1 A bill to be entitled
2 An act relating to Medicaid managed care; creating pt. IV
3 of ch. 409, F.S.; creating s. 409.961, F.S.; providing for
4 statutory construction; providing applicability of
5 specified provisions throughout the part; providing
6 rulemaking authority for specified agencies; creating s.
7 409.962, F.S.; providing definitions; creating s. 409.963,
8 F.S.; designating the Agency for Health Care
9 Administration as the single state agency to administer
10 the Medicaid program; providing for specified agency
11 responsibilities; requiring client consent for release of
12 medical records; creating s. 409.964, F.S.; establishing
13 the Medicaid program as the statewide, integrated managed
14 care program for all covered services; authorizing the
15 agency to apply for and implement waivers; providing for
16 public notice and comment; creating s. 409.965, F.S.;
17 providing for mandatory enrollment; providing for
18 exemptions; creating s. 409.966, F.S.; providing
19 requirements for qualified plans; providing that medical
20 homes may be qualified plans; establishing provider
21 service network requirements for qualified plans;
22 providing for qualified plan selection; requiring the
23 agency to use an invitation to negotiate; providing
24 requirements for a databook; establishing regions for
25 separate procurements; providing quality selection
26 criteria for plan selection; establishing preferences for
27 selection; providing limitations on serving recipients
28 during the pendency of litigation; defining "finalized"

29 for purposes of litigation; creating s. 409.967, F.S.;
30 providing for managed care plan accountability;
31 establishing contract terms; providing for contract
32 extension under certain circumstances; establishing
33 payments to noncontract providers; establishing
34 requirements for access; requiring plans to establish and
35 maintain an electronic database; establishing requirements
36 for the database; requiring plans to provide encounter
37 data; requiring the agency to establish performance
38 standards for plans; providing program integrity
39 requirements; establishing a grievance resolution process;
40 providing for penalties for early termination of contracts
41 or reduction in enrollment levels; creating s. 409.968,
42 F.S.; establishing managed care plan payments; providing
43 payment requirements for provider service networks;
44 creating s. 409.969, F.S.; requiring enrollment in managed
45 care plans by specified Medicaid recipients; creating
46 requirements for plan selection by recipients; providing
47 for choice counseling; establishing choice counseling
48 requirements; authorizing disenrollment under certain
49 circumstances; defining "good cause" for purposes of
50 disenrollment; providing time limits on an internal
51 grievance process; providing requirements for agency
52 determination regarding disenrollment; requiring
53 recipients to stay in plans for a specified time; creating
54 s. 409.970, F.S.; requiring the agency to maintain an
55 encounter data system; providing requirements for prepaid
56 plans to submit data; creating s. 409.971, F.S.; creating

57 the managed medical assistance program; providing
58 deadlines to begin and finalize implementation of the
59 program; creating s. 409.972, F.S.; providing for
60 mandatory and voluntary enrollment; creating s. 409.973,
61 F.S.; establishing minimum benefits for managed care plans
62 to cover; authorizing plans to customize benefit packages;
63 requiring plans to establish enhanced benefits programs;
64 providing terms for enhanced benefits package;
65 establishing reserve requirements for plans to fund
66 enhanced benefits programs; creating s. 409.974, F.S.;
67 establishing a specified number of qualified plans to be
68 selected in each region; establishing a deadline for
69 issuing invitations to negotiate; establishing quality
70 selection criteria; establishing the Children's Medical
71 Service Network as a qualified plan; creating s. 409.975;
72 establishing managed care plan accountability; creating a
73 medical loss ratio requirement; authorizing plans to limit
74 providers in networks; mandating certain providers be
75 offered contracts in the first year; requiring certain
76 provider types to participate in plans; requiring plans to
77 monitor the quality and performance history of providers;
78 requiring specified programs and procedures be established
79 by plans; establishing provider payments for hospitals;
80 establishing conflict resolution procedures; establishing
81 plan requirements for medically needy recipients; creating
82 s. 409.976, F.S.; providing for managed care plan payment;
83 requiring the agency to establish a methodology to ensure
84 certain types of payments to specified providers;

85 establishing eligibility for payments; creating s.
86 409.977, F.S.; providing for enrollment; establishing
87 choice counseling requirements; providing for automatic
88 enrollment of certain recipients; establishing opt-out
89 opportunities for recipients; creating s. 409.978, F.S.;
90 requiring the Agency for Health Care Administration be
91 responsible for administering the long-term care managed
92 care program; providing implementation dates for the long-
93 term care managed care program; providing duties for the
94 Department of Elderly Affairs relating to assisting the
95 agency in implementing the program; creating s. 409.979,
96 F.S.; providing eligibility requirements for the long-term
97 care managed care program; creating s. 409.980, F.S.;
98 providing the benefits that a managed care plan shall
99 provide when participating in the long-term care managed
100 care program; creating s. 409.981, F.S.; providing
101 criteria for qualified plans; designating regions for plan
102 implementation throughout the state; providing criteria
103 for the selection of plans to participate in the long-term
104 care managed care program; creating s. 409.982, F.S.;
105 providing the agency shall establish a uniform accounting
106 and reporting methods for plans; providing spending
107 thresholds and consequences relating to spending
108 thresholds; providing for mandatory participation in plans
109 of certain service providers; providing providers can be
110 excluded from plans for failure to meet quality or
111 performance criteria; providing the plans must monitor
112 participating providers using specified criteria;

113 providing certain providers that must be included in plan
114 networks; providing provider payment specifications for
115 nursing homes and hospices; creating s. 409.983, F.S.;
116 providing for negotiation of rates between the agency and
117 the plans participating in the long-term care managed care
118 program; providing specific criteria for calculating and
119 adjusting plan payments; allowing the CARES program to
120 assign plan enrollees to a level of care ; providing
121 incentives for adjustments of payment rates; providing the
122 agency shall establish nursing facility-specific and
123 hospice services payment rates; creating s. 409.984, F.S.;
124 providing that prior to contracting with another vender,
125 the agency shall offer to contract with the aging resource
126 centers to provide choice counseling for the long-term
127 care managed care program; providing criteria for
128 automatic assignments of plan enrollees who fail to chose
129 a plan; creating s. 409.985, F.S.; providing that the
130 agency shall operate the Comprehensive Assessment and
131 Review for Long-Term Care Services program through an
132 interagency agreement with the Department of Elderly
133 Affairs; providing duties of the program; defining the
134 term "nursing facility care"; creating s. 409.986, F.S.;
135 providing authority and agency duties related to long-term
136 care plans; creating s. 409.987, F.S.; providing
137 eligibility requirements for long-term care plans;
138 creating s. 409.988, F.S.; providing benefits for long-
139 term care plans; creating s. 409.989, F.S.; establishing
140 criteria for qualified plans; specifying minimum and

141 maximum number of plans and selection criteria; creating
142 s. 409.990, F.S.; providing requirements for managed care
143 plan accountability; specifying limitations on providers
144 in plan networks; providing for evaluation and payment of
145 network providers; creating s. 409.991, F.S.; providing
146 for payment of managed care plans; providing duties for
147 the Agency for Persons with Disabilities to assign plan
148 enrollees into a payment rate level of care; establishing
149 level of care criteria; providing payment requirements for
150 intermediate care facilities for the developmentally
151 disabled; creating s. 409.992, F.S.; providing
152 requirements for enrollment and choice counseling;
153 specifying enrollment exceptions for certain Medicaid
154 recipients; providing an effective date.
155
156 Be It Enacted by the Legislature of the State of Florida:
157
158 Section 1. Sections 409.961 through 409.992, Florida
159 Statutes, are designated as part IV of chapter 409, Florida
160 Statutes, entitled "Medicaid Managed Care."
161 Section 2. Section 409.961, Florida Statutes, is created
162 to read:
163 409.961 Statutory construction; applicability; rules.—It
164 is the intent of the Legislature that if any conflict exists
165 between the provisions contained in this part and provisions
166 contained in other parts of this chapter, the provisions
167 contained in this part shall control. The provisions of ss.
168 409.961-409.970 apply only to the Medicaid managed medical

169 assistance program, long-term care managed care program, and
170 managed long-term care for persons with developmental
171 disabilities program, as provided in this part. The agency shall
172 adopt any rules necessary to comply with or administer this part
173 and all rules necessary to comply with federal requirements. In
174 addition, the department shall adopt and accept the transfer of
175 any rules necessary to carry out the department's
176 responsibilities for receiving and processing Medicaid
177 applications and determining Medicaid eligibility and for
178 ensuring compliance with and administering the part, as those
179 rules relate to the department's responsibilities, and any other
180 provisions related to the department's responsibility for the
181 determination of Medicaid eligibility.
182 Section 3. Section 409.962, Florida Statutes, is created
183 to read:
184 409.962 Definitions.—As used in this part, except as
185 otherwise specifically provided, the term:
186 (1) "Agency" means the Agency for Health Care
187 Administration. The agency is the Medicaid agency for the state,
188 as provided under federal law.
189 (2) "Benefit" means any benefit, assistance, aid,
190 obligation, promise, debt, liability, or the like, related to
191 any covered injury, illness, or necessary medical care, goods,
192 or services.
193 (3) "Long-term care comprehensive plan" means a long-term
194 care plan that also provides the services described in s.
195 409.973.

196 (4) "Long-term care plan" means a specialty plan that
197 provides institutional and home and community-based services.
198 (5) "Long term care provider service network" means an
199 entity certified pursuant to s. 409.912(4)(d), of which a
200 controlling interest is owned by one or more licensed nursing
201 homes, assisted living facilities with 17 or more beds, home
202 health agencies, Community Care for the Elderly Lead Agencies,
203 or hospices.
204 (6) "Managed care plan" means a qualified plan under
205 contract with the agency to provide services in the Medicaid
206 program.
207 (7) "Medicaid" means the medical assistance program
208 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.
209 1396 et seq., and regulations thereunder, as administered in
210 this state by the agency.
211 (8) "Medicaid recipient" or "recipient" means an
212 individual whom the department or, for Supplemental Security
213 Income, the Social Security Administration determines is
214 eligible pursuant to federal and state law to receive medical
215 assistance and related services for which the agency may make
216 payments under the Medicaid program. For the purposes of
217 determining third-party liability, the term includes an
218 individual formerly determined to be eligible for Medicaid, an
219 individual who has received medical assistance under the
220 Medicaid program, or an individual on whose behalf Medicaid has
221 become obligated.

