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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 eligible plans that provide services in
 20 the Medicaid managed care program; establishing provider
 21 service network requirements for eligible plans; providing
 22 for eligible plan selection; requiring the agency to use
 23 an invitation to negotiate; requiring the agency to
 24 compile and publish certain information; establishing
 25 seven regions for separate procurement of plans; providing
 26 quality criteria for plan selection; providing limitations
 27 on serving recipients during the pendency of procurement
 28 litigation; creating s. 409.967, F.S.; providing for

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29 managed care plan accountability; establishing contract
 30 terms; providing for contract extension under certain
 31 circumstances; establishing payments to noncontract
 32 providers; establishing requirements for access; requiring
 33 plans to establish and maintain an electronic database;
 34 establishing requirements for the database; requiring
 35 plans to provide encounter data; requiring the agency to
 36 maintain an encounter data system; requiring the agency to
 37 establish performance standards for plans; providing
 38 program integrity requirements; establishing a grievance
 39 resolution process; providing for penalties for early
 40 termination of contracts or reduction in enrollment
 41 levels; establishing prompt payment requirements;
 42 requiring plans to accept electronic claims; requiring
 43 fair payment to providers with a controlling interest in a
 44 provider service network by other plans; requiring the
 45 agency and prepaid plans to use a uniform method for
 46 certain financial reports; providing income-sharing
 47 ratios; providing a timeframe for a plan to pay an
 48 additional rebate under certain circumstances; requiring
 49 the agency to return prepaid plan overpayments; creating
 50 s. 409.968, F.S.; establishing managed care plan payments;
 51 providing payment requirements for provider service
 52 networks; requiring the agency to conduct annual cost
 53 reconciliations to determine certain cost savings and
 54 report the results of the reconciliations to the fee-for-
 55 service provider; providing a timeframe for the provider
 56 service to respond to the report; creating s. 409.969,

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57 F.S.; requiring enrollment in managed care plans by all
 58 nonexempt Medicaid recipients; creating requirements for
 59 plan selection by recipients; providing for choice
 60 counseling; establishing choice counseling vendor
 61 requirements; authorizing disenrollment under certain
 62 circumstances; defining the term "good cause" for purposes
 63 of disenrollment; providing time limits on an internal
 64 grievance process; providing requirements for agency
 65 determination regarding disenrollment; requiring
 66 recipients to stay in plans for a specified time; creating
 67 s. 409.970, F.S.; authorizing the agency to accept the
 68 transfer of certain revenues from local governments;
 69 requiring the agency to contract with a representative of
 70 certain entities participating in the low-income pool for
 71 the provision of enhanced access to care; providing for
 72 support of these activities by the low-income pool as
 73 authorized in the General Appropriations Act; establishing
 74 the Access to Care Partnership; requiring the agency to
 75 seek necessary waivers and plan amendments; providing
 76 requirements for prepaid plans to submit data; authorizing
 77 the agency to implement a tiered hospital rate system;
 78 creating s. 409.971, F.S.; creating the managed medical
 79 assistance program; providing deadlines to begin and
 80 finalize implementation of the program; creating s.
 81 409.972, F.S.; providing eligibility requirements for
 82 mandatory and voluntary enrollment; creating s. 409.973,
 83 F.S.; establishing minimum benefits for managed care plans
 84 to cover; authorizing plans to customize benefit packages;

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85 requiring plans to establish a program to encourage
 86 healthy behaviors; creating s. 409.974, F.S.; establishing
 87 a deadline for issuing invitations to negotiate;
 88 establishing a specified number or range of eligible plans
 89 to be selected in each region; establishing quality
 90 selection criteria; establishing requirements for
 91 participation by specialty plans; establishing the
 92 Children's Medical Service Network as an eligible plan;
 93 creating s. 409.975, F.S.; providing for managed care plan
 94 accountability; authorizing plans to limit providers in
 95 networks; requiring plans to include essential Medicaid
 96 providers in their networks unless an alternative
 97 arrangement is approved by the agency; providing for an
 98 achieved savings rebate; identifying statewide essential
 99 providers; specifying provider payments under certain
 100 circumstances; requiring plans to include certain
 101 statewide essential providers in their networks; requiring
 102 good faith negotiations; specifying provider payments
 103 under certain circumstances; allowing plans to exclude
 104 essential providers under certain circumstances; requiring
 105 plans to offer a contract to home medical equipment and
 106 supply providers under certain circumstances; establishing
 107 the Florida medical school quality network; requiring the
 108 agency to contract with a representative of certain
 109 entities to establish a clinical outcome improvement
 110 program in all plans; providing for support of these
 111 activities by certain expenditures and federal matching
 112 funds; requiring the agency to seek necessary waivers and

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113 | plan amendments; providing for eligibility for the quality
 114 | network; requiring plans to monitor the quality and
 115 | performance history of providers; establishing the MomCare
 116 | Network; requiring the agency to contract with a
 117 | representative of all Healthy Start Coalitions to provide
 118 | certain services to recipients; providing for support of
 119 | these activities by certain expenditures and federal
 120 | matching funds; requiring plans to enter into agreements
 121 | with local Healthy Start Coalitions for certain purposes;
 122 | requiring specified programs and procedures be established
 123 | by plans; establishing a screening standard for Early,
 124 | Periodic Screening, Diagnosis and Treatment program;
 125 | requiring managed care plans and hospitals to negotiate
 126 | rates, methods, and terms of payment; providing a limit on
 127 | payments to hospitals; establishing plan requirements for
 128 | medically needy recipients; creating s. 409.976, F.S.;
 129 | providing for managed care plan payment; requiring the
 130 | agency to establish payment rates for statewide inpatient
 131 | psychiatric programs; requiring payments to managed care
 132 | plans to be reconciled to reimburse actual payments to
 133 | statewide inpatient psychiatric programs; creating s.
 134 | 409.977, F.S.; establishing choice counseling
 135 | requirements; providing for automatic enrollment in a
 136 | managed care plan for certain recipients; establishing
 137 | opt-out opportunities for recipients; creating s. 409.978,
 138 | F.S.; requiring the agency to be responsible for
 139 | administering the long-term care managed care program;
 140 | providing implementation dates for the long-term care

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141 managed care program; providing duties of the Department
 142 of Elderly Affairs relating to assisting the agency in
 143 implementing the program; creating s. 409.979, F.S.;
 144 providing eligibility requirements for the long-term care
 145 managed care program; creating s. 409.980, F.S.;
 146 establishing the benefits covered under a managed care
 147 plan participating in the long-term care managed care
 148 program; creating s. 409.981, F.S.; providing criteria for
 149 eligible plans; designating regions for plan
 150 implementation throughout the state; providing criteria
 151 for the selection of plans to participate in the long-term
 152 care managed care program; providing that participation by
 153 the Program of All-Inclusive Care for the Elderly is
 154 pursuant to an agency contract; creating s. 409.982, F.S.;
 155 requiring the agency to establish uniform accounting and
 156 reporting methods for plans; providing for mandatory
 157 participation in plans by certain service providers;
 158 authorizing the exclusion of certain providers from plans
 159 for failure to meet quality or performance criteria;
 160 requiring plans to monitor participating providers using
 161 specified criteria; requiring certain providers to be
 162 included in plan networks; providing provider payment
 163 specifications for nursing homes and hospices; creating s.
 164 409.983, F.S.; providing for negotiation of rates between
 165 the agency and the plans participating in the long-term
 166 care managed care program; providing specific criteria for
 167 calculating and adjusting plan payments; allowing the
 168 CARES program to assign plan enrollees to a level of care;

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169 providing incentives for adjustments of payment rates;
 170 providing the agency shall establish nursing facility-
 171 specific and hospice services payment rates; creating s.
 172 409.984, F.S.; providing that prior to contracting with
 173 another vendor, the agency shall offer to contract with
 174 the aging resource centers to provide choice counseling
 175 for the long-term care managed care program; providing
 176 criteria for automatic assignments of plan enrollees who
 177 fail to chose a plan; providing for hospice selection
 178 within a specified timeframe; providing for a choice of
 179 residential setting under certain circumstances; creating
 180 s. 409.9841; creating the long-term care managed care
 181 technical advisory workgroup; providing duties; providing
 182 membership; providing for reimbursement for per diem and
 183 travel expenses; providing for repeal by a specified date;
 184 creating s. 409.985, F.S.; providing that the agency shall
 185 operate the Comprehensive Assessment and Review for Long-
 186 Term Care Services program through an interagency
 187 agreement with the Department of Elderly Affairs;
 188 providing duties of the program; defining the term
 189 "nursing facility care"; creating s. 409.986, F.S.;
 190 providing authority and agency duties regarding long-term
 191 care programs for persons with developmental disabilities;
 192 authorizing the agency to delegate specific duties to and
 193 collaborate with the Agency for Persons with Disabilities;
 194 requiring the agency to make payments for long-term care
 195 for persons with developmental disabilities under certain
 196 conditions; creating s. 409.987, F.S.; providing

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197 | eligibility requirements for long-term care plans;
 198 | creating s. 409.988, F.S.; specifying covered benefits for
 199 | long-term care plans; creating s. 409.989, F.S.;
 200 | establishing criteria for eligible plans; specifying
 201 | minimum and maximum number of plans and selection
 202 | criteria; authorizing participation by the Children's
 203 | Medical Services Network in long-term care plans under
 204 | certain conditions; creating s. 409.990, F.S.; providing
 205 | requirements for managed care plan accountability;
 206 | specifying limitations on providers in plan networks;
 207 | providing for evaluation and payment of network providers;
 208 | requiring managed care plans to establish family advisory
 209 | committees; creating s. 409.991, F.S.; providing for
 210 | payment of managed care plans; providing duties for the
 211 | Agency for Persons with Disabilities to assign plan
 212 | enrollees into a payment rate level of care; establishing
 213 | level-of-care criteria; providing payment requirements for
 214 | intensive behavior residential habilitation providers and
 215 | intermediate care facilities for the developmentally
 216 | disabled; creating s. 409.992, F.S.; providing
 217 | requirements for enrollment and choice counseling;
 218 | specifying enrollment exceptions for certain Medicaid
 219 | recipients; providing an effective date.

220 |
 221 | Be It Enacted by the Legislature of the State of Florida:
 222 |

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

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

228 409.961 Statutory construction; applicability; rules.—It
 229 is the intent of the Legislature that if any conflict exists
 230 between the provisions contained in this part and provisions
 231 contained in other parts of this chapter, the provisions
 232 contained in this part shall control. The provisions of ss.
 233 409.961-409.970 apply only to the Medicaid managed medical
 234 assistance program, long-term care managed care program, and
 235 managed long-term care for persons with developmental
 236 disabilities program, as provided in this part. The agency shall
 237 adopt any rules necessary to comply with or administer this part
 238 and all rules necessary to comply with federal requirements. In
 239 addition, the department shall adopt and accept the transfer of
 240 any rules necessary to carry out the department's
 241 responsibilities for receiving and processing Medicaid
 242 applications and determining Medicaid eligibility and for
 243 ensuring compliance with and administering this part, as those
 244 rules relate to the department's responsibilities, and any other
 245 provisions related to the department's responsibility for the
 246 determination of Medicaid eligibility.

