
591 4. An explanation of benefit limitations.
592 5. Contact information, including identification of
593 providers participating in the network, geographic locations,
594 and transportation limitations.
595 6. Any other information the agency determines would
596 facilitate a recipient's understanding of the plan or insurance
597 that would best meet his or her needs.
598 (j) To implement ~~develop and recommend~~ a system to ensure
599 that there is a record of recipient acknowledgment that choice
600 counseling has been provided.
601 (k) To implement ~~develop and recommend~~ a choice counseling
602 system to ensure that the choice counseling process and related
603 material are designed to provide counseling through face-to-face
604 interaction, by telephone, and in writing and through other
605 forms of relevant media. Materials shall be written at the
606 fourth-grade reading level and available in a language other
607 than English when 5 percent of the county speaks a language
608 other than English. Choice counseling shall also use language
609 lines and other services for impaired recipients, such as
610 TTD/TTY.

611 (l) To implement ~~develop and recommend~~ a system that
612 prohibits capitated managed care plans, their representatives,
613 and providers employed by or contracted with the capitated
614 managed care plans from recruiting persons eligible for or
615 enrolled in Medicaid, from providing inducements to Medicaid
616 recipients to select a particular capitated managed care plan,
617 and from prejudicing Medicaid recipients against other capitated
618 managed care plans. The system shall require the entity
619 performing choice counseling to determine if the recipient has
620 made a choice of a plan or has opted out because of duress,
621 threats, payment to the recipient, or incentives promised to the
622 recipient by a third party. If the choice counseling entity
623 determines that the decision to choose a plan was unlawfully
624 influenced or a plan violated any of the provisions of s.
625 409.912(21), the choice counseling entity shall immediately
626 report the violation to the agency's program integrity section
627 for investigation. Verification of choice counseling by the
628 recipient shall include a stipulation that the recipient
629 acknowledges the provisions of this subsection.
630 (m) To implement ~~develop and recommend~~ a choice counseling
631 system that promotes health literacy and provides information
632 aimed to reduce minority health disparities through outreach
633 activities for Medicaid recipients.
634 (n) To ~~develop and recommend a system for the agency to~~
635 contract with entities to perform choice counseling. The agency
636 may establish standards and performance contracts, including
637 standards requiring the contractor to hire choice counselors who
638 are representative of the state's diverse population and to

639 train choice counselors in working with culturally diverse
640 populations.
641 (o) To implement ~~determine and recommend descriptions of~~
642 ~~the~~ eligibility assignment processes ~~which will be used~~ to
643 facilitate client choice while ensuring pilot programs of
644 adequate enrollment levels. These processes shall ensure that
645 pilot sites have sufficient levels of enrollment to conduct a
646 valid test of the managed care pilot program within a 2-year
647 timeframe.
648 (p) To implement standards for plan compliance, including,
649 but not limited to, quality assurance and performance
650 improvement standards, peer or professional review standards,
651 grievance policies, and program integrity policies.
652 (q) To develop a data reporting system, seek input from
653 managed care plans to establish patient-encounter reporting
654 requirements, and ensure that the data reported is accurate and
655 complete.
656 (r) To work with managed care plans to establish a uniform
657 system to measure and monitor outcomes of a recipient of
658 Medicaid services which shall use financial, clinical, and other
659 criteria based on pharmacy services, medical services, and other
660 data related to the provision of Medicaid services, including,
661 but not limited to:
662 1. Health Plan Employer Data and Information Set (HEDIS)
663 or HEDIS measures specific to Medicaid.
664 2. Member satisfaction.
665 3. Provider satisfaction.
666 4. Report cards on plan performance and best practices.

667 5. Compliance with the prompt payment of claims
668 requirements provided in ss. 627.613, 641.3155, and 641.513.
669 (s) To require managed care plans that have contracted
670 with the agency to establish a quality assurance system that
671 incorporates the provisions of s. 409.912(27) and any standards,
672 rules, and guidelines developed by the agency.
673 (t) To establish a patient-encounter database to compile
674 data on health care services rendered by health care
675 practitioners that provide services to patients enrolled in
676 managed care plans in the demonstration sites. Health care
677 practitioners and facilities in the demonstration sites shall
678 submit, and managed care plans participating in the
679 demonstration sites shall receive, claims payment and any other
680 information reasonably related to the patient-encounter database
681 electronically in a standard format as required by the agency.
682 The agency shall establish reasonable deadlines for phasing in
683 the electronic transmittal of full-encounter data. The patient-
684 encounter database shall:
685 1. Collect the following information, if applicable, for
686 each type of patient encounter with a health care practitioner
687 or facility, including:
688 a. The demographic characteristics of the patient.
689 b. The principal, secondary, and tertiary diagnosis.
690 c. The procedure performed.
691 d. The date when and the location where the procedure was
692 performed.
693 e. The amount of the payment for the procedure.

694 f. The health care practitioner's universal identification
695 number.
696 g. If the health care practitioner rendering the service
697 is a dependent practitioner, the modifiers appropriate to
698 indicate that the service was delivered by the dependent
699 practitioner.
700 2. Collect appropriate information relating to
701 prescription drugs for each type of patient encounter.
702 3. Collect appropriate information related to health care
703 costs and utilization from managed care plans participating in
704 the demonstration sites. To the extent practicable, the agency
705 shall utilize a standardized claim form or electronic transfer
706 system that is used by health care practitioners, facilities,
707 and payors. ~~To develop and recommend a system to monitor the~~
708 ~~provision of health care services in the pilot program,~~
709 ~~including utilization and quality of health care services for~~
710 ~~the purpose of ensuring access to medically necessary services.~~
711 ~~This system shall include an encounter data-information system~~
712 ~~that collects and reports utilization information. The system~~
713 ~~shall include a method for verifying data integrity within the~~
714 ~~database and within the provider's medical records.~~
715 (u) ~~(q)~~ To implement ~~recommend~~ a grievance resolution
716 process for Medicaid recipients enrolled in a capitated managed
717 care network under the pilot program modeled after the
718 subscriber assistance panel, as created in s. 408.7056. This
719 process shall include a mechanism for an expedited review of no
720 greater than 24 hours after notification of a grievance if the

721 life of a Medicaid recipient is in imminent and emergent
722 jeopardy.
723 (v) ~~(r)~~ To implement ~~recommend~~ a grievance resolution
724 process for health care providers employed by or contracted with
725 a capitated managed care network under the pilot program in
726 order to settle disputes among the provider and the managed care
727 network or the provider and the agency.
728 (w) ~~(s)~~ To implement ~~develop and recommend~~ criteria in an
729 approved federal waiver to designate health care providers as
730 eligible to participate in the pilot program. ~~The agency and~~
731 ~~capitated managed care networks must follow national guidelines~~
732 ~~for selecting health care providers, whenever available.~~ These
733 criteria must include at a minimum those criteria specified in
734 s. 409.907.
735 (x) ~~(t)~~ To use ~~develop and recommend~~ health care provider
736 agreements for participation in the pilot program.
737 (y) ~~(u)~~ To require that all health care providers under
738 contract with the pilot program be duly licensed in the state,
739 if such licensure is available, and meet other criteria as may
740 be established by the agency. These criteria shall include at a
741 minimum those criteria specified in s. 409.907.
742 (z) ~~(v)~~ To ensure that managed care organizations work
743 collaboratively ~~develop and recommend agreements~~ with other
744 state or local governmental programs or institutions for the
745 coordination of health care to eligible individuals receiving
746 services from such programs or institutions.