222 (9) "Medical home network" means a qualified plan
223 designated by the agency as a medical home network in accordance
224 with the criteria established in s. 409.91207.
225 (10) "Prepaid plan" means a qualified plan that is
226 licensed or certified as a risk-bearing entity in the state and
227 is paid a prospective per-member, per-month payment by the
228 agency.
229 (11) "Provider service network" means an entity certified
230 pursuant to s. 409.912(4)(d) of which a controlling interest is
231 owned by a health care provider, or group of affiliated
232 providers, or a public agency or entity that delivers health
233 services. Health care providers include Florida-licensed health
234 care professionals or licensed health care facilities, and
235 federally qualified health care centers.
236 (12) "Qualified plan" means a health insurer authorized
237 under chapter 624, an exclusive provider organization authorized
238 under chapter 627, a health maintenance organization authorized
239 under chapter 641, or a provider service network authorized
240 under s. 409.912(4)(d) that are eligible to participate in the
241 statewide managed care program.
242 (13) "Specialty plan" means a qualified plan that serves
243 Medicaid recipients who meet specified criteria based on age,
244 medical condition, or diagnosis.
245 Section 4. Section 409.963, Florida Statutes, is created
246 to read:
247 409.963 Single state agency.—The Agency for Health Care
248 Administration is designated as the single state agency
249 authorized to manage, operate, and make payments for medical

250 assistance and related services under Title XIX of the Social
251 Security Act. Subject to any limitations or directions provided
252 for in the General Appropriations Act, these payments shall be
253 made only for services included in the program, only on behalf
254 of eligible individuals, and only to qualified providers in
255 accordance with federal requirements for Title XIX of the Social
256 Security Act and the provisions of state law. This program of
257 medical assistance is designated as the "Medicaid program." The
258 department is responsible for Medicaid eligibility
259 determinations, including, but not limited to, policy, rules,
260 and the agreement with the Social Security Administration for
261 Medicaid eligibility determinations for Supplemental Security
262 Income recipients, as well as the actual determination of
263 eligibility. As a condition of Medicaid eligibility, subject to
264 federal approval, the agency and the department shall ensure
265 that each Medicaid recipient consents to the release of her or
266 his medical records to the agency and the Medicaid Fraud Control
267 Unit of the Department of Legal Affairs.
268 Section 5. Section 409.964, Florida Statutes is created to
269 read:
270 409.964 Managed care program; state plan; waivers.—The
271 Medicaid program is established as a statewide, integrated
272 managed care program for all covered services, including long-
273 term care services. The agency shall apply for and implement
274 state plan amendments or waivers of applicable federal laws and
275 regulations necessary to implement the program. Prior to seeking
276 a waiver, the agency shall provide public notice and the
277 opportunity for public comment.

278 Section 6. Section 409.965, Florida Statutes, is created
279 to read:
280 409.965 Mandatory enrollment.—All Medicaid recipients
281 shall receive covered services through the statewide managed
282 care program, except as provided by this part pursuant to an
283 approved federal waiver. The following Medicaid recipients are
284 exempt from participation in the statewide managed care program:
285 (1) Women who are only eligible for family planning
286 services.
287 (2) Women who are only eligible for breast and cervical
288 cancer services.
289 (3) Persons eligible for emergency Medicaid for aliens.
290 Section 7. Section 409.966, Florida Statutes, is created
291 to read:
292 409.966 Qualified plans; selection.—
293 (1) QUALIFIED PLANS.-Services in the Medicaid managed care
294 program shall be provided by qualified plans.
295 (a) A qualified plan may request the agency to designate
296 the plan as a medical home network if it meets the criteria
297 established in s. 409.91207.
298 (b) A provider service network must be capable of
299 providing all covered services to a mandatory Medicaid managed
300 care enrollee or may limit the provision of services toa
301 specific target population based on age, chronic disease, or
302 medical condition to whom it will provide services. A specialty
303 provider service network must be capable of coordinating care
304 and delivering or arranging for the delivery of all covered
305 services to the target population. A provider service network

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V

306 may partner with an insurer licensed under chapter 627 or a
307 health maintenance organization licensed under chapter 641 to
308 meet the requirements of a Medicaid contract.
309 (2) QUALIFIED PLAN SELECTION.-The agency shall select a
310 limited number of qualified plans to participate in the Medicaid
311 program using invitations to negotiate in accordance with s.
312 287.057(3)(a). At least 30 days prior to issuing the invitations
313 to negotiate, the agency shall compile and publish a databook
314 consisting of a comprehensive set of utilization and spending
315 data for the 3 most recent contract years consistent with the
316 rate-setting periods for all Medicaid recipients by region or
317 county. The source of the data in the report shall include both
318 historic fee-for-service claims and validated data from the
319 Medicaid Encounter Data System. The report shall be made
320 available in electronic form and shall delineate utilization use
321 by age, gender, eligibility group, geographic area, and
322 aggregate clinical risk score. Separate and simultaneous
323 procurements shall be conducted in each of the following
324 regions:
325 (a) Region I, which shall consist of Bay, Calhoun,
326 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,
327 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,
328 Walton, and Washington Counties.
329 (b) Region II, which shall consist of Alachua, Baker,
330 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,
331 Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam,
332 St. Johns, Suwannee, Union, and Volusia Counties.

333 (c) Region III, which shall consist of Charlotte, DeSoto,
334 Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco,
335 Pinellas, Polk, and Sarasota Counties.
336 (d) Region IV, which shall consist of Brevard, Indian
337 River, Lake, Orange, Osceola, Seminole, and Sumter Counties.
338 (e) Region V, which shall consist of Broward, Glades,
339 Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.
340 (f) Region VI, which shall consist of Collier, Dade, and
341 Monroe Counties.
342 (3) QUALITY SELECTION CRITERIA.-The invitation to
343 negotiate must specify the criteria and the relative weight of
344 the criteria that will be used for determining the acceptability
345 of the reply and guiding the selection of the organizations with
346 which the agency will negotiate. In addition to criteria
347 established by the agency, the agency shall consider the
348 following factors in the selection of qualified plans:
349 (a) Accreditation by the National Committee for Quality
350 Assurance or another nationally recognized accrediting body.
351 (b) Experience serving similar populations, including the
352 organization's record in achieving specific quality standards
353 with similar populations.
354 (c) Availability and accessibility of primary care and
355 specialty physicians in the provider network.
356 (d) Establishment of community partnerships with providers
357 that create opportunities for reinvestment in community-based
358 services.
359 (e) Organization commitment to quality improvement and
360 documentation of achievements in specific quality improvement

361 projects, including active involvement by organization
362 leadership.
363 (f) Provision of additional benefits, particularly dental
364 care and disease management, and other enhanced benefit
365 programs.
366 (g) History of voluntary or involuntary withdrawal from
367 any state Medicaid program or program area.
368 (h) Evidence that a qualified plan has written agreements
369 or signed contracts or has made substantial progress in
370 establishing relationships with providers prior to the plan
371 submitting a response. The agency shall evaluate and give
372 special weight such evidence, and the evaluation shall be based
373 on the following factors:
374 1. Contracts with primary and specialty physicians in
375 sufficient numbers to meet the specific standards established
376 pursuant to s. 409.967(b).
377 2. Specific arrangements that provide evidence that the
378 compensation offered is sufficient to retain primary and
379 specialty physicians in sufficient numbers to continue to comply
380 with the standards established pursuant to s. 409.967(2)
381 throughout the five-year contract term.
382
383 After negotiations are conducted, the agency shall select the
384 qualified plans determined to be responsive and providing the
385 best value to the state. When all other factors are equal among
386 competing organizations, preference shall be given to
387 organizations designated as medical home networks pursuant to s.
388 409.91207 or organizations with the greatest number of primary

389 care providers who are recognized as patient-centered medical
390 homes by the National Committee for Quality Assurance or
391 organizations with networks that reflect recruitment of minority
392 physicians and other minority providers.
393 (4) ADMININSTRATIVE CHALLENGE. Any qualified plan that
394 participates in an invitation to negotiate in more than one
395 region and is selected in at least one region may not begin
396 serving Medicaid recipients in any region for which it was
397 selected until all administrative challenges to procurements
398 required by this section, to which the qualified plan is a
399 party, have been finalized. For purposes of this subsection, an
400 administrative challenge is finalized if an order granting
401 voluntary dismissal with prejudice has been entered by any court
402 established under Article V of the State Constitution or by the
403 Division of Administrative Hearings, a final order has been
404 entered into by the agency and the deadline for appeal has
405 expired, a final order has been entered by the First District
406 Court of Appeal and the time to seek any available review by the
407 Florida Supreme Court has expired, or a final order has been
408 entered by the Florida Supreme Court and a warrant has been
409 issued.
410 Section 8. Section 409.967, Florida Statutes, is created
411 to read:
412 409.967 Managed care plan accountability.—
413 (1) The agency shall establish a 5-year contract with each
414 of the qualified plans selected through the procurement process
415 described in s. 409.966. A plan contract may not be renewed;

416 however, the agency may extend the terms of a plan contract to
417 cover any delays in transition to a new plan.
418 (2) The agency shall establish such contract requirements
419 as are necessary for the operation of the statewide managed care
420 program. In addition to any other provisions the agency may deem
421 necessary, the contract shall require:
422 (a) Emergency services. Plans shall pay for services
423 required by ss. 395.1041 and 401.45 and rendered by a
424 noncontracted provider within 30 days after receipt of a
425 complete and correct claim. Plans must give providers of these
426 services a specific explanation for each claim denied for being
427 incomplete or incorrect. Payment shall be made at the rate the
428 agency would pay for such services from the same provider.
429 Claims from noncontracted providers shall be accepted by the
430 qualified plan for at least 1 year after the date the services
431 are provided.
432 (b) Access. The agency shall establish specific standards
433 for the number, type, and regional distribution of providers in
434 plan networks to ensure access to care. Each plan must maintain
435 a region-wide network of providers in sufficient numbers to meet
436 the access standards for specific medical services for all
437 recipients enrolled in the plan. Each plan shall establish and
438 maintain an accurate and complete electronic database of
439 contracted providers, including information about licensure or
440 registration, locations and hours of operation, specialty
441 credentials and other certifications, specific performance
442 indicators, and such other information as the agency deems
443 necessary. The database shall be available online to both the

