

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

29 providing limitations on serving recipients during the  
30 pendency of litigation; providing that a qualified plan  
31 that participates in an invitation to negotiate in more  
32 than one region may not serve Medicaid recipients until  
33 all administrative challenges are finalized; creating s.  
34 409.967, F.S.; providing for managed care plan  
35 accountability; establishing contract terms; providing for  
36 contract extension under certain circumstances;  
37 establishing payments to noncontract providers;  
38 establishing requirements for access; requiring plans to  
39 establish and maintain an electronic database;  
40 establishing requirements for the database; requiring  
41 plans to provide encounter data; requiring the agency to  
42 establish performance standards for plans; providing  
43 program integrity requirements; establishing a grievance  
44 resolution process; providing for penalties for early  
45 termination of contracts or reduction in enrollment  
46 levels; creating s. 409.968, F.S.; establishing managed  
47 care plan payments; providing payment requirements for  
48 provider service networks; creating s. 409.969, F.S.;  
49 requiring enrollment in managed care plans by specified  
50 Medicaid recipients; creating requirements for plan  
51 selection by recipients; providing for choice counseling;  
52 establishing choice counseling requirements; authorizing  
53 disenrollment under certain circumstances; defining the  
54 term "good cause" for purposes of disenrollment; providing  
55 time limits on an internal grievance process; providing  
56 requirements for agency determination regarding

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57 | disenrollment; requiring recipients to stay in plans for a  
58 | specified time; creating s. 409.970, F.S.; requiring the  
59 | agency to maintain an encounter data system; providing  
60 | requirements for prepaid plans to submit data; creating s.  
61 | 409.971, F.S.; creating the managed medical assistance  
62 | program; providing deadlines to begin and finalize  
63 | implementation of the program; creating s. 409.972, F.S.;  
64 | providing for mandatory and voluntary enrollment; creating  
65 | s. 409.973, F.S.; establishing minimum benefits for  
66 | managed care plans to cover; authorizing plans to  
67 | customize benefit packages; requiring plans to establish  
68 | enhanced benefits programs; providing terms for enhanced  
69 | benefits package; establishing reserve requirements for  
70 | plans to fund enhanced benefits programs; creating s.  
71 | 409.974, F.S.; establishing a specified number of  
72 | qualified plans to be selected in each region;  
73 | establishing a deadline for issuing invitations to  
74 | negotiate; establishing quality selection criteria;  
75 | establishing the Children's Medical Service Network as a  
76 | qualified plan; creating s. 409.975; establishing managed  
77 | care plan accountability; creating a medical loss ratio  
78 | requirement; authorizing plans to limit providers in  
79 | networks; mandating certain providers be offered contracts  
80 | in the first year; requiring certain provider types to  
81 | participate in plans; requiring plans to monitor the  
82 | quality and performance history of providers; requiring  
83 | specified programs and procedures be established by plans;  
84 | establishing provider payments for hospitals; establishing

85 | conflict resolution procedures; establishing plan  
86 | requirements for medically needy recipients; creating s.  
87 | 409.976, F.S.; providing for managed care plan payment;  
88 | requiring the agency to establish a methodology to ensure  
89 | certain types of payments to specified providers;  
90 | establishing eligibility for payments; creating s.  
91 | 409.977, F.S.; providing for enrollment; establishing  
92 | choice counseling requirements; providing for automatic  
93 | enrollment of certain recipients; establishing opt-out  
94 | opportunities for recipients; creating s. 409.978, F.S.;  
95 | requiring the Agency for Health Care Administration be  
96 | responsible for administering the long-term care managed  
97 | care program; providing implementation dates for the long-  
98 | term care managed care program; providing duties for the  
99 | Department of Elderly Affairs relating to assisting the  
100 | agency in implementing the program; creating s. 409.979,  
101 | F.S.; providing eligibility requirements for the long-term  
102 | care managed care program; creating s. 409.980, F.S.;  
103 | providing the benefits that a managed care plan shall  
104 | provide when participating in the long-term care managed  
105 | care program; creating s. 409.981, F.S.; providing  
106 | criteria for qualified plans; designating regions for plan  
107 | implementation throughout the state; providing criteria  
108 | for the selection of plans to participate in the long-term  
109 | care managed care program; creating s. 409.982, F.S.;  
110 | providing the agency shall establish a uniform accounting  
111 | and reporting methods for plans; providing spending  
112 | thresholds and consequences relating to spending

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

140 providing authority and agency duties related to long-term

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141 care plans; creating s. 409.987, F.S.; providing  
142 eligibility requirements for long-term care plans;  
143 creating s. 409.988, F.S.; providing benefits for long-  
144 term care plans; creating s. 409.989, F.S.; establishing  
145 criteria for qualified plans; specifying minimum and  
146 maximum number of plans and selection criteria; creating  
147 s. 409.990, F.S.; providing requirements for managed care  
148 plan accountability; specifying limitations on providers  
149 in plan networks; providing for evaluation and payment of  
150 network providers; creating s. 409.991, F.S.; providing  
151 for payment of managed care plans; providing duties for  
152 the Agency for Persons with Disabilities to assign plan  
153 enrollees into a payment rate level of care; establishing  
154 level of care criteria; providing payment requirements for  
155 intermediate care facilities for the developmentally  
156 disabled; creating s. 409.992, F.S.; providing  
157 requirements for enrollment and choice counseling;  
158 specifying enrollment exceptions for certain Medicaid  
159 recipients; providing an effective date.

160

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

162

163 Section 1. Sections 409.961 through 409.992, Florida  
164 Statutes, are designated as part IV of chapter 409, Florida  
165 Statutes, entitled "Medicaid Managed Care."

166 Section 2. Section 409.961, Florida Statutes, is created  
167 to read:

168        409.961 Statutory construction; applicability; rules.—It  
 169 is the intent of the Legislature that if any conflict exists  
 170 between the provisions contained in this part and provisions  
 171 contained in other parts of this chapter, the provisions  
 172 contained in this part shall control. The provisions of ss.  
 173 409.961-409.970 apply only to the Medicaid managed medical  
 174 assistance program, long-term care managed care program, and  
 175 managed long-term care for persons with developmental  
 176 disabilities program, as provided in this part. The agency shall  
 177 adopt any rules necessary to comply with or administer this part  
 178 and all rules necessary to comply with federal requirements. In  
 179 addition, the department shall adopt and accept the transfer of  
 180 any rules necessary to carry out the department's  
 181 responsibilities for receiving and processing Medicaid  
 182 applications and determining Medicaid eligibility and for  
 183 ensuring compliance with and administering this part, as those  
 184 rules relate to the department's responsibilities, and any other  
 185 provisions related to the department's responsibility for the  
 186 determination of Medicaid eligibility.

187        Section 3. Section 409.962, Florida Statutes, is created  
 188 to read:

189        409.962 Definitions.—As used in this part, except as  
 190 otherwise specifically provided, the term:

191        (1) "Agency" means the Agency for Health Care  
 192 Administration. The agency is the Medicaid agency for the state,  
 193 as provided under federal law.

194        (2) "Benefit" means any benefit, assistance, aid,  
 195 obligation, promise, debt, liability, or the like, related to

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196 any covered injury, illness, or necessary medical care, goods,  
197 or services.

198 (3) "Direct care management" means care management  
199 activities that involve direct interaction between providers and  
200 patients.

201 (4) "Long-term care comprehensive plan" means a long-term  
202 care plan that also provides the services described in s.  
203 409.973.

204 (5) "Long-term care plan" means a specialty plan that  
205 provides institutional and home and community-based services.

206 (6) "Long term care provider service network" means an  
207 entity certified pursuant to s. 409.912(4)(d), of which a  
208 controlling interest is owned by one or more licensed nursing  
209 homes, assisted living facilities with 17 or more beds, home  
210 health agencies, community care for the elderly lead agencies,  
211 or hospices.

212 (7) "Managed care plan" means a qualified plan under  
213 contract with the agency to provide services in the Medicaid  
214 program.

215 (8) "Medicaid" means the medical assistance program  
216 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.  
217 1396 et seq., and regulations thereunder, as administered in  
218 this state by the agency.

219 (9) "Medicaid recipient" or "recipient" means an  
220 individual who the department or, for Supplemental Security  
221 Income, the Social Security Administration determines is  
222 eligible pursuant to federal and state law to receive medical  
223 assistance and related services for which the agency may make



224 payments under the Medicaid program. For the purposes of  
 225 determining third-party liability, the term includes an  
 226 individual formerly determined to be eligible for Medicaid, an  
 227 individual who has received medical assistance under the  
 228 Medicaid program, or an individual on whose behalf Medicaid has  
 229 become obligated.

230 (10) "Medical home network" means a qualified plan  
 231 designated by the agency as a medical home network in accordance  
 232 with the criteria established in s. 409.91207.

233 (11) "Prepaid plan" means a qualified plan that is  
 234 licensed or certified as a risk-bearing entity in the state and  
 235 is paid a prospective per-member, per-month payment by the  
 236 agency.

237 (12) "Provider service network" means an entity certified  
 238 pursuant to s. 409.912(4)(d) of which a controlling interest is  
 239 owned by a health care provider, or group of affiliated  
 240 providers, or a public agency or entity that delivers health  
 241 services. Health care providers include Florida-licensed health  
 242 care professionals or licensed health care facilities and  
 243 federally qualified health care centers.

244 (13) "Qualified plan" means a health insurer authorized  
 245 under chapter 624, an exclusive provider organization authorized  
 246 under chapter 627, a health maintenance organization authorized  
 247 under chapter 641, or a provider service network authorized  
 248 under s. 409.912(4)(d) that is eligible to participate in the  
 249 statewide managed care program.

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250       (14) "Specialty plan" means a qualified plan that serves  
251 Medicaid recipients who meet specified criteria based on age,  
252 medical condition, or diagnosis.

