

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

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

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

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

162
 163 Be It Enacted by the Legislature of the State of Florida:

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

168 Section 2. Section 409.961, Florida Statutes, is created
 169 to read:

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

189 Section 3. Section 409.962, Florida Statutes, is created
 190 to read:

191 409.962 Definitions.—As used in this part, except as
 192 otherwise specifically provided, the term:

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

196 (2) "Benefit" means any benefit, assistance, aid,
 197 obligation, promise, debt, liability, or the like, related to
 198 any covered injury, illness, or necessary medical care, goods,
 199 or services.

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

203 (4) "Long-term care comprehensive plan" means a long-term
 204 care plan that also provides the services described in s.
 205 409.973.

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

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

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

217 (8) "Medicaid" means the medical assistance program
 218 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.
 219 1396 et seq., and regulations thereunder, as administered in
 220 this state by the agency.

221 (9) "Medicaid recipient" or "recipient" means an
 222 individual who the department or, for Supplemental Security
 223 Income, the Social Security Administration determines is

224 eligible pursuant to federal and state law to receive medical
225 assistance and related services for which the agency may make
226 payments under the Medicaid program. For the purposes of
227 determining third-party liability, the term includes an
228 individual formerly determined to be eligible for Medicaid, an
229 individual who has received medical assistance under the
230 Medicaid program, or an individual on whose behalf Medicaid has
231 become obligated.

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

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

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

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

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

255 Section 4. Section 409.963, Florida Statutes, is created
 256 to read:

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

278 Section 5. Section 409.964, Florida Statutes is created to
 279 read:

280 409.964 Managed care program; state plan; waivers.—The
 281 Medicaid program is established as a statewide, integrated
 282 managed care program for all covered services, including long-
 283 term care services. The agency shall apply for and implement
 284 state plan amendments or waivers of applicable federal laws and
 285 regulations necessary to implement the program. Prior to seeking
 286 a waiver, the agency shall provide public notice and the
 287 opportunity for public comment and shall include public feedback
 288 in the waiver application. The agency shall include the public
 289 feedback in the application. The agency shall hold one public
 290 meeting in each of the regions described in s. 409.966(2) and
 291 the time period for public comment for each region shall end no
 292 sooner than 30 days after the completion of the public meeting
 293 in that region.

294 Section 6. Section 409.965, Florida Statutes, is created
 295 to read:

296 409.965 Mandatory enrollment.—All Medicaid recipients
 297 shall receive covered services through the statewide managed
 298 care program, except as provided by this part pursuant to an
 299 approved federal waiver. The following Medicaid recipients are
 300 exempt from participation in the statewide managed care program:

301 (1) Women who are only eligible for family planning
 302 services.

303 (2) Women who are only eligible for breast and cervical
 304 cancer services.

305 (3) Persons who are eligible for emergency Medicaid for
 306 aliens.

307 Section 7. Section 409.966, Florida Statutes, is created
 308 to read:

309 409.966 Qualified plans; selection.-

310 (1) QUALIFIED PLANS.-Services in the Medicaid managed care
 311 program shall be provided by qualified plans.

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

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

327 (2) QUALIFIED PLAN SELECTION.-The agency shall select a
 328 limited number of qualified plans to participate in the Medicaid
 329 program using invitations to negotiate in accordance with s.
 330 287.057(3)(a). At least 30 days prior to issuing an invitation
 331 to negotiate, the agency shall compile and publish a databook
 332 consisting of a comprehensive set of utilization and spending
 333 data for the 3 most recent contract years consistent with the
 334 rate-setting periods for all Medicaid recipients by region or

335 county. The source of the data in the report shall include both
336 historic fee-for-service claims and validated data from the
337 Medicaid Encounter Data System. The report shall be made
338 available in electronic form and shall delineate utilization use
339 by age, gender, eligibility group, geographic area, and
340 aggregate clinical risk score. Separate and simultaneous
341 procurements shall be conducted in each of the following
342 regions:

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

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

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

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

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

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

360 (3) QUALITY SELECTION CRITERIA.-The invitation to
361 negotiate must specify the criteria and the relative weight of
362 the criteria that will be used for determining the acceptability

363 of the reply and guiding the selection of the organizations with
364 which the agency negotiates. In addition to criteria established
365 by the agency, the agency shall consider the following factors
366 in the selection of qualified plans:

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

369 (b) Experience serving similar populations, including the
370 organization's record in achieving specific quality standards
371 with similar populations.

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

374 (d) Establishment of community partnerships with providers
375 that create opportunities for reinvestment in community-based
376 services.

377 (e) Organization commitment to quality improvement and
378 documentation of achievements in specific quality improvement
379 projects, including active involvement by organization
380 leadership.

381 (f) Provision of additional benefits, particularly dental
382 care and disease management, and other enhanced-benefit
383 programs.

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

386 (h) Evidence that a qualified plan has written agreements
387 or signed contracts or has made substantial progress in
388 establishing relationships with providers prior to the plan
389 submitting a response. The agency shall evaluate and give

390 special weight to such evidence, and the evaluation shall be
 391 based on the following factors:

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

395 2. Specific arrangements that provide evidence that the
 396 compensation offered is sufficient to retain primary and
 397 specialty physicians in sufficient numbers to continue to comply
 398 with the standards established pursuant to s. 409.967(2)
 399 throughout the 5-year contract term.

400
 401 After negotiations are conducted, the agency shall select the
 402 qualified plans that are determined to be responsive and provide
 403 the best value to the state. Preference shall be given to
 404 organizations designated as medical home networks pursuant to s.
 405 409.91207 or organizations with the greatest number of primary
 406 care providers that are recognized as patient-centered medical
 407 homes by the National Committee for Quality Assurance or
 408 organizations with networks that reflect recruitment of minority
 409 physicians and other minority providers.