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

249 409.962 Definitions.—As used in this part, except as
 250 otherwise specifically provided, the term:

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- 251 (1) "Agency" means the Agency for Health Care
 252 Administration.
- 253 (2) "Aging network service provider" means a provider that
 254 participated in a home and community-based waiver administered
 255 by the Department of Elderly Affairs or the community care
 256 service system pursuant to s. 430.205, as of October 1, 2013.
- 257 (3) "Comprehensive long-term care plan" means a managed
 258 care plan that provides services described in s. 409.973 and
 259 also provides the services described in s.409.980 or s. 409.988
- 260 (4) "Department" means the Department of Children and
 261 Family Services.
- 262 (5) "Developmental disability provider service network"
 263 means a provider service network, a controlling interest of
 264 which includes one or more entities licensed pursuant to s.
 265 393.067 or s. 400.962 with 18 or more licensed beds and the
 266 owner or owners of which have at least 10 years experience
 267 servng this population.
- 268 (6) "Direct care management" means care management
 269 activities that involve direct interaction with Medicaid
 270 recipients.
- 271 (7) "Eligible plan" means a health insurer authorized
 272 under chapter 624, an exclusive provider organization authorized
 273 under chapter 627, a health maintenance organization authorized
 274 under chapter 641, or a provider service network authorized
 275 under s. 409.912(4) (d). For purposes of the managed medical
 276 assistance program, the term also includes the Children's
 277 Medical Services Network authorized under chapter 391. For
 278 purposes of the long-term care managed care program, the term

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279 also includes entities qualified under 42 C.F.R. part 422 as
 280 Medicare Advantage Preferred Provider Organizations, Medicare
 281 Advantage Provider-sponsored Organizations, and Medicare
 282 Advantage Special Needs Plans, and the Program for All-Inclusive
 283 Care for the Elderly.

284 (8) "Long-term care plan" means a managed care plan that
 285 provides the services described in s. 409.980 for the long-term
 286 care managed care program or the services described in s.
 287 409.988 for the long-term care managed care program for persons
 288 with developmental disabilities.

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

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

297 (11) "Medicaid" means the medical assistance program
 298 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.
 299 1396 et seq., and regulations thereunder, as administered in
 300 this state by the agency.

301 (12) "Medicaid recipient" or "recipient" means an
 302 individual who the department or, for Supplemental Security
 303 Income, the Social Security Administration determines is
 304 eligible pursuant to federal and state law to receive medical
 305 assistance and related services for which the agency may make
 306 payments under the Medicaid program. For the purposes of

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307 determining third-party liability, the term includes an
 308 individual formerly determined to be eligible for Medicaid, an
 309 individual who has received medical assistance under the
 310 Medicaid program, or an individual on whose behalf Medicaid has
 311 become obligated.

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

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

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

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

328 409.963 Single state agency.—The Agency for Health Care
 329 Administration is designated as the single state agency
 330 authorized to manage, operate, and make payments for medical
 331 assistance and related services under Title XIX of the Social
 332 Security Act. Subject to any limitations or directions provided
 333 for in the General Appropriations Act, these payments shall be
 334 made only for services included in the program, only on behalf

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335 of eligible individuals, and only to qualified providers in
 336 accordance with federal requirements for Title XIX of the Social
 337 Security Act and the provisions of state law. This program of
 338 medical assistance is designated as the "Medicaid program." The
 339 department is responsible for Medicaid eligibility
 340 determinations, including, but not limited to, policy, rules,
 341 and the agreement with the Social Security Administration for
 342 Medicaid eligibility determinations for Supplemental Security
 343 Income recipients, as well as the actual determination of
 344 eligibility. As a condition of Medicaid eligibility, subject to
 345 federal approval, the agency and the department shall ensure
 346 that each Medicaid recipient consents to the release of her or
 347 his medical records to the agency and the Medicaid Fraud Control
 348 Unit of the Department of Legal Affairs.

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

351 409.964 Managed care program; state plan; waivers.—The
 352 Medicaid program is established as a statewide, integrated
 353 managed care program for all covered services, including long-
 354 term care services. The agency shall apply for and implement
 355 state plan amendments or waivers of applicable federal laws and
 356 regulations necessary to implement the program. Prior to seeking
 357 a waiver, the agency shall provide public notice and the
 358 opportunity for public comment and shall include public feedback
 359 in the waiver application. The agency shall hold one public
 360 meeting in each of the regions described in s. 409.966(2) and
 361 the time period for public comment for each region shall end no

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362 sooner than 30 days after the completion of the public meeting
 363 in that region.

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

366 409.965 Mandatory enrollment.—All Medicaid recipients
 367 shall receive covered services through the statewide managed
 368 care program, except as provided by this part pursuant to an
 369 approved federal waiver. The following Medicaid recipients are
 370 exempt from participation in the statewide managed care program:

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

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

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

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

379 409.966 Eligible plans; selection.—

380 (1) ELIGIBLE PLANS.—Services in the Medicaid managed care
 381 program shall be provided by eligible plans. A provider service
 382 network must be capable of providing all covered services to a
 383 mandatory Medicaid managed care enrollee or may limit the
 384 provision of services to a specific target population based on
 385 the age, chronic disease state, or the medical condition of the
 386 enrollee to whom the network will provide services. A specialty
 387 provider service network must be capable of coordinating care
 388 and delivering or arranging for the delivery of all covered
 389 services to the target population. A provider service network

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390 may partner with an insurer licensed under chapter 627 or a
 391 health maintenance organization licensed under chapter 641 to
 392 meet the requirements of a Medicaid contract.

393 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a
 394 limited number of eligible plans to participate in the Medicaid
 395 program using invitations to negotiate in accordance with s.
 396 287.057(3) (a). At least 90 days prior to issuing an invitation
 397 to negotiate, the agency shall compile and publish a databook
 398 consisting of a comprehensive set of utilization and spending
 399 data for the 3 most recent contract years consistent with the
 400 rate-setting periods for all Medicaid recipients by region or
 401 county. The source of the data in the report shall include both
 402 historic fee-for-service claims and validated data from the
 403 Medicaid Encounter Data System. The report shall be made
 404 available in electronic form and shall delineate utilization use
 405 by age, gender, eligibility group, geographic area, and
 406 aggregate clinical risk score. Separate and simultaneous
 407 procurements shall be conducted in each of the following
 408 regions:

409 (a) Region I, which shall consist of Bay, Calhoun,
 410 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,
 411 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,
 412 Walton, and Washington Counties.

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

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417 (c) Region III, which shall consist of Hernando,
 418 Hillsborough, Pasco, Pinellas, and Polk Counties.
 419 (d) Region IV, which shall consist of Brevard, Lake,
 420 Marion, Orange, Osceola, Seminole, and Sumter Counties.
 421 (e) Region V, which shall consist of Charlotte, Collier,
 422 DeSoto, Hardee, Highlands, Lee, Manatee, and Sarasota Counties.
 423 (f) Region VI, which shall consist of Broward, Glades,
 424 Hendry, Indian River, Martin, Okeechobee, Palm Beach, and St.
 425 Lucie Counties.
 426 (g) Region VII, which shall consist of Dade and Monroe
 427 Counties.
 428 (3) QUALITY SELECTION CRITERIA.—
 429 (a) The invitation to negotiate must specify the criteria
 430 and the relative weight of the criteria that will be used for
 431 determining the acceptability of the reply and guiding the
 432 selection of the organizations with which the agency negotiates.
 433 In addition to criteria established by the agency, the agency
 434 shall consider the following factors in the selection of
 435 eligible plans:
 436 1. Accreditation by the National Committee for Quality
 437 Assurance or another nationally recognized accrediting body.
 438 2. Experience serving similar populations, including the
 439 organization's record in achieving specific quality standards
 440 with similar populations.
 441 3. Availability and accessibility of primary care and
 442 specialty physicians in the provider network.

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

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

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

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

457 8. Comments submitted in writing by any enrolled Medicaid
 458 provider relating to a specifically identified plan
 459 participating in the procurement in the same region as the
 460 submitting provider.

461 9. The business relationships a qualified plan has with
 462 any other qualified plan which responds to the invitation to
 463 negotiate.

464
 465 A qualified plan must disclose any business relationship it has
 466 with any other qualified plan which responds to the invitation
 467 to negotiate. For the purpose of this section, "business
 468 relationship" means: an ownership or controlling interest; an
 469 affiliate or subsidiary relationship; a common parent; or any
 470 mutual interest in any limited partnership, limited liability

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471 partnership, limited liability company, or other entity or
 472 business association, including all wholly or partially owned
 473 subsidiaries, majority-owned subsidiaries, parent companies, or
 474 affiliates of such entities, business associations, or other
 475 enterprises, that exists for the purpose of making profit.
 476 Failure to disclose any business relationship will result in
 477 disqualification.

478 (b) After negotiations are conducted, the agency shall
 479 select the eligible plans that are determined to be responsive
 480 and provide the best value to the state. Preference shall be
 481 given to plans which demonstrate the following:

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

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

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

496 (c) To ensure managed care plan participation in Region I,
 497 the agency shall award contracts in Region VII to each managed

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498 care plan selected in Region I for such plans which submitted
 499 responsive bids in Region VII.

500 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that
 501 participates in an invitation to negotiate in more than one
 502 region and is selected in at least one region may not begin
 503 servicing Medicaid recipients in any region for which it was
 504 selected until all administrative challenges to procurements
 505 required by this section to which the eligible plan is a party
 506 have been finalized. If the number of plans selected is less
 507 than the maximum amount of plans permitted in the region, the
 508 agency may contract with other selected plans in the region not
 509 participating in the administrative challenge prior to
 510 resolution of the administrative challenge. For purposes of this
 511 subsection, an administrative challenge is finalized if an order
 512 granting voluntary dismissal with prejudice has been entered by
 513 any court established under Article V of the State Constitution
 514 or by the Division of Administrative Hearings, a final order has
 515 been entered into by the agency and the deadline for appeal has
 516 expired, a final order has been entered by the First District
 517 Court of Appeal and the time to seek any available review by the
 518 Florida Supreme Court has expired, or a final order has been
 519 entered by the Florida Supreme Court and a warrant has been
 520 issued.

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

523 409.967 Managed care plan accountability.—

524 (1) The agency shall establish a 5-year contract with each
 525 managed care plan selected through the procurement process

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526 described in s. 409.966. A plan contract may not be renewed;
 527 however, the agency may extend the terms of a plan contract to
 528 cover any delays in transition to a new plan.

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

533 (a) Emergency services.—Managed care plans shall pay for
 534 services required by ss. 395.1041 and 401.45 and rendered by a
 535 noncontracted provider within 30 days after receipt of a
 536 complete and correct claim. Plans must give providers of these
 537 services a specific explanation for each claim denied for being
 538 incomplete or incorrect. Providers may resubmit corrected claims
 539 for reconsideration within 30 days after receiving notice from
 540 the managed care plans that the claims are incomplete or
 541 incorrect. Claims from noncontracted providers shall be accepted
 542 by the managed care plan for at least 1 year after the date the
 543 services are provided. Reimbursement for services under this
 544 paragraph shall be the lesser of:

- 545 1. The provider's charges;
- 546 2. The usual and customary provider charges for similar
 547 services in the community where the services were provided;
- 548 3. The charge mutually agreed to by the entity and the
 549 provider within 60 days after submittal of the claim; or
- 550 4. The rate the agency would have paid on the first day of
 551 the contract between the provider and the plan.

552 (b) Access.—The agency shall establish specific standards
 553 for the number, type, and regional distribution of providers in

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554 managed care plan networks to ensure access to care. Each plan
 555 must maintain a region-wide network of providers in sufficient
 556 numbers to meet the access standards for specific medical
 557 services for all recipients enrolled in the plan. Consistent
 558 with the standards established by the agency, provider networks
 559 may include providers located outside the region. Each plan
 560 shall establish and maintain an accurate and complete electronic
 561 database of contracted providers, including information about
 562 licensure or registration, locations and hours of operation,
 563 specialty credentials and other certifications, specific
 564 performance indicators, and such other information as the agency
 565 deems necessary. The database shall be available online to both
 566 the agency and the public and shall have the capability to
 567 compare the availability of providers to network adequacy
 568 standards and to accept and display feedback from each
 569 provider's patients. Each plan shall submit quarterly reports to
 570 the agency identifying the number of enrollees assigned to each
 571 primary care provider.

