1 A bill to be entitled
2 An act relating to Medicaid managed care; amending s.
3 409.912, F.S.; providing the Agency for Health Care
4 Administration with authority to extend or modify
5 certain contracts with behavioral health care
6 providers under specified circumstances; removes the
7 expiration of the authority of the agency to impose
8 fines against entities under contract with the
9 department under specified circumstances; providing
10 rebates under specified circumstances; amending s.
11 409.9122, F.S., directing the agency to calculate a
12 medical loss ratio for managed care plans under
13 specified circumstances; providing method of
14 calculation; directing the agency to create a pilot
15 accountability system for Medicaid pre-paid dental
16 plans; amending s. 409.962, F.S.; including certain
17 Medicare plans in the definition of "comprehensive
18 long-term care plan"; including certain Medicare plans
19 in the managed medical assistance program by amending
20 the definition of "eligible plan"; amending s.
21 409.966, F.S.; modifying a preference for plans with
22 in-state operations; deleting a definition; amending
23 s. 409.967, F.S.; directing the agency to calculate a
24 medical loss ratio for managed care plans under
25 specified circumstances; providing method of
26 calculation; amending 409.973, F.S.; providing that a
27 managed care plan shall inform the recipient of the
28 importance of having a primary care provider;

29 amending s. 409.974, F.S.; modifying requirements for
30 participation by certain Medicare plans; requiring
31 contracts meeting certain standards; setting
32 enrollment requirements; amending s. 409.981, F.S.;
33 modifying requirements for participation by certain
34 Medicare plans; requiring contracts meeting certain
35 standards; setting enrollment requirements; providing
36 an effective date.
37
38 Be It Enacted by the Legislature of the State of Florida:
39 Section 1. Paragraph (b) of subsection (4) and subsection
40 (21) of section 409.912, Florida Statutes, is amended to read:
41 409.912 Cost-effective purchasing of health care.—The
42 agency shall purchase goods and services for Medicaid recipients
43 in the most cost-effective manner consistent with the delivery
44 of quality medical care. To ensure that medical services are
45 effectively utilized, the agency may, in any case, require a
46 confirmation or second physician's opinion of the correct
47 diagnosis for purposes of authorizing future services under the
48 Medicaid program. This section does not restrict access to
49 emergency services or poststabilization care services as defined
50 in 42 C.F.R. part 438.114. Such confirmation or second opinion
51 shall be rendered in a manner approved by the agency. The agency
52 shall maximize the use of prepaid per capita and prepaid
53 aggregate fixed-sum basis services when appropriate and other
54 alternative service delivery and reimbursement methodologies,
55 including competitive bidding pursuant to s. 287.057, designed
56 to facilitate the cost-effective purchase of a case-managed

57 continuum of care. The agency shall also require providers to
58 minimize the exposure of recipients to the need for acute
59 inpatient, custodial, and other institutional care and the
60 inappropriate or unnecessary use of high-cost services. The
61 agency shall contract with a vendor to monitor and evaluate the
62 clinical practice patterns of providers in order to identify
63 trends that are outside the normal practice patterns of a
64 provider's professional peers or the national guidelines of a
65 provider's professional association. The vendor must be able to
66 provide information and counseling to a provider whose practice
67 patterns are outside the norms, in consultation with the agency,
68 to improve patient care and reduce inappropriate utilization.
69 The agency may mandate prior authorization, drug therapy
70 management, or disease management participation for certain
71 populations of Medicaid beneficiaries, certain drug classes, or
72 particular drugs to prevent fraud, abuse, overuse, and possible
73 dangerous drug interactions. The Pharmaceutical and Therapeutics
74 Committee shall make recommendations to the agency on drugs for
75 which prior authorization is required. The agency shall inform
76 the Pharmaceutical and Therapeutics Committee of its decisions
77 regarding drugs subject to prior authorization. The agency is
78 authorized to limit the entities it contracts with or enrolls as
79 Medicaid providers by developing a provider network through
80 provider credentialing. The agency may competitively bid single-
81 source-provider contracts if procurement of goods or services
82 results in demonstrated cost savings to the state without
83 limiting access to care. The agency may limit its network based
84 on the assessment of beneficiary access to care, provider