747 (aa) ~~(w)~~ To implement procedures to minimize the risk of
748 Medicaid fraud and abuse in all plans operating in the Medicaid
749 managed care pilot program authorized in this section:
750 1. The agency shall ensure that applicable provisions of
751 chapters 409, 414, 626, 641, and 932, relating to Medicaid fraud
752 and abuse, are applied and enforced at the demonstration sites.
753 2. Providers shall have the necessary certification,
754 license, and credentials required by law and federal waiver.
755 3. The agency shall ensure that the plan is in compliance
756 with the provisions of s. 409.912(21) and (22).
757 4. The agency shall require each plan to establish program
758 integrity functions and activities to reduce the incidence of
759 fraud and abuse. Plans must report instances of fraud and abuse
760 pursuant to chapter 641.
761 5. The plan shall have written administrative and
762 management procedures, including a mandatory compliance plan,
763 that are designed to guard against fraud and abuse. The plan
764 shall designate a compliance officer with sufficient experience
765 in health care.
766 6.a. The agency shall require all managed care plan
767 contractors in the pilot program to report all instances of
768 suspected fraud and abuse. A failure to report instances of
769 suspected fraud and abuse is a violation of law and subject to
770 the penalties provided by law.
771 b. An instance of fraud and abuse in the managed care
772 plan, including, but not limited to, defrauding the state health
773 care benefit program by misrepresentation of fact in reports,
774 claims, certifications, enrollment claims, demographic

775 statistics, and patient-encounter data; misrepresentation of the
776 qualifications of persons rendering health care and ancillary
777 services; bribery and false statements relating to the delivery
778 of health care; unfair and deceptive marketing practices; and
779 managed care false claims actions, is a violation of law and
780 subject to the penalties provided by law.
781 c. The agency shall require all contractors to make all
782 files and relevant billing and claims data accessible to state
783 regulators and investigators and all such data shall be linked
784 into a unified system for seamless reviews and investigations.
785 ~~To develop and recommend a system to oversee the activities of~~
786 ~~pilot program participants, health care providers, capitated~~
787 ~~managed care networks, and their representatives in order to~~
788 ~~prevent fraud or abuse, overutilization or duplicative~~
789 ~~utilization, underutilization or inappropriate denial of~~
790 ~~services, and neglect of participants and to recover~~
791 ~~overpayments as appropriate. For the purposes of this paragraph,~~
792 ~~the terms "abuse" and "fraud" have the meanings as provided in~~
793 ~~s. 409.913. The agency must refer incidents of suspected fraud,~~
794 ~~abuse, overutilization and duplicative utilization, and~~
795 ~~underutilization or inappropriate denial of services to the~~
796 ~~appropriate regulatory agency.~~
797 (bb) ~~(x)~~ To develop and provide actuarial and benefit
798 design analyses that indicate the effect on capitation rates and
799 benefits offered in the pilot program over a prospective 5-year
800 period based on the following assumptions:
801 1. Growth in capitation rates which is limited to the
802 estimated growth rate in general revenue.

803 2. Growth in capitation rates which is limited to the
804 average growth rate over the last 3 years in per-recipient
805 Medicaid expenditures.
806 3. Growth in capitation rates which is limited to the
807 growth rate of aggregate Medicaid expenditures between the 2003-
808 2004 fiscal year and the 2004-2005 fiscal year.
809 (cc) ~~(y)~~ To develop a mechanism to require capitated
810 managed care plans to reimburse qualified emergency service
811 providers, including, but not limited to, ambulance services, in
812 accordance with ss. 409.908 and 409.9128. The pilot program must
813 include a provision for continuing fee-for-service payments for
814 emergency services, including, but not limited to, individuals
815 who access ambulance services or emergency departments and who
816 are subsequently determined to be eligible for Medicaid
817 services.
818 (dd) ~~(z)~~ To ensure ~~develop a system whereby~~ school
819 districts participating in the certified school match program
820 pursuant to ss. 409.908(21) and 1011.70 shall be reimbursed by
821 Medicaid, subject to the limitations of s. 1011.70(1), for a
822 Medicaid-eligible child participating in the services as
823 authorized in s. 1011.70, as provided for in s. 409.9071,
824 regardless of whether the child is enrolled in a capitated
825 managed care network. Capitated managed care networks must make
826 a good faith effort to execute agreements with school districts
827 regarding the coordinated provision of services authorized under
828 s. 1011.70. County health departments delivering school-based
829 services pursuant to ss. 381.0056 and 381.0057 must be
830 reimbursed by Medicaid for the federal share for a Medicaid-

831 eligible child who receives Medicaid-covered services in a
832 school setting, regardless of whether the child is enrolled in a
833 capitated managed care network. Capitated managed care networks
834 must make a good faith effort to execute agreements with county
835 health departments regarding the coordinated provision of
836 services to a Medicaid-eligible child. To ensure continuity of
837 care for Medicaid patients, the agency, the Department of
838 Health, and the Department of Education shall develop procedures
839 for ensuring that a student's capitated managed care network
840 provider receives information relating to services provided in
841 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
842 (ee) ~~(aa)~~ To implement ~~develop and recommend~~ a mechanism
843 whereby Medicaid recipients who are already enrolled in a
844 managed care plan or the MediPass program in the pilot areas
845 shall be offered the opportunity to change to capitated managed
846 care plans on a staggered basis, as defined by the agency. All
847 Medicaid recipients shall have 30 days in which to make a choice
848 of capitated managed care plans. Those Medicaid recipients who
849 do not make a choice shall be assigned to a capitated managed
850 care plan in accordance with paragraph (4)(a) and shall be
851 exempt from s. 409.9122. To facilitate continuity of care for a
852 Medicaid recipient who is also a recipient of Supplemental
853 Security Income (SSI), prior to assigning the SSI recipient to a
854 capitated managed care plan, the agency shall determine whether
855 the SSI recipient has an ongoing relationship with a provider or
856 capitated managed care plan, and, if so, the agency shall assign
857 the SSI recipient to that provider or capitated managed care
858 plan where feasible. Those SSI recipients who do not have such a