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

576 1. Each prepaid plan must comply with the agency's
 577 reporting requirements for the Medicaid Encounter Data System.
 578 Prepaid plans must submit encounter data electronically in a
 579 format that complies with the Health Insurance Portability and
 580 Accountability Act provisions for electronic claims and in
 581 accordance with deadlines established by the agency. Prepaid

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582 plans must certify that the data reported is accurate and
 583 complete.

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

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

600 (d) Continuous improvement.—The agency shall establish
 601 specific performance standards and expected milestones or
 602 timelines for improving performance over the term of the
 603 contract. By the end of the fourth year of the first contract
 604 term, the agency shall issue a request for information to
 605 determine whether cost savings could be achieved by contracting
 606 for plan oversight and monitoring, including analysis of
 607 encounter data, assessment of performance measures, and
 608 compliance with other contractual requirements. Each managed
 609 care plan shall establish an internal health care quality

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610 improvement system, including enrollee satisfaction and
 611 disenrollment surveys. The quality improvement system shall
 612 include incentives and disincentives for network providers.

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

616 1. A provider credentialing system and ongoing provider
 617 monitoring;

618 2. An effective prepayment and postpayment review process
 619 including, but not limited to, data analysis, system editing,
 620 and auditing of network providers;

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

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

626 5. Designation of a program integrity compliance officer.

627 (f) Grievance resolution.—Each managed care plan shall
 628 establish and the agency shall approve an internal process for
 629 reviewing and responding to grievances from enrollees consistent
 630 with the requirements of s. 641.511. Each plan shall submit
 631 quarterly reports on the number, description, and outcome of
 632 grievances filed by enrollees. The agency shall maintain a
 633 process for provider service networks consistent with s.
 634 408.7056.

635 (g) Penalties.—Managed care plans that reduce enrollment
 636 levels or leave a region prior to the end of the contract term
 637 shall reimburse the agency for the cost of enrollment changes

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638 and other transition activities, including the cost of
 639 additional choice counseling services. If more than one plan
 640 leaves a region at the same time, costs shall be shared by the
 641 departing plans proportionate to their enrollments. In addition
 642 to the payment of costs, departing plans shall pay a per
 643 enrollee penalty not to exceed 1 month's payment. Plans shall
 644 provide the agency notice no less than 180 days prior to
 645 withdrawing from a region.

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

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

650 (j) Fair payment.—Provider service networks must ensure
 651 that no network provider with a controlling interest in the
 652 network charges any Medicaid managed care plan more than the
 653 amount paid to that provider by the provider service network for
 654 the same service.

655 (3) ACHIEVED SAVINGS REBATE.—

656 (a) The agency shall establish and the prepaid plans shall
 657 use a uniform method for annually reporting premium revenue,
 658 medical and administrative costs, and income or losses, across
 659 all Florida Medicaid prepaid plan lines of business in all
 660 regions. The reports shall be due to the agency no more than
 661 270 days after the conclusion of the reporting period and the
 662 agency may audit the reports. Achieved savings rebates shall be
 663 due within 30 days after the report is submitted. Except as
 664 provided in paragraph (b), the achieved savings rebate will be

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665 established by determining pre-tax income as a percentage of
 666 revenues and applying the following income sharing ratios:
 667 1. One hundred percent of income up to and including 5
 668 percent of revenue shall be retained by the plan.
 669 2. Fifty percent of income above 5 percent and up to 9
 670 percent shall be retained by the plan, with the other 50 percent
 671 refunded to the state.
 672 3. One hundred percent of income above 9 percent of
 673 revenue shall be refunded to the state.
 674 (b) For any plan which meets or exceeds agency-defined
 675 quality measures in the reporting period, the achieved savings
 676 rebate will be established by determining pre-tax income as a
 677 percentage of revenues and applying the following income sharing
 678 ratios:
 679 1. One hundred percent of income up to and including 6
 680 percent of revenue shall be retained by the plan.
 681 2. Fifty percent of income above 5 percent and up to 10
 682 percent shall be retained by the plan, with the other 50 percent
 683 refunded to the state.
 684 3. One hundred percent of income above 10 percent of
 685 revenue shall be refunded to the state.
 686 (c) The following expenses may not be included in
 687 calculating income to the plan:
 688 1. Payment of achieved savings rebates.
 689 2. Any financial incentive payments made to the plan
 690 outside of the capitation rate.
 691 3. Any financial disincentive payments levied by the state
 692 or federal governments.

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693 | 4. Expenses associated with lobbying activities.

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

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

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

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

710 | 409.968 Managed care plan payment.—

711 | (1) Prepaid plans shall receive per-member, per-month
 712 | payments negotiated pursuant to the procurements described in s.
 713 | 409.966. Payments shall be risk-adjusted rates based on
 714 | historical utilization and spending data, projected forward, and
 715 | adjusted to reflect the eligibility category, geographic area,
 716 | and the clinical risk profile of the recipients.

717 | (2) Provider service networks may be prepaid plans and
 718 | receive per-member, per-month payments negotiated pursuant to
 719 | the procurement process described in s. 409.966. Provider
 720 | service networks that choose not to be prepaid plans shall

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721 receive fee-for-service rates with a shared savings settlement.
 722 The fee-for-service option shall be available to a provider
 723 service network only for the first 5 years of its operation in a
 724 given region. The agency shall annually conduct cost
 725 reconciliations to determine the amount of cost savings achieved
 726 by fee-for-service provider service networks for the dates of
 727 service within the period being reconciled. Only payments for
 728 covered services for dates of service within the reconciliation
 729 period and paid within 6 months after the last date of service
 730 in the reconciliation period shall be included. The agency shall
 731 perform the necessary adjustments for the inclusion of claims
 732 incurred but not reported within the reconciliation period for
 733 claims that could be received and paid by the agency after the
 734 6-month claims processing time lag. The agency shall provide the
 735 results of the reconciliations to the fee-for-service provider
 736 service networks within 45 days after the end of the
 737 reconciliation period. The fee-for-service provider service
 738 networks shall review and provide written comments or a letter
 739 of concurrence to the agency within 45 days after receipt of the
 740 reconciliation results. This reconciliation shall be considered
 741 final.

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

744 409.969 Enrollment; choice counseling; automatic
 745 assignment; disenrollment.-

746 (1) ENROLLMENT.-All Medicaid recipients shall be enrolled
 747 in a managed care plan unless specifically exempted under this
 748 part. Each recipient shall have a choice of plans and may select

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749 any available plan unless that plan is restricted by contract to
 750 a specific population that does not include the recipient.
 751 Medicaid recipients shall have 30 days in which to make a choice
 752 of plans. All recipients shall be offered choice counseling
 753 services in accordance with this section.

754 (2) CHOICE COUNSELING.—The agency shall provide choice
 755 counseling for Medicaid recipients. The agency may contract for
 756 the provision of choice counseling. Any such contract shall be
 757 with a vendor which employs Floridians to accomplish the
 758 contract requirements and shall be for a period of 5 years. The
 759 agency may renew a contract for an additional 5-year period;
 760 however, prior to renewal of the contract the agency shall hold
 761 at least one public meeting in each of the regions covered by
 762 the choice counseling vendor. The agency may extend the term of
 763 the contract to cover any delays in transition to a new
 764 contractor. Printed choice information and choice counseling
 765 shall be offered in the native or preferred language of the
 766 recipient, consistent with federal requirements. The manner and
 767 method of choice counseling shall be modified as necessary to
 768 ensure culturally competent, effective communication with people
 769 from diverse cultural backgrounds. The agency shall maintain a
 770 record of the recipients who receive such services, identifying
 771 the scope and method of the services provided. The agency shall
 772 make available clear and easily understandable choice
 773 information to Medicaid recipients that includes:

774 (a) An explanation that each recipient has the right to
 775 choose a managed care plan at the time of enrollment in Medicaid
 776 and again at regular intervals set by the agency, and that if a

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777 recipient does not choose a plan, the agency will assign the
 778 recipient to a plan according to the criteria specified in this
 779 section.

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

782 (c) An explanation of benefit limits.

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

785 (e) Managed care plan performance data.

786 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has
 787 enrolled in a managed care plan, the recipient shall have 90
 788 days to voluntarily disenroll and select another plan. After 90
 789 days, no further changes may be made except for good cause. For
 790 purposes of this section, "good cause" includes, but is not
 791 limited to, poor quality of care, lack of access to necessary
 792 specialty services, an unreasonable delay or denial of service,
 793 or fraudulent enrollment. The agency must make a determination
 794 as to whether good cause exists. The agency may require a
 795 recipient to use the plan's grievance process prior to the
 796 agency's determination of good cause, except in cases in which
 797 immediate risk of permanent damage to the recipient's health is
 798 alleged.

799 (a) The managed care plan internal grievance process, when
 800 used, must be completed in time to permit the recipient to
 801 disenroll by the first day of the second month after the month
 802 the disenrollment request was made. If the result of the
 803 grievance process is approval of an enrollee's request to

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804 disenroll, the agency is not required to make a determination in
 805 the case.

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

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

822 (d) On the first day of the next month after receiving
 823 notice from a recipient that the recipient has moved to another
 824 region, the agency shall automatically disenroll the recipient
 825 from the managed care plan the recipient is currently enrolled
 826 in and treat the recipient as if the recipient is a new Medicaid
 827 enrollee. At that time, the recipient may choose another plan
 828 pursuant to the enrollment process established in this section.

829 (e) The agency must monitor plan disenrollment throughout
 830 the contract term to identify any discriminatory practices.

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831 Section 11. Section 409.970, Florida Statutes, is created
 832 to read:
 833 409.970 State and local Medicaid partnerships.-
 834 (1) INTERGOVERNMENTAL TRANSFERS.-In addition to the
 835 contributions required pursuant to s. 409.915, beginning in
 836 Fiscal Year 2014-2015, the agency may accept voluntary transfers
 837 of local taxes and other qualified revenue from counties,
 838 municipalities, and special taxing districts. Such transfers
 839 must be contributed to advance the general goals of the Florida
 840 Medicaid program without restriction and must be executed
 841 pursuant to a contract between the agency and the local funding
 842 source. Contracts executed prior to October 31 shall result in
 843 contributions to Medicaid for that same state fiscal year.
 844 Contracts executed between November 1 and June 30 shall result
 845 in contributions for the following state fiscal year. Based on
 846 the date of the signed contracts, the agency shall allocate to
 847 the low-income pool the first contributions received up to the
 848 limit established by subsection (2). No more than 40 percent of
 849 the low-income pool funding shall come from any single funding
 850 source. Contributions in excess of the low-income pool shall be
 851 allocated to the disproportionate share programs defined in ss.
 852 409.911(3) and 409.9113 and to hospital rates pursuant to
 853 subsection (4). The local funding source shall designate in the
 854 contract which Medicaid providers ensure access to care for low
 855 income and uninsured people within the applicable jurisdiction
 856 and are eligible for low-income pool funding. Eligible
 857 providers may include both hospitals and primary care providers.

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858 (2) LOW-INCOME POOL.—The agency shall establish and
 859 maintain a low-income pool in a manner authorized by federal
 860 waiver. The low-income pool is created to compensate a network
 861 of providers designated pursuant to subsection (1). Funding of
 862 the low-income pool shall be limited to the maximum amount
 863 permitted by federal waiver minus a percentage specified in the
 864 General Appropriations Act. The low-income pool must be used to
 865 support enhanced access to services by offsetting shortfalls in
 866 Medicaid reimbursement, paying for otherwise uncompensated care,
 867 and financing coverage for the uninsured. The low-income pool
 868 shall be distributed in periodic payments to the Access to Care
 869 Partnership throughout the fiscal year. Distribution of low-
 870 income pool funds by the Access to Care Partnership to
 871 participating providers may be made through capitated payments,
 872 fees for services, or contracts for specific deliverables. The
 873 agency shall include the distribution amount for each provider
 874 in the contract with the Access to Care Partnership pursuant to
 875 subsection (3). Regardless of the method of distribution,
 876 providers participating in the Access to Care Partnership shall
 877 receive payments such that the aggregate benefit in the
 878 jurisdiction of each local funding source, as defined in
 879 subsection (1), equals the amount of the contribution plus a
 880 factor specified in the General Appropriations Act.