444 agency and the public and shall have the capability to compare
445 the availability of providers to network adequacy standards and
446 to accept and display feedback from each provider's patients.
447 Each plan shall submit quarterly reports to the agency
448 identifying the number of enrollees assigned to each primary
449 care provider.
450 (c) Encounter data. Each prepaid plan must comply with the
451 agency's reporting requirements for the Medicaid Encounter Data
452 System.
453 (d) Continuous improvement. The agency shall establish
454 specific performance standards and expected milestones or
455 timelines for improving performance over the term of the
456 contract. Each plan shall establish an internal health care
457 quality improvement system, including enrollee satisfaction and
458 disenrollment surveys. The quality improvement system shall
459 include incentives and disincentives for network providers.
460 (e) Program integrity. Each plan shall establish program
461 integrity functions and activities to reduce the incidence of
462 fraud and abuse, including, at a minimum:
463 1. A provider credentialing system and ongoing provider
464 monitoring;
465 2. An effective prepayment and postpayment review process
466 including, but not limited to, data analysis, system editing,
467 and auditing of network providers;
468 3. Procedures for reporting instances of fraud and abuse
469 pursuant to chapter 641;

470 4. Administrative and management arrangements or
471 procedures, including a mandatory compliance plan, designed to
472 prevent fraud and abuse; and
473 5. Designation of a program integrity compliance officer.
474 (f) Grievance resolution. Each plan shall establish an
475 internal process for reviewing and responding to grievances from
476 enrollees. The contract shall specify timeframes for submission,
477 plan response, and resolution. Grievances not resolved by a
478 plan's internal process shall be submitted to the subscriber
479 assistance panel pursuant to s. 408.7056. Each plan shall submit
480 quarterly reports on the number, description, and outcome of
481 grievances filed by enrollees. The agency shall maintain a
482 similar process for provider service networks.
483 (g) Penalties. Plans that reduce enrollment levels or
484 leave a region prior to the end of the contract term shall
485 reimburse the agency for the cost of enrollment changes and
486 other transition activities, including the cost of additional
487 choice counseling services. If more than one plan leaves a
488 region at the same time, costs shall be shared by the departing
489 plans proportionate to their enrollments. In addition to the
490 payment of costs, departing plans shall pay a per enrollee
491 penalty not to exceed 5 percent of one month's payment. Plans
492 shall provide the agency notice no less than 180 days prior to
493 withdrawing from a region.
494 Section 9. Section 409.968, Florida Statutes, is created
495 to read:
496 409.968 Managed care plan payment.—

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497 (1) Prepaid plans shall receive per-member, per-month
498 payments negotiated pursuant to the procurements described in s.
499 409.966. Payments shall be risk-adjusted rates based on
500 historical utilization and spending data, projected forward, and
501 adjusted to reflect the eligibility category, geographic area,
502 and the clinical risk profile of the recipients.
503 (2) Beginning September 1, 2010, the agency shall update
504 the rate setting methodology by initiating a transition to rates
505 based on statewide encounter data submitted by Medicaid managed
506 care plans pursuant to s. 409.970. Prior to this transition, the
507 agency shall conduct appropriate tests and establish specific
508 milestones in order to determine that the Medicaid Encounter
509 Data system consists of valid, complete, and sound data for a
510 sufficient period of time to provide a reliable basis for
511 establishing actuarially sound payment rates. The transition
512 shall be implemented within 3 years or less, and shall utilize
513 such other data sources as necessary and reliable to make
514 appropriate adjustments during the transition. The agency shall
515 establish a technical advisory panel to obtain input from the
516 prepaid plans regarding the incorporation of encounter data in
517 the rate setting process.
518 (3) Provider service networks may be prepaid plans and
519 receive per member, per month payments negotiated pursuant to
520 the procurement process described in s. 409.966. Provider
521 service networks which choose not to be prepaid plans shall
522 receive fee-for-service rates with a shared savings settlement.
523 The fee-for-service option shall be available to a provider
524 service network only for the first 5 years of the plan's

525 operation in a given region or until the contract year beginning
526 in October 2015, whichever is later. The agency shall annually
527 conduct cost reconciliations to determine the amount of cost
528 savings achieved by fee-for-service provider service networks
529 for the dates of service in the period being reconciled. Only
530 payments for covered services for dates of service within the
531 reconciliation period and paid within 6 months after the last
532 date of service in the reconciliation period shall be included.
533 The agency shall perform the necessary adjustments for the
534 inclusion of incurred but not reported claims within the
535 reconciliation for claims that could be received and paid by the
536 agency after the 6-month claims processing time lag. The agency
537 shall provide the results of the reconciliations to the fee-for-
538 service provider service networks within 45 days after the end
539 of the reconciliation period. The fee-for-service provider
540 service networks shall review and provide written comments or a
541 letter of concurrence to the agency within 45 days after receipt
542 of the reconciliation results. This reconciliation shall be
543 considered final.
544 Section 10. Section 409.969, Florida Statutes, is created
545 to read:
546 409.969 Enrollment; choice counseling; automatic
547 assignment; disenrollment.—
548 (1) ENROLLMENT.—All Medicaid recipients shall be enrolled
549 in a managed care plan unless specifically exempted in this
550 part. Each recipient shall have a choice of plans and may select
551 any available plan unless that plan is restricted by contract to
552 a specific population that does not include the recipient.

553 Medicaid recipients shall have 30 days in which to make a choice
554 of plans. All recipients shall be offered choice counseling
555 services in accordance with this section.
556 (2) CHOICE COUNSELING.—The agency shall provide choice
557 counseling for Medicaid recipients. The agency may contract for
558 the provision of choice counseling. Any such contract shall be
559 for a period of 5 years and may be renewed for an additional 5-
560 year period. The agency may extend the term of the contract to
561 cover any delays in transition to a new contractor. Choice
562 counseling shall be offered in the native or preferred language
563 of the recipient, consistent with federal requirements. The
564 agency shall maintain a record of the recipients who receive
565 such services, identifying the scope and method of the services
566 provided. The agency shall make available clear and easily
567 understandable choice information to Medicaid recipients that
568 includes:
569 (a) An explanation that each recipient has the right to
570 choose a managed care plan at the time of enrollment in Medicaid
571 and again at regular intervals set by the agency, and that if a
572 recipient does not choose a plan, the agency will assign the
573 recipient to a plan according to the criteria specified in this
574 section.
575 (b) A list and description of the benefits provided in
576 each plan.
577 (c) An explanation of benefit limits.
578 (d) A current list of providers participating in the
579 network, including location and contact information.
580 (e) Plan performance data.

581 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has
582 enrolled in a managed care plan, the recipient shall have 90
583 days to voluntarily disenroll and select another plan. After 90
584 days, no further changes may be made except for good cause. Good
585 cause includes, but is not limited to, poor quality of care,
586 lack of access to necessary specialty services, an unreasonable
587 delay or denial of service, or fraudulent enrollment. The agency
588 must make a determination as to whether good cause exists. The
589 agency may require a recipient to use the plan's grievance
590 process prior to the agency's determination of good cause,
591 except in cases in which immediate risk of permanent damage to
592 the recipient's health is alleged.
593 (a) The managed care plan internal grievance process, when
594 utilized, must be completed in time to permit the recipient to
595 disenroll by the first day of the second month after the month
596 the disenrollment request was made. If the result of the
597 grievance process is approval of an enrollee's request to
598 disenroll, the agency is not required to make a determination in
599 the case.
600 (b) The agency must make a determination and take final
601 action on a recipient's request so that disenrollment occurs no
602 later than the first day of the second month after the month the
603 request was made. If the agency fails to act within the
604 specified timeframe, the recipient's request to disenroll is
605 deemed to be approved as of the date agency action was required.
606 Recipients who disagree with the agency's finding that good
607 cause does not exist for disenrollment shall be advised of their

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608 right to pursue a Medicaid fair hearing to dispute the agency's
609 finding.
610 (c) Medicaid recipients enrolled in a managed care plan
611 after the 90-day period shall remain in the plan for the
612 remainder of the 12-month period. After 12 months, the recipient
613 may select another plan. However, nothing shall prevent a
614 Medicaid recipient from changing primary care providers within
615 the plan during that period.
616 Section 11. Section 409.970, Florida Statutes, is created
617 to read:
618 409.970 Encounter data.—The agency shall maintain and
619 operate the Medicaid Encounter Data System to collect, process,
620 store, and report on covered services provided to all Medicaid
621 recipients enrolled in prepaid plans. Prepaid plans shall submit
622 encounter data electronically in a format that complies with the
623 Health Insurance Portability and Accountability Act provisions
624 for electronic claims and in accordance with deadlines
625 established by the agency. Prepaid plans must certify that the
626 data reported is accurate and complete. The agency is
627 responsible for validating the data submitted by the plans. The
628 agency shall make encounter data available to those plans
629 accepting enrollees who are assigned to them from other plans
630 leaving a region.
631 Section 12. Section 409.971, Florida Statutes, is created
632 to read:
633 409.971 Managed medical assistance program.—The agency
634 shall make payments for primary and acute medical assistance and
635 related services using a managed care model. By January 1, 2012,

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636 the agency shall begin implementation of the statewide managed
637 medical assistance program, with full implementation in all
638 regions by October 1, 2013.
639 Section 13. Section 409.972, Florida Statutes, is created
640 to read:
641 409.972. Mandatory and voluntary enrollment.—
642 (1) Persons eligible for the program known as "medically
643 needy" pursuant to s. 409.904(2)(a) shall enroll in managed care
644 plans. Medically needy recipients shall meet the share of cost
645 by paying the plan premium, up to the share of cost amount,
646 contingent upon federal approval.
647 (2) The following Medicaid-eligible persons are exempt
648 from mandatory managed care enrollment required by s. 409.965,
649 and may voluntarily choose to participate in the managed medical
650 assistance program:
651 (a) Medicaid recipients who have other creditable health
652 care coverage, excluding Medicare.
653 (b) Medicaid recipients residing in residential commitment
654 facilities operated through the Department of Juvenile Justice,
655 group care facilities operated by the Department of Children and
656 Families, and treatment facilities funded through the Substance
657 Abuse and Mental Health program of the Department of Children
658 and Families.
659 (c) Persons eligible for refugee assistance.
660 (d) Medicaid recipients who are residents of a
661 developmental disability center including Sunland Center in
662 Marianna and Tacachale in Gainesville.