859 provider relationship shall be assigned to a capitated managed
860 care plan provider in accordance with paragraph (4)(a) and shall
861 be exempt from s. 409.9122.
862 (ff) ~~(bb)~~ To develop and recommend a service delivery
863 alternative for children having chronic medical conditions which
864 establishes a medical home project to provide primary care
865 services to this population. The project shall provide
866 community-based primary care services that are integrated with
867 other subspecialties to meet the medical, developmental, and
868 emotional needs for children and their families. This project
869 shall include an evaluation component to determine impacts on
870 hospitalizations, length of stays, emergency room visits, costs,
871 and access to care, including specialty care and patient and
872 family satisfaction.
873 (gg) ~~(cc)~~ To develop and recommend service delivery
874 mechanisms within capitated managed care plans to provide
875 Medicaid services as specified in ss. 409.905 and 409.906 to
876 persons with developmental disabilities sufficient to meet the
877 medical, developmental, and emotional needs of these persons.
878 (hh) ~~(dd)~~ To develop and recommend service delivery
879 mechanisms within capitated managed care plans to provide
880 Medicaid services as specified in ss. 409.905 and 409.906 to
881 Medicaid-eligible children in foster care. These services must
882 be coordinated with community-based care providers as specified
883 in s. 409.1675, where available, and be sufficient to meet the
884 medical, developmental, and emotional needs of these children.
885 (4)(a) A Medicaid recipient in the pilot area who is not
886 currently enrolled in a capitated managed care plan upon

887 implementation is not eligible for services as specified in ss.
888 409.905 and 409.906, for the amount of time that the recipient
889 does not enroll in a capitated managed care network. If a
890 Medicaid recipient has not enrolled in a capitated managed care
891 plan within 30 days after eligibility, the agency shall assign
892 the Medicaid recipient to a capitated managed care plan based on
893 the assessed needs of the recipient as determined by the agency
894 and shall be exempt from s. 409.9122. When making assignments,
895 the agency shall take into account the following criteria:
896 1. A capitated managed care network has sufficient network
897 capacity to meet the needs of members.
898 2. The capitated managed care network has previously
899 enrolled the recipient as a member, or one of the capitated
900 managed care network's primary care providers has previously
901 provided health care to the recipient.
902 3. The agency has knowledge that the member has previously
903 expressed a preference for a particular capitated managed care
904 network as indicated by Medicaid fee-for-service claims data,
905 but has failed to make a choice.
906 4. The capitated managed care network's primary care
907 providers are geographically accessible to the recipient's
908 residence.
909 (b) When more than one capitated managed care network
910 provider meets the criteria specified in paragraph (3)(h), the
911 agency shall make recipient assignments consecutively by family
912 unit.
913 (c) If a recipient is currently enrolled with a Medicaid
914 managed care organization that also operates an approved reform

915 plan within a pilot area and the recipient fails to choose a
916 plan during the reform enrollment process or during
917 redetermination of eligibility, the recipient shall be
918 automatically assigned by the agency into the most appropriate
919 reform plan operated by the recipient's current Medicaid managed
920 care organization. If the recipient's current managed care
921 organization does not operate a reform plan in the pilot area
922 that adequately meets the needs of the Medicaid recipient, the
923 agency shall use the auto assignment process as prescribed in
924 the Centers for Medicare and Medicaid Services Special Terms and
925 Conditions number 11-W-00206/4. All agency enrollment and choice
926 counseling materials shall communicate the provisions of this
927 paragraph to current managed care recipients.
928 (d) ~~(c)~~ The agency may not engage in practices that are
929 designed to favor one capitated managed care plan over another
930 or that are designed to influence Medicaid recipients to enroll
931 in a particular capitated managed care network in order to
932 strengthen its particular fiscal viability.
933 (e) ~~(d)~~ After a recipient has made a selection or has been
934 enrolled in a capitated managed care network, the recipient
935 shall have 90 days in which to voluntarily disenroll and select
936 another capitated managed care network. After 90 days, no
937 further changes may be made except for cause. Cause shall
938 include, but not be limited to, poor quality of care, lack of
939 access to necessary specialty services, an unreasonable delay or
940 denial of service, inordinate or inappropriate changes of
941 primary care providers, service access impairments due to
942 significant changes in the geographic location of services, or

943 fraudulent enrollment. The agency may require a recipient to use
944 the capitated managed care network's grievance process as
945 specified in paragraph (3)(g) prior to the agency's
946 determination of cause, except in cases in which immediate risk
947 of permanent damage to the recipient's health is alleged. The
948 grievance process, when used, must be completed in time to
949 permit the recipient to disenroll no later than the first day of
950 the second month after the month the disenrollment request was
951 made. If the capitated managed care network, as a result of the
952 grievance process, approves an enrollee's request to disenroll,
953 the agency is not required to make a determination in the case.
954 The agency must make a determination and take final action on a
955 recipient's request so that disenrollment occurs no later than
956 the first day of the second month after the month the request
957 was made. If the agency fails to act within the specified
958 timeframe, the recipient's request to disenroll is deemed to be
959 approved as of the date agency action was required. Recipients
960 who disagree with the agency's finding that cause does not exist
961 for disenrollment shall be advised of their right to pursue a
962 Medicaid fair hearing to dispute the agency's finding.
963 (f) ~~(e)~~ The agency shall apply for federal waivers from the
964 Centers for Medicare and Medicaid Services to lock eligible
965 Medicaid recipients into a capitated managed care network for 12
966 months after an open enrollment period. After 12 months of
967 enrollment, a recipient may select another capitated managed
968 care network. However, nothing shall prevent a Medicaid
969 recipient from changing primary care providers within the
970 capitated managed care network during the 12-month period.