253       Section 4. Section 409.963, Florida Statutes, is created  
254 to read:

255       409.963 Single state agency.—The Agency for Health Care  
256 Administration is designated as the single state agency  
257 authorized to manage, operate, and make payments for medical  
258 assistance and related services under Title XIX of the Social  
259 Security Act. Subject to any limitations or directions provided  
260 for in the General Appropriations Act, these payments shall be  
261 made only for services included in the program, only on behalf  
262 of eligible individuals, and only to qualified providers in  
263 accordance with federal requirements for Title XIX of the Social  
264 Security Act and the provisions of state law. This program of  
265 medical assistance is designated as the "Medicaid program." The  
266 department is responsible for Medicaid eligibility  
267 determinations, including, but not limited to, policy, rules,  
268 and the agreement with the Social Security Administration for  
269 Medicaid eligibility determinations for Supplemental Security  
270 Income recipients, as well as the actual determination of  
271 eligibility. As a condition of Medicaid eligibility, subject to  
272 federal approval, the agency and the department shall ensure  
273 that each Medicaid recipient consents to the release of her or  
274 his medical records to the agency and the Medicaid Fraud Control  
275 Unit of the Department of Legal Affairs.

276       Section 5. Section 409.964, Florida Statutes is created to  
277 read:

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278        409.964 Managed care program; state plan; waivers.—The  
279 Medicaid program is established as a statewide, integrated  
280 managed care program for all covered services, including long-  
281 term care services. The agency shall apply for and implement  
282 state plan amendments or waivers of applicable federal laws and  
283 regulations necessary to implement the program. Prior to seeking  
284 a waiver, the agency shall provide public notice and the  
285 opportunity for public comment.

286        Section 6. Section 409.965, Florida Statutes, is created  
287 to read:

288        409.965 Mandatory enrollment.—All Medicaid recipients  
289 shall receive covered services through the statewide managed  
290 care program, except as provided by this part pursuant to an  
291 approved federal waiver. The following Medicaid recipients are  
292 exempt from participation in the statewide managed care program:

293        (1) Women who are only eligible for family planning  
294 services.

295        (2) Women who are only eligible for breast and cervical  
296 cancer services.

297        (3) Persons who are eligible for emergency Medicaid for  
298 aliens.

299        Section 7. Section 409.966, Florida Statutes, is created  
300 to read:

301        409.966 Qualified plans; selection.—

302        (1) QUALIFIED PLANS.—Services in the Medicaid managed care  
303 program shall be provided by qualified plans.

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304 (a) A qualified plan may request the agency to designate  
305 the plan as a medical home network if it meets the criteria  
306 established in s. 409.91207.

307 (b) A provider service network must be capable of  
308 providing all covered services to a mandatory Medicaid managed  
309 care enrollee or may limit the provision of services to a  
310 specific target population based on the age, chronic disease  
311 state, or the medical condition of the enrollee to whom the  
312 network will provide services. A specialty provider service  
313 network must be capable of coordinating care and delivering or  
314 arranging for the delivery of all covered services to the target  
315 population. A provider service network may partner with an  
316 insurer licensed under chapter 627 or a health maintenance  
317 organization licensed under chapter 641 to meet the requirements  
318 of a Medicaid contract.

319 (2) QUALIFIED PLAN SELECTION.-The agency shall select a  
320 limited number of qualified plans to participate in the Medicaid  
321 program using invitations to negotiate in accordance with s.  
322 287.057(3) (a). At least 30 days prior to issuing an invitation  
323 to negotiate, the agency shall compile and publish a databook  
324 consisting of a comprehensive set of utilization and spending  
325 data for the 3 most recent contract years consistent with the  
326 rate-setting periods for all Medicaid recipients by region or  
327 county. The source of the data in the report shall include both  
328 historic fee-for-service claims and validated data from the  
329 Medicaid Encounter Data System. The report shall be made  
330 available in electronic form and shall delineate utilization use  
331 by age, gender, eligibility group, geographic area, and

332 aggregate clinical risk score. Separate and simultaneous  
 333 procurements shall be conducted in each of the following  
 334 regions:

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

339 (b) Region II, which shall consist of Alachua, Baker,  
 340 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,  
 341 Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam,  
 342 St. Johns, Suwannee, Union, and Volusia Counties.

343 (c) Region III, which shall consist of Charlotte, DeSoto,  
 344 Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco,  
 345 Pinellas, Polk, and Sarasota Counties.

346 (d) Region IV, which shall consist of Brevard, Indian  
 347 River, Lake, Orange, Osceola, Seminole, and Sumter Counties.

348 (e) Region V, which shall consist of Broward, Glades,  
 349 Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

350 (f) Region VI, which shall consist of Collier, Dade, and  
 351 Monroe Counties.

352 (3) QUALITY SELECTION CRITERIA.-The invitation to  
 353 negotiate must specify the criteria and the relative weight of  
 354 the criteria that will be used for determining the acceptability  
 355 of the reply and guiding the selection of the organizations with  
 356 which the agency negotiates. In addition to criteria established  
 357 by the agency, the agency shall consider the following factors  
 358 in the selection of qualified plans:

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359 (a) Accreditation by the National Committee for Quality  
360 Assurance or another nationally recognized accrediting body.

361 (b) Experience serving similar populations, including the  
362 organization's record in achieving specific quality standards  
363 with similar populations.

364 (c) Availability and accessibility of primary care and  
365 specialty physicians in the provider network.

366 (d) Establishment of community partnerships with providers  
367 that create opportunities for reinvestment in community-based  
368 services.

369 (e) Organization commitment to quality improvement and  
370 documentation of achievements in specific quality improvement  
371 projects, including active involvement by organization  
372 leadership.

373 (f) Provision of additional benefits, particularly dental  
374 care and disease management, and other enhanced-benefit  
375 programs.

376 (g) History of voluntary or involuntary withdrawal from  
377 any state Medicaid program or program area.

378 (h) Evidence that a qualified plan has written agreements  
379 or signed contracts or has made substantial progress in  
380 establishing relationships with providers prior to the plan  
381 submitting a response. The agency shall evaluate and give  
382 special weight to such evidence, and the evaluation shall be  
383 based on the following factors:

384 1. Contracts with primary and specialty physicians in  
385 sufficient numbers to meet the specific standards established  
386 pursuant to s. 409.967(2)(b).

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387        2. Specific arrangements that provide evidence that the  
388 compensation offered is sufficient to retain primary and  
389 specialty physicians in sufficient numbers to continue to comply  
390 with the standards established pursuant to s. 409.967(2)  
391 throughout the 5-year contract term.

392  
393 After negotiations are conducted, the agency shall select the  
394 qualified plans that are determined to be responsive and provide  
395 the best value to the state. If all other factors are equal  
396 among competing organizations, preference shall be given to  
397 organizations designated as medical home networks pursuant to s.  
398 409.91207 or organizations with the greatest number of primary  
399 care providers that are recognized as patient-centered medical  
400 homes by the National Committee for Quality Assurance or  
401 organizations with networks that reflect recruitment of minority  
402 physicians and other minority providers.

403        (4) ADMINISTRATIVE CHALLENGE.—Any qualified plan that  
404 participates in an invitation to negotiate in more than one  
405 region and is selected in at least one region may not begin  
406 servicing Medicaid recipients in any region for which it was  
407 selected until all administrative challenges to procurements  
408 required by this section to which the qualified plan is a party  
409 have been finalized. For purposes of this subsection, an  
410 administrative challenge is finalized if an order granting  
411 voluntary dismissal with prejudice has been entered by any court  
412 established under Article V of the State Constitution or by the  
413 Division of Administrative Hearings, a final order has been  
414 entered into by the agency and the deadline for appeal has

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415 expired, a final order has been entered by the First District  
416 Court of Appeal and the time to seek any available review by the  
417 Florida Supreme Court has expired, or a final order has been  
418 entered by the Florida Supreme Court and a warrant has been  
419 issued.

420 Section 8. Section 409.967, Florida Statutes, is created  
421 to read:

422 409.967 Managed care plan accountability.-

423 (1) The agency shall establish a 5-year contract with each  
424 of the qualified plans selected through the procurement process  
425 described in s. 409.966. A plan contract may not be renewed;  
426 however, the agency may extend the terms of a plan contract to  
427 cover any delays in transition to a new plan.

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

432 (a) Emergency services.-Plans shall pay for services  
433 required by ss. 395.1041 and 401.45 and rendered by a  
434 noncontracted provider within 30 days after receipt of a  
435 complete and correct claim. Plans must give providers of these  
436 services a specific explanation for each claim denied for being  
437 incomplete or incorrect. Payment shall be made at the rate the  
438 agency would pay for such services from the same provider.  
439 Claims from noncontracted providers shall be accepted by the  
440 qualified plan for at least 1 year after the date the services  
441 are provided.



442        (b) Access.—The agency shall establish specific standards  
443 for the number, type, and regional distribution of providers in  
444 plan networks to ensure access to care. Each plan must maintain  
445 a region-wide network of providers in sufficient numbers to meet  
446 the access standards for specific medical services for all  
447 recipients enrolled in the plan. Each plan shall establish and  
448 maintain an accurate and complete electronic database of  
449 contracted providers, including information about licensure or  
450 registration, locations and hours of operation, specialty  
451 credentials and other certifications, specific performance  
452 indicators, and such other information as the agency deems  
453 necessary. The database shall be available online to both the  
454 agency and the public and shall have the capability to compare  
455 the availability of providers to network adequacy standards and  
456 to accept and display feedback from each provider's patients.  
457 Each plan shall submit quarterly reports to the agency  
458 identifying the number of enrollees assigned to each primary  
459 care provider.

460        (c) Encounter data.—Each prepaid plan must comply with the  
461 agency's reporting requirements for the Medicaid Encounter Data  
462 System.

463        (d) Continuous improvement.—The agency shall establish  
464 specific performance standards and expected milestones or  
465 timelines for improving performance over the term of the  
466 contract. Each plan shall establish an internal health care  
467 quality improvement system, including enrollee satisfaction and  
468 disenrollment surveys. The quality improvement system shall  
469 include incentives and disincentives for network providers.

470 (e) Program integrity.—Each plan shall establish program  
471 integrity functions and activities to reduce the incidence of  
472 fraud and abuse, including, at a minimum:

473 1. A provider credentialing system and ongoing provider  
474 monitoring;

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

478 3. Procedures for reporting instances of fraud and abuse  
479 pursuant to chapter 641;

480 4. Administrative and management arrangements or  
481 procedures, including a mandatory compliance plan, designed to  
482 prevent fraud and abuse; and

483 5. Designation of a program integrity compliance officer.