663 (3) Persons eligible for Medicaid but exempt from
664 mandatory participation who do not choose to enroll in managed
665 care shall be served in the Medicaid fee-for-service program as
666 provided in part III of this chapter.
667 Section 14. Section 409.973, Florida Statutes, is created
668 to read:
669 409.973 Benefits.—
670 (1) MINIMUM BENEFITS. Managed care plans shall cover, at a
671 minimum, the following services:
672 (a) Advanced registered nurse practitioner services.
673 (b) Ambulatory surgical treatment center services.
674 (c) Birthing center services.
675 (d) Chiropractic services.
676 (e) Dental services.
677 (f) Early periodic screening diagnosis and treatment
678 services for recipients under age 21.
679 (g) Emergency services.
680 (h) Family planning services and supplies.
681 (i) Healthy start services.
682 (j) Hearing services.
683 (k) Home health agency services.
684 (l) Hospice services.
685 (m) Hospital inpatient services.
686 (n) Hospital outpatient services.
687 (o) Laboratory and X-ray services.
688 (p) Medical supplies, equipment, prostheses, and orthoses.
689 (q) Mental health services.
690 (r) Nursing care.

691 (s) Optical services and supplies.
692 (t) Optometrist services.
693 (u) Physical, occupational, respiratory, and speech
694 therapy services.
695 (v) Physician services.
696 (w) Podiatric services.
697 (x) Prescription drugs.
698 (y) Renal dialysis services.
699 (z) Respiratory equipment and supplies.
700 (aa) Rural health clinic services.
701 (bb) Substance abuse treatment services.
702 (cc) Transportation to access covered services.
703 (2) CUSTOMIZED BENEFITS. Managed care plans may customize
704 benefit packages for nonpregnant adults, vary cost-sharing
705 provisions, and provide coverage for additional services. The
706 agency shall evaluate the proposed benefit packages to ensure
707 services are sufficient to meet the needs of the plans'
708 enrollees and to verify actuarial equivalence.
709 (3) ENHANCED BENEFITS. Each plan operating in the managed
710 medical assistance program shall establish an incentive program
711 that rewards specific healthy behaviors with credits in a
712 flexible spending account.
713 (a) At the discretion of the recipient, credits shall be
714 used to purchase otherwise uncovered health and related services
715 during the entire period of, and for a maximum of 3 years after,
716 the recipient's Medicaid eligibility, whether or not the
717 recipient remains continuously enrolled in the plan in which the
718 credits were earned.

719 (b) Enhanced benefits shall be structured to provide
720 greater incentives for those diseases linked with lifestyle and
721 conditions or behaviors associated with avoidable utilization of
722 high-cost services.
723 (c) To fund these credits, each plan must maintain a
724 reserve account in an amount of up to 2 percent of the plan's
725 Medicaid premium revenue, or benchmark premium revenue in the
726 case of provider service networks, based on an actuarial
727 assessment of the value of the enhanced benefits program.
728 Section 15. Section 409.974, Florida Statutes, is created
729 to read:
730 409.974. Qualified plans.—
731 (1) QUALIFIED PLAN SELECTION.-The agency shall select
732 qualified plans through the procurement described in s. 409.966.
733 The agency shall notice invitations to negotiate no later than
734 January 1, 2012.
735 (a) The agency shall procure three plans for Region I. At
736 least one plan shall be a provider service network, if any
737 provider service network submits a responsive bid.
738 (b) The agency shall procure at least four and no more
739 than seven plans for Region II. At least one plan shall be a
740 provider service network, if any provider service network
741 submits a responsive bid.
742 (c) The agency shall procure at least five plans and no
743 more than ten plans for Region III. At least two plans shall be
744 provider service networks, if any two provider service networks
745 submit a responsive bid.

746 (d) The agency shall procure at least four plans and no
747 more than eight plans for Region IV. At least one plan shall be
748 a provider service network if any provider service network
749 submits a responsive bid.
750 (e) The agency shall procure at least four plans and no
751 more than seven plans for Region V. At least one plan shall be a
752 provider service network, if any provider service network
753 submits a responsive bid.
754 (f) The agency shall procure at least five plans and no
755 more than ten plans for Region VI. At least two plans shall be
756 provider service networks, if any two provider service networks
757 submit a responsive bid.
758 (2) QUALITY SELECTION CRITERIA.-In addition to the
759 criteria established in s. 409.966, the agency shall consider
760 evidence that a qualified plan has written agreements or signed
761 contracts or has made substantial progress in establishing
762 relationships with providers prior to the plan submitting a
763 response. The agency shall evaluate and give special weight to
764 evidence of signed contracts with providers of critical services
765 pursuant to s. 409.975(3)(a)-(d). The agency shall also consider
766 whether the organization is a specialty plan. When all other
767 factors are equal, the agency shall consider whether the
768 organization has a contract to provide managed long-term care
769 services in the same region and shall exercise a preference for
770 such plans.
771 (3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's
772 Medical Services Network authorized under chapter 391 is a
773 qualified plan for purposes of the managed medical assistance

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774 program. Participation by the Children's Medical Services
775 Network shall be pursuant to a single, statewide contract with
776 the agency that is not subject to the procurement requirements
777 or regional plan number limits of this section. The Children's
778 Medical Services Network must meet all other plan requirements
779 for the managed medical assistance program.
780 Section 16. Section 409.975, Florida Statutes, is created
781 to read:
782 409.975 MEDICAL LOSS RATIO. Managed care plan
783 accountability.—In addition to the requirements of s. 409.967,
784 plans and providers participating in the managed medical
785 assistance program shall comply with the requirements of this
786 section.
787 (1) The agency shall establish and managed care plans
788 shall use a uniform method of accounting for and reporting
789 medical, direct care management, and nonmedical costs. The
790 agency shall evaluate plan spending patterns beginning after the
791 plan completes 2 full years of operation and at least annually
792 thereafter. The agency shall implement the following thresholds
793 and consequences of various spending patterns:
794 (a) Plans that spend less than 75 percent of Medicaid
795 premium revenue on medical services and direct care management
796 as determined by the agency shall be excluded from automatic
797 enrollments and shall be required to pay back the amount between
798 actual spending and 85 percent of the Medicaid premium revenue.
799 (b) Plans that spend less than 85 percent of Medicaid
800 premium revenue on medical services and direct care management
801 as determined by the agency shall be required to pay back the

802 amount between actual spending and 85 percent of the Medicaid
803 premium revenue.
804 (c) Plans that spend more than 92 percent of Medicaid
805 premium revenue shall be evaluated by the agency to determine
806 whether higher expenditures are the result of failures in care
807 management. Such a determination may result in the plan being
808 excluded from automatic enrollments.
809 (2) PROVIDER NETWORKS. Plans may limit the providers in
810 their networks based on credentials, quality indicators, and
811 price. However, in the first contract period after a qualified
812 plan is selected in a region by the agency, the plan must offer
813 a network contract to the following providers in the region:
814 (a) Federally qualified health centers.
815 (b) Primary care providers certified as medical homes.
816 (c) Providers listed in paragraphs (3)(a)-(d).
817
818 After 12 months of active participation in a plan's network, the
819 plan may exclude any of the above-named providers from the
820 network for failure to meet quality or performance criteria.
821 (3) SELECT PROVIDER PARTICIPATION. Except as provided in
822 this subsection, providers may limit the plans they join. The
823 following providers must agree to participate in any qualified
824 plan selected by the agency in the region in which the provider
825 is located:
826 (a) Statutory teaching hospitals as defined in s.
827 408.07(45) and their medical staff who are employees or under
828 contract and are essential for delivery of the teaching
829 hospital's specialty and subspecialty services.

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830 (b) Hospitals that are trauma centers as defined in s.
831 395.4001(14) and their medical staff who are employees or under
832 contract and are essential for delivery of hospital's trauma
833 services.
834 (c) Hospitals that are regional perinatal intensive care
835 centers as defined in s. 383.16(2) and their medical staffs who
836 are employees or under contract and are essential for delivery
837 of the hospital's perinatal services.
838 (d) Hospitals licensed as specialty children's hospitals
839 pursuant to s. 395.002(28) and their medical staff who are
840 employees or under contract and are essential for delivery of
841 the hospital's specialty children's services.
842 (e) Providers with both an active Medicaid provider
843 agreement under s. 409.907 and a Certificate of Need.
844 (4) PERFORMANCE MEASUREMENT. Each plan shall monitor the
845 quality and performance of each participating provider. At the
846 beginning of the contract period, each plan shall notify all its
847 network providers of the metrics used by the plan for evaluating
848 the provider's performance and determining continued
849 participation in the network.
850 (5) PREGNANCY AND INFANT HEALTH. Each plan shall establish
851 specific programs and procedures to improve pregnancy outcomes
852 and infant health, including, but not limited to, coordination
853 with the Healthy Start program, immunization programs, and
854 referral to the Special Supplemental Nutrition Program for
855 Women, Infants, and Children, and the Children's Medical
856 Services program for children with special health care needs.