85 availability, provider quality standards, time and distance
86 standards for access to care, the cultural competence of the
87 provider network, demographic characteristics of Medicaid
88 beneficiaries, practice and provider-to-beneficiary standards,
89 appointment wait times, beneficiary use of services, provider
90 turnover, provider profiling, provider licensure history,
91 previous program integrity investigations and findings, peer
92 review, provider Medicaid policy and billing compliance records,
93 clinical and medical record audits, and other factors. Providers
94 are not entitled to enrollment in the Medicaid provider network.
95 The agency shall determine instances in which allowing Medicaid
96 beneficiaries to purchase durable medical equipment and other
97 goods is less expensive to the Medicaid program than long-term
98 rental of the equipment or goods. The agency may establish rules
99 to facilitate purchases in lieu of long-term rentals in order to
100 protect against fraud and abuse in the Medicaid program as
101 defined in s. 409.913. The agency may seek federal waivers
102 necessary to administer these policies.
103 (4) The agency may contract with:
104 (b) An entity that is providing comprehensive behavioral
105 health care services to certain Medicaid recipients through a
106 capitated, prepaid arrangement pursuant to the federal waiver
107 provided for by s. 409.905(5). Such entity must be licensed
108 under chapter 624, chapter 636, or chapter 641, or authorized
109 under paragraph (c) or paragraph (d), and must possess the
110 clinical systems and operational competence to manage risk and
111 provide comprehensive behavioral health care to Medicaid
112 recipients. As used in this paragraph, the term "comprehensive

113 behavioral health care services" means covered mental health and
114 substance abuse treatment services that are available to
115 Medicaid recipients. The secretary of the Department of Children
116 and Family Services shall approve provisions of procurements
117 related to children in the department's care or custody before
118 enrolling such children in a prepaid behavioral health plan. Any
119 contract awarded under this paragraph must be competitively
120 procured. In developing the behavioral health care prepaid plan
121 procurement document, the agency shall ensure that the
122 procurement document requires the contractor to develop and
123 implement a plan to ensure compliance with s. 394.4574 related
124 to services provided to residents of licensed assisted living
125 facilities that hold a limited mental health license. Except as
126 provided in subparagraph 5., and except in counties where the
127 Medicaid managed care pilot program is authorized pursuant to s.
128 409.91211, the agency shall seek federal approval to contract
129 with a single entity meeting these requirements to provide
130 comprehensive behavioral health care services to all Medicaid
131 recipients not enrolled in a Medicaid managed care plan
132 authorized under s. 409.91211, a provider service network
133 authorized under paragraph (d), or a Medicaid health maintenance
134 organization in an AHCA area. In an AHCA area where the Medicaid
135 managed care pilot program is authorized pursuant to s.
136 409.91211 in one or more counties, the agency may procure a
137 contract with a single entity to serve the remaining counties as
138 an AHCA area or the remaining counties may be included with an
139 adjacent AHCA area and are subject to this paragraph. Each
140 entity must offer a sufficient choice of providers in its

141 network to ensure recipient access to care and the opportunity
142 to select a provider with whom they are satisfied. The network
143 shall include all public mental health hospitals. To ensure
144 unimpaired access to behavioral health care services by Medicaid
145 recipients, all contracts issued pursuant to this paragraph must
146 require 80 percent of the capitation paid to the managed care
147 plan, including health maintenance organizations and capitated
148 provider service networks, to be expended for the provision of
149 behavioral health care services. If the managed care plan
150 expends less than 80 percent of the capitation paid for the
151 provision of behavioral health care services, the difference
152 shall be returned to the agency. The agency shall provide the
153 plan with a certification letter indicating the amount of
154 capitation paid during each calendar year for behavioral health
155 care services pursuant to this section. The agency may reimburse
156 for substance abuse treatment services on a fee-for-service
157 basis until the agency finds that adequate funds are available
158 for capitated, prepaid arrangements.
159 1. The agency shall modify the contracts with the entities
160 providing comprehensive inpatient and outpatient mental health
161 care services to Medicaid recipients in Hillsborough, Highlands,
162 Hardee, Manatee, and Polk Counties, to include substance abuse
163 treatment services.
164 2. Except as provided in subparagraph 5., the agency and
165 the Department of Children and Family Services shall contract
166 with managed care entities in each AHCA area except area 6 or
167 arrange to provide comprehensive inpatient and outpatient mental
168 health and substance abuse services through capitated prepaid