484 (f) Grievance resolution.—Each plan shall establish an  
485 internal process for reviewing and responding to grievances from  
486 enrollees. The contract shall specify timeframes for submission,  
487 plan response, and resolution. Grievances not resolved by a  
488 plan's internal process shall be submitted to the subscriber  
489 assistance panel pursuant to s. 408.7056. Each plan shall submit  
490 quarterly reports on the number, description, and outcome of  
491 grievances filed by enrollees. The agency shall maintain a  
492 similar process for provider service networks.

493 (g) Penalties.—Plans that reduce enrollment levels or  
494 leave a region prior to the end of the contract term shall  
495 reimburse the agency for the cost of enrollment changes and  
496 other transition activities, including the cost of additional  
497 choice counseling services. If more than one plan leaves a

498 region at the same time, costs shall be shared by the departing  
 499 plans proportionate to their enrollments. In addition to the  
 500 payment of costs, departing plans shall pay a per enrollee  
 501 penalty not to exceed 5 percent of 1 month's payment. Plans  
 502 shall provide the agency notice no less than 180 days prior to  
 503 withdrawing from a region.

504 Section 9. Section 409.968, Florida Statutes, is created  
 505 to read:

506 409.968 Managed care plan payment.—

507 (1) Prepaid plans shall receive per-member, per-month  
 508 payments negotiated pursuant to the procurements described in s.  
 509 409.966. Payments shall be risk-adjusted rates based on  
 510 historical utilization and spending data, projected forward, and  
 511 adjusted to reflect the eligibility category, geographic area,  
 512 and the clinical risk profile of the recipients.

513 (2) Beginning September 1, 2010, the agency shall update  
 514 the rate-setting methodology by initiating a transition to rates  
 515 based on statewide encounter data submitted by Medicaid managed  
 516 care plans pursuant to s. 409.970. Prior to this transition, the  
 517 agency shall conduct appropriate tests and establish specific  
 518 milestones in order to determine that the Medicaid Encounter  
 519 Data system consists of valid, complete, and sound data for a  
 520 sufficient period of time to provide a reliable basis for  
 521 establishing actuarially sound payment rates. The transition  
 522 shall be implemented within 3 years or less, and shall utilize  
 523 such other data sources as necessary and reliable to make  
 524 appropriate adjustments during the transition. The agency shall  
 525 establish a technical advisory panel to obtain input from the

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526 prepaid plans regarding the incorporation of encounter data in  
527 the rate setting process.

528 (3) Provider service networks may be prepaid plans and  
529 receive per-member, per-month payments negotiated pursuant to  
530 the procurement process described in s. 409.966. Provider  
531 service networks that choose not to be prepaid plans shall  
532 receive fee-for-service rates with a shared savings settlement.  
533 The fee-for-service option shall be available to a provider  
534 service network only for the first 5 years of the plan's  
535 operation in a given region or until the contract year that  
536 begins on October 1, 2015, whichever is later. The agency shall  
537 annually conduct cost reconciliations to determine the amount of  
538 cost savings achieved by fee-for-service provider service  
539 networks for the dates of service within the period being  
540 reconciled. Only payments for covered services for dates of  
541 service within the reconciliation period and paid within 6  
542 months after the last date of service in the reconciliation  
543 period shall be included. The agency shall perform the necessary  
544 adjustments for the inclusion of incurred but not reported  
545 claims within the reconciliation period for claims that could be  
546 received and paid by the agency after the 6-month claims  
547 processing time lag. The agency shall provide the results of the  
548 reconciliations to the fee-for-service provider service networks  
549 within 45 days after the end of the reconciliation period. The  
550 fee-for-service provider service networks shall review and  
551 provide written comments or a letter of concurrence to the  
552 agency within 45 days after receipt of the reconciliation  
553 results. This reconciliation shall be considered final.

554 Section 10. Section 409.969, Florida Statutes, is created  
 555 to read:

556 409.969 Enrollment; choice counseling; automatic  
 557 assignment; disenrollment.—

558 (1) ENROLLMENT.—All Medicaid recipients shall be enrolled  
 559 in a managed care plan unless specifically exempted in this  
 560 part. Each recipient shall have a choice of plans and may select  
 561 any available plan unless that plan is restricted by contract to  
 562 a specific population that does not include the recipient.  
 563 Medicaid recipients shall have 30 days in which to make a choice  
 564 of plans. All recipients shall be offered choice counseling  
 565 services in accordance with this section.

566 (2) CHOICE COUNSELING.—The agency shall provide choice  
 567 counseling for Medicaid recipients. The agency may contract for  
 568 the provision of choice counseling. Any such contract shall be  
 569 for a period of 5 years and may be renewed for an additional 5-  
 570 year period. The agency may extend the term of the contract to  
 571 cover any delays in transition to a new contractor. Choice  
 572 counseling shall be offered in the native or preferred language  
 573 of the recipient, consistent with federal requirements. The  
 574 agency shall maintain a record of the recipients who receive  
 575 such services, identifying the scope and method of the services  
 576 provided. The agency shall make available clear and easily  
 577 understandable choice information to Medicaid recipients that  
 578 includes:

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

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582 recipient does not choose a plan, the agency will assign the  
583 recipient to a plan according to the criteria specified in this  
584 section.

585 (b) A list and description of the benefits provided in  
586 each plan.

587 (c) An explanation of benefit limits.

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

590 (e) Plan performance data.

591 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has  
592 enrolled in a managed care plan, the recipient shall have 90  
593 days to voluntarily disenroll and select another plan. After 90  
594 days, no further changes may be made except for good cause. Good  
595 cause includes, but is not limited to, poor quality of care,  
596 lack of access to necessary specialty services, an unreasonable  
597 delay or denial of service, or fraudulent enrollment. The agency  
598 must make a determination as to whether good cause exists. The  
599 agency may require a recipient to use the plan's grievance  
600 process prior to the agency's determination of good cause,  
601 except in cases in which immediate risk of permanent damage to  
602 the recipient's health is alleged.

603 (a) The managed care plan internal grievance process, when  
604 utilized, must be completed in time to permit the recipient to  
605 disenroll by the first day of the second month after the month  
606 the disenrollment request was made. If the result of the  
607 grievance process is approval of an enrollee's request to  
608 disenroll, the agency is not required to make a determination in  
609 the case.

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610        (b) The agency must make a determination and take final  
611 action on a recipient's request so that disenrollment occurs no  
612 later than the first day of the second month after the month the  
613 request was made. If the agency fails to act within the  
614 specified timeframe, the recipient's request to disenroll is  
615 deemed to be approved as of the date agency action was required.  
616 Recipients who disagree with the agency's finding that good  
617 cause does not exist for disenrollment shall be advised of their  
618 right to pursue a Medicaid fair hearing to dispute the agency's  
619 finding.

620        (c) Medicaid recipients enrolled in a managed care plan  
621 after the 90-day period shall remain in the plan for the  
622 remainder of the 12-month period. After 12 months, the recipient  
623 may select another plan. However, nothing shall prevent a  
624 Medicaid recipient from changing primary care providers within  
625 the plan during that period.

626        Section 11. Section 409.970, Florida Statutes, is created  
627 to read:

628        409.970 Encounter data.—The agency shall maintain and  
629 operate the Medicaid Encounter Data System to collect, process,  
630 store, and report on covered services provided to all Medicaid  
631 recipients enrolled in prepaid plans. Prepaid plans shall submit  
632 encounter data electronically in a format that complies with the  
633 Health Insurance Portability and Accountability Act provisions  
634 for electronic claims and in accordance with deadlines  
635 established by the agency. Prepaid plans must certify that the  
636 data reported is accurate and complete. The agency is  
637 responsible for validating the data submitted by the plans. The

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638 agency shall make encounter data available to those plans  
639 accepting enrollees who are assigned to them from other plans  
640 leaving a region.

641 Section 12. Section 409.971, Florida Statutes, is created  
642 to read:

643 409.971 Managed medical assistance program.—The agency  
644 shall make payments for primary and acute medical assistance and  
645 related services using a managed care model. By January 1, 2012,  
646 the agency shall begin implementation of the statewide managed  
647 medical assistance program, with full implementation in all  
648 regions by October 1, 2013.

649 Section 13. Section 409.972, Florida Statutes, is created  
650 to read:

651 409.972 Mandatory and voluntary enrollment.—

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

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

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

663 (b) Medicaid recipients residing in residential commitment  
664 facilities operated through the Department of Juvenile Justice,  
665 group care facilities operated by the Department of Children and



666 Families, and treatment facilities funded through the Substance  
 667 Abuse and Mental Health program of the Department of Children  
 668 and Families.

669 (c) Persons eligible for refugee assistance.

670 (d) Medicaid recipients who are residents of a  
 671 developmental disability center including Sunland Center in  
 672 Marianna and Tacachale in Gainesville.

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

677 Section 14. Section 409.973, Florida Statutes, is created  
 678 to read:

679 409.973 Benefits.—

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

682 (a) Advanced registered nurse practitioner services.

683 (b) Ambulatory surgical treatment center services.

684 (c) Birthing center services.

685 (d) Chiropractic services.

686 (e) Dental services.

687 (f) Early periodic screening diagnosis and treatment  
 688 services for recipients under age 21.

689 (g) Emergency services.

690 (h) Family planning services and supplies.

691 (i) Healthy start services.

692 (j) Hearing services.

693 (k) Home health agency services.