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857 (6) Each plan shall achieve an annual Early and Periodic
858 Screening, Diagnosis, and Treatment Service screening rate of at
859 least 60 percent for those recipients continuously enrolled for
860 at least 8 months.
861 (7) PROVIDER PAYMENT. Plans and hospitals shall negotiate
862 mutually acceptable rates, methods, and terms of payment. At a
863 minimum, plans shall pay hospitals the Medicaid rate. Payments
864 to hospitals shall not exceed 150 percent of the Medicaid rate,
865 unless specifically approved by the agency. For purposes of this
866 subsection, the Medicaid rate is the rate the agency would have
867 paid on the first day of the contract between the provider and
868 the plan. Payment rates may be updated periodically.
869 (8) CONFLICT RESOLUTION. The agency shall establish a
870 process for resolving disputes between qualified plans Medicaid
871 inpatient hospital providers or the medical staff of the
872 providers listed in s. 409.975(3)(a)-(d) when the agency is
873 notified by either party of irreconcilable differences and the
874 agency determines that the dispute jeopardizes access to or
875 quality of services for Medicaid recipients. The agency may
876 contract with an outside entity for any portion of this process.
877 When this process is invoked by one or both of the parties, the
878 agency is authorized to establish payment rates, contract terms,
879 and other conditions on either or both parties. This process may
880 not be used to review and reverse any plan decision to exclude
881 any provider that fails to meet quality standards.
882 Administration costs of each instance of conflict resolution
883 shall be paid by the entities which invoke it, in equal parts.

884 (9) MEDICALLY NEEDY ENROLLEES. Each selected plan shall
885 accept any medically needy recipient who selects or is assigned
886 to the plan and provide that recipient with continuous
887 enrollment for 12 months. After the first month of qualifying as
888 a medically needy recipient and enrolling in a plan, and
889 contingent upon federal approval, the enrollee shall pay the
890 plan a portion of the monthly premium equal to the enrollee's
891 share of the cost as determined by the department. The agency
892 shall pay the remainder of the monthly premium. Plans must
893 provide a grace period of at least 60 days before disenrolling
894 recipients who fail to pay their shares of the premium.
895 Section 17. Section 409.976, Florida Statutes, is created
896 to read:
897 409.976 Managed care plan payment.—In addition to the
898 payment provisions of s. 409.968, the agency shall provide
899 payment to plans in the managed medical assistance program
900 pursuant to this section.
901 (1) Prepaid payment rates shall be negotiated between the
902 agency and the qualified plans as part of the procurement
903 described in s. 409.966.
904 (2) The agency shall develop a methodology to ensure the
905 availability of intergovernmental transfers in the statewide
906 integrated managed care program to support providers that have
907 historically served Medicaid recipients. Such providers include,
908 but are not limited to, safety net providers, trauma hospitals,
909 children's hospitals, statutory teaching hospitals, and medical
910 and osteopathic physicians employed by or under contract with a
911 medical school in this state. The agency may develop a

912 supplemental capitation rate, risk pool, or incentive payment to
913 plans that contract with these providers. A plan is eligible for
914 a supplemental payment only if there are sufficient
915 intergovernmental transfers available from allowable sources and
916 the plan can demonstrate that it pays a reimbursement rate not
917 less than the equivalent fee-for-service rate. The agency may
918 develop the supplemental capitation rate to consider rates
919 higher than the fee-for-service Medicaid rate when needed to
920 ensure access and supported by funds provided by a locality. The
921 agency shall evaluate the development of the rate cell to
922 accurately reflect the underlying utilization to the maximum
923 extent possible. This may include interim rate adjustments as
924 permitted under federal regulations. Any such methodology will
925 preserve federal funding to these entities and must be
926 actuarially sound. In the absence of federal approval for the
927 above methodology, the agency is authorized to set an enhanced
928 rate and require that plans pay the enhanced rate, if the agency
929 determines the enhanced rate is necessary to ensure access to
930 care by the providers described in this subsection.
931 Section 18. Section 409.977, Florida Statutes, is created
932 to read:
933 409.977 Choice counseling and enrollment.—
934 (1) CHOICE COUNSELING.-In addition to the choice
935 counseling information required by s. 409.969, the agency shall
936 make available clear and easily understandable choice
937 information to Medicaid recipients that includes:
938 (a) Information about earning credits in the plan's
939 enhanced benefit program.

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940 (b) Information about cost sharing requirements of each
941 plan.
942 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically
943 enroll into a managed care plan those Medicaid recipients who do
944 not voluntarily choose a plan pursuant to s. 409.969. The agency
945 shall automatically enroll recipients in plans that meet or
946 exceed the performance or quality standards established pursuant
947 to s. 409.967, and shall not automatically enroll recipients in
948 a plan that is deficient in those performance or quality
949 standards. The agency may not engage in practices that are
950 designed to favor one managed care plan over another. When
951 automatically enrolling recipients in plans, the agency shall
952 take into account the following criteria:
953 (a) Whether the plan has sufficient network capacity to
954 meet the needs of the recipients.
955 (b) Whether the recipient has previously received services
956 from one of the plan's primary care providers.
957 (c) Whether primary care providers in one plan are more
958 geographically accessible to the recipient's residence than
959 those in other plans.
960 (d) The recipient’s medical condition or diagnosis, and
961 the availability of a plan to accommodate the condition or
962 diagnosis.
963 (3) OPT OUT OPTION.-The agency shall develop a process to
964 enable any recipient with access to employer-sponsored insurance
965 to opt out of all qualified plans in the Medicaid program and to
966 use Medicaid financial assistance to pay for the recipient's
967 share of the cost in any such plan. Contingent upon federal

968 approval, the agency shall also enable recipients with access to
969 other insurance or related products providing access to health
970 care services created pursuant to state law, including any
971 product available under the Cover Florida Health Access Program,
972 the Florida Health Choices Program, or any health exchange, to
973 opt out. The amount of financial assistance provided for each
974 recipient may not exceed the amount of the Medicaid premium that
975 would have been paid to a plan for that recipient.
976 Section 19. Section 409.978, Florida Statutes, is created
977 to read:
978 409.978 Long-term Care Managed Care Program.—
979 (1) Pursuant to s. 409.963, the agency shall administer
980 the long-term care managed care program described in ss.
981 409.978-409.985, but may delegate specific duties and
982 responsibilities for the program to the Department of Elderly
983 Affairs and other state agencies. By July 1, 2011, the agency
984 shall begin implementation of the statewide long-term care
985 managed care program, with full implementation in all regions by
986 October 1, 2012.
987 (2) The agency shall make payments for long-term care,
988 including home and community-based services, using a managed
989 care model. Unless otherwise specified, the provisions of ss.
990 409.961-409.970 apply to the long-term care managed care
991 program.
992 (3) The Department of Elderly Affairs shall assist the
993 agency to develop specifications for use in the invitation to
994 negotiate and the model contract; determine clinical eligibility
995 for enrollment in managed long-term care plans; monitor plan

996 performance and measure quality of service delivery; assist
997 clients and families to address complaints with the plans;
998 facilitate working relationships between plans and providers
999 serving elders and disabled adults; and perform other functions
1000 specified in a memorandum of agreement.
1001 Section 20. Section 409.979, Florida Statutes, is created
1002 to read:
1003 409.979 Eligibility.—
1004 (1) Medicaid recipients who meet all of the following
1005 criteria are eligible to participate in the long-term care
1006 managed care program. The recipient must be:
1007 (a) Sixty-five years of age or older or eligible for
1008 Medicaid by reason of a disability.
1009 (b) Determined by the Comprehensive Assessment Review and
1010 Evaluation for Long-Term Care Services (CARES) Program to
1011 require nursing facility care.
1012 (2) Medicaid recipients who on the date long-term care
1013 managed care plans becomes available in the recipient's region,
1014 are residing in a nursing home facility or enrolled in one of
1015 the following long-term care Medicaid waiver programs are
1016 eligible to participate in the long-term care managed care
1017 program:
1018 (a) The Assisted Living for the Frail Elderly Waiver.
1019 (b) The Aged and Disabled Adult Waiver.
1020 (c) The Adult Day Health Care Waiver.
1021 (d) The Consumer-Directed Care Plus Program as described
1022 in s. 409.221.
1023 (e) The Program of All-inclusive Care for the Elderly.

1024 (f) The Long-Term Care Community-Based Diversion Pilot
1025 Project as described in s. 430.705.
1026 (g) The Channeling Services Waiver for Frail Elders.
1027 Section 21. Section 409.980, Florida Statutes, is created
1028 to read:
1029 409.980 Benefits.—Managed care plans shall cover, at a
1030 minimum, the following services:
1031 (1) Nursing facility.
1032 (2) Assisted living facility.
1033 (3) Hospice.
1034 (4) Adult day care.
1035 (5) Medical equipment and supplies, including incontinence
1036 supplies.
1037 (5) Personal care.
1038 (7) Home accessibility adaptation.
1039 (9) Behavior management.
1040 (9) Home delivered meals.
1041 (10) Case management.
1042 (11) Therapies:
1043 (a)Occupational therapy
1044 (b) Speech therapy
1045 (c) Respiratory therapy
1046 (d) Physical therapy.
1047 (12) Intermittent and skilled nursing.
1048 (13) Medication administration.
1049 (14) Medication management.
1050 (15) Nutritional assessment and risk reduction.
1051 (16) Caregiver training.

1052 (17) Respite care.
1053 (18) Transportation.
1054 (19) Personal emergency response system.
1055 Section 22. Section 409.981, Florida Statutes, is created
1056 to read:
1057 409.981 Qualified plans.—
1058 (1) QUALIFIED PLANS. For purposes of the long-term care
1059 managed care program, qualified plans also include entities who
1060 are qualified under 42 C.F.R. part 422 as Medicare Advantage
1061 Preferred Provider Organizations, Medicare Advantage Provider-
1062 sponsored Organizations, and Medicare Advantage Special Needs
1063 Plans. Such plans are eligible to participate in the statewide
1064 long-term care managed care program. Qualified plans that are
1065 provider service networks must be long-term care provider
1066 service networks. Qualified plans may either be long-term care
1067 plans that cover benefits pursuant to s. 409.980, or
1068 comprehensive long-term care plans that cover benefits pursuant
1069 to ss. 409.973 and 409.980.
1070 (2) QUALIFIED PLAN SELECTION. The agency shall select
1071 qualified plans through the procurement described in s. 409.966.
1072 The agency shall notice invitations to negotiate no later than
1073 July 1, 2011.
1074 (a) The agency shall procure three plans for Region I. At
1075 least one plan shall be a provider service network, if any
1076 submit a responsive bid.
1077 (b) The agency shall procure at least four and no more
1078 than seven plans for Region II. At least one plan shall be a
1079 provider service network, if any submit a responsive bid.

