

The Agency for Health Care Administration shall develop a plan pursuant to Chapter 409 F. S. providing for a statewide managed care program that combines the Medicaid acute and preventative healthcare, ICF/MR and HCBS waiver services for persons with developmental disabilities eligible under Chapter 393 F.S. and submit the plan to the Governor, President of the Senate and Speaker of the House of Representatives no later than January 1, 2008. The goal of the plan shall be to provide services in a coordinated and cost efficient manner in order to achieve high quality outcomes and stabilize the budgetary requirements.

Components of the plan shall authorize the Agency to seek any new waivers and/or amendments to existing waivers, if necessary, in order to achieve the following goals of such a program:

1. Combine Medicaid services and funds including State Plan services, both the Developmental Disabilities and Family and Supported Living (HCBS) Waivers, the Individual and Family Supports program, funds associated with public and private ICF/MRs, and other appropriate general revenue and trust fund initiatives appropriated in the APD budget for persons with a developmental disability into a single comprehensive program. The CDC+ Program implemented, as an 1115 waiver, will be excluded. The MRDP program shall be excluded.
2. Include the cost of individuals with catastrophic conditions in the program rate structure methodology.
3. Include all persons currently eligible under Chapter 393 F.S. receiving services in the program categories specified above who are, or who can be determined, Medicaid eligible. .
4. Utilize a Request for Proposals to select the managing entity (ies) who shall meet the requirements as set forth in this section as well as be managed care organizations licensed under Chapter 641 F.S.
5. Provide for eligible persons with a developmental disability with an opportunity to make an informed choice of program plans by an independent choice counselor, and shall be assigned to one of the plans if they do not make a choice. The timeframes for choice and plan changes will be the same as those used in the Medicaid Reform initiative. The plan shall include a 12-month lock in provision.
6. Establish an actuarially sound, risk-adjusted capitated rate and takes into account such factors as the need for residential services, functional characteristics, behavioral needs, adaptive needs, and the presence of complex medical conditions.
7. Ensure that all providers within the plan's network utilize person centered planning and provides for requirements that advance the use of self-directed options for services within specified limitations.
8. Provide for the development of standards for a comprehensive network of service providers and a system of care coordination and shall require the use of traditional providers with demonstrated experience. The plan shall provide for preference of providers with national accreditation that will be included as a specification for inclusion in the network.
9. Provide for an advisory council comprised of representatives of the various stakeholder organizations including family members and self-advocates on the development of the program. This council will recommend desired outcomes for

the program and standards for quality and suggest the parameters for the evaluation.”