410 (4) ADMINISTRATIVE CHALLENGE.—Any qualified plan that
 411 participates in an invitation to negotiate in more than one
 412 region and is selected in at least one region may not begin
 413 serving Medicaid recipients in any region for which it was
 414 selected until all administrative challenges to procurements
 415 required by this section to which the qualified plan is a party
 416 have been finalized. For purposes of this subsection, an
 417 administrative challenge is finalized if an order granting

418 voluntary dismissal with prejudice has been entered by any court
419 established under Article V of the State Constitution or by the
420 Division of Administrative Hearings, a final order has been
421 entered into by the agency and the deadline for appeal has
422 expired, a final order has been entered by the First District
423 Court of Appeal and the time to seek any available review by the
424 Florida Supreme Court has expired, or a final order has been
425 entered by the Florida Supreme Court and a warrant has been
426 issued.

427 Section 8. Section 409.967, Florida Statutes, is created
428 to read:

429 409.967 Managed care plan accountability.—

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

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

439 (a) Emergency services.—Plans shall pay for services
440 required by ss. 395.1041 and 401.45 and rendered by a
441 noncontracted provider within 30 days after receipt of a
442 complete and correct claim. Plans must give providers of these
443 services a specific explanation for each claim denied for being
444 incomplete or incorrect. Payment shall be made at the rate the
445 agency would pay for such services from the same provider.

446 Claims from noncontracted providers shall be accepted by the
447 qualified plan for at least 1 year after the date the services
448 are provided.

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

467 (c) Encounter data.—Each prepaid plan must comply with the
468 agency's reporting requirements for the Medicaid Encounter Data
469 System. The agency shall develop methods and protocols for
470 ongoing analysis of the encounter data that adjusts for
471 differences in characteristics of plans' enrollees to allow
472 comparison of service utilization among plans and against
473 expected levels of use. The analysis shall be used to identify

474 possible cases of systemic under-utilization or denials of
475 claims and inappropriate service utilization such as higher than
476 expected emergency department encounters. The analysis shall
477 provide periodic feedback to the plans and enable the agency to
478 establish corrective action plans when necessary. One of the
479 primary focus areas for the analysis shall be the use of
480 prescription drugs.

481 (d) Continuous improvement.—The agency shall establish
482 specific performance standards and expected milestones or
483 timelines for improving performance over the term of the
484 contract. Each plan shall establish an internal health care
485 quality improvement system, including enrollee satisfaction and
486 disenrollment surveys. The quality improvement system shall
487 include incentives and disincentives for network providers.

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

- 491 1. A provider credentialing system and ongoing provider
492 monitoring;
- 493 2. An effective prepayment and postpayment review process
494 including, but not limited to, data analysis, system editing,
495 and auditing of network providers;
- 496 3. Procedures for reporting instances of fraud and abuse
497 pursuant to chapter 641;
- 498 4. Administrative and management arrangements or
499 procedures, including a mandatory compliance plan, designed to
500 prevent fraud and abuse; and
- 501 5. Designation of a program integrity compliance officer.

502 (f) Grievance resolution.—Each plan shall establish and
 503 the agency shall approve an internal process for reviewing and
 504 responding to grievances from enrollees consistent with the
 505 requirements of s. 641.511. Each plan shall submit quarterly
 506 reports on the number, description, and outcome of grievances
 507 filed by enrollees. The agency shall maintain a process for
 508 provider service networks consistent with s. 408.7056.

509 (g) Penalties.—Plans that reduce enrollment levels or
 510 leave a region prior to the end of the contract term shall
 511 reimburse the agency for the cost of enrollment changes and
 512 other transition activities, including the cost of additional
 513 choice counseling services. If more than one plan leaves a
 514 region at the same time, costs shall be shared by the departing
 515 plans proportionate to their enrollments. In addition to the
 516 payment of costs, departing plans shall pay a per enrollee
 517 penalty not to exceed 5 percent of 1 month's payment. Plans
 518 shall provide the agency notice no less than 180 days prior to
 519 withdrawing from a region.

520 (h) Prompt payment.—For all electronically submitted
 521 claims, a managed care plan shall:

522 1. Within 24 hours after the beginning of the next
 523 business day after receipt of the claim, provide electronic
 524 acknowledgment of the receipt of the claim to the electronic
 525 source submitting the claim;

526 2. Within 20 days after receipt of the claim, pay the
 527 claim or notify the provider or designee if a claim is denied or
 528 contested. Notice of the organization's action on the claim and
 529 payment of the claim is considered to be made on the date the

530 notice or payment was mailed or electronically transferred; and
531 3. Within 90 days after receipt of the claim, pay or deny
532 the claim. Failure to pay or deny a claim within 120 days after
533 receipt of the claim creates an uncontestable obligation to pay
534 the claim.

535 (i) Electronic claims.-Plans shall accept electronic
536 claims in compliance with federal standards.

537 (j) Medical home development.-The managed care plan, if
538 not designated as a medical home network pursuant to s.
539 409.91207, must develop a plan to assist and to provide
540 incentives for its primary care providers to become recognized
541 as patient-centered medical homes by the National Committee for
542 Quality Assurance.

543 Section 9. Section 409.968, Florida Statutes, is created
544 to read:

545 409.968 Managed care plan payment.-

546 (1) Prepaid plans shall receive per-member, per-month
547 payments negotiated pursuant to the procurements described in s.
548 409.966. Payments shall be risk-adjusted rates based on
549 historical utilization and spending data, projected forward, and
550 adjusted to reflect the eligibility category, geographic area,
551 and the clinical risk profile of the recipients.