- 694        (l) Hospice services.
- 695        (m) Hospital inpatient services.
- 696        (n) Hospital outpatient services.
- 697        (o) Laboratory and X-ray services.
- 698        (p) Medical supplies, equipment, prostheses, and orthoses.
- 699        (q) Mental health services.
- 700        (r) Nursing care.
- 701        (s) Optical services and supplies.
- 702        (t) Optometrist services.
- 703        (u) Physical, occupational, respiratory, and speech
- 704 therapy services.
- 705        (v) Physician services.
- 706        (w) Podiatric services.
- 707        (x) Prescription drugs.
- 708        (y) Renal dialysis services.
- 709        (z) Respiratory equipment and supplies.
- 710        (aa) Rural health clinic services.
- 711        (bb) Substance abuse treatment services.
- 712        (cc) Transportation to access covered services.
- 713        (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
- 714 benefit packages for nonpregnant adults, vary cost-sharing
- 715 provisions, and provide coverage for additional services. The
- 716 agency shall evaluate the proposed benefit packages to ensure
- 717 services are sufficient to meet the needs of the plans'
- 718 enrollees and to verify actuarial equivalence.
- 719        (3) ENHANCED BENEFITS.—Each plan operating in the managed
- 720 medical assistance program shall establish an incentive program

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721 that rewards specific healthy behaviors with credits in a  
722 flexible spending account.

723 (a) At the discretion of the recipient, credits shall be  
724 used to purchase otherwise uncovered health and related services  
725 during the entire period of, and for a maximum of 3 years after,  
726 the recipient's Medicaid eligibility, whether or not the  
727 recipient remains continuously enrolled in the plan in which the  
728 credits were earned.

729 (b) Enhanced benefits shall be structured to provide  
730 greater incentives for those diseases linked with lifestyle and  
731 conditions or behaviors associated with avoidable utilization of  
732 high-cost services.

733 (c) To fund these credits, each plan must maintain a  
734 reserve account in an amount of up to 2 percent of the plan's  
735 Medicaid premium revenue, or benchmark premium revenue in the  
736 case of provider service networks, based on an actuarial  
737 assessment of the value of the enhanced benefits program.

738 Section 15. Section 409.974, Florida Statutes, is created  
739 to read:

740 409.974 Qualified plans.—

741 (1) QUALIFIED PLAN SELECTION.—The agency shall select  
742 qualified plans through the procurement described in s. 409.966.  
743 The agency shall notice invitations to negotiate no later than  
744 January 1, 2012.

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

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748 (b) The agency shall procure at least four and no more  
749 than seven plans for Region II. At least one plan shall be a  
750 provider service network, if any provider service network  
751 submits a responsive bid.

752 (c) The agency shall procure at least five plans and no  
753 more than ten plans for Region III. At least two plans shall be  
754 provider service networks, if any two provider service networks  
755 submit a responsive bid.

756 (d) The agency shall procure at least four plans and no  
757 more than eight plans for Region IV. At least one plan shall be  
758 a provider service network if any provider service network  
759 submits a responsive bid.

760 (e) The agency shall procure at least four plans and no  
761 more than seven plans for Region V. At least one plan shall be a  
762 provider service network, if any provider service network  
763 submits a responsive bid.

764 (f) The agency shall procure at least five plans and no  
765 more than ten plans for Region VI. At least two plans shall be  
766 provider service networks, if any two provider service networks  
767 submit a responsive bid.

768 (2) QUALITY SELECTION CRITERIA.-In addition to the  
769 criteria established in s. 409.966, the agency shall consider  
770 evidence that a qualified plan has written agreements or signed  
771 contracts or has made substantial progress in establishing  
772 relationships with providers prior to the plan submitting a  
773 response. The agency shall evaluate and give special weight to  
774 evidence of signed contracts with providers of critical services  
775 pursuant to s. 409.975 (3) (a)-(d). The agency shall also consider

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776 whether the organization is a specialty plan. When all other  
777 factors are equal, the agency shall consider whether the  
778 organization has a contract to provide managed long-term care  
779 services in the same region and shall exercise a preference for  
780 such plans.

781 (3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's  
782 Medical Services Network authorized under chapter 391 is a  
783 qualified plan for purposes of the managed medical assistance  
784 program. Participation by the Children's Medical Services  
785 Network shall be pursuant to a single, statewide contract with  
786 the agency that is not subject to the procurement requirements  
787 or regional plan number limits of this section. The Children's  
788 Medical Services Network must meet all other plan requirements  
789 for the managed medical assistance program.

790 Section 16. Section 409.975, Florida Statutes, is created  
791 to read:

792 409.975 Managed care plan accountability.-In addition to  
793 the requirements of s. 409.967, plans and providers  
794 participating in the managed medical assistance program shall  
795 comply with the requirements of this section.

796 (1) MEDICAL LOSS RATIO.-The agency shall establish and  
797 implement managed care plans that shall use a uniform method of  
798 accounting for and reporting medical, direct care management,  
799 and nonmedical costs. The agency shall evaluate plan spending  
800 patterns beginning after the plan completes 2 full years of  
801 operation and at least annually thereafter. The agency shall  
802 implement the following thresholds and consequences of various  
803 spending patterns:

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804 (a) Plans that spend less than 75 percent of Medicaid  
805 premium revenue on medical services and direct care management  
806 as determined by the agency shall be excluded from automatic  
807 enrollments and shall be required to pay back the amount between  
808 actual spending and 85 percent of the Medicaid premium revenue.

809 (b) Plans that spend less than 85 percent of Medicaid  
810 premium revenue on medical services and direct care management  
811 as determined by the agency shall be required to pay back the  
812 amount between actual spending and 85 percent of the Medicaid  
813 premium revenue.

814 (c) Plans that spend more than 92 percent of Medicaid  
815 premium revenue shall be evaluated by the agency to determine  
816 whether higher expenditures are the result of failures in care  
817 management. Such a determination may result in the plan being  
818 excluded from automatic enrollments.

819 (2) PROVIDER NETWORKS.—Plans may limit the providers in  
820 their networks based on credentials, quality indicators, and  
821 price. However, in the first contract period after a qualified  
822 plan is selected in a region by the agency, the plan must offer  
823 a network contract to the following providers in the region:

824 (a) Federally qualified health centers.

825 (b) Primary care providers certified as medical homes.

826 (c) Providers listed in paragraphs (3) (a)–(d).

827  
828 After 12 months of active participation in a plan's network, the  
829 plan may exclude any of the above-named providers from the  
830 network for failure to meet quality or performance criteria.

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831       (3) SELECT PROVIDER PARTICIPATION.—Providers may not be  
832 required to participate in any qualified plan selected by the  
833 agency except as provided in this subsection. The following  
834 providers must agree to participate with each qualified plan  
835 selected by the agency in the regions where they are located:

836       (a) Statutory teaching hospitals as defined in s.  
837 408.07(45).

838       (b) Hospitals that are trauma centers as defined in s.  
839 395.4001(14).

840       (c) Hospitals that are regional perinatal intensive care  
841 centers as defined in s. 383.16(2).

842       (d) Hospitals licensed as specialty children's hospitals  
843 as defined in s. 395.002(28).

844       (e) Hospitals with both an active Medicaid provider  
845 agreement under s. 409.907 and a certificate of need.

846  
847 To the extent that the contracts between the hospitals described  
848 in paragraphs (a)-(d) and the qualified plans require the  
849 services of the hospital's medical staff who are employees or  
850 under contract with the hospital to meet the hospital's  
851 contractual obligations, such staff is also required to contract  
852 with the plans selected by the agency. Any services provided by  
853 the medical staff independent of their employment or contractual  
854 obligations to the hospital are not covered by this subsection.

855       (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the  
856 quality and performance of each participating provider. At the  
857 beginning of the contract period, each plan shall notify all its  
858 network providers of the metrics used by the plan for evaluating

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859 the provider's performance and determining continued  
860 participation in the network.

861 (5) PREGNANCY AND INFANT HEALTH.—Each plan shall establish  
862 specific programs and procedures to improve pregnancy outcomes  
863 and infant health, including, but not limited to, coordination  
864 with the Healthy Start program, immunization programs, and  
865 referral to the Special Supplemental Nutrition Program for  
866 Women, Infants, and Children, and the Children's Medical  
867 Services program for children with special health care needs.

868 (6) SCREENING RATE.—Each plan shall achieve an annual  
869 Early and Periodic Screening, Diagnosis, and Treatment Service  
870 screening rate of at least 60 percent for those recipients  
871 continuously enrolled for at least 8 months.

872 (7) PROVIDER PAYMENT.—Plans and hospitals shall negotiate  
873 mutually acceptable rates, methods, and terms of payment. At a  
874 minimum, plans shall pay hospitals the Medicaid rate. Payments  
875 to hospitals shall not exceed 150 percent of the Medicaid rate,  
876 unless specifically approved by the agency. For purposes of this  
877 subsection, the Medicaid rate is the rate the agency would have  
878 paid on the first day of the contract between the provider and  
879 the plan. Payment rates may be updated periodically.

880 (8) CONFLICT RESOLUTION.—The agency shall establish a  
881 process for resolving disputes between qualified plans Medicaid  
882 inpatient hospital providers or the medical staff of the  
883 providers listed in s. 409.975(3)(a)-(d) when the agency is  
884 notified by either party of irreconcilable differences and the  
885 agency determines that the dispute jeopardizes access to or  
886 quality of services for Medicaid recipients. The agency may



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887 contract with an outside entity for any portion of this process.  
888 When this process is invoked by one or both of the parties, the  
889 agency is authorized to establish payment rates, contract terms,  
890 and other conditions on either or both parties. This process may  
891 not be used to review and reverse any plan decision to exclude  
892 any provider that fails to meet quality standards.

893 Administration costs of each instance of conflict resolution  
894 shall be paid by the entities which invoke it, in equal parts.

895 (9) MEDICALLY NEEDED ENROLLEES.—Each selected plan shall  
896 accept any medically needy recipient who selects or is assigned  
897 to the plan and provide that recipient with continuous  
898 enrollment for 12 months. After the first month of qualifying as  
899 a medically needy recipient and enrolling in a plan, and  
900 contingent upon federal approval, the enrollee shall pay the  
901 plan a portion of the monthly premium equal to the enrollee's  
902 share of the cost as determined by the department. The agency  
903 shall pay the remainder of the monthly premium. Plans must  
904 provide a grace period of at least 60 days before disenrolling  
905 recipients who fail to pay their shares of the premium.