881 (3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract
 882 with an administrative services organization that has operating
 883 agreements with all health care facilities, programs, and
 884 providers supported with local taxes or certified public
 885 expenditures and designated pursuant to subsection (1). The

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886 contract shall provide for enhanced access to care for Medicaid,
 887 low-income, and uninsured Floridians. The partnership shall be
 888 responsible for an ongoing program of activities that provides
 889 needed, but uncovered or undercompensated, health services to
 890 Medicaid enrollees and persons receiving charity care, as
 891 defined in s. 409.911. Accountability for services rendered
 892 under this contract must be based on the number of services
 893 provided to unduplicated qualified beneficiaries, the total
 894 units of service provided to these persons, and the
 895 effectiveness of services provided as measured by specific
 896 standards of care. The agency shall seek such plan amendments or
 897 waivers as may be necessary to authorize the implementation of
 898 the low-income pool as the Access to Care Partnership pursuant
 899 to this section.

900 (4) HOSPITAL RATE DISTRIBUTION.—

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

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

910 2. Tier 2 hospitals are community hospitals not included
 911 in Tier 1 that provided more than 9 percent of the hospital's
 912 total inpatient days to Medicaid patients and charity patients,

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913 as defined in s. 409.911, and are located in the jurisdiction of
 914 a local funding source pursuant to subsection (1).

915 3. Tier 3 hospitals include all community hospitals.

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

918 1. Tier 1 (T1A) = 0.15 x TTA;

919 2. Tier 2 (T2A) = 0.35 x TTA

920 3. Tier 3 (T3A) = 0.50 x TTA

921 (c) The tier allocation shall be distributed as a
 922 percentage increase to the hospital specific base rate (HSBR)
 923 established pursuant to s. 409.905(5)(c). The increase in each
 924 tier shall be calculated according to the proportion of tier-
 925 specific allocation to the total estimated inpatient spending
 926 (TEIS) for all hospitals in each tier:

927 1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total
 928 estimated inpatient spending (T1TEIS).

929 2. Tier 2 percent increase (T2PI) = T2A/Tier 2 total
 930 estimated inpatient spending (T2TEIS).

931 3. Tier 3 percent increase (T3PI) = T3A/Tier 3 total
 932 estimated inpatient spending (T3TEIS).

933 (d) The hospital-specific tiered rate (HSTR) shall be
 934 calculated as follows:

935 1. For hospitals in Tier 3: HSTR = (1 + T3PI) x HSBR

936 2. For hospitals in Tier 2: HSTR = (1 + T2PI) x HSBR)

937 3. For hospitals in Tier 1: HSTR = (1 + T1PI) x HSBR)

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

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940 409.971 Managed medical assistance program.—The agency
 941 shall make payments for primary and acute medical assistance and
 942 related services using a managed care model. By January 1, 2013,
 943 the agency shall begin implementation of the statewide managed
 944 medical assistance program, with full implementation in all
 945 regions by October 1, 2014.

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

948 409.972 Mandatory and voluntary enrollment.—

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

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

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

960 (b) Medicaid recipients residing in residential commitment
 961 facilities operated through the Department of Juvenile Justice
 962 or mental health treatment facilities as defined by s.
 963 394.455(32).

964 (c) Persons eligible for refugee assistance.

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

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

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

974 | 409.973 Benefits.—

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

977 | (a) Advanced registered nurse practitioner services.

978 | (b) Ambulatory surgical treatment center services.

979 | (c) Birthing center services.

980 | (d) Chiropractic services.

981 | (e) Dental services.

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

984 | (g) Emergency services.

985 | (h) Family planning services and supplies.

986 | (i) Healthy start services.

987 | (j) Hearing services.

988 | (k) Home health agency services.

989 | (l) Hospice services.

990 | (m) Hospital inpatient services.

991 | (n) Hospital outpatient services.

992 | (o) Laboratory and imaging services.

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

994 | (q) Mental health services.

995 | (r) Nursing care.

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- 996 (s) Optical services and supplies.
- 997 (t) Optometrist services.
- 998 (u) Physical, occupational, respiratory, and speech
- 999 therapy services.
- 1000 (v) Physician services.
- 1001 (w) Podiatric services.
- 1002 (x) Prescription drugs.
- 1003 (y) Renal dialysis services.
- 1004 (z) Respiratory equipment and supplies.
- 1005 (aa) Rural health clinic services.
- 1006 (bb) Substance abuse treatment services.
- 1007 (cc) Transportation to access covered services.
- 1008 (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
- 1009 benefit packages for nonpregnant adults, vary cost-sharing
- 1010 provisions, and provide coverage for additional services. The
- 1011 agency shall evaluate the proposed benefit packages to ensure
- 1012 services are sufficient to meet the needs of the plan's
- 1013 enrollees and to verify actuarial equivalence.
- 1014 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed
- 1015 medical assistance program shall establish a program to
- 1016 encourage and reward healthy behaviors.
- 1017 Section 15. Section 409.974, Florida Statutes, is created
- 1018 to read:
- 1019 409.974 Eligible plans.—
- 1020 (1) ELIGIBLE PLAN SELECTION.—The agency shall select
- 1021 eligible plans through the procurement process described in s.
- 1022 409.966. The agency shall notice invitations to negotiate no
- 1023 later than January 1, 2013.

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1024 (a) The agency shall procure three plans for Region I. At
 1025 least one plan shall be a provider service network, if any
 1026 provider service network submits a responsive bid.

1027 (b) The agency shall procure at least three and no more
 1028 than six plans for Region II. At least one plan shall be a
 1029 provider service network, if any provider service network
 1030 submits a responsive bid.

1031 (c) The agency shall procure at least four plans and no
 1032 more than eight plans for Region III. At least two plans shall
 1033 be provider service networks, if any two provider service
 1034 networks submit responsive bids.

1035 (d) The agency shall procure at least four plans and no
 1036 more than seven plans for Region IV. At least two plans shall be
 1037 provider service networks if any two provider service networks
 1038 submit responsive bids.

1039 (e) The agency shall procure three plans for Region V. At
 1040 least one plan shall be a provider service network, if any
 1041 provider service network submits a responsive bid.

1042 (f) The agency shall procure at least four plans and no
 1043 more than seven plans for Region VI. At least two plans shall be
 1044 provider service networks, if any two provider service networks
 1045 submit a responsive bid.

1046 (g) The agency shall procure at least five plans and no
 1047 more than nine plans for Region VII. At least two plans shall be
 1048 provider service networks, if any two provider service network
 1049 submit responsive bids.

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1051 If no provider service network submits a responsive bid, the
 1052 agency shall procure no more than one less than the maximum
 1053 number of eligible plans permitted in that region. Within 12
 1054 months after the initial invitation to negotiate, the agency
 1055 shall attempt to procure a provider service network. The agency
 1056 shall notice another invitation to negotiate only with provider
 1057 service networks in such region where no provider service
 1058 network has been selected.

1059 (2) QUALITY SELECTION CRITERIA.—In addition to the
 1060 criteria established in s. 409.966, the agency shall consider
 1061 evidence that an eligible plan has written agreements or signed
 1062 contracts or has made substantial progress in establishing
 1063 relationships with providers prior to the plan submitting a
 1064 response. The agency shall evaluate and give special weight to
 1065 evidence of signed contracts with essential providers as defined
 1066 by the agency pursuant to s. 409.975(2). The agency shall
 1067 exercise a preference for plans with a provider network in which
 1068 over 10 percent of the providers use electronic health records,
 1069 as defined in s. 408.051. When all other factors are equal, the
 1070 agency shall consider whether the organization has a contract to
 1071 provide managed long-term care services in the same region and
 1072 shall exercise a preference for such plans.

1073 (3) SPECIALTY PLANS.—Participation by specialty plans
 1074 shall be subject to the procurement requirements and regional
 1075 plan number limits of this section. However, a specialty plan
 1076 whose target population includes no more than 10 percent of the
 1077 enrollees of that region shall not be subject to the regional
 1078 plan number limits of this section.

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1079 (4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by
 1080 the Children's Medical Services Network shall be pursuant to a
 1081 single, statewide contract with the agency that is not subject
 1082 to the procurement requirements or regional plan number limits
 1083 of this section. The Children's Medical Services Network must
 1084 meet all other plan requirements for the managed medical
 1085 assistance program.

1086 Section 16. Section 409.975, Florida Statutes, is created
 1087 to read:

1088 409.975 Managed care plan accountability.—In addition to
 1089 the requirements of s. 409.967, plans and providers
 1090 participating in the managed medical assistance program shall
 1091 comply with the requirements of this section.

1092 (1) PROVIDER NETWORKS.—Managed care plans must develop and
 1093 maintain provider networks that meet the medical needs of their
 1094 enrollees in accordance with standards established pursuant to
 1095 409.967(2)(b). Except as provided in this section, managed care
 1096 plans may limit the providers in their networks based on
 1097 credentials, quality indicators, and price.

1098 (a) Plans must include all providers in the region that
 1099 are classified by the agency as essential Medicaid providers,
 1100 unless the agency approves, in writing, an alternative
 1101 arrangement for securing the types of services offered by the
 1102 essential providers. Providers are essential for serving
 1103 Medicaid enrollees if they offer services that are not available
 1104 from any other provider within a reasonable access standard, or
 1105 if they provided a substantial share of the total units of a
 1106 particular service used by Medicaid patients within the region

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1107 during the last 3 years and the combined capacity of other
 1108 service providers in the region is insufficient to meet the
 1109 total needs of the Medicaid patients. The agency may not
 1110 classify physicians and other practitioners as essential
 1111 providers. The agency, at a minimum, shall determine which
 1112 providers in the following categories are essential Medicaid
 1113 providers:

- 1114 1. Federally qualified health centers;
- 1115 2. Statutory teaching hospitals as defined in s.
 1116 408.07(45);
- 1117 3. Hospitals that are trauma centers as defined in s.
 1118 395.4001(14);
- 1119 4. Hospitals located at least 25 miles from any other
 1120 hospital with similar services.

1121

1122 Managed care plans that have not contracted with all essential
 1123 providers in the region as of the first date of recipient
 1124 enrollment, or with whom an essential provider has terminated
 1125 its contract, must negotiate in good faith with such essential
 1126 providers for 1 year or until an agreement is reached, whichever
 1127 is first. Payments for services rendered by a nonparticipating
 1128 essential provider shall be made at the applicable Medicaid rate
 1129 as of the first day of the contract between the agency and the
 1130 plan. A rate schedule for all essential providers shall be
 1131 attached to the contract between the agency and the plan. After
 1132 1 year, managed care plans that are unable to contract with
 1133 essential providers shall notify the agency and propose an
 1134 alternative arrangement for securing the essential services for

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1135 Medicaid enrollees. The arrangement must rely on contracts with
 1136 other participating providers, regardless of whether those
 1137 providers are located within the same region as the
 1138 nonparticipating essential service provider. If the alternative
 1139 arrangement is approved by the agency, payments to
 1140 nonparticipating essential providers after the date of the
 1141 agency's approval shall equal 90 percent of the applicable
 1142 Medicaid rate. If the alternative arrangement is not approved by
 1143 the agency, payment to nonparticipating essential providers
 1144 shall equal 110 percent of the applicable Medicaid rate.