552 (2) Beginning September 1, 2010, the agency shall update
553 the rate-setting methodology by initiating a transition to rates
554 based on statewide encounter data submitted by Medicaid managed
555 care plans pursuant to s. 409.970. Prior to this transition, the
556 agency shall conduct appropriate tests and establish specific
557 milestones in order to determine that the Medicaid Encounter

558 Data system consists of valid, complete, and sound data for a
559 sufficient period of time to provide a reliable basis for
560 establishing actuarially sound payment rates. The transition
561 shall be implemented within 3 years or less, and shall utilize
562 such other data sources as necessary and reliable to make
563 appropriate adjustments during the transition. The agency shall
564 establish a technical advisory panel to obtain input from the
565 prepaid plans regarding the incorporation of encounter data in
566 the rate setting process.

567 (3) Provider service networks may be prepaid plans and
568 receive per-member, per-month payments negotiated pursuant to
569 the procurement process described in s. 409.966. Provider
570 service networks that choose not to be prepaid plans shall
571 receive fee-for-service rates with a shared savings settlement.
572 The fee-for-service option shall be available to a provider
573 service network only for the first 5 years of the plan's
574 operation in a given region or until the contract year that
575 begins on October 1, 2015, whichever is later. The agency shall
576 annually conduct cost reconciliations to determine the amount of
577 cost savings achieved by fee-for-service provider service
578 networks for the dates of service within the period being
579 reconciled. Only payments for covered services for dates of
580 service within the reconciliation period and paid within 6
581 months after the last date of service in the reconciliation
582 period shall be included. The agency shall perform the necessary
583 adjustments for the inclusion of incurred but not reported
584 claims within the reconciliation period for claims that could be
585 received and paid by the agency after the 6-month claims

586 processing time lag. The agency shall provide the results of the
587 reconciliations to the fee-for-service provider service networks
588 within 45 days after the end of the reconciliation period. The
589 fee-for-service provider service networks shall review and
590 provide written comments or a letter of concurrence to the
591 agency within 45 days after receipt of the reconciliation
592 results. This reconciliation shall be considered final.

593 Section 10. Section 409.969, Florida Statutes, is created
594 to read:

595 409.969 Enrollment; choice counseling; automatic
596 assignment; disenrollment.-

597 (1) ENROLLMENT.-All Medicaid recipients shall be enrolled
598 in a managed care plan unless specifically exempted in this
599 part. Each recipient shall have a choice of plans and may select
600 any available plan unless that plan is restricted by contract to
601 a specific population that does not include the recipient.
602 Medicaid recipients shall have 30 days in which to make a choice
603 of plans. All recipients shall be offered choice counseling
604 services in accordance with this section.

605 (2) CHOICE COUNSELING.-The agency shall provide choice
606 counseling for Medicaid recipients. The agency may contract for
607 the provision of choice counseling. Any such contract shall be
608 for a period of 5 years. The agency may renew a contract for an
609 additional 5-year period; however, prior to renewal of the
610 contract the agency shall hold at least one public meeting in
611 each of the regions covered by the choice counseling vendor. The
612 agency may extend the term of the contract to cover any delays
613 in transition to a new contractor. Printed choice information

614 and choice counseling shall be offered in the native or
615 preferred language of the recipient, consistent with federal
616 requirements. The manner and method of choice counseling shall
617 be modified as necessary to assure culturally competent,
618 effective communication with people from diverse cultural
619 backgrounds. The agency shall maintain a record of the
620 recipients who receive such services, identifying the scope and
621 method of the services provided. The agency shall make available
622 clear and easily understandable choice information to Medicaid
623 recipients that includes:

624 (a) An explanation that each recipient has the right to
625 choose a managed care plan at the time of enrollment in Medicaid
626 and again at regular intervals set by the agency, and that if a
627 recipient does not choose a plan, the agency will assign the
628 recipient to a plan according to the criteria specified in this
629 section.

630 (b) A list and description of the benefits provided in
631 each plan.

632 (c) An explanation of benefit limits.

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

635 (e) Plan performance data.

636 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has
637 enrolled in a managed care plan, the recipient shall have 90
638 days to voluntarily disenroll and select another plan. After 90
639 days, no further changes may be made except for good cause. Good
640 cause includes, but is not limited to, poor quality of care,
641 lack of access to necessary specialty services, an unreasonable

642 delay or denial of service, or fraudulent enrollment. The agency
643 must make a determination as to whether good cause exists. The
644 agency may require a recipient to use the plan's grievance
645 process prior to the agency's determination of good cause,
646 except in cases in which immediate risk of permanent damage to
647 the recipient's health is alleged.

648 (a) The managed care plan internal grievance process, when
649 utilized, must be completed in time to permit the recipient to
650 disenroll by the first day of the second month after the month
651 the disenrollment request was made. If the result of the
652 grievance process is approval of an enrollee's request to
653 disenroll, the agency is not required to make a determination in
654 the case.

655 (b) The agency must make a determination and take final
656 action on a recipient's request so that disenrollment occurs no
657 later than the first day of the second month after the month the
658 request was made. If the agency fails to act within the
659 specified timeframe, the recipient's request to disenroll is
660 deemed to be approved as of the date agency action was required.
661 Recipients who disagree with the agency's finding that good
662 cause does not exist for disenrollment shall be advised of their
663 right to pursue a Medicaid fair hearing to dispute the agency's
664 finding.