971 (g) ~~(f)~~ The agency shall apply for federal waivers from the
972 Centers for Medicare and Medicaid Services to allow recipients
973 to purchase health care coverage through an employer-sponsored
974 health insurance plan instead of through a Medicaid-certified
975 plan. This provision shall be known as the opt-out option.
976 1. A recipient who chooses the Medicaid opt-out option
977 shall have an opportunity for a specified period of time, as
978 authorized under a waiver granted by the Centers for Medicare
979 and Medicaid Services, to select and enroll in a Medicaid-
980 certified plan. If the recipient remains in the employer-
981 sponsored plan after the specified period, the recipient shall
982 remain in the opt-out program for at least 1 year or until the
983 recipient no longer has access to employer-sponsored coverage,
984 until the employer's open enrollment period for a person who
985 opts out in order to participate in employer-sponsored coverage,
986 or until the person is no longer eligible for Medicaid,
987 whichever time period is shorter.
988 2. Notwithstanding any other provision of this section,
989 coverage, cost sharing, and any other component of employer-
990 sponsored health insurance shall be governed by applicable state
991 and federal laws.
992 ~~(5) This section does not authorize the agency to~~
993 ~~implement any provision of s. 1115 of the Social Security Act~~
994 ~~experimental, pilot, or demonstration project waiver to reform~~
995 ~~the state Medicaid program in any part of the state other than~~
996 ~~the two geographic areas specified in this section unless~~
997 ~~approved by the Legislature.~~

998 (5) ~~(6)~~ The agency shall develop and submit for approval
999 applications for waivers of applicable federal laws and
1000 regulations as necessary to implement the managed care pilot
1001 project as defined in this section. The agency shall post all
1002 waiver applications under this section on its Internet website
1003 30 days before submitting the applications to the United States
1004 Centers for Medicare and Medicaid Services. All waiver
1005 applications shall be provided for review and comment to the
1006 appropriate committees of the Senate and House of
1007 Representatives for at least 10 working days prior to
1008 submission. All waivers submitted to and approved by the United
1009 States Centers for Medicare and Medicaid Services under this
1010 section must be approved by the Legislature. Federally approved
1011 waivers must be submitted to the President of the Senate and the
1012 Speaker of the House of Representatives for referral to the
1013 appropriate legislative committees. The appropriate committees
1014 shall recommend whether to approve the implementation of any
1015 waivers to the Legislature as a whole. The agency shall submit a
1016 plan containing a recommended timeline for implementation of any
1017 waivers and budgetary projections of the effect of the pilot
1018 program under this section on the total Medicaid budget for the
1019 2006-2007 through 2009-2010 state fiscal years. This
1020 implementation plan shall be submitted to the President of the
1021 Senate and the Speaker of the House of Representatives at the
1022 same time any waivers are submitted for consideration by the
1023 Legislature. The agency is authorized to implement the waiver
1024 and Centers for Medicare and Medicaid Services Special Terms and
1025 Conditions number 11-W-00206/4. If the agency seeks approval by

1026 the Federal Government of any modifications to these special
1027 terms and conditions, the agency shall provide written
1028 notification of its intent to modify these terms and conditions
1029 to the President of the Senate and Speaker of the House of
1030 Representatives at least 15 days prior to submitting the
1031 modifications to the Federal Government for consideration. The
1032 notification shall identify all modifications being pursued and
1033 the reason they are needed. Upon receiving federal approval of
1034 any modifications to the special terms and conditions, the
1035 agency shall report to the Legislature describing the federally
1036 approved modifications to the special terms and conditions
1037 within 7 days after their approval by the Federal Government.
1038 (6) ~~(7)~~ Upon review and approval of the applications for
1039 waivers of applicable federal laws and regulations to implement
1040 the managed care pilot program by the Legislature, the agency
1041 may initiate adoption of rules pursuant to ss. 120.536(1) and
1042 120.54 to implement and administer the managed care pilot
1043 program as provided in this section.
1044 (7) The Office of Insurance Regulation shall conduct an
1045 annual review of the Medicaid managed care pilot program's risk-
1046 adjusted rate setting methodology as developed by the agency.
1047 The Office of Insurance Regulation shall contract with an
1048 independent actuary firm to assist in the annual review and to
1049 provide technical expertise.
1050 (a) After reviewing the actuarial analysis provided by the
1051 agency, the Office of Insurance Regulation shall make advisory
1052 recommendations to the Governor and the Legislature regarding:

1053 1. The methodology adopted by the agency for risk-adjusted
1054 rates.
1055 2. Alternative rate options based on the agency's
1056 methodology.
1057 3. The risk-adjusted rate for each Medicaid eligibility
1058 category in the demonstration program.
1059 4. Administrative and implementation issues regarding the
1060 use of risk-adjusted rates, including, but not limited to, cost,
1061 simplicity, client privacy, data accuracy, and data exchange.
1062 (b) For each annual review, the Office of Insurance
1063 Regulation shall solicit input concerning the agency's rate
1064 setting methodology from the Florida Association of Health
1065 Plans, the Florida Hospital Association, the Florida Medical
1066 Association, Medicaid recipient advocacy groups, and other
1067 stakeholder representatives as necessary to obtain a broad
1068 representation of perspectives on the effects of the agency's
1069 adopted rate setting methodology and recommendations on possible
1070 modifications to the methodology.
1071 (c) The Office of Insurance Regulation shall submit its
1072 findings and advisory recommendations to the Governor and the
1073 Legislature no later than February 1 of each year for
1074 consideration by the Legislature for inclusion in the General
1075 Appropriations Act.
1076 (8) For purposes of this section, the term "capitated
1077 managed care plan" includes health insurers authorized under
1078 chapter 624, exclusive provider organizations authorized under
1079 chapter 627, health maintenance organizations authorized under
1080 chapter 641, and provider service networks that elect to be paid

1081 fee-for-service for up to 3 years as authorized under this
1082 section.
1083 Section 5. Section 409.91212, Florida Statutes, is created
1084 to read:
1085 409.91212 Medicaid reform demonstration program
1086 expansion.--
1087 (1) The agency may expand the Medicaid reform
1088 demonstration program pursuant to s. 409.91211 into any county
1089 of the state beginning in year two of the demonstration program
1090 if readiness criteria are met, the Joint Legislative Committee
1091 on Medicaid Reform Implementation has submitted a recommendation
1092 pursuant to s. 11.72 regarding the extent to which the criteria
1093 have been met, and the agency has secured budget approval from
1094 the Legislative Budget Commission pursuant to s. 11.90. For the
1095 purpose of this section, the term "readiness" means there is
1096 evidence that at least two programs in a county meet the
1097 following criteria:
1098 (a) Demonstrate knowledge and understanding of managed
1099 care under the framework of Medicaid reform.
1100 (b) Demonstrate financial capability to meet solvency
1101 standards.
1102 (c) Demonstrate adequate controls and process for
1103 financial management.
1104 (d) Demonstrate the capability for clinical management of
1105 Medicaid recipients.
1106 (e) Demonstrate the adequacy, capacity, and accessibility
1107 of the services network.
1108 (f) Demonstrate the capability to operate a management

1109 information system and an encounter data system.
1110 (g) Demonstrate capability to implement quality assurance
1111 and utilization management activities.
1112 (h) Demonstrate capability to implement fraud control
1113 activities.
1114 (2) The agency shall conduct meetings and public hearings
1115 in the targeted expansion county with the public and provider
1116 community. The agency shall provide notice regarding public
1117 hearings. The agency shall maintain records of the proceedings.
1118 (3) The agency shall provide a 30-day notice of intent to
1119 expand the demonstration program with supporting documentation
1120 that the readiness criteria has been met to the President of the
1121 Senate, the Speaker of the House of Representatives, the
1122 Minority Leader of the Senate, the Minority Leader of the House
1123 of Representatives, and the Office of Program Policy Analysis
1124 and Government Accountability.
1125 (4) The agency shall request a hearing and consideration
1126 by the Joint Legislative Committee on Medicaid Reform
1127 Implementation after the 30-day notice required in subsection
1128 (3) has expired in the form of a letter to the chair of the
1129 committee.
1130 (5) Upon receiving a memorandum from the Joint Legislative
1131 Committee on Medicaid Reform Implementation regarding the extent
1132 to which the expansion criteria pursuant to subsection (1) have
1133 been met, the agency may submit a budget amendment, pursuant to
1134 chapter 216, to request the necessary budget transfers
1135 associated with the expansion of the demonstration program.