906 Section 17. Section 409.976, Florida Statutes, is created  
907 to read:

908 409.976 Managed care plan payment.—In addition to the  
909 payment provisions of s. 409.968, the agency shall provide  
910 payment to plans in the managed medical assistance program  
911 pursuant to this section.

912 (1) Prepaid payment rates shall be negotiated between the  
913 agency and the qualified plans as part of the procurement  
914 described in s. 409.966.

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915       (2) The agency shall develop a methodology to ensure the  
916 availability of intergovernmental transfers in the statewide  
917 integrated managed care program to support providers that have  
918 historically served Medicaid recipients. Such providers include,  
919 but are not limited to, safety net providers, trauma hospitals,  
920 children's hospitals, statutory teaching hospitals, and medical  
921 and osteopathic physicians employed by or under contract with a  
922 medical school in this state. The agency may develop a  
923 supplemental capitation rate, risk pool, or incentive payment to  
924 plans that contract with these providers. A plan is eligible for  
925 a supplemental payment only if there are sufficient  
926 intergovernmental transfers available from allowable sources and  
927 the plan can demonstrate that it pays a reimbursement rate not  
928 less than the equivalent fee-for-service rate. The agency may  
929 develop the supplemental capitation rate to consider rates  
930 higher than the fee-for-service Medicaid rate when needed to  
931 ensure access and supported by funds provided by a locality. The  
932 agency shall evaluate the development of the rate cell to  
933 accurately reflect the underlying utilization to the maximum  
934 extent possible. This methodology may include interim rate  
935 adjustments as permitted under federal regulations. Any such  
936 methodology shall preserve federal funding to these entities and  
937 must be actuarially sound. In the absence of federal approval  
938 for the above methodology, the agency is authorized to set an  
939 enhanced rate and require that plans pay the enhanced rate, if  
940 the agency determines the enhanced rate is necessary to ensure  
941 access to care by the providers described in this subsection.

942 Section 18. Section 409.977, Florida Statutes, is created  
 943 to read:

944 409.977 Choice counseling and enrollment.-

945 (1) CHOICE COUNSELING.-In addition to the choice  
 946 counseling information required by s. 409.969, the agency shall  
 947 make available clear and easily understandable choice  
 948 information to Medicaid recipients that includes:

949 (a) Information about earning credits in the plan's  
 950 enhanced benefit program.

951 (b) Information about cost sharing requirements of each  
 952 plan.

953 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically  
 954 enroll into a managed care plan those Medicaid recipients who do  
 955 not voluntarily choose a plan pursuant to s. 409.969. The agency  
 956 shall automatically enroll recipients in plans that meet or  
 957 exceed the performance or quality standards established pursuant  
 958 to s. 409.967, and shall not automatically enroll recipients in  
 959 a plan that is deficient in those performance or quality  
 960 standards. The agency may not engage in practices that are  
 961 designed to favor one managed care plan over another. When  
 962 automatically enrolling recipients in plans, the agency shall  
 963 take into account the following criteria:

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

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

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

971 (d) The recipient's medical condition or diagnosis, and  
 972 the availability of a plan to accommodate the condition or  
 973 diagnosis.

974 (3) OPT-OUT OPTION.-The agency shall develop a process to  
 975 enable any recipient with access to employer-sponsored insurance  
 976 to opt out of all qualified plans in the Medicaid program and to  
 977 use Medicaid financial assistance to pay for the recipient's  
 978 share of the cost in any such plan. Contingent upon federal  
 979 approval, the agency shall also enable recipients with access to  
 980 other insurance or related products providing access to health  
 981 care services created pursuant to state law, including any  
 982 product available under the Cover Florida Health Access Program,  
 983 the Florida Health Choices Program, or any health exchange, to  
 984 opt out. The amount of financial assistance provided for each  
 985 recipient may not exceed the amount of the Medicaid premium that  
 986 would have been paid to a plan for that recipient.

987 Section 19. Section 409.978, Florida Statutes, is created  
 988 to read:

989 409.978 Long-term care managed care program.-

990 (1) Pursuant to s. 409.963, the agency shall administer  
 991 the long-term care managed care program described in ss.  
 992 409.978-409.985, but may delegate specific duties and  
 993 responsibilities for the program to the Department of Elderly  
 994 Affairs and other state agencies. By July 1, 2011, the agency  
 995 shall begin implementation of the statewide long-term care

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996 managed care program, with full implementation in all regions by  
 997 October 1, 2012.

998 (2) The agency shall make payments for long-term care,  
 999 including home and community-based services, using a managed  
 1000 care model. Unless otherwise specified, the provisions of ss.  
 1001 409.961-409.970 apply to the long-term care managed care  
 1002 program.

1003 (3) The Department of Elderly Affairs shall assist the  
 1004 agency to develop specifications for use in the invitation to  
 1005 negotiate and the model contract; determine clinical eligibility  
 1006 for enrollment in managed long-term care plans; monitor plan  
 1007 performance and measure quality of service delivery; assist  
 1008 clients and families to address complaints with the plans;  
 1009 facilitate working relationships between plans and providers  
 1010 serving elders and disabled adults; and perform other functions  
 1011 specified in a memorandum of agreement.

1012 Section 20. Section 409.979, Florida Statutes, is created  
 1013 to read:

1014 409.979 Eligibility.-

1015 (1) Medicaid recipients who meet all of the following  
 1016 criteria are eligible to participate in the long-term care  
 1017 managed care program. The recipient must be:

1018 (a) Sixty-five years of age or older or eligible for  
 1019 Medicaid by reason of a disability.

1020 (b) Determined by the Comprehensive Assessment Review and  
 1021 Evaluation for Long-Term Care Services (CARES) Program to  
 1022 require nursing facility care.

1023 (2) Medicaid recipients who on the date long-term care

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1024 managed care plans becomes available in the recipient's region,  
 1025 are residing in a nursing home facility or enrolled in one of  
 1026 the following long-term care Medicaid waiver programs are  
 1027 eligible to participate in the long-term care managed care  
 1028 program:

1029 (a) The Assisted Living for the Frail Elderly Waiver.

1030 (b) The Aged and Disabled Adult Waiver.

1031 (c) The Adult Day Health Care Waiver.

1032 (d) The Consumer-Directed Care Plus Program as described  
 1033 in s. 409.221.

1034 (e) The Program of All-inclusive Care for the Elderly.

1035 (f) The Long-Term Care Community-Based Diversion Pilot  
 1036 Project as described in s. 430.705.

1037 (g) The Channeling Services Waiver for Frail Elders.

1038 Section 21. Section 409.980, Florida Statutes, is created  
 1039 to read:

1040 409.980 Benefits.—Managed care plans shall cover, at a  
 1041 minimum, the following services:

1042 (1) Nursing facility.

1043 (2) Assisted living facility.

1044 (3) Hospice.

1045 (4) Adult day care.

1046 (5) Medical equipment and supplies, including incontinence  
 1047 supplies.

1048 (5) Personal care.

1049 (7) Home accessibility adaptation.

1050 (9) Behavior management.

1051 (9) Home delivered meals.

- 1052        (10) Case management.
- 1053        (11) Therapies:
- 1054        (a) Occupational therapy
- 1055        (b) Speech therapy
- 1056        (c) Respiratory therapy
- 1057        (d) Physical therapy.
- 1058        (12) Intermittent and skilled nursing.
- 1059        (13) Medication administration.
- 1060        (14) Medication management.
- 1061        (15) Nutritional assessment and risk reduction.
- 1062        (16) Caregiver training.
- 1063        (17) Respite care.
- 1064        (18) Transportation.
- 1065        (19) Personal emergency response system.
- 1066        Section 22. Section 409.981, Florida Statutes, is created
- 1067        to read:
- 1068        409.981 Qualified plans.—
- 1069        (1) QUALIFIED PLANS.—For purposes of the long-term care
- 1070        managed care program, qualified plans also include entities who
- 1071        are qualified under 42 C.F.R. part 422 as Medicare Advantage
- 1072        Preferred Provider Organizations, Medicare Advantage Provider-
- 1073        sponsored Organizations, and Medicare Advantage Special Needs
- 1074        Plans. Such plans are eligible to participate in the statewide
- 1075        long-term care managed care program. Qualified plans that are
- 1076        provider service networks must be long-term care provider
- 1077        service networks. Qualified plans may either be long-term care
- 1078        plans that cover benefits pursuant to s. 409.980, or

1079 comprehensive long-term care plans that cover benefits pursuant  
 1080 to ss. 409.973 and 409.980.

1081 (2) QUALIFIED PLAN SELECTION.—The agency shall select  
 1082 qualified plans through the procurement described in s. 409.966.  
 1083 The agency shall notice invitations to negotiate no later than  
 1084 July 1, 2011.

1085 (a) The agency shall procure three plans for Region I. At  
 1086 least one plan shall be a provider service network, if any  
 1087 submit a responsive bid.

1088 (b) The agency shall procure at least four and no more  
 1089 than seven plans for Region II. At least one plan shall be a  
 1090 provider service network, if any submit a responsive bid.

1091 (c) The agency shall procure at least five plans and no  
 1092 more than ten plans for Region III. At least two plans shall be  
 1093 provider service networks, if any two submit a responsive bid.

1094 (d) The agency shall procure at least four plans and no  
 1095 more than eight plans for Region IV. At least one plan shall be  
 1096 a provider service network if any submit a responsive bid.

1097 (e) The agency shall procure at least four plans and no  
 1098 more than seven plans for Region V. At least one plan shall be a  
 1099 provider service network, if any submit a responsive bid.

1100 (f) The agency shall procure at least five plans and no  
 1101 more than ten plans for Region VI. At least two plans shall be  
 1102 provider service networks, if any two submit a responsive bid.

1103 (3) QUALITY SELECTION CRITERIA.—In addition to the criteria  
 1104 established in s. 409.966, the agency shall consider the  
 1105 following factors in the selection of qualified plans:



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1106 (a) Specialized staffing. Plan employment of executive  
1107 managers with expertise and experience in serving aged and  
1108 disabled persons who require long-term care.

1109 (b) Network qualifications. Plan establishment of a  
1110 network of service providers dispersed throughout the region and  
1111 in sufficient numbers to meet specific service standards  
1112 established by the agency for specialty services for persons  
1113 receiving home and community-based care.