1145 (b) Certain providers are statewide resources and
 1146 essential providers for all managed care plans in all regions.
 1147 All managed care plans must include these essential providers in
 1148 their networks. Statewide essential providers include:

- 1149 1. Faculty plans of Florida medical schools.
- 1150 2. Regional perinatal intensive care centers as defined in
 1151 s. 383.16(2).
- 1152 3. Hospitals licensed as specialty children's hospitals as
 1153 defined in s. 395.002(28).

1154
 1155 Managed care plans that have not contracted with all statewide
 1156 essential providers in all regions as of the first date of
 1157 recipient enrollment must continue to negotiate in good faith.
 1158 Payments to physicians on the faculty of nonparticipating
 1159 Florida medical schools shall be made at the applicable Medicaid
 1160 rate. Payments for services rendered by a regional perinatal
 1161 intensive care centers shall be made at the applicable Medicaid
 1162 rate as of the first day of the contract between the agency and

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1163 the plan. Payments to nonparticipating specialty children's
 1164 hospitals shall equal the highest rate established by contract
 1165 between that provider and any other Medicaid managed care plan.

1166 (c) After 12 months of active participation in a plan's
 1167 network, the plan may exclude any essential provider from the
 1168 network for failure to meet quality or performance criteria. If
 1169 the plan excludes an essential provider from the plan, the plan
 1170 must provide written notice to all recipients who have chosen
 1171 that provider for care. The notice shall be provided at least 30
 1172 days prior to the effective date of the exclusion.

1173 (d) Each managed care plan must offer a network contract
 1174 to each home medical equipment and supplies provider in the
 1175 region which meets quality and fraud prevention and detection
 1176 standards established by the plan and which agrees to accept the
 1177 lowest price previously negotiated between the plan and another
 1178 such provider.

1179 (2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency
 1180 shall contract with a single organization representing medical
 1181 schools and graduate medical education programs in the state for
 1182 the purpose of establishing an active and ongoing program to
 1183 improve clinical outcomes in all managed care plans. Contracted
 1184 activities must support greater clinical integration for
 1185 Medicaid enrollees through interdependent and cooperative
 1186 efforts of all providers participating in managed care plans.
 1187 The agency shall support these activities with certified public
 1188 expenditures of general revenue appropriated to the
 1189 participating medical schools and any earned federal matching
 1190 funds, and shall seek any plan amendments or waivers necessary

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1191 to comply with this subsection. To be eligible to participate in
 1192 the quality network, a medical school must contract with each
 1193 managed care plan in its region.

1194 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
 1195 monitor the quality and performance of each participating
 1196 provider. At the beginning of the contract period, each plan
 1197 shall notify all its network providers of the metrics used by
 1198 the plan for evaluating the provider's performance and
 1199 determining continued participation in the network.

1200 (4) MOMCARE NETWORK.—

1201 (a) The agency shall contract with an administrative
 1202 services organization representing all Healthy Start Coalitions
 1203 providing risk appropriate care coordination and other services
 1204 in accordance with a federal waiver and pursuant to s. 409.906.
 1205 The contract shall require the network of coalitions to provide
 1206 choice counseling, education, risk-reduction and case management
 1207 services, and quality assurance for all enrollees of the waiver.
 1208 The agency shall evaluate the impact of the MomCare network by
 1209 monitoring each plan's performance on specific measures to
 1210 determine the adequacy, timeliness, and quality of services for
 1211 pregnant women and infants. The agency shall support this
 1212 contract with certified public expenditures of general revenue
 1213 appropriated for Healthy Start services and any earned federal
 1214 matching funds.

1215 (b) Each managed care plan shall establish specific
 1216 programs and procedures to improve pregnancy outcomes and infant
 1217 health, including, but not limited to, coordination with the
 1218 Healthy Start program, immunization programs, and referral to

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1219 the Special Supplemental Nutrition Program for Women, Infants,
 1220 and Children, and the Children's Medical Services program for
 1221 children with special health care needs. Each plan's programs
 1222 and procedures shall include agreements with each local Healthy
 1223 Start Coalition in the region to provide risk-appropriate care
 1224 coordination for pregnant women and infants, consistent with the
 1225 agency and the MomCare Network.

1226 (5) TRANSPORTATION.—Non-emergency transportation services
 1227 shall be provided pursuant to a single, statewide contract
 1228 between the agency and the Commission for the Transportation
 1229 Disadvantaged. The agency shall establish performance standards
 1230 in the contract and shall evaluate the performance of the
 1231 Commission for the Transportation Disadvantaged.

1232 (6) SCREENING RATE.—After the end of the second contract
 1233 year, each managed care plan shall achieve an annual Early and
 1234 Periodic Screening, Diagnosis, and Treatment Service screening
 1235 rate of at least 80 percent of those recipients continuously
 1236 enrolled for at least 8 months.

1237 (7) PROVIDER PAYMENT.—Managed care plan and hospitals
 1238 shall negotiate mutually acceptable rates, methods, and terms of
 1239 payment. For rates, methods and terms of payment negotiated
 1240 after the contract between the agency and the plan is executed,
 1241 plans shall pay hospitals, at a minimum, the rate the agency
 1242 would have paid on the first day of the contract between the
 1243 provider and the plan. Such payments to hospitals shall not
 1244 exceed 120 percent of the rate the agency would have paid on the
 1245 first day of the contract between the provider and the plan,

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1246 unless specifically approved by the agency. Payment rates may be
 1247 updated periodically.

1248 (8) MEDICALLY NEEDED ENROLLEES.—Each managed care plan
 1249 shall accept any medically needy recipient who selects or is
 1250 assigned to the plan and provide that recipient with continuous
 1251 enrollment for 12 months. After the first month of qualifying as
 1252 a medically needy recipient and enrolling in a plan, and
 1253 contingent upon federal approval, the enrollee shall pay the
 1254 plan a portion of the monthly premium equal to the enrollee's
 1255 share of the cost as determined by the department. The agency
 1256 shall pay any remaining portion of the monthly premium. Plans
 1257 are not obligated to pay claims for medically needy patients for
 1258 services provided prior to enrollment in the plan. Medically
 1259 Needy patients are responsible for payment of incurred claims
 1260 that are used to determine eligibility. Plans must provide a
 1261 grace period of at least 90 days before disenrolling recipients
 1262 who fail to pay their shares of the premium.

1263 Section 17. Section 409.976, Florida Statutes, is created
 1264 to read:

1265 409.976 Managed care plan payment.—In addition to the
 1266 payment provisions of s. 409.968, the agency shall provide
 1267 payment to plans in the managed medical assistance program
 1268 pursuant to this section.

1269 (1) Prepaid payment rates shall be negotiated between the
 1270 agency and the eligible plans as part of the procurement process
 1271 described in s. 409.966.

1272 (2) The agency shall establish payment rates for statewide
 1273 inpatient psychiatric programs. Payments to managed care plans

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1274 shall be reconciled to reimburse actual payments to statewide
 1275 inpatient psychiatric programs.

1276 Section 18. Section 409.977, Florida Statutes, is created
 1277 to read:

1278 409.977 Choice counseling and enrollment.-

1279 (1) CHOICE COUNSELING.-In addition to the choice
 1280 counseling information required by s. 409.969, the agency shall
 1281 make available clear and easily understandable choice
 1282 information to Medicaid recipients that includes information
 1283 about the cost sharing requirements of each managed care plan.

1284 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically
 1285 enroll into a managed care plan those Medicaid recipients who do
 1286 not voluntarily choose a plan pursuant to s. 409.969. The agency
 1287 shall automatically enroll recipients in plans that meet or
 1288 exceed the performance or quality standards established pursuant
 1289 to s. 409.967 and may not automatically enroll recipients in a
 1290 plan that is deficient in those performance or quality
 1291 standards. When a specialty plan is available to accommodate a
 1292 specific condition or diagnosis of a recipient, the agency shall
 1293 assign the recipient to that plan. In the first year of the
 1294 first contract term only, if a recipient was previously enrolled
 1295 in a plan which is still available in the region, the agency
 1296 shall automatically enroll the recipient in that plan unless an
 1297 applicable specialty plan is available. Except as otherwise
 1298 provided in this part, the agency may not engage in practices
 1299 that are designed to favor one managed care plan over another.
 1300 When automatically enrolling recipients in managed care plans,

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1301 the agency shall automatically enroll based on the following
 1302 criteria:

1303 (a) Whether the plan has sufficient network capacity to
 1304 meet the needs of the recipients.

1305 (b) Whether the recipient has previously received services
 1306 from one of the plan's primary care providers.

1307 (c) Whether primary care providers in one plan are more
 1308 geographically accessible to the recipient's residence than
 1309 those in other plans.

1310 (3) OPT-OUT OPTION.—The agency shall develop a process to
 1311 enable any recipient with access to employer-sponsored health
 1312 care coverage to opt out of all managed care plans and to use
 1313 Medicaid financial assistance to pay for the recipient's share
 1314 of the cost in such employer-sponsored coverage. Contingent upon
 1315 federal approval, the agency shall also enable recipients with
 1316 access to other insurance or related products providing access
 1317 to health care services created pursuant to state law, including
 1318 any product available under the Florida Health Choices Program,
 1319 or any health exchange, to opt out. The amount of financial
 1320 assistance provided for each recipient may not exceed the amount
 1321 of the Medicaid premium that would have been paid to a managed
 1322 care plan for that recipient.

1323 Section 19. Section 409.978, Florida Statutes, is created
 1324 to read:

1325 409.978 Long-term care managed care program.—

1326 (1) Pursuant to s. 409.963, the agency shall administer
 1327 the long-term care managed care program described in ss.
 1328 409.978-409.985, but may delegate specific duties and

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1329 responsibilities for the program to the Department of Elderly
 1330 Affairs and other state agencies. By July 1, 2012, the agency
 1331 shall begin implementation of the statewide long-term care
 1332 managed care program, with full implementation in all regions by
 1333 October 1, 2013.

1334 (2) The agency shall make payments for long-term care,
 1335 including home and community-based services, using a managed
 1336 care model. Unless otherwise specified, the provisions of ss.
 1337 409.961-409.970 apply to the long-term care managed care
 1338 program.

1339 (3) The Department of Elderly Affairs shall assist the
 1340 agency to develop specifications for use in the invitation to
 1341 negotiate and the model contract; determine clinical eligibility
 1342 for enrollment in managed long-term care plans; monitor plan
 1343 performance and measure quality of service delivery; assist
 1344 clients and families to address complaints with the plans;
 1345 facilitate working relationships between plans and providers
 1346 serving elders and disabled adults; and perform other functions
 1347 specified in a memorandum of agreement.

1348 Section 20. Section 409.979, Florida Statutes, is created
 1349 to read:

1350 409.979 Eligibility.-

1351 (1) Medicaid recipients who meet all of the following
 1352 criteria are eligible to receive long-term care services and
 1353 must receive long-term care services by participating in the
 1354 long-term care managed care program. The recipient must be:

1355 (a) Sixty-five years of age or older or eligible for
 1356 Medicaid by reason of a disability.

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1357 (b) Determined by the Comprehensive Assessment Review and
 1358 Evaluation for Long-Term Care Services (CARES) Program to
 1359 require nursing facility care as defined in s. 409.985(3).

1360 (2) Medicaid recipients who, on the date long-term care
 1361 managed care plans become available in their region, reside in a
 1362 nursing home facility or are enrolled in one of the following
 1363 long-term care Medicaid waiver programs are eligible to
 1364 participate in the long-term care managed care program for up to
 1365 24 months without being reevaluated for their need of nursing
 1366 facility care as defined in s. 409.985(3):

1367 (a) The Assisted Living for the Frail Elderly Waiver.

1368 (b) The Aged and Disabled Adult Waiver.