665 (c) Medicaid recipients enrolled in a managed care plan
666 after the 90-day period shall remain in the plan for the
667 remainder of the 12-month period. After 12 months, the recipient
668 may select another plan. However, nothing shall prevent a

669 Medicaid recipient from changing primary care providers within
 670 the plan during that period.

671 (d) On the first day of the next month after receiving
 672 notice from a recipient that the recipient has moved to another
 673 region, the agency shall automatically disenroll the recipient
 674 from the plan the recipient is currently enrolled in and treat
 675 the recipient as if the recipient is a new Medicaid enrollee. At
 676 that time, the recipient may choose another plan pursuant to the
 677 enrollment process established in this section.

678 Section 11. Section 409.970, Florida Statutes, is created
 679 to read:

680 409.970 Encounter data.—The agency shall maintain and
 681 operate the Medicaid Encounter Data System to collect, process,
 682 store, and report on covered services provided to all Medicaid
 683 recipients enrolled in prepaid plans. Prepaid plans shall submit
 684 encounter data electronically in a format that complies with the
 685 Health Insurance Portability and Accountability Act provisions
 686 for electronic claims and in accordance with deadlines
 687 established by the agency. Prepaid plans must certify that the
 688 data reported is accurate and complete. The agency is
 689 responsible for validating the data submitted by the plans. The
 690 agency shall make encounter data available to those plans
 691 accepting enrollees who are assigned to them from other plans
 692 leaving a region.

693 Section 12. Section 409.971, Florida Statutes, is created
 694 to read:

695 409.971 Managed medical assistance program.—The agency
 696 shall make payments for primary and acute medical assistance and

697 related services using a managed care model. By January 1, 2012,
 698 the agency shall begin implementation of the statewide managed
 699 medical assistance program, with full implementation in all
 700 regions by October 1, 2013.

701 Section 13. Section 409.972, Florida Statutes, is created
 702 to read:

703 409.972 Mandatory and voluntary enrollment.—

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

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

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

715 (b) Medicaid recipients residing in residential commitment
 716 facilities operated through the Department of Juvenile Justice,
 717 group care facilities operated by the Department of Children and
 718 Families, and treatment facilities funded through the Substance
 719 Abuse and Mental Health program of the Department of Children
 720 and Families.

721 (c) Persons eligible for refugee assistance.

722 (d) Medicaid recipients who are residents of a
 723 developmental disability center including Sunland Center in
 724 Marianna and Tacachale in Gainesville.

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

729 Section 14. Section 409.973, Florida Statutes, is created
 730 to read:

731 409.973 Benefits.—

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

734 (a) Advanced registered nurse practitioner services.

735 (b) Ambulatory surgical treatment center services.

736 (c) Birthing center services.

737 (d) Chiropractic services.

738 (e) Dental services.

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

741 (g) Emergency services.

742 (h) Family planning services and supplies.

743 (i) Healthy start services.

744 (j) Hearing services.

745 (k) Home health agency services.

746 (l) Hospice services.

747 (m) Hospital inpatient services.

748 (n) Hospital outpatient services.

749 (o) Laboratory and X-ray services.

750 (p) Medical supplies, equipment, prostheses, and orthoses.

751 (q) Mental health services.

752 (r) Nursing care.

753 (s) Optical services and supplies.
 754 (t) Optometrist services.
 755 (u) Physical, occupational, respiratory, and speech
 756 therapy services.
 757 (v) Physician services.
 758 (w) Podiatric services.
 759 (x) Prescription drugs.
 760 (y) Renal dialysis services.
 761 (z) Respiratory equipment and supplies.
 762 (aa) Rural health clinic services.
 763 (bb) Substance abuse treatment services.
 764 (cc) Transportation to access covered services.
 765 (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
 766 benefit packages for nonpregnant adults, vary cost-sharing
 767 provisions, and provide coverage for additional services. The
 768 agency shall evaluate the proposed benefit packages to ensure
 769 services are sufficient to meet the needs of the plans'
 770 enrollees and to verify actuarial equivalence.
 771 (3) ENHANCED BENEFITS.—Each plan operating in the managed
 772 medical assistance program shall establish an incentive program
 773 that rewards specific healthy behaviors with credits in a
 774 flexible spending account.
 775 (a) At the discretion of the recipient, credits shall be
 776 used to purchase otherwise uncovered health and related services
 777 during the entire period of, and for a maximum of 3 years after,
 778 the recipient's Medicaid eligibility, whether or not the
 779 recipient remains continuously enrolled in the plan in which the
 780 credits were earned.

781 (b) Enhanced benefits shall be structured to provide
782 greater incentives for those diseases linked with lifestyle and
783 conditions or behaviors associated with avoidable utilization of
784 high-cost services.

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

790 Section 15. Section 409.974, Florida Statutes, is created
791 to read:

792 409.974 Qualified plans.—

793 (1) QUALIFIED PLAN SELECTION.—The agency shall select
794 qualified plans through the procurement described in s. 409.966.
795 The agency shall notice invitations to negotiate no later than
796 January 1, 2012.

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

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

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

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

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

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

820 If no provider service network submits a responsive bid, the
821 agency shall procure no more than one less than the maximum
822 number of qualified plans permitted in that region. Within 12
823 months after the initial invitation to negotiate, the agency
824 shall attempt to procure a qualified plan that is a provider
825 service network. The agency shall notice another invitation to
826 negotiate only with provider service networks in such region
827 where no provider service network has been selected.