1114 (c) Whether a plan is proposing to establish a  
1115 comprehensive long-term care plan and whether the qualified plan  
1116 has a contract to provide managed medical assistance services in  
1117 the same region. The agency shall exercise a preference for such  
1118 plans.

1119 (d) Whether a plan is designated as a medical home network  
1120 pursuant to s. 409.91207 or offers consumer-directed care  
1121 services to enrollees pursuant to s. 409.221. Consumer-directed  
1122 care services provide a flexible budget which is managed by  
1123 enrolled individuals and their families or representatives and  
1124 allows them to choose providers of services, determine provider  
1125 rates of payment and direct the delivery of services to best  
1126 meet their special long-term care needs. When all other factors  
1127 are equal among competing qualified plans, the agency shall  
1128 exercise a preference for such plans.

1129 (e) Evidence that a qualified plan has written agreements  
1130 or signed contracts or has made substantial progress in  
1131 establishing relationships with providers prior to the plan  
1132 submitting a response. The agency shall evaluate and give

1133 special weight to evidence of signed contracts with providers of  
 1134 critical services pursuant to s. 409.982(2)(a)-(c).

1135 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—The  
 1136 Program for All-Inclusive Care for the Elderly (PACE) is a  
 1137 qualified plan for purposes of the long-term care managed care  
 1138 program. Participation by PACE shall be pursuant to a contract  
 1139 with the agency and not subject to the procurement requirements  
 1140 or regional plan number limits of this section. PACE plans may  
 1141 continue to provide services to individuals at such levels and  
 1142 enrollment caps as authorized by the General Appropriations Act.

1143 Section 23. Section 409.982, Florida Statutes, is created  
 1144 to read:

1145 409.982 Managed care plan accountability.—In addition to  
 1146 the requirements of s. 409.967, plans and providers  
 1147 participating in the long-term care managed care program shall  
 1148 comply with the requirements of this section.

1149 (1) MEDICAL LOSS RATIO.—The agency shall establish and  
 1150 plans shall use a uniform method of accounting and reporting  
 1151 long-term care service costs, direct care management costs, and  
 1152 administrative costs. The agency shall evaluate plan spending  
 1153 patterns beginning after the plan completes 2 full years of  
 1154 operation and at least annually thereafter. The agency shall  
 1155 implement the following thresholds and consequences of various  
 1156 spending patterns:

1157 (a) Plans that spend less than 75 percent of Medicaid  
 1158 premium revenue on long-term care services, including direct  
 1159 care management as determined by the agency shall be excluded  
 1160 from automatic enrollments and shall be required to pay back the

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1161 amount between actual spending and 85 percent of the Medicaid  
1162 premium revenue.

1163 (b) Plans that spend less than 85 percent of Medicaid  
1164 premium revenue on long-term care services, including direct  
1165 care management as determined by the agency shall be required to  
1166 pay back the amount of the difference between actual spending  
1167 and 85 percent of Medicaid premium revenue.

1168 (c) Plans that spend more than 92 percent of Medicaid  
1169 premium revenue on long-term care services, including direct  
1170 care management as determined by the agency shall be evaluated  
1171 by the agency to determine whether higher expenditures are the  
1172 result of failures in care management. Such a determination may  
1173 result in the plan being excluded from automatic enrollments.

1174 (2) PROVIDER NETWORKS.—Plans may limit the providers in  
1175 their networks based on credentials, quality indicators, and  
1176 price. However, in the first contract period after a qualified  
1177 plan is selected in a region by the agency, the plan must offer  
1178 a network contract to the following providers in the region:

1179 (a) Nursing homes.

1180 (b) Hospices.

1181 (c) Aging network service providers that have previously  
1182 participated in home and community-based waivers serving elders  
1183 or community-service programs administered by the Department of  
1184 Elderly Affairs.

1185  
1186 After 12 months of active participation in a plan's network, the  
1187 plan may exclude any of the providers named in this subsection

1188 from the network for failure to meet quality or performance  
 1189 criteria.

1190 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in  
 1191 this subsection, providers may limit the plans they join.  
 1192 Nursing homes and hospices must participate in all qualified  
 1193 plans selected by the agency in the region in which the provider  
 1194 is located.

1195 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the  
 1196 quality and performance of each participating provider. At the  
 1197 beginning of the contract period, each plan shall notify all its  
 1198 network providers of the metrics used by the plan for evaluating  
 1199 the provider's performance and determining continued  
 1200 participation in the network.

1201 (5) PROVIDER NETWORK STANDARDS.—The agency shall establish  
 1202 and each plan must comply with specific standards for the  
 1203 number, type, and regional distribution of providers in the  
 1204 plan's network, which must include:

- 1205 (a) Adult day centers.
- 1206 (b) Adult family care homes.
- 1207 (c) Assisted living facilities.
- 1208 (d) Health care services pools.
- 1209 (e) Home health agencies.
- 1210 (f) Homemaker and companion services.
- 1211 (g) Hospices.
- 1212 (h) Community Care for the Elderly Lead Agencies.
- 1213 (i) Nurse registries.
- 1214 (j) Nursing homes.

1215           (6) PROVIDER PAYMENT.—Plans and providers shall negotiate  
 1216 mutually acceptable rates, methods, and terms of payment. Plans  
 1217 shall pay nursing homes an amount equal to the nursing facility-  
 1218 specific payment rates set by the agency. Plans shall pay  
 1219 hospice providers an amount equal to the per diem rate set by  
 1220 the agency. For recipients residing in a nursing facility and  
 1221 receiving hospice services, the plan shall pay the hospice  
 1222 provider the per diem rate set by the agency minus the nursing  
 1223 facility component and shall pay the nursing facility the  
 1224 appropriate state rate.

1225           Section 24. Section 409.983, Florida Statutes, is created  
 1226 to read:

1227           409.983 Managed care plan payment.—In addition to the  
 1228 payment provisions of s. 409.968, the agency shall provide  
 1229 payment to plans in the long-term care managed care program  
 1230 pursuant to this section.

1231           (1) Prepaid payment rates for long-term care managed care  
 1232 plans shall be negotiated between the agency and the qualified  
 1233 plans as part of the procurement described in s. 409.966.

1234           (2) Payment rates for comprehensive long-term care plans  
 1235 covering services described in s. 409.973 shall be combined with  
 1236 rates for long-term care plans for services specified in s.  
 1237 409.980.

1238           (3) Payment rates for plans shall reflect historic  
 1239 utilization and spending for covered services projected forward  
 1240 and adjusted to reflect the level of care profile for enrollees  
 1241 of each plan. The payment shall be adjusted to provide an  
 1242 incentive for reducing institutional placements and increasing

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1243 the utilization of home and community-based services.

1244 (4) The initial assessment of an enrollee's level of care  
1245 shall be made by the Comprehensive Assessment and Review for  
1246 Long-Term-Care Services (CARES) program, which shall assign the  
1247 recipient into one of the following levels of care:

1248 (a) Level of care 1 consists of recipients residing in  
1249 nursing homes or needing immediate placement in a nursing home.

1250 (b) Level of care 2 consists of recipients who require the  
1251 constant availability of routine medical and nursing treatment  
1252 and care, and require extensive health-related care and services  
1253 because of mental or physical incapacitation.

1254 (c) Level of care 3 consists of recipients who require the  
1255 constant availability of routine medical and nursing treatment  
1256 and care, have a limited need for health-related care and  
1257 services, are mildly medically or physically incapacitated, and  
1258 have a priority score of 5 or above.

1259  
1260 The agency shall periodically adjust payment rates to account  
1261 for changes in the level of care profile for each plan based on  
1262 encounter data.

1263 (5) The incentive adjustment for reducing institutional  
1264 placements shall be modified in each successive rate period  
1265 during the contract in order to encourage a progressive  
1266 rebalancing of the spending distribution for institutional and  
1267 community services. The expected change toward more home and  
1268 community-based services shall be a 5 percent or greater annual  
1269 increase in the ratio of home and community-based service  
1270 expenditures compared to nursing facility expenditures.

1271       (6) The agency shall establish nursing facility-specific  
 1272 payment rates for each licensed nursing home based on facility  
 1273 costs adjusted for inflation and other factors. Payments to  
 1274 long-term care managed care plans shall be reconciled to  
 1275 reimburse actual payments to nursing facilities.

1276       (7) The agency shall establish hospice payment rates.  
 1277 Payments to long-term care managed care plans shall be  
 1278 reconciled to reimburse actual payments to hospices.

1279       Section 25. Section 409.984, Florida Statutes, is created  
 1280 to read:

1281       409.984 Choice counseling; enrollment.—

1282       (1) CHOICE COUNSELING.—Before contracting with a vendor to  
 1283 provide choice counseling as authorized under s. 409.969, the  
 1284 agency shall offer to contract with aging resource centers  
 1285 established under s. 430.2053 for choice counseling services. If  
 1286 the aging resource center is determined not to be the vendor  
 1287 that provides choice counseling, the agency shall establish a  
 1288 memorandum of understanding with the aging resource center to  
 1289 coordinate staffing and collaborate with the choice counseling  
 1290 vendor.

1291       (2) AUTOMATIC ENROLLMENT.—The agency shall automatically  
 1292 enroll into a long-term care managed care plan those Medicaid  
 1293 recipients who do not voluntarily choose a plan pursuant to s.  
 1294 409.969. The agency shall automatically enroll recipients in  
 1295 plans that meet or exceed the performance or quality standards  
 1296 established pursuant to s. 409.967, and shall not automatically  
 1297 enroll recipients in a plan that is deficient in those  
 1298 performance or quality standards. The agency shall assign

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1299 individuals who are deemed dually eligible for Medicaid and  
 1300 Medicare to a plan that provides both Medicaid and Medicare  
 1301 services. The agency may not engage in practices that are  
 1302 designed to favor one managed care plan over another. When  
 1303 automatically enrolling recipients in plans, the agency shall  
 1304 take into account the following criteria:

1305 (a) Whether the plan has sufficient network capacity to  
 1306 meet the needs of the recipients.