1369 (c) The Adult Day Health Care Waiver.

1370 (d) The Consumer-Directed Care Plus Program as described
 1371 in s. 409.221.

1372 (e) The Program of All-inclusive Care for the Elderly.

1373 (f) The long-term care community-based diversion pilot
 1374 project as described in s. 430.705.

1375 (g) The Channeling Services Waiver for Frail Elders.

1376 Section 21. Section 409.980, Florida Statutes, is created
 1377 to read:

1378 409.980 Benefits.—Long-term care plans shall cover, at a
 1379 minimum, the following:

1380 (1) Nursing facility care.

1381 (2) Services provided in assisted living facilities.

1382 (3) Hospice.

1383 (4) Adult day care.

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- 1384 (5) Medical equipment and supplies, including incontinence
- 1385 supplies.
- 1386 (6) Personal care.
- 1387 (7) Home accessibility adaptation.
- 1388 (8) Behavior management.
- 1389 (9) Home delivered meals.
- 1390 (10) Case management.
- 1391 (11) Therapies:
- 1392 (a) Occupational therapy
- 1393 (b) Speech therapy
- 1394 (c) Respiratory therapy
- 1395 (d) Physical therapy.
- 1396 (12) Intermittent and skilled nursing.
- 1397 (13) Medication administration.
- 1398 (14) Medication management.
- 1399 (15) Nutritional assessment and risk reduction.
- 1400 (16) Caregiver training.
- 1401 (17) Respite care.
- 1402 (18) Transportation.
- 1403 (19) Personal emergency response system.

1404 Section 22. Section 409.981, Florida Statutes, is created
 1405 to read:

1406 409.981 Eligible plans.—

- 1407 (1) ELIGIBLE PLANS.—Provider service networks must be
- 1408 long-term care provider service networks. Other eligible plans
- 1409 may either be long-term care plans or comprehensive long-term
- 1410 care plans.

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1411 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
 1412 eligible plans through the procurement process described in s.
 1413 409.966. The agency shall provide notice of invitations to
 1414 negotiate no later than July 1, 2012.

1415 (a) The agency shall procure three plans for Region I. At
 1416 least one plan shall be a provider service network, if any
 1417 provider service network submits a responsive bid.

1418 (b) The agency shall procure at least three and no more
 1419 than six plans for Region II. At least one plan shall be a
 1420 provider service network, if any submit a responsive bid.

1421 (c) The agency shall procure at least four plans and no
 1422 more than eight plans for Region III. At least two plans shall
 1423 be provider service networks, if any two submit responsive bids.

1424 (d) The agency shall procure at least four plans and no
 1425 more than seven plans for Region IV. At least two plans shall be
 1426 provider service networks, if any two submit responsive bids.

1427 (e) The agency shall procure three plans for Region V. At
 1428 least one plan shall be a provider service network, if any
 1429 submit a responsive bid.

1430 (f) The agency shall procure at least four plans and no
 1431 more than seven plans for Region VI. At least two plans shall be
 1432 provider service networks, if any two submit a responsive bid.

1433 (g) The agency shall procure at least five plans and no
 1434 more than ten plans for Region VII. At least two plans shall be
 1435 provider service networks, if any two submit responsive bids.

1436
 1437 If no provider service network submits a responsive bid, the
 1438 agency shall procure one fewer eligible plan in each of the

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1439 regions. Within 12 months after the initial invitation to
 1440 negotiate, the agency shall attempt to procure an eligible plan
 1441 that is a provider service network. The agency shall notice
 1442 another invitation to negotiate only with provider service
 1443 networks in such region where no provider service network has
 1444 been selected.

1445 (3) QUALITY SELECTION CRITERIA.—In addition to the
 1446 criteria established in s. 409.966, the agency shall consider
 1447 the following factors in the selection of eligible plans:

1448 (a) Evidence of the employment of executive managers with
 1449 expertise and experience in serving aged and disabled persons
 1450 who require long-term care.

1451 (b) Whether a plan has established a network of service
 1452 providers dispersed throughout the region and in sufficient
 1453 numbers to meet specific service standards established by the
 1454 agency for specialty services for persons receiving home and
 1455 community-based care.

1456 (c) Whether a plan is proposing to establish a
 1457 comprehensive long-term care plan and whether the eligible plan
 1458 has a contract to provide managed medical assistance services in
 1459 the same region.

1460 (d) Whether a plan offers consumer-directed care services
 1461 to enrollees pursuant to s. 409.221.

1462 (e) Whether a plan is proposing to provide home and
 1463 community based services in addition to the minimum benefits
 1464 required by s. 409.980.

1465 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—
 1466 Participation by the Program for All-Inclusive Care for the

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1467 Elderly (PACE) shall be pursuant to a contract with the agency
 1468 and not subject to the procurement requirements or regional plan
 1469 number limits of this section. PACE plans may continue to
 1470 provide services to individuals at such levels and enrollment
 1471 caps as authorized by the General Appropriations Act.

1472 Section 23. Section 409.982, Florida Statutes, is created
 1473 to read:

1474 409.982 Managed care plan accountability.—In addition to
 1475 the requirements of s. 409.967, plans and providers
 1476 participating in the long-term care managed care program shall
 1477 comply with the requirements of this section.

1478 (1) PROVIDER NETWORKS.—Managed care plans may limit the
 1479 providers in their networks based on credentials, quality
 1480 indicators, and price. For the period between October 1, 2013-
 1481 September 30, 2014, each selected plan must offer a network
 1482 contract to all the following providers in the region:

1483 (a) Nursing homes.

1484 (b) Hospices.

1485 (c) Aging network service providers that have previously
 1486 participated in home and community-based waivers serving elders
 1487 or community-service programs administered by the Department of
 1488 Elderly Affairs.

1489
 1490 After 12 months of active participation in a managed care plan's
 1491 network, the plan may exclude any of the providers named in this
 1492 subsection from the network for failure to meet quality or
 1493 performance criteria. If the plan excludes a provider from the
 1494 plan, the plan must provide written notice to all recipients who

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1495 have chosen that provider for care. The notice shall be provided
 1496 at least 30 days prior to the effective date of the exclusion.
 1497 The agency shall establish contract provisions governing the
 1498 transfer of recipients from excluded residential providers.

1499 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1500 this subsection, providers may limit the managed care plans they
 1501 join. Nursing homes and hospices which are enrolled Medicaid
 1502 providers must participate in all eligible plans selected by the
 1503 agency in the region in which the provider is located.

1504 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
 1505 monitor the quality and performance of each participating
 1506 provider using measures adopted by and collected by the agency
 1507 and any additional measures mutually agreed upon by the provider
 1508 and the plan.

1509 (4) PROVIDER NETWORK STANDARDS.—The agency shall establish
 1510 and each managed care plan must comply with specific standards
 1511 for the number, type, and regional distribution of providers in
 1512 the plan's network, which must include:

- 1513 (a) Adult day centers.
- 1514 (b) Adult family care homes.
- 1515 (c) Assisted living facilities.
- 1516 (d) Health care services pools.
- 1517 (e) Home health agencies.
- 1518 (f) Homemaker and companion services.
- 1519 (g) Hospices.
- 1520 (h) Community Care for the Elderly Lead Agencies.
- 1521 (i) Nurse registries.
- 1522 (j) Nursing homes.

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1523 (5) PROVIDER PAYMENT.—Managed care plans and providers
 1524 shall negotiate mutually acceptable rates, methods, and terms of
 1525 payment. Plans shall pay nursing homes an amount equal to the
 1526 nursing facility-specific payment rates set by the agency;
 1527 however, mutually acceptable higher rates may be negotiated for
 1528 medically complex care. Plans shall pay hospice providers an
 1529 amount equal to the per diem rate set by the agency. For
 1530 recipients residing in a nursing facility and receiving hospice
 1531 services, the plan shall pay the hospice provider the per diem
 1532 rate set by the agency minus the nursing facility component and
 1533 shall pay the nursing facility the applicable state rate. Plans
 1534 shall ensure that electronic nursing home and hospice claims
 1535 that contain sufficient information for processing are paid
 1536 within 10 business days after receipt.

1537 Section 24. Section 409.983, Florida Statutes, is created
 1538 to read:

1539 409.983 Managed care plan payment.—In addition to the
 1540 payment provisions of s. 409.968, the agency shall provide
 1541 payment to plans in the long-term care managed care program
 1542 pursuant to this section.

1543 (1) Prepaid payment rates for long-term care managed care
 1544 plans shall be negotiated between the agency and the eligible
 1545 plans as part of the procurement described in s. 409.966.

1546 (2) Payment rates for comprehensive long-term care plans
 1547 covering services described in s. 409.973 shall be blended with
 1548 rates for long-term care plans for services specified in s.
 1549 409.980.

1550 (3) Payment rates for plans shall reflect historic

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1551 utilization and spending for covered services projected forward
 1552 and adjusted to reflect the level of care profile for enrollees
 1553 of each plan. The payment shall be adjusted to provide an
 1554 incentive for reducing institutional placements and increasing
 1555 the utilization of home and community-based services.

1556 (4) The initial assessment of an enrollee's level of care
 1557 shall be made by the Comprehensive Assessment and Review for
 1558 Long-Term-Care Services (CARES) program, which shall assign the
 1559 recipient into one of the following levels of care:

1560 (a) Level of care 1 consists of recipients residing in or
 1561 who must be placed in a nursing home.

1562 (b) Level of care 2 consists of recipients at imminent
 1563 risk of nursing home placement as evidenced by the need for the
 1564 constant availability of routine medical and nursing treatment
 1565 and care, and require extensive health-related care and services
 1566 because of mental or physical incapacitation.

1567 (c) Level of care 3 consists of recipients at imminent
 1568 risk of nursing home placement as evidenced by the need for the
 1569 constant availability of routine medical and nursing treatment
 1570 and care, have a limited need for health-related care and
 1571 services, are mildly medically or physically incapacitated

1572
 1573 The agency shall periodically adjust payment rates to account
 1574 for changes in the level of care profile for each managed care
 1575 plan based on encounter data.

1576 (5) The agency shall make an incentive adjustment in
 1577 payment rates to encourage the increased utilization of home and
 1578 community based services and a commensurate reduction of

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1579 institutional placement. The incentive adjustment shall be
 1580 modified in each successive rate period during the first
 1581 contract period, as follows:

1582 (a) A 2 percentage point shift in the first rate setting
 1583 period;

1584 (b) A 2 percentage point shift in the second rate setting
 1585 period, as compared to the utilization mix at the end of the
 1586 first rate setting period;

1587 (c) A 3 percentage point shift in the third rate setting
 1588 period, and in each subsequent rate setting period during the
 1589 first contract period, as compared to the utilization mix at the
 1590 end of the immediately preceding rate setting period.

1591
 1592 The incentive adjustment shall continue in subsequent contract
 1593 periods, at a rate of 3 percentage points per year as compared
 1594 to the utilization mix at the end of the immediately preceding
 1595 rate setting period, until no more than 35 percent of the plan's
 1596 enrollees are placed in institutional settings. The agency shall
 1597 annually report to the Legislature the actual change in the
 1598 utilization mix of home and community based services compared to
 1599 institutional placements and provide a recommendation for
 1600 utilization mix requirements for future contracts.

1601 (6) The agency shall establish nursing facility-specific
 1602 payment rates for each licensed nursing home based on facility
 1603 costs adjusted for inflation and other factors as authorized in
 1604 the General Appropriations Act. Payments to long-term care
 1605 managed care plans shall be reconciled to reimburse actual
 1606 payments to nursing facilities.

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1607 (7) The agency shall establish hospice payment rates.
 1608 Payments to long-term care managed care plans shall be
 1609 reconciled to reimburse actual payments to hospices.