828 (2) QUALITY SELECTION CRITERIA.-In addition to the
829 criteria established in s. 409.966, the agency shall consider
830 evidence that a qualified plan has written agreements or signed
831 contracts or has made substantial progress in establishing
832 relationships with providers prior to the plan submitting a
833 response. The agency shall evaluate and give special weight to
834 evidence of signed contracts with providers of critical services
835 pursuant to s. 409.975(3)(a)-(d). The agency shall also consider

836 whether the organization is a specialty plan. When all other
837 factors are equal, the agency shall consider whether the
838 organization has a contract to provide managed long-term care
839 services in the same region and shall exercise a preference for
840 such plans.

841 (3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's
842 Medical Services Network authorized under chapter 391 is a
843 qualified plan for purposes of the managed medical assistance
844 program. Participation by the Children's Medical Services
845 Network shall be pursuant to a single, statewide contract with
846 the agency that is not subject to the procurement requirements
847 or regional plan number limits of this section. The Children's
848 Medical Services Network must meet all other plan requirements
849 for the managed medical assistance program.

850 Section 16. Section 409.975, Florida Statutes, is created
851 to read:

852 409.975 Managed care plan accountability.-In addition to
853 the requirements of s. 409.967, plans and providers
854 participating in the managed medical assistance program shall
855 comply with the requirements of this section.

856 (1) MEDICAL LOSS RATIO.-The agency shall establish and
857 implement managed care plans that shall use a uniform method of
858 accounting for and reporting medical, direct care management,
859 and nonmedical costs. The agency shall evaluate plan spending
860 patterns beginning after the plan completes 2 full years of
861 operation and at least annually thereafter. The agency shall
862 implement the following thresholds and consequences of various
863 spending patterns:

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

869 (b) Plans that spend less than 85 percent of Medicaid
870 premium revenue on medical services and direct care management
871 as determined by the agency shall be required to pay back the
872 amount between actual spending and 85 percent of the Medicaid
873 premium revenue.

874 (c) Plans that spend more than 92 percent of Medicaid
875 premium revenue shall be evaluated by the agency to determine
876 whether higher expenditures are the result of failures in care
877 management.

878 (d) Plans that spend 95 percent or more of Medicaid
879 premium revenue and are determined to be failing to
880 appropriately manage care shall be excluded from automatic
881 enrollments.

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

887 (a) Federally qualified health centers.

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

889 (c) Providers listed in paragraphs (3) (a)-(d).

890

891 After 12 months of active participation in a plan's network, the
 892 plan may exclude any of the above-named providers from the
 893 network for failure to meet quality or performance criteria. If
 894 the plan excludes a provider from the plan, the plan must
 895 provide written notice to all recipients who have chosen that
 896 provider for care. The notice shall be provided at least 30 days
 897 prior to the effective date of the exclusion.

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

903 (a) Statutory teaching hospitals as defined in s.
 904 408.07(45).

905 (b) Hospitals that are trauma centers as defined in s.
 906 395.4001(14).

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

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

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

913
 914 The hospitals described in paragraphs (a)-(d) shall make
 915 adequate arrangements for medical staff sufficient to fulfill
 916 their contractual obligations with the plans.

917 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
 918 quality and performance of each participating provider. At the

919 beginning of the contract period, each plan shall notify all its
 920 network providers of the metrics used by the plan for evaluating
 921 the provider's performance and determining continued
 922 participation in the network.

923 (5) PREGNANCY AND INFANT HEALTH.—Each plan shall establish
 924 specific programs and procedures to improve pregnancy outcomes
 925 and infant health, including, but not limited to, coordination
 926 with the Healthy Start program, immunization programs, and
 927 referral to the Special Supplemental Nutrition Program for
 928 Women, Infants, and Children, and the Children's Medical
 929 Services program for children with special health care needs.

930 (6) SCREENING RATE.—Each plan shall achieve an annual
 931 Early and Periodic Screening, Diagnosis, and Treatment Service
 932 screening rate of at least 80 percent of those recipients
 933 continuously enrolled for at least 8 months.

934 (7) PROVIDER PAYMENT.—Plans and hospitals shall negotiate
 935 mutually acceptable rates, methods, and terms of payment. At a
 936 minimum, plans shall pay hospitals the Medicaid rate. Payments
 937 to hospitals shall not exceed 150 percent of the rate the agency
 938 would have paid on the first day of the contract between the
 939 provider and the plan, unless specifically approved by the
 940 agency. Payment rates may be updated periodically.

941 (8) CONFLICT RESOLUTION.—In order to protect the continued
 942 statewide operation of the Medicaid managed care program, the
 943 Medicaid Resolution Board is established to resolve disputes
 944 between managed care plans and hospitals and between managed
 945 care plans and the medical staff of the providers listed in s.
 946 409.975(3)(a)-(d). The board shall consist of two members

947 appointed by the Speaker of the House of Representatives, two
948 members appointed by the President of the Senate, and three
949 members appointed by the Governor. The costs of the board's
950 activities to review and resolve disputes shall be shared
951 equally by the parties to the dispute. Any managed care plan or
952 above-named provider may initiate a review by the board for any
953 conflict related to payment rates, contract terms, or other
954 conditions. The board shall make recommendations to the agency
955 regarding payment rates, procedures, or other contract terms to
956 resolve such conflicts. The agency may amend the terms of the
957 contracts with the parties to ensure compliance with these
958 recommendations. This process shall not be used to review and
959 reverse any managed care plan decision to exclude any provider
960 that fails to meet quality standards.

961 (9) MEDICALLY NEEDED ENROLLEES.—Each selected plan shall
962 accept any medically needy recipient who selects or is assigned
963 to the plan and provide that recipient with continuous
964 enrollment for 12 months. After the first month of qualifying as
965 a medically needy recipient and enrolling in a plan, and
966 contingent upon federal approval, the enrollee shall pay the
967 plan a portion of the monthly premium equal to the enrollee's
968 share of the cost as determined by the department. The agency
969 shall pay the remainder of the monthly premium. Plans must
970 provide a grace period of at least 120 days before disenrolling
971 recipients who fail to pay their shares of the premium.