1136 Section 6. Subsections (8) through (14) of section
1137 409.9122, Florida Statutes, are renumbered as subsections (7)
1138 through (13), respectively, and paragraphs (e), (f), (g), (h),
1139 (k), and (l) of subsection (2) and present subsection (7) of
1140 that section are amended to read:
1141 409.9122 Mandatory Medicaid managed care enrollment;
1142 programs and procedures.--
1143 (2)
1144 (e) ~~Medicaid recipients who are already enrolled in a~~
1145 ~~managed care plan or MediPass shall be offered the opportunity~~
1146 ~~to change managed care plans or MediPass providers on a~~
1147 ~~staggered basis, as defined by the agency.~~ All Medicaid
1148 recipients shall have 30 days in which to make a choice of
1149 managed care plans or MediPass providers. ~~Those Medicaid~~
1150 ~~recipients who do not make a choice shall be assigned to a~~
1151 ~~managed care plan or MediPass in accordance with paragraph (f).~~
1152 ~~To facilitate continuity of care, for a Medicaid recipient who~~
1153 ~~is also a recipient of Supplemental Security Income (SSI), prior~~
1154 ~~to assigning the SSI recipient to a managed care plan or~~
1155 ~~MediPass, the agency shall determine whether the SSI recipient~~
1156 ~~has an ongoing relationship with a MediPass provider or managed~~
1157 ~~care plan, and if so, the agency shall assign the SSI recipient~~
1158 ~~to that MediPass provider or managed care plan. Those SSI~~
1159 ~~recipients who do not have such a provider relationship shall be~~
1160 ~~assigned to a managed care plan or MediPass provider in~~
1161 ~~accordance with paragraph (f).~~
1162 (f) When a Medicaid recipient does not choose a managed
1163 care plan or MediPass provider, the agency shall assign the

1164 Medicaid recipient to a managed care plan ~~or MediPass provider~~.
1165 Medicaid recipients who are subject to mandatory assignment but
1166 who fail to make a choice shall be assigned to managed care
1167 plans ~~until an enrollment of 40 percent in MediPass and 60~~
1168 ~~percent in managed care plans is achieved~~. ~~Once this enrollment~~
1169 ~~is achieved, the assignments shall be divided in order to~~
1170 ~~maintain an enrollment in MediPass and managed care plans which~~
1171 ~~is in a 40 percent and 60 percent proportion, respectively.~~
1172 ~~Thereafter, assignment of Medicaid recipients who fail to make a~~
1173 ~~choice shall be based proportionally on the preferences of~~
1174 ~~recipients who have made a choice in the previous period. Such~~
1175 ~~proportions shall be revised at least quarterly to reflect an~~
1176 ~~update of the preferences of Medicaid recipients. The agency~~
1177 ~~shall disproportionately assign Medicaid-eligible recipients who~~
1178 ~~are required to but have failed to make a choice of managed care~~
1179 ~~plan or MediPass, including children, and who are to be assigned~~
1180 ~~to the MediPass program to children's networks as described in~~
1181 ~~s. 409.912(4)(g), Children's Medical Services Network as defined~~
1182 ~~in s. 391.021, exclusive provider organizations, provider~~
1183 ~~service networks, minority physician networks, and pediatric~~
1184 ~~emergency department diversion programs authorized by this~~
1185 ~~chapter or the General Appropriations Act, in such manner as the~~
1186 ~~agency deems appropriate, until the agency has determined that~~
1187 ~~the networks and programs have sufficient numbers to be~~
1188 ~~economically operated.~~ For purposes of this paragraph, when
1189 referring to assignment, the term "managed care plans" includes
1190 health maintenance organizations, exclusive provider
1191 organizations, provider service networks, minority physician

1192 networks, Children's Medical Services Network, and pediatric
1193 emergency department diversion programs authorized by this
1194 chapter or the General Appropriations Act. When making
1195 assignments, the agency shall take into account the following
1196 criteria:
1197 1. A managed care plan has sufficient network capacity to
1198 meet the need of members.
1199 2. The managed care plan ~~or MediPass~~ has previously
1200 enrolled the recipient as a member, or one of the managed care
1201 plan's primary care providers ~~or MediPass providers~~ has
1202 previously provided health care to the recipient.
1203 3. The agency has knowledge that the member has previously
1204 expressed a preference for a particular managed care plan or
1205 MediPass provider as indicated by Medicaid fee-for-service
1206 claims data, but has failed to make a choice.
1207 4. The managed care plan is ~~plan's or MediPass primary~~
1208 ~~care providers are~~ geographically accessible to the recipient's
1209 residence.
1210 5. The agency has authority to make mandatory assignments
1211 based on quality of service and performance of managed care
1212 plans.
1213 (g) When more than one managed care plan ~~or MediPass~~
1214 ~~provider~~ meets the criteria specified in paragraph (f), the
1215 agency shall make recipient assignments consecutively by family
1216 unit.
1217 (h) The agency may not engage in practices that are
1218 designed to favor one managed care plan over another ~~or that are~~
1219 ~~designed to influence Medicaid recipients to enroll in MediPass~~

