

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Florida
DEFINITION OF A HEALTH MAINTENANCE ORGANIZATION

Health Maintenance Organizations (HMO) are limited to any public or private entity paid on a prepaid or fixed-sum basis which provides health service insurance coverage or provides health services to recipients and which:

- (1) Is organized primarily for the purpose of insuring or providing health care or other services of the type regularly offered to Medicaid recipients;
- (2) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;
- (3) Manages the care of Medicaid recipients and assigns patients to primary care physicians responsible for providing primary care services and authorizing specialty care;
- (4) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity;
- (5) Submits to the agency, if a private entity, a financial plan that the agency finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or \$200,000, whichever is greater;
- (6) Furnishes evidence satisfactory to the agency of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;
- (7) Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the agency;
- (8) Provides organizational, operational, financial, and other information required by the agency;
- (9) Maintains at all times, in addition to meeting any applicable statutory surplus requirements, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance, an amount equal to one-and-one-half times its monthly prepaid Medicaid revenues.

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In the event an entity's surplus falls below any applicable statutory requirements, or an entity's total of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency or the Department of Insurance falls below one-and-one-half times its monthly prepaid Medicaid revenues, the agency shall prohibit the entity from engaging in enrollment activities, shall cease to process new enrollments for the entity, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection shall not apply:

- (a) Where a public entity agrees to fund any deficit incurred by the contracting entity; or
- (b) Where a public entity's performance and obligations are guaranteed in writing by a guaranteeing organization which:
 1. Has been in operation for at least five years and has assets in excess of \$50 million; or
 2. Submits a written guarantee acceptable to the agency which is irrevocable during the term of the contracting entity's contract with the agency and, upon termination of the contract, until the agency receives proof of satisfaction of all outstanding obligations incurred under the contract.

(10) Provides organizational, operational, financial, and other information required by the agency;

(11) Does not know, or reasonably should not know that any officer, director, agent managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:

- (a) Fraud;
- (b) Violation of federal or state antitrust statutes, including those prescribing price fixing between competitors and the allocation of customers among competitors;
- (c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or
- (d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(12) If the entity is an insurer, it must be organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance;

(13) If the entity provides no prepaid health care services other than Medicaid services under contract with the agency, the entity shall be exempt from the provisions of Part 1 of Chapter 641, Florida Statutes, which provides authority to the Florida Department of Insurance to license and regulate health maintenance organizations.

(14) The agency may enter into a risk contract agreement either through a competitive bid process or through a sole source procurement with any qualified provider who meets all of the above.