1307 (b) Whether the recipient has previously received services  
 1308 from one of the plan's home and community-based service  
 1309 providers.

1310 (c) Whether the home and community-based providers in one  
 1311 plan are more geographically accessible to the recipient's  
 1312 residence than those in other plans.

1313 (3) Notwithstanding the provisions of s. 409.969(3)(c),  
 1314 when a recipient is referred for hospice services, the recipient  
 1315 shall have a 30-day period during which the recipient may select  
 1316 to enroll in another plan to access the hospice provider of the  
 1317 recipient's choice.

1318 Section 26. Section 409.985, Florida Statutes, is created  
 1319 to read:

1320 409.985 Comprehensive Assessment and Review for Long-Term  
 1321 Care Services (CARES) Program.—

1322 (1) The agency shall operate the Comprehensive Assessment  
 1323 and Review for Long-Term Care Services (CARES) preadmission  
 1324 screening program to ensure that only individuals whose  
 1325 conditions require long-term care services are enrolled in the  
 1326 long-term care managed care program.



1327       (2) The agency shall operate the CARES program through an  
 1328 interagency agreement with the Department of Elderly Affairs.  
 1329 The agency, in consultation with the Department of Elderly  
 1330 Affairs, may contract for any function or activity of the CARES  
 1331 program, including any function or activity required by 42  
 1332 C.F.R. part 483.20, relating to preadmission screening and  
 1333 review.

1334       (3) The CARES program shall determine if an individual  
 1335 requires nursing facility care and, if the individual requires  
 1336 such care, assign the individual to a level of care as described  
 1337 in s. 409.983(4). For the purposes of the long-term care managed  
 1338 care program, "nursing facility care" means the individual:

1339       (a) Requires the constant availability of routine medical  
 1340 and nursing treatment and care, and requires extensive health-  
 1341 related care and services because of mental or physical  
 1342 incapacitation; or

1343       (b) Requires the constant availability of routine medical  
 1344 and nursing treatment and care, has a limited need for health-  
 1345 related care and services, is mildly medically or physically  
 1346 incapacitated, and has a priority score of 5 or above.

1347       (4) For individuals whose nursing home stay is initially  
 1348 funded by Medicare and Medicare coverage is being terminated for  
 1349 lack of progress towards rehabilitation, CARES staff shall  
 1350 consult with the person making the determination of progress  
 1351 toward rehabilitation to ensure that the recipient is not being  
 1352 inappropriately disqualified from Medicare coverage. If, in  
 1353 their professional judgment, CARES staff believes that a  
 1354 Medicare beneficiary is still making progress toward

1355 rehabilitation, they may assist the Medicare beneficiary with an  
 1356 appeal of the disqualification from Medicare coverage. The use  
 1357 of CARES teams to review Medicare denials for coverage under  
 1358 this section is authorized only if it is determined that such  
 1359 reviews qualify for federal matching funds through Medicaid. The  
 1360 agency shall seek or amend federal waivers as necessary to  
 1361 implement this section.

1362 Section 27. Section 409.986, Florida Statutes, is created  
 1363 to read:

1364 409.986 Managed long-term care for persons with  
 1365 developmental disabilities.-

1366 (1) Pursuant to s. 409.963, the agency is responsible for  
 1367 administering the long-term care managed care program for  
 1368 persons with developmental disabilities described in ss.  
 1369 409.986-409.992, but may delegate specific duties and  
 1370 responsibilities for the program to the Agency for Persons with  
 1371 Disabilities and other state agencies. By January 1, 2014, the  
 1372 agency shall begin implementation of statewide long-term care  
 1373 managed care for persons with developmental disabilities, with  
 1374 full implementation in all regions by October 1, 2015.

1375 (2) The agency shall make payments for long-term care for  
 1376 persons with developmental disabilities, including home and  
 1377 community-based services, using a managed care model. Unless  
 1378 otherwise specified, the provisions of ss. 409.961-409.970 apply  
 1379 to the long-term care managed care program for persons with  
 1380 developmental disabilities.

1381 (3) The Agency for Persons with Disabilities shall assist  
 1382 the agency to develop the specifications for use in the

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1383 invitations to negotiate and the model contract; determine  
 1384 clinical eligibility for enrollment in long-term care plans for  
 1385 persons with developmental disabilities; assist the agency to  
 1386 monitor plan performance and measure quality; assist clients and  
 1387 families to address complaints with the plans; facilitate  
 1388 working relationships between plans and providers serving  
 1389 persons with developmental disabilities; and perform other  
 1390 functions specified in a memorandum of agreement.

1391 Section 28. Section 409.987, Florida Statutes, is created  
 1392 to read:

1393 409.987 Eligibility.-

1394 (1) Medicaid recipients who meet all of the following  
 1395 criteria are eligible to be enrolled in a developmental  
 1396 disabilities comprehensive long-term care plan or developmental  
 1397 disabilities long-term care plan:

1398 (a) Medicaid eligible pursuant to income and asset tests  
 1399 in state and federal law.

1400 (b) A Florida resident who has a developmental disability  
 1401 as defined in s. 393.063.

1402 (c) Meets the level of care need including:

1403 1. The recipient's intelligence quotient is 59 or less;

1404 2. The recipient's intelligence quotient is 60-69,  
 1405 inclusive, and the recipient has a secondary handicapping  
 1406 condition that includes cerebral palsy, spina bifida, Prader-  
 1407 Willi syndrome, epilepsy, or autism; or ambulation, sensory,  
 1408 chronic health, and behavioral problems;

1409 3. The recipient's intelligence quotient is 60-69,  
 1410 inclusive, and the recipient has severe functional limitations

1411 in at least three major life activities including self-care,  
 1412 learning, mobility, self-direction, understanding and use of  
 1413 language, and capacity for independent living; or

1414 4. The recipient is eligible under a primary disability of  
 1415 autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.

1416 In addition, the condition must result in substantial functional  
 1417 limitations in three or more major life activities, including  
 1418 self-care, learning, mobility, self-direction, understanding and  
 1419 use of language, and capacity for independent living.

1420 (d) Meets the level of care need for services in an  
 1421 intermediate care facility for the developmentally disabled.

1422 (e) Is enrolled or has been offered enrollment in one of  
 1423 the four tier waivers established in s. 393.0661(3) or the  
 1424 recipient is a Medicaid-funded resident of a private  
 1425 intermediate care facility for the developmentally disabled on  
 1426 the date the managed long-term care plans for persons with  
 1427 disabilities become available in the recipient's region.

1428 (2) Unless specifically exempted, all eligible persons must  
 1429 be enrolled in a developmental disabilities comprehensive long-  
 1430 term care plan or a developmental disabilities long-term care  
 1431 plan. Medicaid recipients who are residents of a developmental  
 1432 disability center, including Sunland Center in Marianna and  
 1433 Tacachale Center in Gainesville, are exempt from mandatory  
 1434 enrollment but may voluntarily enroll in a long-term care plan.

1435 Section 29. Section 409.988, Florida Statutes, is created  
 1436 to read:

1437 409.988 Benefits.-Managed care plans shall cover, at a  
 1438 minimum, the services in this section. Plans may customize

1439 benefit packages or offer additional benefits to meet the needs  
 1440 of enrollees in the plan.  
 1441 (1) Intermediate care for developmentally disabled.  
 1442 (2) Alternative residential services, including, but not  
 1443 limited to:  
 1444 (a) Group homes and foster care homes licensed pursuant to  
 1445 chapters 393 and 409.  
 1446 (b) Comprehensive transitional education programs licensed  
 1447 pursuant to chapter 393.  
 1448 (c) Residential habilitation centers licensed pursuant to  
 1449 chapter 393.  
 1450 (d) Assisted living facilities, and transitional living  
 1451 facilities licensed pursuant to chapters 400 and 429.  
 1452 (3) Adult day training.  
 1453 (4) Behavior analysis services.  
 1454 (5) Companion services.  
 1455 (6) Consumable medical supplies.  
 1456 (7) Durable medical equipment and supplies.  
 1457 (8) Environmental accessibility adaptations.  
 1458 (9) In-home support services.  
 1459 (10) Therapies, including occupational, speech,  
 1460 respiratory, and physical therapy.  
 1461 (11) Personal care assistance.  
 1462 (12) Residential habilitation services.  
 1463 (13) Intensive behavior residential habilitation services.  
 1464 (14) Behavior focus residential habilitation services.  
 1465 (15) Residential nursing services.  
 1466 (16) Respite care.

1467        (17) Case management.

1468        (18) Supported employment.

1469        (19) Supported living coaching.

1470        (20) Transportation.

1471        Section 30. Section 409.989, Florida Statutes, is created  
1472 to read:

1473        409.989 Qualified plans.—

1474        (1) QUALIFIED PLANS.—Qualified plans may either be  
1475 developmental disabilities long-term care plans that cover  
1476 benefits pursuant to s. 409.988, or developmental disabilities  
1477 comprehensive long- term care plans that cover benefits pursuant  
1478 to ss. 409.973 and 409.988.

1479        (2) SPECIALTY PROVIDER SERVICE NETWORKS.—Provider service  
1480 networks targeted to serve persons with disabilities must  
1481 include one or more owners licensed pursuant to s. 393.067 or s.  
1482 400.962 and with at least 10 years experience in serving this  
1483 population.

1484        (3) QUALIFIED PLAN SELECTION.—The agency shall select  
1485 qualified plans through the procurement described in s. 409.966.  
1486 The agency shall notice invitations to negotiate no later than  
1487 January 1, 2014.

1488        (a) The agency shall procure two plans for Region I. At  
1489 least one plan shall be a provider service network, if any  
1490 submit a responsive bid.

1491        (b) The agency shall procure at least two and no more than  
1492 five plans for Region II. At least one plan shall be a provider  
1493 service network, if any submit a responsive bid.

1494        (c) The agency shall procure at least three plans and no  
 1495 more than six plans for Region III. At least one plan shall be a  
 1496 provider service network, if any submit a responsive bid.

1497        (d) The agency shall procure at least three plans and no  
 1498 more than six plans for Region IV. At least one plan shall be a  
 1499 provider service network if any submit a responsive bid.