1080 (c) The agency shall procure at least five plans and no
1081 more than ten plans for Region III. At least two plans shall be
1082 provider service networks, if any two submit a responsive bid.
1083 (d) The agency shall procure at least four plans and no
1084 more than eight plans for Region IV. At least one plan shall be
1085 a provider service network if any submit a responsive bid.
1086 (e) The agency shall procure at least four plans and no
1087 more than seven plans for Region V. At least one plan shall be a
1088 provider service network, if any submit a responsive bid.
1089 (f) The agency shall procure at least five plans and no
1090 more than ten plans for Region VI. At least two plans shall be
1091 provider service networks, if any two submit a responsive bid.
1092 (3) QUALITY SELECTION CRITERIA. In addition to the criteria
1093 established in s. 409.966, the agency shall consider the
1094 following factors in the selection of qualified plans:
1095 (a) Specialized staffing. Plan employment of executive
1096 managers with expertise and experience in serving aged and
1097 disabled persons who require long-term care.
1098 (b) Network qualifications. Plan establishment of a
1099 network of service providers dispersed throughout the region and
1100 in sufficient numbers to meet specific service standards
1101 established by the agency for specialty services for persons
1102 receiving home and community-based care.
1103 (c) Whether a plan is proposing to establish a
1104 comprehensive long-term care plan and whether the qualified plan
1105 has a contract to provide managed medical assistance services in
1106 the same region. The agency shall exercise a preference for such
1107 plans.

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1108 (d) Whether a plan is designated as a medical home network
1109 pursuant to s. 409.91207 or offers consumer-directed care
1110 services to enrollees pursuant to s. 409.221. Consumer-directed
1111 care services provide a flexible budget which is managed by
1112 enrolled individuals and their families or representatives and
1113 allows them to choose providers of services, determine provider
1114 rates of payment and direct the delivery of services to best
1115 meet their special long-term care needs. When all other factors
1116 are equal among competing qualified plans, the agency shall
1117 exercise a preference for such plans.
1118 (e) Evidence that a qualified plan has written agreements
1119 or signed contracts or has made substantial progress in
1120 establishing relationships with providers prior to the plan
1121 submitting a response. The agency shall evaluate and give
1122 special weight to evidence of signed contracts with providers of
1123 critical services pursuant to s. 409.982(2)(a)-(c).
1124 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY. The
1125 Program for All-Inclusive Care for the Elderly (PACE) is a
1126 qualified plan for purposes of the long-term care managed care
1127 program. Participation by PACE shall be pursuant to a contract
1128 with the agency and not subject to the procurement requirements
1129 or regional plan number limits of this section. PACE plans may
1130 continue to provide services to individuals at such levels and
1131 enrollment caps as authorized by the General Appropriations Act.
1132 Section 23. Section 409.982, Florida Statutes, is created
1133 to read:
1134 409.982 Managed care plan accountability.—In addition to
1135 the requirements of s. 409.967, plans and providers

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1136 participating in the long-term care managed care program shall
1137 comply with the requirements of this section.
1138 (1) MEDICAL LOSS RATIO. The agency shall establish and
1139 plans shall use a uniform method of accounting and reporting
1140 long-term care service costs, direct care management costs, and
1141 administrative costs. The agency shall evaluate plan spending
1142 patterns beginning after the plan completes 2 full years of
1143 operation and at least annually thereafter. The agency shall
1144 implement the following thresholds and consequences of various
1145 spending patterns:
1146 (a) Plans that spend less than 75 percent of Medicaid
1147 premium revenue on long-term care services, including direct
1148 care management as determined by the agency shall be excluded
1149 from automatic enrollments and shall be required to pay back the
1150 amount between actual spending and 85 percent of the Medicaid
1151 premium revenue.
1152 (b) Plans that spend less than 85 percent of Medicaid
1153 premium revenue on long-term care services, including direct
1154 care management as determined by the agency shall be required to
1155 pay back the amount of the difference between actual spending
1156 and 85 percent of Medicaid premium revenue.
1157
1158 (c) Plans that spend more than 92 percent of Medicaid
1159 premium revenue on long-term care services, including direct
1160 care management as determined by the agency shall be evaluated
1161 by the agency to determine whether higher expenditures are the
1162 result of failures in care management. Such a determination may
1163 result in the plan being excluded from automatic enrollments.

1164 (2) PROVIDER NETWORKS. Plans may limit the providers in
1165 their networks based on credentials, quality indicators, and
1166 price. However, in the first contract period after a qualified
1167 plan is selected in a region by the agency, the plan must offer
1168 a network contract to the following providers in the region:
1169 (a) Nursing homes.
1170 (b) Hospices.
1171 (c) Aging network service providers that have previously
1172 participated in home and community-based waivers serving elders
1173 or community-service programs administered by the Department of
1174 Elderly Affairs.
1175
1176 After 12 months of active participation in a plan's network, the
1177 plan may exclude any of the providers named in this subsection
1178 from the network for failure to meet quality or performance
1179 criteria.
1180 (3) SELECT PROVIDER PARTICIPATION. Except as provided in
1181 this subsection, providers may limit the plans they join.
1182 Nursing homes and hospices must participate in all qualified
1183 plans selected by the agency in the region in which the provider
1184 is located.
1185 (4) PERFORMANCE MEASUREMENT. Each plan shall monitor the
1186 quality and performance of each participating provider. At the
1187 beginning of the contract period, each plan shall notify all its
1188 network providers of the metrics used by the plan for evaluating
1189 the provider's performance and determining continued
1190 participation in the network.
1191 (5) PROVIDER NETWORK STANDARDS. The agency shall establish

1192 and each plan must comply with specific standards for the
1193 number, type, and regional distribution of providers in the
1194 plan's network, which must include:
1195 (a) Adult day centers.
1196 (b) Adult family care homes.
1197 (c) Assisted living facilities.
1198 (d) Health care services pools.
1199 (e) Home health agencies.
1200 (f) Homemaker and companion services.
1201 (g) Hospices.
1202 (h) Community Care for the Elderly Lead Agencies.
1203 (i) Nurse registries.
1204 (j) Nursing homes.
1205 (6) PROVIDER PAYMENT. Plans and providers shall negotiate
1206 mutually acceptable rates, methods, and terms of payment. Plans
1207 shall pay nursing homes an amount equal to the nursing facility-
1208 specific payment rates set by the agency. Plans shall pay
1209 hospice providers an amount equal to the per diem rate set by
1210 the agency. For recipients residing in a nursing facility and
1211 receiving hospice services, the plan shall pay the hospice
1212 provider the per diem rate set by the agency minus the nursing
1213 facility component and shall pay the nursing facility the
1214 appropriate state rate.
1215 Section 24. Section 409.983, Florida Statutes, is created
1216 to read:
1217 409.983 Managed care plan payment.—In addition to the
1218 payment provisions of s. 409.968, the agency shall provide

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1219 payment to plans in the long-term care managed care program
1220 pursuant to this section.
1221 (1) Prepaid payment rates for long-term care managed care
1222 plans shall be negotiated between the agency and the qualified
1223 plans as part of the procurement described in s. 409.966.
1224 (2) Payment rates for comprehensive long-term care plans
1225 covering services described in s. 409.973 shall be combined with
1226 rates for long-term care plans for services specified in s.
1227 409.980.
1228 (3) Payment rates for plans shall reflect historic
1229 utilization and spending for covered services projected forward
1230 and adjusted to reflect the level of care profile for enrollees
1231 of each plan. The payment shall be adjusted to provide an
1232 incentive for reducing institutional placements and increasing
1233 the utilization of home and community-based services.
1234 (4) The initial assessment of an enrollee's level of care
1235 shall be made by the Comprehensive Assessment and Review for
1236 Long-Term-Care Services (CARES) program, which shall assign the
1237 recipient into one of the following levels of care:
1238 (a) Level of care 1 consists of recipients residing in
1239 nursing homes or needing immediate placement in a nursing home.
1240 (b) Level of care 2 consists of recipients who require the
1241 constant availability of routine medical and nursing treatment
1242 and care, and require extensive health-related care and services
1243 because of mental or physical incapacitation.
1244 (c) Level of care 3 consists of recipients who require the
1245 constant availability of routine medical and nursing treatment
1246 and care, have a limited need for health-related care and

1247 services, are mildly medically or physically incapacitated, and
1248 have a priority score of 5 or above.
1249
1250 The agency shall periodically adjust payment rates to account
1251 for changes in the level of care profile for each plan based on
1252 encounter data.
1253 (5) The incentive adjustment for reducing institutional
1254 placements shall be modified in each successive rate period
1255 during the contract in order to encourage a progressive
1256 rebalancing of the spending distribution for institutional and
1257 community services. The expected change toward more home and
1258 community-based services shall be a 5 percent or greater annual
1259 increase in the ratio of home and community-based service
1260 expenditures compared to nursing facility expenditures.
1261 (6) The agency shall establish nursing facility-specific
1262 payment rates for each licensed nursing home based on facility
1263 costs adjusted for inflation and other factors. Payments to
1264 long-term care managed care plans shall be reconciled to
1265 reimburse actual payments to nursing facilities.
1266 (7) The agency shall establish hospice payment rates.
1267 Payments to long-term care managed care plans shall be
1268 reconciled to reimburse actual payments to hospices.
1269 Section 25. Section 409.984, Florida Statutes, is created
1270 to read:
1271 409.984 Choice counseling; enrollment.—
1272 (1) CHOICE COUNSELING. Before contracting with a vendor
1273 to provide choice counseling as authorized under s. 409.969, the
1274 agency shall offer to contract with aging resource centers

1275 established under s. 430.2053 for choice counseling services. If
1276 the aging resource center is determined not to be the vendor
1277 that provides choice counseling, the agency shall establish a
1278 memorandum of understanding with the aging resource center to
1279 coordinate staffing and collaborate with the choice counseling
1280 vendor.
1281 (2) AUTOMATIC ENROLLMENT. The agency shall automatically
1282 enroll into a long-term care managed care plan those Medicaid
1283 recipients who do not voluntarily choose a plan pursuant to s.
1284 409.969. The agency shall automatically enroll recipients in
1285 plans that meet or exceed the performance or quality standards
1286 established pursuant to s. 409.967, and shall not automatically
1287 enroll recipients in a plan that is deficient in those
1288 performance or quality standards. The agency shall assign
1289 individuals who are deemed dually eligible for Medicaid and
1290 Medicare to a plan that provides both Medicaid and Medicare
1291 services. The agency may not engage in practices that are
1292 designed to favor one managed care plan over another. When
1293 automatically enrolling recipients in plans, the agency shall
1294 take into account the following criteria:
1295 (a) Whether the plan has sufficient network capacity to
1296 meet the needs of the recipients.
1297 (b) Whether the recipient has previously received services
1298 from one of the plan's home and community-based service
1299 providers.
1300 (c) Whether the home and community-based providers in one
1301 plan are more geographically accessible to the recipient's
1302 residence than those in other plans.