1220 ~~rather than in a managed care plan or to enroll in a managed~~
1221 ~~care plan rather than in MediPass~~. This subsection does not
1222 prohibit the agency from reporting on the performance of
1223 MediPass or any managed care plan, as measured by performance
1224 criteria developed by the agency.
1225 ~~(k) When a Medicaid recipient does not choose a managed~~
1226 ~~care plan or MediPass provider, the agency shall assign the~~
1227 ~~Medicaid recipient to a managed care plan, except in those~~
1228 ~~counties in which there are fewer than two managed care plans~~
1229 ~~accepting Medicaid enrollees, in which case assignment shall be~~
1230 ~~to a managed care plan or a MediPass provider. Medicaid~~
1231 ~~recipients in counties with fewer than two managed care plans~~
1232 ~~accepting Medicaid enrollees who are subject to mandatory~~
1233 ~~assignment but who fail to make a choice shall be assigned to~~
1234 ~~managed care plans until an enrollment of 40 percent in MediPass~~
1235 ~~and 60 percent in managed care plans is achieved. Once that~~
1236 ~~enrollment is achieved, the assignments shall be divided in~~
1237 ~~order to maintain an enrollment in MediPass and managed care~~
1238 ~~plans which is in a 40 percent and 60 percent proportion,~~
1239 ~~respectively. In service areas 1 and 6 of the Agency for Health~~
1240 ~~Care Administration where the agency is contracting for the~~
1241 ~~provision of comprehensive behavioral health services through a~~
1242 ~~capitated prepaid arrangement, recipients who fail to make a~~
1243 ~~choice shall be assigned equally to MediPass or a managed care~~
1244 ~~plan. For purposes of this paragraph, when referring to~~
1245 ~~assignment, the term "managed care plans" includes exclusive~~
1246 ~~provider organizations, provider service networks, Children's~~
1247 ~~Medical Services Network, minority physician networks, and~~

1248 ~~pediatric emergency department diversion programs authorized by~~
1249 ~~this chapter or the General Appropriations Act. When making~~
1250 ~~assignments, the agency shall take into account the following~~
1251 ~~criteria:~~
1252 ~~1. A managed care plan has sufficient network capacity to~~
1253 ~~meet the need of members.~~
1254 ~~2. The managed care plan or MediPass has previously~~
1255 ~~enrolled the recipient as a member, or one of the managed care~~
1256 ~~plan's primary care providers or MediPass providers has~~
1257 ~~previously provided health care to the recipient.~~
1258 ~~3. The agency has knowledge that the member has previously~~
1259 ~~expressed a preference for a particular managed care plan or~~
1260 ~~MediPass provider as indicated by Medicaid fee-for-service~~
1261 ~~claims data, but has failed to make a choice.~~
1262 ~~4. The managed care plan's or MediPass primary care~~
1263 ~~providers are geographically accessible to the recipient's~~
1264 ~~residence.~~
1265 ~~5. The agency has authority to make mandatory assignments~~
1266 ~~based on quality of service and performance of managed care~~
1267 ~~plans.~~
1268 (k)~~(l)~~ Notwithstanding the provisions of chapter 287, the
1269 agency may, at its discretion, renew cost-effective contracts
1270 for choice counseling services once or more for such periods as
1271 the agency may decide. However, all such renewals may not
1272 combine to exceed a total period longer than the term of the
1273 original contract.

1274 ~~(7) The agency shall investigate the feasibility of~~
1275 ~~developing managed care plan and MediPass options for the~~
1276 ~~following groups of Medicaid recipients:~~
1277 ~~(a) Pregnant women and infants.~~
1278 ~~(b) Elderly and disabled recipients, especially those who~~
1279 ~~are at risk of nursing home placement.~~
1280 ~~(c) Persons with developmental disabilities.~~
1281 ~~(d) Qualified Medicare beneficiaries.~~
1282 ~~(e) Adults who have chronic, high-cost medical conditions.~~
1283 ~~(f) Adults and children who have mental health problems.~~
1284 ~~(g) Other recipients for whom managed care plans and~~
1285 ~~MediPass offer the opportunity of more cost-effective care and~~
1286 ~~greater access to qualified providers.~~
1287 Section 7. The Agency for Health Care Administration shall
1288 report to the Legislature by April 1, 2006, the specific
1289 preimplementation milestones required by the Centers for
1290 Medicare and Medicaid Services Special Terms and Conditions
1291 related to the low income pool that have been approved by the
1292 Federal Government and the status of any remaining
1293 preimplementation milestones that have not been approved by the
1294 Federal Government.
1295 Section 8. Quarterly progress and annual reports.--The
1296 Agency for Health Care Administration shall submit to the
1297 Governor, the President of the Senate, the Speaker of the House
1298 of Representatives, the Minority Leader of the Senate, the
1299 Minority Leader of the House of Representatives, and the Office
1300 of Program Policy Analysis and Government Accountability the
1301 following reports:

1302 (1) Quarterly progress reports submitted to Centers for
1303 Medicare and Medicaid Services no later than 60 days following
1304 the end of each quarter. These reports shall present the
1305 agency's analysis and the status of various operational areas.
1306 The quarterly progress reports shall include, but are not
1307 limited to, the following:
1308 (a) Documentation of events that occurred during the
1309 quarter or that are anticipated to occur in the near future that
1310 affect health care delivery, including, but not limited to, the
1311 approval of contracts with new managed care plans, the
1312 procedures for designating coverage areas, the process of
1313 phasing in managed care, a description of the populations served
1314 and the benefits provided, the number of recipients enrolled, a
1315 list of grievances submitted by enrollees, and other operational
1316 issues.
1317 (b) Action plans for addressing policy and administrative
1318 issues.
1319 (c) Documentation of agency efforts related to the
1320 collection and verification of encounter and utilization data.
1321 (d) Enrollment data for each managed care plan according
1322 to the following specifications: total number of enrollees,
1323 eligibility category, number of enrollees receiving Temporary
1324 Assistance for Needy Families or Supplemental Security Income,
1325 market share, and percentage change in enrollment. In addition,
1326 the agency shall provide a summary of voluntary and mandatory
1327 selection rates and disenrollment data. Enrollment data, number
1328 of members by month, and expenditures shall be submitted in the
1329 format for monitoring budget neutrality provided by the Centers

1330 for Medicare and Medicaid Services.
1331 (e) Documentation of low income pool activities and
1332 associated expenditures.
1333 (f) Documentation of activities related to the
1334 implementation of choice counseling including efforts to improve
1335 health literacy and the methods used to obtain public input
1336 including recipient focus groups.
1337 (g) Participation rates in the Enhanced Benefit Accounts
1338 Program, as established in the Centers for Medicare and Medicaid
1339 Services Special Terms and Conditions number 11-W-00206/4, which
1340 shall include: participation levels, summary of activities and
1341 associated expenditures, number of accounts established
1342 including active participants and individuals who continue to
1343 retain access to funds in an account but no longer actively
1344 participate, estimated quarterly deposits in accounts, and
1345 expenditures from the accounts.
1346 (h) Enrollment data on employer-sponsored insurance that
1347 documents the number of individuals selecting to opt out when
1348 employer-sponsored insurance is available. The agency shall
1349 include data that identifies enrollee characteristics to include
1350 eligibility category, type of employer-sponsored insurance, and
1351 type of coverage based on whether the coverage is for the
1352 individual or the family. The agency shall develop and maintain
1353 disenrollment reports specifying the reason for disenrolling in
1354 an employer-sponsored insurance program. The agency shall also
1355 track and report on those enrollees who elect to reenroll in the
1356 Medicaid reform waiver demonstration program.
1357 (i) Documentation of progress toward the demonstration