169 arrangements to all Medicaid recipients who are eligible to
170 participate in such plans under federal law and regulation. In
171 AHCA areas where eligible individuals number less than 150,000,
172 the agency shall contract with a single managed care plan to
173 provide comprehensive behavioral health services to all
174 recipients who are not enrolled in a Medicaid health maintenance
175 organization, a provider service network authorized under
176 paragraph (d), or a Medicaid capitated managed care plan
177 authorized under s. 409.91211. The agency may contract with more
178 than one comprehensive behavioral health provider to provide
179 care to recipients who are not enrolled in a Medicaid capitated
180 managed care plan authorized under s. 409.91211, a provider
181 service network authorized under paragraph (d), or a Medicaid
182 health maintenance organization in AHCA areas where the eligible
183 population exceeds 150,000. In an AHCA area where the Medicaid
184 managed care pilot program is authorized pursuant to s.
185 409.91211 in one or more counties, the agency may procure a
186 contract with a single entity to serve the remaining counties as
187 an AHCA area or the remaining counties may be included with an
188 adjacent AHCA area and shall be subject to this paragraph.
189 Contracts for comprehensive behavioral health providers awarded
190 pursuant to this section shall be competitively procured. Both
191 for-profit and not-for-profit corporations are eligible to
192 compete. Managed care plans contracting with the agency under
193 subsection (3) or paragraph (d) shall provide and receive
194 payment for the same comprehensive behavioral health benefits as
195 provided in AHCA rules, including handbooks incorporated by
196 reference. In AHCA area 11, the agency shall contract with at

197 least two comprehensive behavioral health care providers to
198 provide behavioral health care to recipients in that area who
199 are enrolled in, or assigned to, the MediPass program. One of
200 the behavioral health care contracts must be with the existing
201 provider service network pilot project, as described in
202 paragraph (d), for the purpose of demonstrating the cost-
203 effectiveness of the provision of quality mental health services
204 through a public hospital-operated managed care model. Payment
205 shall be at an agreed-upon capitated rate to ensure cost
206 savings. Of the recipients in area 11 who are assigned to
207 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
208 MediPass-enrolled recipients shall be assigned to the existing
209 provider service network in area 11 for their behavioral care.
210 3. Children residing in a statewide inpatient psychiatric
211 program, or in a Department of Juvenile Justice or a Department
212 of Children and Family Services residential program approved as
213 a Medicaid behavioral health overlay services provider may not
214 be included in a behavioral health care prepaid health plan or
215 any other Medicaid managed care plan pursuant to this paragraph.
216 4. Traditional community mental health providers under
217 contract with the Department of Children and Family Services
218 pursuant to part IV of chapter 394, child welfare providers
219 under contract with the Department of Children and Family
220 Services in areas 1 and 6, and inpatient mental health providers
221 licensed pursuant to chapter 395 must be offered an opportunity
222 to accept or decline a contract to participate in any provider
223 network for prepaid behavioral health services.
224 5. All Medicaid-eligible children, except children in area