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1303 (3) Notwithstanding the provisions 409.969(3)(c), when a
1304 recipient is referred for hospice services, the recipient shall
1305 have a 30-day period in which the recipient may select to enroll
1306 in another plan to access the hospice provider of the
1307 recipient's choice.
1308
1309 Section 26. Section 409.985, Florida Statutes, is created
1310 to read:
1311 409.985 Comprehensive Assessment and Review for Long-Term
1312 Care Services (CARES) Program.—
1313 (1) The agency shall operate the Comprehensive Assessment
1314 and Review for Long-Term Care Services (CARES) preadmission
1315 screening program to ensure that only individuals whose
1316 conditions require long-term care services are enrolled in the
1317 long-term care managed care program.
1318 (2) The agency shall operate the CARES program through an
1319 interagency agreement with the Department of Elderly Affairs.
1320 The agency, in consultation with the Department of Elderly
1321 Affairs, may contract for any function or activity of the CARES
1322 program, including any function or activity required by 42
1323 C.F.R. part 483.20, relating to preadmission screening and
1324 review.
1325 (3) The CARES program shall determine if an individual
1326 requires nursing facility care and, if the individual requires
1327 such care, assign the individual to a level of care as described
1328 in s. 409.983(4). For the purposes of the long-term care managed
1329 care program, "nursing facility care" means the individual:
1330 (a) Requires the constant availability of routine medical

1331 and nursing treatment and care, and requires extensive health-
1332 related care and services because of mental or physical
1333 incapacitation; or
1334 (b) Requires the constant availability of routine medical
1335 and nursing treatment and care, has a limited need for health-
1336 related care and services, is mildly medically or physically
1337 incapacitated, and has a priority score of 5 or above.
1338 (4) For individuals whose nursing home stay is initially
1339 funded by Medicare and Medicare coverage is being terminated for
1340 lack of progress towards rehabilitation, CARES staff shall
1341 consult with the person making the determination of progress
1342 toward rehabilitation to ensure that the recipient is not being
1343 inappropriately disqualified from Medicare coverage. If, in
1344 their professional judgment, CARES staff believes that a
1345 Medicare beneficiary is still making progress toward
1346 rehabilitation, they may assist the Medicare beneficiary with an
1347 appeal of the disqualification from Medicare coverage. The use
1348 of CARES teams to review Medicare denials for coverage under
1349 this section is authorized only if it is determined that such
1350 reviews qualify for federal matching funds through Medicaid. The
1351 agency shall seek or amend federal waivers as necessary to
1352 implement this section.
1353 Section 27. Section 409.986, Florida Statutes, is created
1354 to read:
1355 409.986 .Managed Long-Term Care for Persons with
1356 Developmental Disabilities—
1357 (1) Pursuant to s. 409.963, the agency is responsible for
1358 administering the long-term care managed care program for

1359 persons with developmental disabilities described in ss.
1360 409.986-409.992, but may delegate specific duties and
1361 responsibilities for the program to the Agency for Persons with
1362 Disabilities and other state agencies. By January 1, 2014, the
1363 agency shall begin implementation of statewide long-term care
1364 managed care for persons with developmental disabilities, with
1365 full implementation in all regions by October 1, 2015.
1366 (2) The agency shall make payments for long-term care for
1367 persons with developmental disabilities, including home and
1368 community-based services, using a managed care model. Unless
1369 otherwise specified, the provisions of ss. 409.961-409.970 apply
1370 to the long-term care managed care program for persons with
1371 developmental disabilities.
1372 (3) The Agency for Persons with Disabilities shall assist
1373 the agency to develop the specifications for use in the
1374 invitations to negotiate and the model contract; determine
1375 clinical eligibility for enrollment in long-term care plans for
1376 persons with developmental disabilities; assist the agency to
1377 monitor plan performance and measure quality; assist clients and
1378 families to address complaints with the plans; facilitate
1379 working relationships between plans and providers serving
1380 persons with developmental disabilities; and perform other
1381 functions specified in a memorandum of agreement.
1382 Section 28. Section 409.987, Florida Statutes, is created
1383 to read:
1384 409.987 Eligibility.—
1385 (1) Medicaid recipients who meet all of the following
1386 criteria are eligible to be enrolled in a developmental

1387 disabilities comprehensive long-term care plan or developmental
1388 disabilities long-term care plan:
1389 (a) Medicaid eligible pursuant to income and asset tests
1390 in state and federal law.
1391 (b) A Florida resident who has a developmental disability
1392 as defined in s. 393.063.
1393 (c) Meets the level of care need including:
1394 1. The recipient's intelligence quotient is 59 or less;
1395 2. The recipient's intelligence quotient is 60-69,
1396 inclusive, and the recipient has a secondary handicapping
1397 condition that includes cerebral palsy, spina bifida, Prader-
1398 Willi syndrome, epilepsy, or autism; or ambulation, sensory,
1399 chronic health, and behavioral problems;
1400 3. The recipient's intelligence quotient is 60-69,
1401 inclusive, and the recipient has severe functional limitations
1402 in at least three major life activities including self-care,
1403 learning, mobility, self-direction, understanding and use of
1404 language, and capacity for independent living; or
1405 4. The recipient is eligible under a primary disability of
1406 autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.
1407 In addition, the condition must result in substantial functional
1408 limitations in three or more major life activities, including
1409 self-care, learning, mobility, self-direction, understanding and
1410 use of language, and capacity for independent living.
1411 (d) Meets the level of care need for services in an
1412 intermediate care facility for the developmentally disabled.
1413 (e) Is enrolled or has been offered enrollment in one of
1414 the four tier waivers established in s. 393.0661(3) or the

1415 recipient is a Medicaid-funded resident of a private
1416 intermediate care facility for the developmentally disabled
1417 onthe date the managed long-term care plans for persons with
1418 disabilities become available in the recipient's region.
1419 (2) Unless specifically exempted, all eligible persons must
1420 be enrolled in a developmental disabilities comprehensive long-
1421 term care plan or a developmental disabilities long-term care
1422 plan. Medicaid recipients who are residents of a developmental
1423 disability center including Sunland Center in Marianna and
1424 Tacachale Center in Gainesville are exempt from mandatory
1425 enrollment, but may voluntarily enroll in a long-term care plan.
1426 Section 29. Section 409.988, Florida Statutes, is created
1427 to read:
1428 409.988 Benefits.-Managed care plans shall cover, at a
1429 minimum, the services in this section. Plans may customize
1430 benefit packages or offer additional benefits to meet the needs
1431 of enrollees in the plan.
1432 (1) Intermediate care for developmentally disabled.
1433 (2) Alternative residential services, including, but not
1434 limited to:
1435 (a) Group homes and foster care homes licensed pursuant to
1436 chapters 393 and 409.
1437 (b) Comprehensive transitional education programs licensed
1438 pursuant to chapter 393.
1439 (c) Residential habilitation centers licensed pursuant to
1440 chapter 393.
1441 (d) Assisted living facilities, and transitional living
1442 facilities licensed pursuant to chapters 400 and 429.

1443 (3) Adult day training.
1444 (4) Behavior analysis services.
1445 (5) Companion services.
1446 (6) Consumable medical supplies.
1447 (7) Durable medical equipment and supplies.
1448 (8) Environmental accessibility adaptations.
1449 (9) In-home support services.
1450 (10) Therapies, including occupational, speech,
1451 respiratory, and physical therapy.
1452 (11) Personal care assistance.
1453 (12) Residential habilitation services.
1454 (13) Intensive behavior residential habilitation services.
1455 (14) Behavior focus residential habilitation services.
1456 (15) Residential nursing services.
1457 (16) Respite care.
1458 (17) Case management.
1459 (18) Supported employment.
1460 (19) Supported living coaching.
1461 (20) Transportation.
1462 Section 30. Section 409.989, Florida Statutes, is created
1463 to read:
1464 409.989 Qualified plans.—
1465 (1) QUALIFIED PLANS. Qualified plans may either be
1466 developmental disabilities long-term care plans that cover
1467 benefits pursuant to s. 409.988, or developmental disabilities
1468 comprehensive long- term care plans that cover benefits pursuant
1469 to ss. 409.973 and 409.988.

