A bill to be entitled

An act relating to the statewide Medicaid managed care program; amending s. 409.964, F.S.; deleting an obsolete provision; amending s. 409.966, F.S.; requiring that a required databook consist of validated Medicaid encounter data for the two most recent contract years; revising the designation and county makeup of regions of the state for purposes of procuring health plans that may participate in the Medicaid program; requiring the Agency for Health Care Administration to exercise a preference in selecting plans for such plans proposing to establish a comprehensive long-term care plan; authorizing certain contract awards under certain circumstances; amending s. 409.967, F.S.; requiring the Agency to test provider network databases maintained by Medicaid managed care plans; requiring the Agency to impose fines and authorizing other sanctions on managed care plans that fail to comply with certain payment of claims requirements; amending s. 409.971, F.S.; deleting an obsolete provision; amending s. 409.972, F.S.; requiring the Agency to seek federal approval to require Medicaid enrollees to engage in work activities consistent with the requirements for the temporary cash assistance program to maintain

eligibility; requiring the Agency to seek federal approval to establish monthly premiums payable by enrollees; allowing for premiums to be waived for hardship or successful completion of healthy behaviors; authorizing rules; making premium payments a condition of eligibility and re-enrollment; establishing a 60-day grace period for failure to pay premiums; prohibiting an enrollee who fails to pay premiums after the 60-day grace period from re-enrolling in Medicaid managed care program for 12 months; amending s. 409.974, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state in the managed medical assistance program; deleting a requirement to issue an invitation to negotiate for a provider service network, under certain circumstances; deleting a procurement preference for comprehensive plans; amending s. 409.978, F.S.; deleting an obsolete provision; amending s. 409.981, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state in the managed long-term care program; deleting a requirement to issue an invitation to negotiate for a provider service network, under certain circumstances; deleting a requirement that the agency consider a

specific factor relating to the selection of managed medical assistance plans; amending s. 409.983, F.S.; deleting the requirement that the Agency establish payment rates for each licensed nursing home to be paid by each long-term care managed care plan; requiring long-term care managed care plans and providers to negotiate payment rates, methods, and terms of payment to provide services to enrollees; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.964, Florida Statutes, is amended to read:

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

than 30 days after the completion of the public meeting in that region. ~~The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.~~

Section 2. Subsection (2) and paragraphs (a), (d), and (e) of subsection (3) of section 409.966, Florida Statutes, are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data for the 2 ~~3~~ most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county. The source of the data in the report must include ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System. The report must be available in electronic form and delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. Separate and simultaneous procurements shall be conducted in each of the following regions:

(a) Region A ~~Region 1~~, which consists of Bay, Calhoun,

Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, ~~and~~ Walton, and Washington Counties.

(b) Region B ~~Region 2~~, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia ~~Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington~~ Counties.

(c) Region C ~~Region 3~~, which consists of Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk ~~Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union~~ Counties.

(d) Region D ~~Region 4~~, which consists of Brevard, Orange, Osceola, and Seminole ~~Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia~~ Counties.

(e) Region E ~~Region 5~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota ~~Pasco and Pinellas~~ Counties.

(f) Region F ~~Region 6~~, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie ~~Hardee, Highlands, Hillsborough, Manatee, and Polk~~ Counties.

(g) Region G ~~Region 7~~, which consists of Broward County

~~Brevard, Orange, Osceola, and Seminole Counties~~.

(h) Region H ~~Region 8~~, which consists of Miami-Dade and Monroe ~~Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota~~ Counties.

~~(i) Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.~~

~~(j) Region 10, which consists of Broward County.~~

~~(k) Region 11, which consists of Miami-Dade and Monroe Counties.~~

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. The agency shall exercise a preference for plans which propose to establish a comprehensive long-term care plan. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and

specialty physicians in the provider network.

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

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

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

7. Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitting a response.

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

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

(d) For the first year of the first contract term, the

agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.

1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.

2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.

(e) To ensure managed care plan participation in Regions A and E ~~Regions 1 and 2~~, the agency shall award an additional contract to each plan with a contract award in Region A ~~Region 1~~ or Region E ~~Region 2~~. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region A ~~Region 1~~ or Region E ~~Region 2~~, the additional contract is automatically terminated 180 days after the imposition of the

penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.