1358 program goals.
1359 (j) Documentation of evaluation activities.
1360 (2) The annual report shall document accomplishments,
1361 program status, quantitative and case study findings,
1362 utilization data, and policy and administrative difficulties in
1363 the operation of the Medicaid reform waiver demonstration
1364 program. The agency shall submit the draft annual report no
1365 later than October 1 after the end of each fiscal year.
1366 (a) Beginning with the annual report for demonstration
1367 program year two, the agency shall include a section on the
1368 administration of enhanced benefit accounts, participation
1369 rates, an assessment of expenditures, and potential cost
1370 savings.
1371 (b) Beginning with the annual report for demonstration
1372 program year four, the agency shall include a section that
1373 provides qualitative and quantitative data that describes the
1374 impact of the low income pool on the number of uninsured persons
1375 in the state from the start of the implementation of the
1376 demonstration program.
1377 Section 9. Section 11.72, Florida Statutes, is created to
1378 read:
1379 11.72 Joint Legislative Committee on Medicaid Reform
1380 Implementation; creation; membership; powers; duties.--
1381 (1) There is created a standing joint committee of the
1382 Legislature designated the Joint Legislative Committee on
1383 Medicaid Reform Implementation for the purpose of reviewing
1384 policy issues related to expansion of the Medicaid managed care
1385 pilot program pursuant to s. 409.91211.

1386 (2) The Joint Legislative Committee on Medicaid Reform
1387 Implementation shall be composed of eight members appointed as
1388 follows: four members of the House of Representatives appointed
1389 by the Speaker of the House of Representatives, one of whom
1390 shall be a member of the minority party; and four members of the
1391 Senate appointed by the President of the Senate, one of whom
1392 shall be a member of the minority party. The President of the
1393 Senate shall appoint the chair in even-numbered years and the
1394 vice chair in odd-numbered years, and the Speaker of the House
1395 of Representatives shall appoint the chair in odd-numbered years
1396 and the vice chair in even-numbered years from among the
1397 committee membership. Vacancies shall be filled in the same
1398 manner as the original appointment. Members shall serve without
1399 compensation, except that members are entitled to reimbursement
1400 for per diem and travel expenses in accordance with s. 112.061.
1401 (3) The committee shall be governed by joint rules of the
1402 Senate and the House of Representatives which shall remain in
1403 effect until repealed or amended by concurrent resolution.
1404 (4) The committee shall meet at the call of the chair. The
1405 committee may hold hearings on matters within its purview which
1406 are in the public interest. A quorum shall consist of a majority
1407 of members from each house, plus one additional member from
1408 either house. Action by the committee requires a majority vote
1409 of the members present of each house.
1410 (5) The committee shall be jointly staffed by the
1411 appropriations and substantive committees of the House of
1412 Representatives and the Senate. During even-numbered years the

1413 Senate shall serve as lead staff and during odd-numbered years
1414 the House of Representatives shall serve as lead staff.
1415 (6) The committee shall:
1416 (a) Review reports, public hearing proceedings, documents,
1417 and materials provided by the Agency for Health Care
1418 Administration relating to the expansion of the Medicaid managed
1419 care pilot program to other counties of the state pursuant to s.
1420 409.91212.
1421 (b) Consult with the substantive and fiscal committees of
1422 the House of Representatives and the Senate which have
1423 jurisdiction over the Medicaid matters relating to agency action
1424 to expand the Medicaid managed care pilot program.
1425 (c) Meet to consider and make a recommendation regarding
1426 the extent to which the expansion criteria pursuant to s.
1427 409.91212 have been met.
1428 (7) Within 2 days after meeting, during which the
1429 committee reviewed documents, material, and testimony related to
1430 the expansion criteria, the committee shall submit a memorandum
1431 to the Speaker of the House of Representatives, the President of
1432 the Senate, the Legislative Budget Commission, and the agency
1433 delineating the extent to which the agency met the expansion
1434 criteria.
1435 Section 10. It is the intent of the Legislature that if
1436 any conflict exists between the provisions contained in s.
1437 409.91211, Florida Statutes, and other provisions of chapter
1438 409, Florida Statutes, as they relate to implementation of the
1439 Medicaid managed care pilot program, the provisions contained in
1440 s. 409.91211, Florida Statutes, shall control. The Agency for

1441 Health Care Administration shall provide a written report to the
1442 President of the Senate and the Speaker of the House of
1443 Representatives by April 1, 2006, identifying any provisions of
1444 chapter 409, Florida Statutes, that conflict with the
1445 implementation of the Medicaid managed care pilot program as
1446 created in s. 409.91211, Florida Statutes. After April 1, 2006,
1447 the agency shall provide a written report to the President of
1448 the Senate and the Speaker of the House of Representatives
1449 immediately upon identifying any provisions of chapter 409,
1450 Florida Statutes, that conflict with the implementation of the
1451 Medicaid managed care pilot program as created in s. 409.91211,
1452 Florida Statutes.
1453 Section 11. Section 216.346, Florida Statutes, is amended
1454 to read:
1455 216.346 Contracts between state agencies; restriction on
1456 overhead or other indirect costs.--In any contract between state
1457 agencies, including any contract involving the State University
1458 System or the Florida Community College System, the agency
1459 receiving the contract or grant moneys shall charge no more than
1460 a reasonable percentage ~~5 percent~~ of the total cost of the
1461 contract or grant for overhead or indirect costs or any other
1462 costs not required for the payment of direct costs. This
1463 provision is not intended to limit an agency's ability to
1464 certify matching funds or designate in-kind contributions which
1465 will allow the drawdown of federal Medicaid dollars that do not
1466 affect state budgeting.
1467 Section 12. One full-time equivalent position is
1468 authorized and the sum of $250,000 is appropriated for fiscal

1469 year 2006-2007 from the General Revenue Fund to the Office of
1470 Insurance Regulation of the Financial Services Commission to
1471 fund the annual review of the Medicaid managed care pilot
1472 program's risk-adjusted rate setting methodology.
1473 Section 13. This act shall take effect upon becoming a
1474 law.