1610 Section 25. Section 409.984, Florida Statutes, is created
 1611 to read:

1612 409.984 Choice counseling; enrollment.—

1613 (1) CHOICE COUNSELING.—Before contracting with a vendor to
 1614 provide choice counseling as authorized under s. 409.969, the
 1615 agency shall offer to contract with aging resource centers
 1616 established under s. 430.2053 for choice counseling services. If
 1617 the aging resource center is determined not to be the vendor
 1618 that provides choice counseling, the agency shall establish a
 1619 memorandum of understanding with the aging resource center to
 1620 coordinate staffing and collaborate with the choice counseling
 1621 vendor. In addition to the requirements of s. 409.969, any
 1622 contract to provide choice counseling for the long-term care
 1623 managed care program shall provide that each recipient be given
 1624 the option of having in-person choice counseling.

1625 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
 1626 enroll into a long-term care managed care plan those Medicaid
 1627 recipients who do not voluntarily choose a plan pursuant to s.
 1628 409.969. The agency shall automatically enroll recipients in
 1629 plans that meet or exceed the performance or quality standards
 1630 established pursuant to s. 409.967, and shall not automatically
 1631 enroll recipients in a plan that is deficient in those
 1632 performance or quality standards. If a recipient is deemed
 1633 dually eligible for Medicaid and Medicare services and is
 1634 currently receiving Medicare services from an entity qualified

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1635 under 42 C.F.R. part 422 as a Medicare Advantage Preferred
 1636 Provider Organization, Medicare Advantage Provider-sponsored
 1637 Organization, or Medicare Advantage Special Needs Plan, then the
 1638 agency shall automatically enroll the recipient in such plan for
 1639 Medicaid services if the plan is currently participating in the
 1640 long-term care managed care program. Except as provided by this
 1641 chapter, the agency may not engage in practices that are
 1642 designed to favor one managed care plan over another. When
 1643 automatically enrolling recipients in plans, the agency shall
 1644 take into account the following criteria:

1645 (a) Whether the plan has sufficient network capacity to
 1646 meet the needs of the recipients.

1647 (b) Whether the recipient has previously received services
 1648 from one of the plan's home and community-based service
 1649 providers.

1650 (c) Whether the home and community-based providers in one
 1651 plan are more geographically accessible to the recipient's
 1652 residence than those in other plans.

1653 (3) HOSPICE SELECTION.—Notwithstanding the provisions of
 1654 s. 409.969(3)(c), when a recipient is referred for hospice
 1655 services, the recipient shall have a 30-day period during which
 1656 the recipient may select to enroll in another managed care plan
 1657 to access the hospice provider of the recipient's choice.

1658 (4) CHOICE of RESIDENTIAL SETTING.—When a recipient is
 1659 referred for placement in a nursing home or assisted living
 1660 facility, the plan shall inform the recipient of any facilities
 1661 within the plan that have specific cultural or religious
 1662 affiliations and, if requested by the recipient, make a

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1663 reasonable effort to place the recipient in the facility of the
 1664 recipient's choice.

1665 Section 26. Section 409.9841. Florida Statutes is created
 1666 to read:

1667 409.9841 Long-term care managed care technical advisory
 1668 workgroup.-

1669 (1) Before August 1, 2011, the agency shall establish a
 1670 technical advisory workgroup to assist in developing:

1671 (a) the method of determining Medicaid eligibility
 1672 pursuant to s. 409.985(3).

1673 (b) the requirements for provider payments to nursing
 1674 homes under s. 409.982(6).

1675 (c) the method for managing non-payment of Medicare co-
 1676 insurance crossover claims .

1677 (d) uniform requirements for claims submissions and
 1678 payments, including electronic funds transfers and claims
 1679 processing.

1680 (e) the process for enrollment of and payment for
 1681 individuals pending determination of Medicaid eligibility.

1682 (2) The advisory workgroup must include, but is not
 1683 limited to, representatives of providers and plans who could
 1684 potentially participate in long-term care managed care. Members
 1685 of the workgroup shall serve without compensation but are may be
 1686 reimbursed for per diem and travel expenses as provided in s.
 1687 112.061.

1688 (3) This section is repealed on June 30, 2013.

1689 Section 27. Section 409.985, Florida Statutes, is created
 1690 to read:

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1691 409.985 Comprehensive Assessment and Review for Long-Term
 1692 Care Services (CARES) Program.—

1693 (1) The agency shall operate the Comprehensive Assessment
 1694 and Review for Long-Term Care Services (CARES) preadmission
 1695 screening program to ensure that only individuals whose
 1696 conditions require long-term care services are enrolled in the
 1697 long-term care managed care program.

1698 (2) The agency shall operate the CARES program through an
 1699 interagency agreement with the Department of Elderly Affairs.
 1700 The agency, in consultation with the Department of Elderly
 1701 Affairs, may contract for any function or activity of the CARES
 1702 program, including any function or activity required by 42
 1703 C.F.R. part 483.20, relating to preadmission screening and
 1704 review.

1705 (3) The CARES program shall determine if an individual
 1706 requires nursing facility care and, if the individual requires
 1707 such care, assign the individual to a level of care as described
 1708 in s. 409.983(4). When determining the need for nursing facility
 1709 care, consideration shall be given to the nature of the services
 1710 prescribed and which level of nursing or other health care
 1711 personnel meets the qualifications necessary to provide such
 1712 services and the availability to and access by the individual of
 1713 community or alternative resources. For the purposes of the
 1714 long-term care managed care program, "nursing facility care"
 1715 means the individual:

1716 (a) Requires nursing home placement as evidenced by the
 1717 need for medical observation throughout a 24 hour period and
 1718 care required to be performed on a daily basis by, or under the

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1719 direct supervision of, a registered nurse or other health care
 1720 professionals and requires services that are sufficiently
 1721 medically complex to require supervision, assessment, planning,
 1722 or intervention by a registered nurse because of mental or
 1723 physical incapacitation by the individual; or
 1724 (b) Requires or is at imminent risk of nursing home
 1725 placement as evidenced by the need for observation throughout a
 1726 24 hour period and care and the constant availability of medical
 1727 and nursing treatment and requires services on a daily or
 1728 intermittent basis that are to be performed under the
 1729 supervision of licensed nursing or other health professionals
 1730 because the individual who is incapacitated mentally or
 1731 physically; or
 1732 (c) Requires or is at imminent risk of nursing home
 1733 placement as evidenced by the need for observation throughout a
 1734 24 hour period and care and the constant availability of medical
 1735 and nursing treatment and requires limited services that are to
 1736 be performed under the supervision of licensed nursing or other
 1737 health professionals because the individual who is mildly
 1738 incapacitated mentally or physically.
 1739 (4) For individuals whose nursing home stay is initially
 1740 funded by Medicare and Medicare coverage is being terminated for
 1741 lack of progress towards rehabilitation, CARES staff shall
 1742 consult with the person making the determination of progress
 1743 toward rehabilitation to ensure that the recipient is not being
 1744 inappropriately disqualified from Medicare coverage. If, in
 1745 their professional judgment, CARES staff believes that a
 1746 Medicare beneficiary is still making progress toward

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1747 rehabilitation, they may assist the Medicare beneficiary with an
 1748 appeal of the disqualification from Medicare coverage. The use
 1749 of CARES teams to review Medicare denials for coverage under
 1750 this section is authorized only if it is determined that such
 1751 reviews qualify for federal matching funds through Medicaid. The
 1752 agency shall seek or amend federal waivers as necessary to
 1753 implement this section.

1754 Section 28. Section 409.986, Florida Statutes, is created
 1755 to read:

1756 409.986 Managed long-term care for persons with
 1757 developmental disabilities.-

1758 (1) Pursuant to s. 409.963, the agency is responsible for
 1759 administering the long-term care managed care program for
 1760 persons with developmental disabilities described in ss.
 1761 409.986-409.992, but may delegate specific duties and
 1762 responsibilities for the program to the Agency for Persons with
 1763 Disabilities and other state agencies. By January 1,2015, the
 1764 agency shall begin implementation of statewide long-term care
 1765 managed care for persons with developmental disabilities, with
 1766 full implementation in all regions by October 1, 2016.

1767 (2) The agency shall make payments for long-term care for
 1768 persons with developmental disabilities, including home and
 1769 community-based services, using a managed care model. Unless
 1770 otherwise specified, the provisions of ss. 409.961-409.970 apply
 1771 to the long-term care managed care program for persons with
 1772 developmental disabilities.

1773 (3) The Agency for Persons with Disabilities shall assist
 1774 the agency to develop the specifications for use in the

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1775 invitations to negotiate and the model contract; determine
 1776 clinical eligibility for enrollment in long-term care plans for
 1777 persons with developmental disabilities; assist the agency to
 1778 monitor plan performance and measure quality; assist clients and
 1779 families to address complaints with the plans; facilitate
 1780 working relationships between plans and providers serving
 1781 persons with developmental disabilities; and perform other
 1782 functions specified in a memorandum of agreement.

1783 Section 29. Section 409.987, Florida Statutes, is created
 1784 to read:

1785 409.987 Eligibility.-

1786 (1) Medicaid recipients who meet all of the following
 1787 criteria are eligible and will be enrolled in a comprehensive
 1788 long-term care plan or long-term care plan:

1789 (a) Medicaid eligible pursuant to s.409.904.

1790 (b) A Florida resident who has a developmental disability
 1791 as defined in s. 393.063.

1792 (c) Meets the level of care need including:

1793 1. The recipient's intelligence quotient is 59 or less;

1794 2. The recipient's intelligence quotient is 60-69,
 1795 inclusive, and the recipient has a secondary condition that
 1796 includes cerebral palsy, spina bifida, Prader-Willi syndrome,
 1797 epilepsy, or autistic disorder; or ambulation, sensory, chronic
 1798 health, and behavioral problems;

1799 3. The recipient's intelligence quotient is 60-69,
 1800 inclusive, and the recipient has severe functional limitations
 1801 in at least three major life activities including self-care,

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1802 learning, mobility, self-direction, understanding and use of
 1803 language, and capacity for independent living; or

1804 4. The recipient is eligible under a primary disability of
 1805 autistic disorder, cerebral palsy, spina bifida, or Prader-Willi
 1806 syndrome. In addition, the condition must result in substantial
 1807 functional limitations in three or more major life activities,
 1808 including self-care, learning, mobility, self-direction,
 1809 understanding and use of language, and capacity for independent
 1810 living.

1811 (d) Meets the level of care need for services in an
 1812 intermediate care facility for the developmentally disabled.

1813 (e) Is enrolled in a home and community based Medicaid
 1814 waiver established in chapter 393, or the Consumer Directed Care
 1815 Plus program for persons with developmental disabilities under
 1816 the Medicaid state plan or the recipient is a Medicaid-funded
 1817 resident of a private intermediate care facility for the
 1818 developmentally disabled on the date the managed long-term care
 1819 plans for persons with disabilities become available in the
 1820 recipient's region or the recipient has been offered enrollment
 1821 in a comprehensive long-term care plan or long-term care plan.

1822 1. The Agency for Persons with Disabilities shall make
 1823 offers for enrollment to eligible individuals based on the
 1824 waitlist prioritization in s.393.065(5) and subject to
 1825 availability of funds. Prior to enrollment offers, the agency
 1826 shall determine that sufficient funds exist to support
 1827 additional enrollment into plans.

1828 (2) Unless specifically exempted, all eligible persons
 1829 must be enrolled in a comprehensive long-term care plan or a

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1830 long-term care plan. Medicaid recipients who are residents of a
 1831 developmental disability center, including Sunland Center in
 1832 Marianna and Tacachale Center in Gainesville, are exempt from
 1833 mandatory enrollment but may voluntarily enroll in a long-term
 1834 care plan.