1500        (e) The agency shall procure at least three plans and no  
 1501 more than six plans for Region V. At least one plan shall be a  
 1502 provider service network, if any submit a responsive bid.

1503        (f) The agency shall procure at least three plans and no  
 1504 more than six plans for Region VI. At least one plan shall be a  
 1505 provider service network, if any submit a responsive bid.

1506        (4) QUALITY SELECTION CRITERIA.—In addition to the  
 1507 criteria established in s. 409.966, the agency shall consider  
 1508 the following factors in the selection of qualified plans:

1509        (a) Specialized staffing. Plan employment of executive  
 1510 managers with expertise and experience in serving persons with  
 1511 developmental disabilities.

1512        (b) Network qualifications. Plan establishment of a  
 1513 network of service providers dispersed throughout the region and  
 1514 in sufficient numbers to meet specific accessibility standards  
 1515 established by the agency for specialty services for persons  
 1516 with developmental disabilities.

1517        (c) Whether the plan has proposed to be a developmental  
 1518 disabilities comprehensive long-term care plan and has a  
 1519 contract to provide managed medical assistance services in the  
 1520 same region. The agency shall exercise a preference for such  
 1521 plans.

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1522 (d) Whether the plan offers consumer-directed care  
1523 services to enrollees pursuant to s. 409.221. Consumer-directed  
1524 care services provide a flexible budget which is managed by  
1525 enrolled individuals and their families or representatives and  
1526 allows them to choose providers of services, determine provider  
1527 rates of payment and direct the delivery of services to best  
1528 meet their special long-term care needs. When all other factors  
1529 are equal among competing qualified plans, the agency shall  
1530 exercise a preference for such plans.

1531 (e) Evidence that a qualified plan has written agreements  
1532 or signed contracts or has made substantial progress in  
1533 establishing relationships with providers prior to the plan  
1534 submitting a response. The agency shall evaluate and give  
1535 special weight to evidence of signed contracts with providers of  
1536 critical services pursuant to s. 409.990(2)a)-(b).

1537 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's  
1538 Medical Services Network authorized under chapter 391 is a  
1539 qualified plan for purposes of the developmental disabilities  
1540 long-term care plans and developmental disabilities  
1541 comprehensive long-term care plans. Participation by the  
1542 Children's Medical Services Network shall be pursuant to a  
1543 single, statewide contract with the agency not subject to the  
1544 procurement requirements or regional plan number limits of this  
1545 section. The Children's Medical Services Network must meet all  
1546 other plan requirements.

1547 Section 31. Section 409.990, Florida Statutes, is created  
1548 to read:



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1549        409.990 Managed care plan accountability.—In addition to  
1550 the requirements of s. 409.967, qualified plans and providers  
1551 shall comply with the requirements of this section.

1552        (1) MEDICAL LOSS RATIO.—The agency shall establish and  
1553 plans shall use a uniform method of accounting and reporting  
1554 long-term care service costs, direct care management costs, and  
1555 administrative costs. The agency shall evaluate plan spending  
1556 patterns beginning after the plan completes 2 full years of  
1557 operation and at least annually thereafter. The agency shall  
1558 implement the following thresholds and consequences of various  
1559 spending patterns:

1560        (a) Plans that spend less than 75 percent of Medicaid  
1561 premium revenue on long-term care services, including direct  
1562 care management as determined by the agency shall be excluded  
1563 from automatic enrollments and shall be required to pay back the  
1564 amount between actual spending and 85 percent of the Medicaid  
1565 premium revenue.

1566        (b) Plans that spend less than 85 percent of Medicaid  
1567 premium revenue on long-term care services, including direct  
1568 care management as determined by the agency shall be required to  
1569 pay back the amount between actual spending and 85 percent of  
1570 the Medicaid premium revenue.

1571        (c) Plans that spend more than 92 percent of Medicaid  
1572 premium revenue on long-term care services including direct care  
1573 management shall be evaluated by the agency to determine whether  
1574 higher expenditures are the result of failures in care  
1575 management. Such a determination may result in the plan being  
1576 excluded from automatic enrollments.

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1577        (2) PROVIDER NETWORKS.—Plans may limit the providers in  
1578 their networks based on credentials, quality indicators, and  
1579 price. However, in the first contract period after a qualified  
1580 plan is selected in a region by the agency, the plan must offer  
1581 a network contract to the following providers in the region:

1582            (a) Providers with licensed institutional care facilities  
1583 for the developmentally disabled.

1584            (b) Providers of alternative residential facilities  
1585 specified in s.409.988.

1586

1587 After 12 months of active participation in a plan's network, the  
1588 plan may exclude any of the above-named providers from the  
1589 network for failure to meet quality or performance criteria.

1590        (3) SELECT PROVIDER PARTICIPATION.—Except as provided in  
1591 this subsection, providers may limit the plans they join.

1592 Licensed institutional care facilities for the developmentally  
1593 disabled with an active Medicaid provider agreement must agree  
1594 to participate in any qualified plan selected by the agency in  
1595 the region in which the provider is located.

1596        (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the  
1597 quality and performance of each participating provider. At the  
1598 beginning of the contract period, each plan shall notify all its  
1599 network providers of the metrics used by the plan for evaluating  
1600 the provider's performance and determining continued  
1601 participation in the network.

1602        (5) PROVIDER PAYMENT.—Plans and providers shall negotiate  
1603 mutually acceptable rates, methods, and terms of payment. Plans  
1604 shall pay intermediate care facilities for the developmentally

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1605 disabled an amount equal to the facility-specific payment rate  
1606 set by the agency.

1607 (6) CONSUMER AND FAMILY INVOLVEMENT.—Plans must establish  
1608 a family advisory committee to participate in program design and  
1609 oversight.

1610 Section 32. Section 409.991, Florida Statutes, is created  
1611 to read:

1612 409.991 Managed care plan payment.—In addition to the  
1613 payment provisions of s. 409.968, the agency shall provide  
1614 payment to developmental disabilities comprehensive long-term  
1615 care plans and developmental disabilities long-term care plans  
1616 pursuant to this section.

1617 (1) Prepaid payment rates shall be negotiated between the  
1618 agency and the qualified plans as part of the procurement  
1619 described in s. 409.966.

1620 (2) Payment for developmental disabilities comprehensive  
1621 long-term care plans covering services pursuant to s. 409.973  
1622 shall be combined with payments for developmental disabilities  
1623 long-term care plans for services specified in s. 409.988.

1624 (3) Payment rates for plans covering service specified in  
1625 s. 409.988 shall be based on historical utilization and spending  
1626 for covered services projected forward and adjusted to reflect  
1627 the level of care profile of each plan's enrollees.

1628 (4) The Agency for Persons with Disabilities shall conduct  
1629 the initial assessment of an enrollee's level of care. The  
1630 evaluation of level of care shall be based on assessment and  
1631 service utilization information from the most recent version of

1632 the Questionnaire for Situational Information and encounter  
 1633 data.

1634 (5) Payment rates for developmental disabilities long-term  
 1635 care plans shall be classified into five levels of care to  
 1636 account for variations in risk status and service needs among  
 1637 enrollees.

1638 (a) Level of care 1 consists of individuals receiving  
 1639 services in an intermediate care facility for the  
 1640 developmentally disabled.

1641 (b) Level of care 2 consists of individuals with intensive  
 1642 medical or adaptive needs and that are essential for avoiding  
 1643 institutionalization, or who possess behavioral problems that  
 1644 are exceptional in intensity, duration, or frequency and present  
 1645 a substantial risk of harm to themselves or others.

1646 (c) Level of care 3 consists of individuals with service  
 1647 needs, including a licensed residential facility and a moderate  
 1648 level of support for standard residential habilitation services  
 1649 or a minimal level of support for behavior focus residential  
 1650 habilitation services, or individuals in supported living who  
 1651 require more than 6 hours a day of in-home support services.

1652 (d) Level of care 4 consists of individuals requiring less  
 1653 than moderate level of residential habilitation support in a  
 1654 residential placement, or individuals in independent or  
 1655 supported living situations, or who live in their family home.

1656 (e) Level of care 5 consists of individuals requiring  
 1657 minimal support services while living in independent or  
 1658 supported living situations and individuals who live in their  
 1659 family home.

1660  
 1661 The agency shall periodically adjust payment rates to account  
 1662 for changes in the level of care profile of each plan's  
 1663 enrollees based on encounter data.

1664 (6) The agency will establish intermediate care facility  
 1665 for the developmentally disabled-specific payment rates for each  
 1666 licensed intermediate care facility based on facility costs  
 1667 adjusted for inflation and other factors. Payments to  
 1668 intermediate care facilities for the developmentally disabled  
 1669 shall be reconciled to reimburse the plan's actual payments to  
 1670 the facilities.

1671 Section 33. Section 409.992, Florida Statutes, is created  
 1672 to read:

1673 409.992 Automatic enrollment.—

1674 (1) The agency shall automatically enroll into a  
 1675 developmental disabilities comprehensive long-term care plan or  
 1676 a developmental disabilities long-term care plan those Medicaid  
 1677 recipients who do not voluntarily choose a plan pursuant to s.  
 1678 409.969. The agency shall automatically enroll recipients in  
 1679 plans that meet or exceed the performance or quality standards  
 1680 established pursuant to s. 409.967, and shall not automatically  
 1681 enroll recipients in a plan that is deficient in those  
 1682 performance or quality standards. The agency shall assign  
 1683 individuals who are deemed dually eligible for Medicaid and  
 1684 Medicare, to a plan that provides both Medicaid and Medicare  
 1685 services. The agency may not engage in practices that are  
 1686 designed to favor one managed care plan over another. When

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1687 automatically enrolling recipients in plans, the agency shall  
1688 take into account the following criteria:

1689 (a) Whether the plan has sufficient network capacity to  
1690 meet the needs of the recipients.

1691 (b) Whether the recipient has previously received services  
1692 from one of the plan's home and community-based service  
1693 providers.

1694 (c) Whether home and community-based providers in one plan  
1695 are more geographically accessible to the recipient's residence  
1696 than those in other plans.

1697 Section 34. This act shall take effect July 1, 2010.