Health Care Regulation Committee

(Addendum)

Monday, December 5, 2005
2:00 - 4:45 PM
212 Knott Building

Allan G. Bense
Speaker

Rene Garcia
Chair

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 3B**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Garcia offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 1044-1076 and insert:
6 (7)(a) The Office of Insurance Regulation shall provide
7 ongoing guidance to the agency in the implementation of risk
8 adjusted rates. Beginning on the effective date of this act, the
9 Office of Insurance Regulation shall make advisory
10 recommendations to the agency regarding the following items:
11 1. The methodology adopted by the agency for risk-adjusted
12 rates, including any suggestions to improve upon the predictive
13 value of the system.
14 2. Alternative options based on the agency's methodology.
15 3. The risk-adjusted rate for each Medicaid eligibility
16 category in the demonstration program.
17 4. Administrative and implementation issues regarding the
18 use of risk-adjusted rates, including, but not limited to, cost,
19 simplicity, client privacy, data accuracy, and date exchange.
20 5. The appropriateness of phasing in risk-adjusted rates.

21 (b) As a part of this process, the Office of Insurance
22 Regulation shall contract with an independent actuary firm to
23 assist in the annual review and to provide technical expertise.
24 (c) As a part of this process, the agency shall solicit
25 input concerning the agency's rate setting methodology from the
26 Florida Association of Health Plans, the Florida Hospital
27 Association, the Florida Medical Association, Medicaid recipient
28 advocacy groups, and other stakeholder representatives as
29 necessary to obtain a broad representation of perspectives on
30 the effects of the agency's adopted rate setting methodology and
31 recommendations on possible modifications to the methodology.
32 (d) The Office of Insurance Regulation shall submit a
33 report of its findings and advisory recommendations to the
34 Governor and the Legislature prior to the implementation of
35 risk-adjusted rates on July 1, 2006 and annually thereafter no
36 later than February 1 of each year for consideration by the
37 Legislature for inclusion in the General Appropriations Act.
38 (8) Other provisions of law to the contrary
39 notwithstanding, adjustments to risk-adjusted capitation rates
40 shall be implemented through rules of the agency, as required by
41 s. 409.9124, based upon the recommendation of the committee.
42 (9) The capitation rates for plans participating under s.
43 409.91211 shall be phased in as follows:
44 (a) In the first year shall be weighted so that 75 percent
45 of each capitation rate is based on the current methodology and
46 25 percent is based upon a new risk-adjusted capitation rate
47 methodology.
48 (b) In the second year, the capitation rates shall be
49 weighted so that 50 percent of each capitation rate is based

50 upon the current methodology and 50 percent is based upon a new
51 risk-adjusted rate methodology.
52 (c) In the third year, the capitation rates shall be
53 weighted so that 25 percent of each capitation rate is based
54 upon the current methodology and 75 percent is based upon a new
55 risk-adjusted capitation rate methodology.
56 (d) In the following fiscal year, the risk-adjusted
57 capitation methodology may be fully implemented.
58 (10) The agency must ensure the following when using a
59 risk-adjustment rate methodology in whole or part:
60 (a) The agency's total annual payment shall be based on
61 each managed care plan's own aggregate risk score, except that
62 in no case shall the aggregate risk score of any managed care
63 plan in an area vary by more than 10 percent from the aggregate
64 weighted mean of all managed care plans providing comprehensive
65 benefits to TANF and SSI recipients in that area. The agency's
66 total annual payment to a managed care plan shall be based on
67 such revised aggregate risk score.
68 (b) After any adjustments required pursuant to paragraph
69 (a), the aggregate payments calculated to be made to managed
70 care plans on behalf of enrollees in any pilot area must be no
71 less that what the aggregate payments would have been using the
72 current rate methodology pursuant to s. 409.9124. If the agency
73 determines that such aggregate payments under the risk-adjusted
74 methodology will be lower than the aggregate payments that the
75 plans would have been paid using the current rate methodology
76 pursuant to s. 409.9124, supplemental payments shall be made to
77 managed care plans such that the proportion of overall revenue
78 remains the same on an aggregate basis per plan. Such

79 supplemental payments shall be made to bring total payments up
80 to the amount that would have been paid pursuant to s. 409.9124.
81 (11) Prior to the implementation of risk-adjusted
82 capitation rates, the rates shall be certified by an actuary and
83 approved by the Centers for Medicare and Medicaid Services.
84 (12) For purposes of this section, the term "capitated
85
86
87 ========== T I T L E A M E N D M E N T ==========
88 Remove line(s) 35-37 and insert:
89 providing for recommendations to the agency by the Office of
90 Insurance Regulation regarding the pilot program's rate setting
91 methodology; establishing requirements for rate setting and
92 phased-in implementation; requiring annual review and report to
93 the Legislature;

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2 (for drafter's use only)

Bill No. **HB 3B**

COUNCIL/COMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Council/Committee hearing bill Health Care Regulation
2 Representative(s) Garcia offered the following:
3
4 **Amendment (with directory and title amendments)**
5 On line 1043, before the period, insert:
6 , and the agency shall initiate adoption of rules pursuant to
7 ss. 120.536(1) and 120.54 to develop, implement, and administer
8 the following provisions of the managed care pilot program:
9 (a) Risk-adjusted capitation rates pursuant to paragraph
10 (3)(d);
11 (b) A mechanism for providing information to Medicaid
12 recipients pursuant to paragraph (3)(i); and
13 (c) A choice counseling system pursuant to paragraphs
14 (3)(k), 3(l), and (3)(m)
15
16
17 ========== T I T L E A M E N D M E N T ==========
18 On line(s) 34 after the semicolon insert:
19 requiring rules;

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 3 (for drafter's use only)

Bill No. **HB 3B**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ____

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Sobel offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Between line(s) 1075-1076 insert:
6 (8) There is created the Broward County Medicaid Authority
7 for the purpose of periodically reviewing the progress of the
8 implementation of the Medicaid managed care program in Broward
9 County pursuant to s. 409.91211.
10 (a) The Agency for Health Care Administration is required
11 to report to the Broward County Medicaid Authority, as requested
12 by the Authority, on the status, plans and issues of the
13 implementation of the Medicaid pilot program.
14 (b) The Broward County Medicaid Authority will host
15 quarterly public hearings to hear public testimony from Broward
16 County residents on the effects of the Medicaid pilot program.
17 (c) The Broward County Medicaid Authority will submit its
18 findings and recommendations to the Legislature.
19 (d) The Broward County Medicaid Authority shall be
20 composed of six members that include a county commissioner
21 appointed by the chair of the Broward County Commission, a judge

22 appointed by the Chief Judge of the Circuit, one member of the
23 House Representatives Broward County delegation appointed by the
24 Speaker of the House, one member of the Senate Broward County
25 delegation appointed by the Senate President, a medical doctor
26 and a hospital representative each appointed by the chair of the
27 Broward County Commission.
28 (e) The Authority will dismantle following six months
29 after the Medicaid pilot program is completed.
30
31
32 ========== T I T L E A M E N D M E N T ==========
33 On line(s) 37 insert after the second semicolon:
34
35 creating the Broward County Medicaid Authority;
36 establishing powers and duties;