972 Section 17. Section 409.976, Florida Statutes, is created
973 to read:

974 409.976 Managed care plan payment.—In addition to the
975 payment provisions of s. 409.968, the agency shall provide
976 payment to plans in the managed medical assistance program
977 pursuant to this section.

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

981 (2) The agency shall develop a methodology to ensure the
982 availability of intergovernmental transfers in the statewide
983 integrated managed care program to support providers that have
984 historically served Medicaid recipients. Such providers include,
985 but are not limited to, safety net providers, trauma hospitals,
986 children's hospitals, statutory teaching hospitals, and medical
987 and osteopathic physicians employed by or under contract with a
988 medical school in this state. The agency may develop a
989 supplemental capitation rate, risk pool, or incentive payment to
990 plans that contract with these providers. A plan is eligible for
991 a supplemental payment only if there are sufficient
992 intergovernmental transfers available from allowable sources and
993 the plan can demonstrate that it pays a reimbursement rate not
994 less than the equivalent fee-for-service rate. The agency may
995 develop the supplemental capitation rate to consider rates
996 higher than the fee-for-service Medicaid rate when needed to
997 ensure access and supported by funds provided by a locality. The
998 agency shall evaluate the development of the rate cell to
999 accurately reflect the underlying utilization to the maximum
1000 extent possible. This methodology may include interim rate
1001 adjustments as permitted under federal regulations. Any such

1002 methodology shall preserve federal funding to these entities and
 1003 must be actuarially sound. In the absence of federal approval
 1004 for the above methodology, the agency is authorized to set an
 1005 enhanced rate and require that plans pay the enhanced rate, if
 1006 the agency determines the enhanced rate is necessary to ensure
 1007 access to care by the providers described in this subsection.
 1008 The amount paid to the plans to make supplemental payments or to
 1009 enhance provider rates pursuant to this subsection shall be
 1010 reconciled to the exact amounts the plans are required to pay to
 1011 providers. The plans shall make the designated payments to
 1012 providers within 15 business days of notification by the agency
 1013 regarding provider-specific distributions.

1014 Section 18. Section 409.977, Florida Statutes, is created
 1015 to read:

1016 409.977 Choice counseling and enrollment.-

1017 (1) CHOICE COUNSELING.-In addition to the choice
 1018 counseling information required by s. 409.969, the agency shall
 1019 make available clear and easily understandable choice
 1020 information to Medicaid recipients that includes:

1021 (a) Information about earning credits in the plan's
 1022 enhanced benefit program.

1023 (b) Information about cost sharing requirements of each
 1024 plan.

1025 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically
 1026 enroll into a managed care plan those Medicaid recipients who do
 1027 not voluntarily choose a plan pursuant to s. 409.969. The agency
 1028 shall automatically enroll recipients in plans that meet or
 1029 exceed the performance or quality standards established pursuant

1030 to s. 409.967, and shall not automatically enroll recipients in
 1031 a plan that is deficient in those performance or quality
 1032 standards. When a specialty plan is available to accommodate a
 1033 specific condition or diagnosis of a recipient, the agency shall
 1034 assign the recipient to that plan. The agency may not engage in
 1035 practices that are designed to favor one managed care plan over
 1036 another. When automatically enrolling recipients in plans, the
 1037 agency shall automatically enroll based on the following
 1038 criteria:

1039 (a) Whether the plan has sufficient network capacity to
 1040 meet the needs of the recipients.

1041 (b) Whether the recipient has previously received services
 1042 from one of the plan's primary care providers.

1043 (c) Whether primary care providers in one plan are more
 1044 geographically accessible to the recipient's residence than
 1045 those in other plans.

1046 (3) OPT-OUT OPTION.-The agency shall develop a process to
 1047 enable any recipient with access to employer-sponsored insurance
 1048 to opt out of all qualified plans in the Medicaid program and to
 1049 use Medicaid financial assistance to pay for the recipient's
 1050 share of the cost in any such plan. Contingent upon federal
 1051 approval, the agency shall also enable recipients with access to
 1052 other insurance or related products providing access to health
 1053 care services created pursuant to state law, including any
 1054 product available under the Cover Florida Health Access Program,
 1055 the Florida Health Choices Program, or any health exchange, to
 1056 opt out. The amount of financial assistance provided for each

1057 recipient may not exceed the amount of the Medicaid premium that
 1058 would have been paid to a plan for that recipient.

1059 Section 19. Section 409.978, Florida Statutes, is created
 1060 to read:

1061 409.978 Long-term care managed care program.—

1062 (1) Pursuant to s. 409.963, the agency shall administer
 1063 the long-term care managed care program described in ss.
 1064 409.978-409.985, but may delegate specific duties and
 1065 responsibilities for the program to the Department of Elderly
 1066 Affairs and other state agencies. By July 1, 2011, the agency
 1067 shall begin implementation of the statewide long-term care
 1068 managed care program, with full implementation in all regions by
 1069 October 1, 2012.

1070 (2) The agency shall make payments for long-term care,
 1071 including home and community-based services, using a managed
 1072 care model. Unless otherwise specified, the provisions of ss.
 1073 409.961-409.970 apply to the long-term care managed care
 1074 program.

1075 (3) The Department of Elderly Affairs shall assist the
 1076 agency to develop specifications for use in the invitation to
 1077 negotiate and the model contract; determine clinical eligibility
 1078 for enrollment in managed long-term care plans; monitor plan
 1079 performance and measure quality of service delivery; assist
 1080 clients and families to address complaints with the plans;
 1081 facilitate working relationships between plans and providers
 1082 serving elders and disabled adults; and perform other functions
 1083 specified in a memorandum of agreement.