1835 Section 30. Section 409.988, Florida Statutes, is created
 1836 to read:

1837 409.988 Benefits.-Managed care plans shall cover, at a
 1838 minimum, the services in this section. Plans may customize
 1839 benefit packages or offer additional benefits to meet the needs
 1840 of enrollees in the plan.

1841 (1) Intermediate care for the developmentally disabled.

1842 (2) Services in alternative residential settings,
 1843 including, but not limited to:

1844 (a) Group homes and foster care homes licensed pursuant to
 1845 chapters 393 and 409.

1846 (b) Comprehensive transitional education programs licensed
 1847 pursuant to chapter 393.

1848 (c) Residential habilitation centers licensed pursuant to
 1849 chapter 393.

1850 (d) Assisted living facilities, and transitional living
 1851 facilities licensed pursuant to chapters 400 and 429.

1852 (3) Adult day training.

1853 (4) Behavior analysis services.

1854 (5) Companion services.

1855 (6) Consumable medical supplies.

1856 (7) Durable medical equipment and supplies.

1857 (8) Environmental accessibility adaptations.

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- 1858 | (9) In-home support services.
- 1859 | (10) Therapies, including occupational, speech,
- 1860 | respiratory, and physical therapy.
- 1861 | (11) Personal care assistance.
- 1862 | (12) Residential habilitation services.
- 1863 | (13) Intensive behavioral residential habilitation
- 1864 | services.
- 1865 | (14) Behavior focus residential habilitation services.
- 1866 | (15) Residential nursing services.
- 1867 | (16) Respite care.
- 1868 | (17) Support Coordination.
- 1869 | (18) Supported employment.
- 1870 | (19) Supported living coaching.
- 1871 | (20) Transportation.
- 1872 | Section 31. Section 409.989, Florida Statutes, is created
- 1873 | to read:
- 1874 | 409.989 Eligible plans.—
- 1875 | (1) ELIGIBLE PLANS.—Provider service networks may be
- 1876 | either long-term care plans or comprehensive long-term care
- 1877 | plans. Other plans must be comprehensive long-term care plans
- 1878 | and under contract to provide services pursuant to s. 409.973 or
- 1879 | s. 409.980 in any of the regions which form the combined region
- 1880 | as defined in this section.
- 1881 | (2) PROVIDER SERVICE NETWORKS.—Provider service networks
- 1882 | targeted to serve persons with disabilities must include one or
- 1883 | more owners licensed pursuant to s. 393.067 or s. 400.962 and
- 1884 | with at least 10 years experience in serving this population.

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1885 (3) ELIGIBLE PLAN SELECTION.—The agency shall select
 1886 eligible plans through the procurement described in s. 409.966.
 1887 The agency shall notice invitations to negotiate no later than
 1888 January 1, 2015

1889 (a) The agency shall procure at least two plans and no
 1890 more than three plans for services in combined Regions I and II.
 1891 At least one plan shall be a provider service network, if any
 1892 submit a responsive bid.

1893 (b) The agency shall procure at least two plans and no
 1894 more than three plans for services in combined Regions III and
 1895 IV. At least one plan shall be a provider service network, if
 1896 any submit a responsive bid.

1897 (c) The agency shall procure at least two plans and no
 1898 more than four plans for services in combined Regions V, VI and
 1899 VII. At least one plan shall be a provider service network, if
 1900 any submit a responsive bid.

1901
 1902 If no provider service network submits a responsive bid, the
 1903 agency shall procure no more than one less than the maximum
 1904 number of eligible plans permitted in the combined region.
 1905 Within 12 months after the initial invitation to negotiate, the
 1906 agency shall attempt to procure an eligible plan that is a
 1907 provider service network. The agency shall notice another
 1908 invitation to negotiate only with provider service networks in
 1909 such combined region where no provider service network has been
 1910 selected.

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1911 (4) QUALITY SELECTION CRITERIA.—In addition to the
 1912 criteria established in s. 409.966, the agency shall consider
 1913 the following factors in the selection of eligible plans:
 1914 (a) Specialized staffing. Plan employment of executive
 1915 managers with expertise and experience in serving persons with
 1916 developmental disabilities.
 1917 (b) Network qualifications. Plan establishment of a
 1918 network of service providers dispersed throughout the combined
 1919 region and in sufficient numbers to meet specific accessibility
 1920 standards established by the agency for specialty services for
 1921 persons with developmental disabilities.
 1922 (c) Evidence that an eligible plan has written agreements
 1923 or signed contracts or has made substantial progress in
 1924 establishing relationships with providers prior to the plan
 1925 submitting a response. The agency shall give preference to plans
 1926 with evidence of signed contracts with providers listed in s.
 1927 409.990 (2) (a) - (b) .
 1928 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's
 1929 Medical Services Network may provide either long-term care plans
 1930 or comprehensive long-term care plans. Participation by the
 1931 Children's Medical Services Network shall be pursuant to a
 1932 single, statewide contract with the agency not subject to the
 1933 procurement requirements or regional plan number limits of this
 1934 section. The Children's Medical Services Network must meet all
 1935 other plan requirements.
 1936 Section 32. Section 409.990, Florida Statutes, is created
 1937 to read:

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1938 409.990 Managed care plan accountability.—In addition to
 1939 the requirements of s. 409.967, managed care plans and providers
 1940 shall comply with the requirements of this section.

1941 (2) PROVIDER NETWORKS.—Managed care plans may limit the
 1942 providers in their networks based on credentials, quality
 1943 indicators, and price. However, in the first contract period
 1944 after an eligible plan is selected in a region by the agency,
 1945 the plan must offer a network contract to the following
 1946 providers in the region:

1947 (a) Providers with licensed institutional care facilities
 1948 for the developmentally disabled.

1949 (b) Providers of alternative residential facilities
 1950 specified in s.409.988.

1951
 1952 After 12 months of active participation in a managed care plan
 1953 network, the plan may exclude any of the above-named providers
 1954 from the network for failure to meet quality or performance
 1955 criteria. If the plan excludes a provider from the plan, the
 1956 plan must provide written notice to all recipients who have
 1957 chosen that provider for care. The notice shall be issued at
 1958 least 90 days before the effective date of the exclusion.

1959 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1960 this subsection, providers may limit the managed care plans they
 1961 join. Licensed institutional care facilities for the
 1962 developmentally disabled and licensed residential settings
 1963 providing Intensive Behavioral Residential Habilitation services
 1964 with an active Medicaid provider agreement must agree to
 1965 participate in any eligible plan selected by the agency

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1966 (4) PERFORMANCE MEASUREMENT.—Each managed care plan shall
 1967 monitor the quality and performance of each participating
 1968 provider. At the beginning of the contract period, each plan
 1969 shall notify all its network providers of the metrics used by
 1970 the plan for evaluating the provider's performance and
 1971 determining continued participation in the network.

1972 (5) PROVIDER PAYMENT.—Managed care plans and providers
 1973 shall negotiate mutually acceptable rates, methods, and terms of
 1974 payment. Plans shall pay intermediate care facilities for the
 1975 developmentally disabled and intensive behavior residential
 1976 habilitation providers an amount equal to the facility-specific
 1977 payment rate set by the agency.

1978 (6) CONSUMER AND FAMILY INVOLVEMENT.—Each managed care
 1979 plan must establish a family advisory committee to participate
 1980 in program design and oversight.

1981 (7) Consumer-Directed Care.—Each managed care plan must
 1982 offer consumer-directed care services to enrollees pursuant to
 1983 s. 409.221.

1984 Section 33. Section 409.991, Florida Statutes, is created
 1985 to read:

1986 409.991 Managed care plan payment.—In addition to the
 1987 payment provisions of s. 409.968, the agency shall provide
 1988 payment to comprehensive long-term care plans and long-term care
 1989 plans pursuant to this section.

1990 (1) Prepaid payment rates shall be negotiated between the
 1991 agency and the eligible plans as part of the procurement
 1992 described in s. 409.966.

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1993 (2) Payment for comprehensive long-term care plans
 1994 covering services pursuant to s. 409.973 shall be blended with
 1995 payments for long-term care plans for services specified in s.
 1996 409.988.

1997 (3) Payment rates for plans covering service specified in
 1998 s. 409.988 shall be based on historical utilization and spending
 1999 for covered services projected forward and adjusted to reflect
 2000 the level of care profile of each plan's enrollees.

2001 (4) The Agency for Persons with Disabilities shall conduct
 2002 the initial assessment of an enrollee's level of care. The
 2003 evaluation of level of care shall be based on assessment and
 2004 service utilization information from the most recent version of
 2005 the Questionnaire for Situational Information and encounter
 2006 data.

2007 (5) The agency shall assign enrollees of developmental
 2008 disabilities long-term care plans into one of five levels of
 2009 care to account for variations in risk status and service needs
 2010 among enrollees.

2011 (a) Level of care 1 consists of individuals receiving
 2012 services in an intermediate care facility for the
 2013 developmentally disabled.

2014 (b) Level of care 2 consists of individuals with intensive
 2015 medical or adaptive needs and that are essential for avoiding
 2016 institutionalization, or who possess behavioral problems that
 2017 are exceptional in intensity, duration, or frequency and present
 2018 a substantial risk of harm to themselves or others.

2019 (c) Level of care 3 consists of individuals with service
 2020 needs, including a licensed residential facility and a moderate

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2021 level of support for standard residential habilitation services
 2022 or a minimal level of support for behavior focus residential
 2023 habilitation services, or individuals in supported living who
 2024 require more than 6 hours a day of in-home support service.

2025 (d) Level of care 4 consists of individuals requiring less
 2026 than moderate level of residential habilitation support in a
 2027 residential placement, or individuals in supported living who
 2028 require 6 hours a day or less of in-home support service.

2029 (e) Level of care 5 consists of individuals who do not
 2030 receive in-home support service and need minimal support
 2031 services while living in independent or supported living
 2032 situations or in their family home.

2033
 2034 The agency shall periodically adjust aggregate payments to plans
 2035 based on encounter data to account for variations in risk levels
 2036 among plans' enrollees.

2037 (6) The agency shall establish intensive behavior
 2038 residential habilitation rates for providers approved by the
 2039 agency to provide this service. The agency shall also establish
 2040 intermediate care facility for the developmentally disabled-
 2041 specific payment rates for each licensed intermediate care
 2042 facility. Payments to intermediate care facilities for the
 2043 developmentally disabled and providers of intensive behavior
 2044 residential habilitation service shall be reconciled to
 2045 reimburse the plan's actual payments to the facilities.

2046 Section 34. Section 409.992, Florida Statutes, is created
 2047 to read:

2048 409.992 Automatic enrollment.—

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2049 (1) The agency shall automatically enroll into a
 2050 comprehensive long-term care plan or a long-term care plan those
 2051 Medicaid recipients who do not voluntarily choose a plan
 2052 pursuant to s. 409.969. The agency shall automatically enroll
 2053 recipients in plans that meet or exceed the performance or
 2054 quality standards established pursuant to s. 409.967, and shall
 2055 not automatically enroll recipients in a plan that is deficient
 2056 in those performance or quality standards. The agency shall
 2057 assign individuals who are deemed dually eligible for Medicaid
 2058 and Medicare, to a plan that provides both Medicaid and Medicare
 2059 services. The agency may not engage in practices that are
 2060 designed to favor one managed care plan over another. When
 2061 automatically enrolling recipients in plans, the agency shall
 2062 take into account the following criteria:

2063 (a) Whether the plan has sufficient network capacity to
 2064 meet the needs of the recipients.

2065 (b) Whether the recipient has previously received services
 2066 from one of the plan's home and community-based service
 2067 providers.

2068 (c) Whether home and community-based providers in one plan
 2069 are more geographically accessible to the recipient's residence
 2070 than those in other plans.

2071 Section 35. This act shall take effect July 1, 2011.