Section 3. Paragraphs (c) and (j) of subsection (2) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

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

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain

an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract with an entity to conduct, systematic and ongoing testing of the provider network databases maintained by each plan to confirm accuracy and confirm that providers are accepting enrollees, such that enrollees have access to care.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who

have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(j) *Prompt payment.*—Managed care plans shall comply with ss.641.315, 641.3155, and 641.513, and the agency shall impose fines, and may impose other sanctions, on a plan that willfully fails to comply with those sections or s. 409.982(5), as applicable.

Section 4. Section 409.971, Florida Statutes, is amended to read:

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

Section 5. Subsection (3) of section 409.972, Florida Statutes, is amended, and new subsection (4) is added to read:

409.972 Mandatory and voluntary enrollment.—

(3) The agency shall seek federal approval to require enrollees to provide proof to the Department of Children and Families of engagement in work activities consistent with the requirements for temporary cash assistance, as defined in s. 414.0252, pursuant to s. 414.045, as a condition of eligibility and enrollment. ~~The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.~~

(4) The agency shall seek federal approval to charge monthly premiums payable by enrollees with incomes between 50 percent and 100 percent of the federal poverty level in the amount of $10 and by enrollees with incomes at 101 percent of the federal poverty level or higher in the amount of $15. Enrollees are responsible for making a monthly premium payment as a condition of continuing their eligibility and enrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled. Enrollees who fail to make a premium payment by the end of the 60-day grace period will be prohibited from re-enrolling in the Medicaid program for a period of twelve months. Premiums may be waived for hardship as defined by agency rule or upon successful completion of one or more healthy behavior programs pursuant to s. 409.973(3). Premiums shall be collected by the Department of Children and Families and used to offset the cost of medical assistance provided to enrollees. The department may administer this function by contract with an entity having experience performing a similar function.

Section 6. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. ~~The agency shall notice invitations to negotiate no~~

~~later than January 1, 2013.~~

(a) The agency shall procure at least three ~~two~~ plans and up to four plans for Region A ~~Region 1~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure at least three plans and up to six ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure at least five~~three~~ plans and up to ten~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) The agency shall procure at least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(e) The agency shall procure at least three ~~two~~ plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) The agency shall procure at least three ~~four~~ plans and up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) The agency shall procure at least three plans and up to five ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) The agency shall procure at least five ~~two~~ plans and up to ten ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency~~

~~shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.~~

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submits ~~submitting~~ a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). The agency shall exercise a preference for plans with a provider network in which more than ~~over~~ 10 percent of the providers use electronic health records, as defined in s. 408.051. ~~When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.~~

Section 7. Subsection (1) of section 409.978, Florida Statutes, is amended to read:

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly

Affairs and other state agencies. ~~By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.~~

Section 8. Subsection (2) and paragraphs (c), (d), and (e) of subsection (3) of section 409.981, Florida Statutes, are amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. The agency shall procure:

(a) At least three ~~two~~ plans and up to four plans for Region A ~~Region 1~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(b) At least three ~~Two~~ plans and up to six plans for Region B ~~Region 2~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(c) At least five~~three~~ plans and up to ten~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) At least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service

network if any provider service network submits a responsive bid.

(e) At least three ~~two~~ plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) At least three ~~four~~ plans and up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) At least three plans and up to four ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) At least five ~~two~~ plans and up to ten ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11.~~

~~At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid in a region other than Region 1 or Region 2, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.~~

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

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

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

(d) ~~(c)~~ Whether a plan is proposing to provide home and community-based services in addition to the minimum benefits required by s. 409.98.

Section 9. Subsections (6) and (7) of section 409.983, Florida Statutes, are amended to read:

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

~~(6) The agency shall establish nursing-facility-specific payment rates for each licensed nursing home based on facility costs adjusted for inflation and other factors as authorized in the General Appropriations Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to nursing facilities resulting from changes in nursing home per diem rates, but may not be reconciled to actual days experienced by the long-term care managed care plans~~.

(6) ~~(7)~~ Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. The agency shall establish hospice payment rates pursuant to Title XVIII of the Social Security Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to hospices.

Section 10. This act shall take effect July 1, 2017.