1084 Section 20. Section 409.979, Florida Statutes, is created
 1085 to read:

1086 409.979 Eligibility.-

1087 (1) Medicaid recipients who meet all of the following
 1088 criteria are eligible to participate in the long-term care
 1089 managed care program. The recipient must be:

1090 (a) Sixty-five years of age or older or eligible for
 1091 Medicaid by reason of a disability.

1092 (b) Determined by the Comprehensive Assessment Review and
 1093 Evaluation for Long-Term Care Services (CARES) Program to
 1094 require nursing facility care.

1095 (2) Medicaid recipients who on the date long-term care
 1096 managed care plans becomes available in the recipient's region,
 1097 are residing in a nursing home facility or enrolled in one of
 1098 the following long-term care Medicaid waiver programs are
 1099 eligible to participate in the long-term care managed care
 1100 program:

1101 (a) The Assisted Living for the Frail Elderly Waiver.

1102 (b) The Aged and Disabled Adult Waiver.

1103 (c) The Adult Day Health Care Waiver.

1104 (d) The Consumer-Directed Care Plus Program as described
 1105 in s. 409.221.

1106 (e) The Program of All-inclusive Care for the Elderly.

1107 (f) The Long-Term Care Community-Based Diversion Pilot
 1108 Project as described in s. 430.705.

1109 (g) The Channeling Services Waiver for Frail Elders.

1110 Section 21. Section 409.980, Florida Statutes, is created
 1111 to read:

1112 409.980 Benefits.—Managed care plans shall cover, at a
 1113 minimum, the following services:
 1114 (1) Nursing facility.
 1115 (2) Assisted living facility.
 1116 (3) Hospice.
 1117 (4) Adult day care.
 1118 (5) Medical equipment and supplies, including incontinence
 1119 supplies.
 1120 (5) Personal care.
 1121 (7) Home accessibility adaptation.
 1122 (9) Behavior management.
 1123 (9) Home delivered meals.
 1124 (10) Case management.
 1125 (11) Therapies:
 1126 (a) Occupational therapy
 1127 (b) Speech therapy
 1128 (c) Respiratory therapy
 1129 (d) Physical therapy.
 1130 (12) Intermittent and skilled nursing.
 1131 (13) Medication administration.
 1132 (14) Medication management.
 1133 (15) Nutritional assessment and risk reduction.
 1134 (16) Caregiver training.
 1135 (17) Respite care.
 1136 (18) Transportation.
 1137 (19) Personal emergency response system.
 1138 Section 22. Section 409.981, Florida Statutes, is created
 1139 to read:

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409.981 Qualified plans.—
(1) QUALIFIED PLANS.—For purposes of the long-term care managed care program, qualified plans also include entities who are qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans. Such plans are eligible to participate in the statewide long-term care managed care program. Qualified plans that are provider service networks must be long-term care provider service networks. Qualified plans may either be long-term care plans that cover benefits pursuant to s. 409.980, or comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.980.
(2) QUALIFIED PLAN SELECTION.—The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than July 1, 2011.
(a) The agency shall procure three plans for Region I. At least one plan shall be a provider service network, if any submit a responsive bid.
(b) The agency shall procure at least four and no more than seven plans for Region II. At least one plan shall be a provider service network, if any submit a responsive bid.
(c) The agency shall procure at least five plans and no more than ten plans for Region III. At least two plans shall be provider service networks, if any two submit a responsive bid.

1166 (d) The agency shall procure at least four plans and no
1167 more than eight plans for Region IV. At least one plan shall be
1168 a provider service network if any submit a responsive bid.

1169 (e) The agency shall procure at least four plans and no
1170 more than seven plans for Region V. At least one plan shall be a
1171 provider service network, if any submit a responsive bid.

1172 (f) The agency shall procure at least five plans and no
1173 more than ten plans for Region VI. At least two plans shall be
1174 provider service networks, if any two submit a responsive bid.
1175 If no provider service network submits a responsive bid, the
1176 agency shall procure one less qualified plan in each of the
1177 regions. Within 12 months after the initial invitation to
1178 negotiate, the agency shall attempt to procure a qualified plan
1179 that is a provider service network. The agency shall notice
1180 another invitation to negotiate only with provider service
1181 networks in such region where no provider service network has
1182 been selected.

1183 (3) QUALITY SELECTION CRITERIA.—In addition to the criteria
1184 established in s. 409.966, the agency shall consider the
1185 following factors in the selection of qualified plans:

1186 (a) Specialized staffing. Plan employment of executive
1187 managers with expertise and experience in serving aged and
1188 disabled persons who require long-term care.

1189 (b) Network qualifications. Plan establishment of a
1190 network of service providers dispersed throughout the region and
1191 in sufficient numbers to meet specific service standards
1192 established by the agency for specialty services for persons
1193 receiving home and community-based care.

1194 (c) Whether a plan is proposing to establish a
 1195 comprehensive long-term care plan and whether the qualified plan
 1196 has a contract to provide managed medical assistance services in
 1197 the same region. The agency shall exercise a preference for such
 1198 plans.

1199 (d) Whether a plan is designated as a medical home network
 1200 pursuant to s. 409.91207 or offers consumer-directed care
 1201 services to enrollees pursuant to s. 409.221. Consumer-directed
 1202 care services provide a flexible budget which is managed by
 1203 enrolled individuals and their families or representatives and
 1204 allows them to choose providers of services, determine provider
 1205 rates of payment and direct the delivery of services to best
 1206 meet their special long-term care needs. When all other factors
 1207 are equal among competing qualified plans, the agency shall
 1208 exercise a preference for such plans.