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225 1 and children in Highlands County, Hardee County, Polk County,
226 or Manatee County of area 6, that are open for child welfare
227 services in the statewide automated child welfare information
228 system, shall receive their behavioral health care services
229 through a specialty prepaid plan operated by community-based
230 lead agencies through a single agency or formal agreements among
231 several agencies. The agency shall work with the specialty plan
232 to develop clinically effective, evidence-based alternatives as
233 a downward substitution for the statewide inpatient psychiatric
234 program and similar residential care and institutional services.
235 The specialty prepaid plan must result in savings to the state
236 comparable to savings achieved in other Medicaid managed care
237 and prepaid programs. Such plan must provide mechanisms to
238 maximize state and local revenues. The specialty prepaid plan
239 shall be developed by the agency and the Department of Children
240 and Family Services. The agency may seek federal waivers to
241 implement this initiative. Medicaid-eligible children whose
242 cases are open for child welfare services in the statewide
243 automated child welfare information system and who reside in
244 AHCA area 10 shall be enrolled in a capitated provider service
245 network or other capitated managed care plan, which, in
246 coordination with available community-based care providers
247 specified in s. 409.1671, shall provide sufficient medical,
248 developmental, and behavioral health services to meet the needs
249 of these children.
250
251 Effective July, 1, 2012, in order to ensure continuity of care,
252 the agency is authorized to extend or modify current contracts

253 based on current service areas or on a regional basis, as
254 determined appropriate by the agency, with comprehensive
255 behavioral health care providers as described in this paragraph
256 during the period prior to its expiration. This paragraph
257 expires October 1, 2014.
258 (21) The agency may impose a fine for a violation of this
259 section or the contract with the agency by a person or entity
260 that is under contract with the agency. With respect to any
261 nonwillful violation, such fine shall not exceed $2,500 per
262 violation. In no event shall such fine exceed an aggregate
263 amount of $10,000 for all nonwillful violations arising out of
264 the same action. With respect to any knowing and willful
265 violation of this section or the contract with the agency, the
266 agency may impose a fine upon the entity in an amount not to
267 exceed $20,000 for each such violation. In no event shall such
268 fine exceed an aggregate amount of $100,000 for all knowing and
269 willful violations arising out of the same action. ~~This~~
270 ~~subsection expires October 1, 2014.~~
271 Section 2. Section 409.961, Florida Statutes, is amended
272 to read:
273 409.961 Statutory construction; applicability; rules.—It
274 is the intent of the Legislature that if any conflict exists
275 between the provisions contained in this part and in other parts
276 of this chapter, the provisions in this part control. Sections
277 409.961-409.985 apply only to the Medicaid managed medical
278 assistance program and long-term care managed care program, as
279 provided in this part. The agency shall adopt any rules
280 necessary to comply with or administer this part and all rules

281 necessary to comply with federal requirements. In addition, the
282 department shall adopt and accept the transfer of any rules
283 necessary to carry out the department's responsibilities for
284 receiving and processing Medicaid applications and determining
285 Medicaid eligibility and for ensuring compliance with and
286 administering this part, as those rules relate to the
287 department's responsibilities, and any other provisions related
288 to the department's responsibility for the determination of
289 Medicaid eligibility. Contracts with the agency and a person or
290 entity, including Medicaid providers and managed care plans,
291 necessary to administer the Medicaid program are not rules and
292 not subject to rule promulgation under chapter 120.
293 Section 3. Subsection (21) and (22) are added to section
294 409.9122, Florida Statutes, to read:
295 409.9122 Mandatory Medicaid managed care enrollment;
296 programs and procedures.—
297 (21) MEDICAL LOSS RATIO.— If required as a condition of a
298 waiver, the agency may calculate a medical loss ratio for
299 managed care plans. The calculation shall utilize uniform
300 financial data collected from all plans and shall be computed
301 for each plan on a statewide basis. The method for calculating
302 the medical loss ratio shall meet the following criteria:
303 (a) Except as provided in paragraphs (b) and (c),
304 expenditures shall be classified in a manner consistent with 45
305 C.F.R. Part 158.
306 (b) Funds provided by plans to graduate medical education
307 institutions to underwrite the costs of residency positions
308 shall be classified as medical expenditures, provided the