1470 (2) SPECIALTY PROVIDER SERVICE NETWORKS. Provider service
1471 networks targeted to serve persons with disabilities must
1472 include one or more owners licensed pursuant to s. 393.067 or s.
1473 400.962 and with at least 10 years experience in serving this
1474 population.
1475 (3) QUALIFIED PLAN SELECTION. The agency shall select
1476 qualified plans through the procurement described in s. 409.966.
1477 The agency shall notice invitations to negotiate no later than
1478 January 1, 2014.
1479 (a) The agency shall procure two plans for Region I. At
1480 least one plan shall be a provider service network, if any
1481 submit a responsive bid.
1482 (b) The agency shall procure at least two and no more than
1483 five plans for Region II. At least one plan shall be a provider
1484 service network, if any submit a responsive bid.
1485 (c) The agency shall procure at least three plans and no
1486 more than six plans for Region III. At least one plan shall be a
1487 provider service network, if any submit a responsive bid.
1488 (d) The agency shall procure at least three plans and no
1489 more than six plans for Region IV. At least one plan shall be a
1490 provider service network if any submit a responsive bid.
1491 (e) The agency shall procure at least three plans and no
1492 more than six plans for Region V. At least one plan shall be a
1493 provider service network, if any submit a responsive bid.
1494 (f) The agency shall procure at least three plans and no
1495 more than six plans for Region VI. At least one plan shall be a
1496 provider service network, if any submit a responsive bid.

1497 (4) QUALITY SELECTION CRITERIA. In addition to the
1498 criteria established in s. 409.966, the agency shall consider
1499 the following factors in the selection of qualified plans:
1500 (a) Specialized staffing. Plan employment of executive
1501 managers with expertise and experience in serving persons with
1502 developmental disabilities.
1503 (b) Network qualifications. Plan establishment of a
1504 network of service providers dispersed throughout the region and
1505 in sufficient numbers to meet specific accessibility standards
1506 established by the agency for specialty services for persons
1507 with developmental disabilities.
1508 (c) Whether the plan has proposed to be a developmental
1509 disabilities comprehensive long-term care plan and has a
1510 contract to provide managed medical assistance services in the
1511 same region. The agency shall exercise a preference for such
1512 plans.
1513 (d) Whether the plan offers consumer-directed care
1514 services to enrollees pursuant to s. 409.221. Consumer-directed
1515 care services provide a flexible budget which is managed by
1516 enrolled individuals and their families or representatives and
1517 allows them to choose providers of services, determine provider
1518 rates of payment and direct the delivery of services to best
1519 meet their special long-term care needs. When all other factors
1520 are equal among competing qualified plans, the agency shall
1521 exercise a preference for such plans.
1522 (e) Evidence that a qualified plan has written agreements
1523 or signed contracts or has made substantial progress in
1524 establishing relationships with providers prior to the plan

1525 submitting a response. The agency shall evaluate and give
1526 special weight to evidence of signed contracts with providers of
1527 critical services pursuant to s. 409.990(2)a)-(b).
1528 (5) The Children's Medical Services Network authorized
1529 under chapter 391 is a qualified plan for purposes of the
1530 developmental disabilities long-term care plans and
1531 developmental disabilities comprehensive long-term care plans.
1532 Participation by the Children's Medical Services Network shall
1533 be pursuant to a single, statewide contract with the agency not
1534 subject to the procurement requirements or regional plan number
1535 limits of this section. The Children's Medical Services Network
1536 must meet all other plan requirements.
1537 Section 31. Section 409.990, Florida Statutes, is created
1538 to read:
1539 409.990 Managed care plan accountability.—In addition to
1540 the requirements of s. 409.967, qualified plans and providers
1541 shall comply with the requirements of this section.
1542 (1) MEDICAL LOSS RATIO. The agency shall establish and
1543 plans shall use a uniform method of accounting and reporting
1544 long-term care service costs, direct care management costs, and
1545 administrative costs. The agency shall evaluate plan spending
1546 patterns beginning after the plan completes 2 full years of
1547 operation and at least annually thereafter. The agency shall
1548 implement the following thresholds and consequences of various
1549 spending patterns:
1550 (a) Plans that spend less than 75 percent of Medicaid
1551 premium revenue on long-term care services, including direct
1552 care management as determined by the agency shall be excluded

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1553 from automatic enrollments and shall be required to pay back the
1554 amount between actual spending and 85 percent of the Medicaid
1555 premium revenue.
1556 (b) Plans that spend less than 85 percent of Medicaid
1557 premium revenue on long-term care services, including direct
1558 care management as determined by the agency shall be required to
1559 pay back the amount between actual spending and 85 percent of
1560 the Medicaid premium revenue.
1561
1562 (c) Plans that spend more than 92 percent of Medicaid
1563 premium revenue on long-term care services including direct care
1564 management shall be evaluated by the agency to determine whether
1565 higher expenditures are the result of failures in care
1566 management. Such a determination may result in the plan being
1567 excluded from automatic enrollments.
1568 (2) PROVIDER NETWORKS. Plans may limit the providers in
1569 their networks based on credentials, quality indicators, and
1570 price. However, in the first contract period after a qualified
1571 plan is selected in a region by the agency, the plan must offer
1572 a network contract to the following providers in the region:
1573 (a) Providers with licensed institutional care facilities
1574 for the developmentally disabled.
1575 (b) Providers of alternative residential facilities
1576 specified in s.409.988.
1577
1578 After 12 months of active participation in a plan's network, the
1579 plan may exclude any of the above-named providers from the
1580 network for failure to meet quality or performance criteria.

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1581 (3) SELECT PROVIDER PARTICIPATION. Except as provided in
1582 this paragraph, providers may limit the plans they join.
1583 Licensed institutional care facilities for the developmentally
1584 disabled with an active Medicaid provider agreement must agree
1585 to participate in any qualified plan selected by the agency in
1586 the region in which the provider is located.
1587 (4) PERFORMANCE MEASUREMENT. Each plan shall monitor the
1588 quality and performance of each participating provider. At the
1589 beginning of the contract period, each plan shall notify all its
1590 network providers of the metrics used by the plan for evaluating
1591 the provider's performance and determining continued
1592 participation in the network.
1593 (5) PROVIDER PAYMENT.Plans and providers shall negotiate
1594 mutually acceptable rates, methods, and terms of payment. Plans
1595 shall pay intermediate care facilities for the developmentally
1596 disabled an amount equal to the facility-specific payment rate
1597 set by the agency.
1598 (6) CONSUMER AND FAMILY INVOLVEMENT. Plans must establish
1599 a family advisory committee to participate in program design and
1600 oversight.
1601 Section 32. Section 409.991, Florida Statutes, is created
1602 to read:
1603 409.991 Managed care plan payment.—In addition to the
1604 payment provisions of s. 409.968, the agency shall provide
1605 payment to developmental disabilities comprehensive long-term
1606 care plans and developmental disabilities long-term care plans
1607 pursuant to this section.
1608 (1) Prepaid payment rates shall be negotiated between the

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1609 agency and the qualified plans as part of the procurement
1610 described in s. 409.966.
1611 (2) Payment for developmental disabilities comprehensive
1612 long-term care plans covering services pursuant to s. 409.973
1613 shall be combined with payments for developmental disabilities
1614 long-term care plans for services specified in s. 409.988.
1615 (3) Payment rates for plans covering service specified in
1616 s. 409.988 shall be based on historical utilization and spending
1617 for covered services projected forward and adjusted to reflect
1618 the level of care profile of each plan's enrollees.
1619 (4) The Agency for Persons with Disabilities shall conduct
1620 the initial assessment of an enrollee's level of care. The
1621 evaluation of level of care shall be based on assessment and
1622 service utilization information from the most recent version of
1623 the Questionnaire for Situational Information and encounter
1624 data.
1625 (5) Payment rates for developmental disabilities long-term
1626 care plans shall be classified into five levels of care to
1627 account for variations in risk status and service needs among
1628 enrollees.
1629 (a) Level of care 1 consists of individuals receiving
1630 services in an intermediate care facility for the
1631 developmentally disabled.
1632 (b) Level of care 2 consists of individuals with intensive
1633 medical or adaptive needs and that are essential for avoiding
1634 institutionalization, or who possess behavioral problems that
1635 are exceptional in intensity, duration, or frequency and present
1636 a substantial risk of harm to themselves or others.

1637 (c) Level of care 3 consists of individuals with service
1638 needs, including a licensed residential facility and a moderate
1639 level of support for standard residential habilitation services
1640 or a minimal level of support for behavior focus residential
1641 habilitation services, or individuals in supported living who
1642 require more than 6 hours a day of in-home support services.
1643 (d) Level of care 4 consists of individuals requiring less
1644 than moderate level of residential habilitation support in a
1645 residential placement, or individuals in independent or
1646 supported living situations, or who live in their family home.
1647 (e) Level of care 5 consists of individuals requiring
1648 minimal support services while living in independent or
1649 supported living situations and individuals who live in their
1650 family home.
1651
1652 The agency shall periodically adjust payment rates to account
1653 for changes in the level of care profile of each plan's
1654 enrollees based on encounter data.
1655 (6) The agency will establish intermediate care facility
1656 for the developmentally disabled-specific payment rates for each
1657 licensed intermediate care facility based on facility costs
1658 adjusted for inflation and other factors. Payments to
1659 intermediate care facilities for the developmentally disabled
1660 shall be reconciled to reimburse the plan's actual payments to
1661 the facilities.
1662 Section 33. Section 409.992, Florida Statutes, is created
1663 to read:
1664 409.992 Automatic Enrollment.—

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1666 (1) The agency shall automatically enroll into a
1667 developmental disabilities comprehensive long-term care plan or
1668 a developmental disabilities long-term care plan those Medicaid
1669 recipients who do not voluntarily choose a plan pursuant to s.
1670 409.969. The agency shall automatically enroll recipients in
1671 plans that meet or exceed the performance or quality standards
1672 established pursuant to s. 409.967, and shall not automatically
1673 enroll recipients in a plan that is deficient in those
1674 performance or quality standards. The agency shall assign
1675 individuals who are deemed dually eligible for Medicaid and
1676 Medicare, to a plan that provides both Medicaid and Medicare
1677 services. The agency may not engage in practices that are
1678 designed to favor one managed care plan over another. When
1679 automatically enrolling recipients in plans, the agency shall
1680 take into account the following criteria:
1681 (a) Whether the plan has sufficient network capacity to
1682 meet the needs of the recipients.
1683 (b) Whether the recipient has previously received services
1684 from one of the plan's home and community-based service
1685 providers.
1686 (c) Whether home and community-based providers in one plan
1687 are more geographically accessible to the recipient's residence
1688 than those in other plans.
1689 Section 34. This act shall take effect July 1, 2010.

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