309 funding is sufficient to sustain the position for the number of
310 years necessary to complete the residency requirements and the
311 residency positions funded by the plans are active providers of
312 care to Medicaid and uninsured patients.
313 (c) Prior to final determination of the medical loss
314 ratio for any period, a plan may contribute to a designated
315 state trust fund for the purpose of supporting Medicaid and
316 indigent care and have the contribution counted as a medical
317 expenditure for the period.
318 (22) Beginning in fiscal year 2012-2013, the agency shall
319 pilot an accountability system consistent with s. 409.967(3)
320 that calculates income for pre-paid dental plans and collects
321 any applicable rebates.
322 Section 4. Subsections (4) and (6) of section 409.962,
323 Florida Statutes, are amended to read:
324 409.962 Definitions.—As used in this part, except as
325 otherwise specifically provided, the term:
326 (4) "Comprehensive long-term care plan" means a managed
327 care plan, including a Medicare Advantage Special Needs Plan,
328 that provides services described in s. 409.973 and also provides
329 the services described in s. 409.98.
330 (6) "Eligible plan" means a health insurer authorized
331 under chapter 624, an exclusive provider organization authorized
332 under chapter 627, a health maintenance organization authorized
333 under chapter 641, or a provider service network authorized
334 under s. 409.912(4)(d) or an accountable care organization
335 authorized under federal law. For purposes of the managed
336 medical assistance program, the term also includes the

337 Children's Medical Services Network authorized under chapter
338 391~~. For purposes of the long-term care managed care program,~~
339 ~~the term also includes~~ and entities qualified under 42 C.F.R.
340 part 422 as Medicare Advantage Preferred Provider Organizations,
341 Medicare Advantage Provider-sponsored Organizations, Medicare
342 Advantage Health Maintenance Organizations, Medicare Advantage
343 Coordinated Care Plans, and Medicare Advantage Special Needs
344 Plans, and the Program of All-inclusive Care for the Elderly.
345 Section 5. Paragraph (c) of subsection (3) of section
346 409.966, Florida Statutes, is amended to read:
347 409.966 Eligible plans; selection.—
348 (3) QUALITY SELECTION CRITERIA.—
349 (c) After negotiations are conducted, the agency shall
350 select the eligible plans that are determined to be responsive
351 and provide the best value to the state. Preference shall be
352 given to plans that:
353 1. Have signed contracts with primary and specialty
354 physicians in sufficient numbers to meet the specific standards
355 established pursuant to s. 409.967(2)(b).
356 2. Have well-defined programs for recognizing patient-
357 centered medical homes and providing for increased compensation
358 for recognized medical homes, as defined by the plan.
359 3. Are organizations that are based in and perform
360 operational functions in this state, in-house or through
361 contractual arrangements, by staff located in this state. Using
362 a tiered approach, the highest number of points shall be awarded
363 to a plan that has all or substantially all of its operational
364 functions performed in the state. The second highest number of

365 points shall be awarded to a plan that has a majority of its
366 operational functions performed in the state. ~~The agency may~~
367 ~~establish a third tier; however, preference points may not be~~
368 ~~awarded to plans that perform only community outreach, medical~~
369 ~~director functions, and state administrative functions in the~~
370 ~~state.~~ For purposes of this subparagraph, operational functions
371 include <u>corporate headquarters,</u> claims processing, member
372 services, provider relations, utilization and prior
373 authorization, case management, disease and quality functions,
374 and finance and administration. ~~For purposes of this~~
375 ~~subparagraph, the term "based in this state" means that the~~
376 ~~entity's principal office is in this state and the plan is not a~~
377 ~~subsidiary, directly or indirectly through one or more~~
378 ~~subsidiaries of, or a joint venture with, any other entity whose~~
379 ~~principal office is not located in the state.~~
380 4. Have contracts or other arrangements for cancer disease
381 management programs that have a proven record of clinical
382 efficiencies and cost savings.
383 5. Have contracts or other arrangements for diabetes
384 disease management programs that have a proven record of
385 clinical efficiencies and cost savings.
386 6. Have a claims payment process that ensures that claims
387 that are not contested or denied will be promptly paid pursuant
388 to s. 641.3155.
389 Section 6. Subsection (4) is added to section 409.967,
390 Florida Statutes, to read:
391 409.967 Managed care plan accountability.—

392 (4) MEDICAL LOSS RATIO.— If required as a condition of a
393 waiver, the agency may calculate a medical loss ratio for
394 managed care plans. The calculation shall utilize uniform
395 financial data collected from all plans and shall be computed
396 for each plan on a statewide basis. The method for calculating
397 the medical loss ratio shall meet the following criteria:
398 (a) Except as provided in paragraphs (b) and (c),
399 expenditures shall be classified in a manner consistent with 45
400 C.F.R. Part 158.
401 (b) Funds provided by plans to graduate medical education
402 institutions to underwrite the costs of residency positions
403 shall be classified as medical expenditures, provided the
404 funding is sufficient to sustain the position for the number of
405 years necessary to complete the residency requirements and the
406 residency positions funded by the plans are active providers of
407 care to Medicaid and uninsured patients.
408 (c) Prior to final determination of the medical loss
409 ratio for any period, a plan may contribute to a designated
410 state trust fund for the purpose of supporting Medicaid and
411 indigent care and have the contribution counted as a medical
412 expenditure for the period.
413 Section 7. Subsection (4) of section 409.973, Florida
414 Statutes, is amended to read:
415 409.973 Benefits.—
416 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the
417 managed medical assistance program shall establish a program to
418 encourage enrollees to establish a relationship with their
419 primary care provider. Each plan shall:

420 (a) Provide information to each enrollee on the importance
421 of and procedure for selecting a primary care ~~physician~~
422 provider, and thereafter automatically assign to a primary care
423 provider any enrollee who fails to choose a primary care
424 provider.
425 (b) If the enrollee was not a Medicaid recipient before
426 enrollment in the plan, assist the enrollee in scheduling an
427 appointment with the primary care provider. If possible the
428 appointment should be made within 30 days after enrollment in
429 the plan. For enrollees who become eligible for Medicaid between
430 January 1, 2014, and December 31, 2015, the appointment should
431 be scheduled within 6 months after enrollment in the plan.
432 (c) Report to the agency the number of enrollees assigned
433 to each primary care provider within the plan's network.
434 (d) Report to the agency the number of enrollees who have
435 not had an appointment with their primary care provider within
436 their first year of enrollment.
437 (e) Report to the agency the number of emergency room
438 visits by enrollees who have not had at least one appointment
439 with their primary care provider.
440 Section 8. Subsection (5) is added to section 409.974,
441 Florida Statutes, to read:
442 409.974 Eligible plans.—
443 (5) MEDICARE PLANS.—Participation by Medicare Advantage
444 Preferred Provider Organization, Medicare Advantage Provider-
445 sponsored Organization, Medicare Advantage Health Maintenance
446 Organization, Medicare Advantage Coordinated Care Plan, or
447 Medicare Advantage Special Needs Plan shall be pursuant to a

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448 contract with the agency that is consistent with the Medicare
449 Improvement for Patients and Providers Act of 2008, P.L. 110-
450 275. Such plans are not subject to the procurement requirements
451 if the plan's Medicaid enrollees consist exclusively of dually
452 eligible recipients who are enrolled in the plan in order to
453 receive Medicare benefits as of the date that the invitation to
454 negotiate is issued. Otherwise, such plans are subject to all
455 procurement requirements.
456 Section 9. Subsection (5) of section 409.981, Florida
457 Statutes, is amended to read:
458 409.981 Eligible long-term care plans.—
459 (5) MEDICARE ADVANTAGE SPECIAL NEEDS PLANS.—Participation
460 by a ~~Medicare Advantage Preferred Provider Organization,~~
461 ~~Medicare Advantage Provider-sponsored Organization, or~~ Medicare
462 Advantage Special Needs Plan shall be pursuant to a contract
463 with the agency ~~and~~ that is consistent with Medicare Improvement
464 for Patients and Providers Act of 2008, P.L. 110-275. Such plans
465 are not subject to the procurement requirements if the plan's
466 Medicaid enrollees consist exclusively of dually eligible
467 recipients who are enrolled in the plan in order to receive
468 Medicare benefits as of the date the invitation to negotiate is
469 issued. Otherwise, ~~Medicare Advantage Preferred Provider~~
470 ~~Organizations, Medicare Advantage Provider-sponsored~~
471 ~~Organizations, and~~ Medicare Advantage Special Needs Plans are
472 subject to all procurement requirements.
473 Section 10. This act shall take effect July 1, 2012.

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