1209 (e) Evidence that a qualified plan has written agreements
 1210 or signed contracts or has made substantial progress in
 1211 establishing relationships with providers prior to the plan
 1212 submitting a response. The agency shall evaluate and give
 1213 special weight to evidence of signed contracts with providers of
 1214 critical services pursuant to s. 409.982(2)(a)-(c).

1215 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—The
 1216 Program for All-Inclusive Care for the Elderly (PACE) is a
 1217 qualified plan for purposes of the long-term care managed care
 1218 program. Participation by PACE shall be pursuant to a contract
 1219 with the agency and not subject to the procurement requirements
 1220 or regional plan number limits of this section. PACE plans may

1221 continue to provide services to individuals at such levels and
 1222 enrollment caps as authorized by the General Appropriations Act.

1223 Section 23. Section 409.982, Florida Statutes, is created
 1224 to read:

1225 409.982 Managed care plan accountability.—In addition to
 1226 the requirements of s. 409.967, plans and providers
 1227 participating in the long-term care managed care program shall
 1228 comply with the requirements of this section.

1229 (1) MEDICAL LOSS RATIO.—The agency shall establish and
 1230 plans shall use a uniform method of accounting and reporting
 1231 long-term care service costs, direct care management costs, and
 1232 administrative costs. The agency shall evaluate plan spending
 1233 patterns beginning after the plan completes 2 full years of
 1234 operation and at least annually thereafter. The agency shall
 1235 implement the following thresholds and consequences of various
 1236 spending patterns:

1237 (a) Plans that spend less than 75 percent of Medicaid
 1238 premium revenue on long-term care services, including direct
 1239 care management as determined by the agency shall be excluded
 1240 from automatic enrollments and shall be required to pay back the
 1241 amount between actual spending and 85 percent of the Medicaid
 1242 premium revenue.

1243 (b) Plans that spend less than 85 percent of Medicaid
 1244 premium revenue on long-term care services, including direct
 1245 care management as determined by the agency shall be required to
 1246 pay back the amount of the difference between actual spending
 1247 and 85 percent of Medicaid premium revenue.

1248 (c) Plans that spend more than 92 percent of Medicaid

1249 premium revenue on long-term care services, including direct
 1250 care management as determined by the agency, shall be evaluated
 1251 by the agency to determine whether higher expenditures are the
 1252 result of failures in care management.

1253 (d) Plans that spend 95 percent or more of Medicaid
 1254 premium revenue on long-term care services, including direct
 1255 care management as determined by the agency, and are determined
 1256 to be failing to appropriately manage care shall be excluded
 1257 from automatic enrollments.

1258 (2) PROVIDER NETWORKS.—Plans may limit the providers in
 1259 their networks based on credentials, quality indicators, and
 1260 price. However, in the first contract period after a qualified
 1261 plan is selected in a region by the agency, the plan must offer
 1262 a network contract to the following providers in the region:

1263 (a) Nursing homes.

1264 (b) Hospices.

1265 (c) Aging network service providers that have previously
 1266 participated in home and community-based waivers serving elders
 1267 or community-service programs administered by the Department of
 1268 Elderly Affairs.

1269
 1270 After 12 months of active participation in a plan's network, the
 1271 plan may exclude any of the providers named in this subsection
 1272 from the network for failure to meet quality or performance
 1273 criteria.

1274 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1275 this subsection, providers may limit the plans they join.
 1276 Nursing homes and hospices must participate in all qualified

1277 plans selected by the agency in the region in which the provider
 1278 is located.

1279 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
 1280 quality and performance of each participating provider. At the
 1281 beginning of the contract period, each plan shall notify all its
 1282 network providers of the metrics used by the plan for evaluating
 1283 the provider's performance and determining continued
 1284 participation in the network.

1285 (5) PROVIDER NETWORK STANDARDS.—The agency shall establish
 1286 and each plan must comply with specific standards for the
 1287 number, type, and regional distribution of providers in the
 1288 plan's network, which must include:

- 1289 (a) Adult day centers.
- 1290 (b) Adult family care homes.
- 1291 (c) Assisted living facilities.
- 1292 (d) Health care services pools.
- 1293 (e) Home health agencies.
- 1294 (f) Homemaker and companion services.
- 1295 (g) Hospices.
- 1296 (h) Community Care for the Elderly Lead Agencies.
- 1297 (i) Nurse registries.
- 1298 (j) Nursing homes.

1299 (6) PROVIDER PAYMENT.—Plans and providers shall negotiate
 1300 mutually acceptable rates, methods, and terms of payment. Plans
 1301 shall pay nursing homes an amount equal to the nursing facility-
 1302 specific payment rates set by the agency. Plans shall pay
 1303 hospice providers an amount equal to the per diem rate set by
 1304 the agency. For recipients residing in a nursing facility and

1305 receiving hospice services, the plan shall pay the hospice
 1306 provider the per diem rate set by the agency minus the nursing
 1307 facility component and shall pay the nursing facility the
 1308 appropriate state rate.

1309 Section 24. Section 409.983, Florida Statutes, is created
 1310 to read:

1311 409.983 Managed care plan payment.—In addition to the
 1312 payment provisions of s. 409.968, the agency shall provide
 1313 payment to plans in the long-term care managed care program
 1314 pursuant to this section.

1315 (1) Prepaid payment rates for long-term care managed care
 1316 plans shall be negotiated between the agency and the qualified
 1317 plans as part of the procurement described in s. 409.966.

1318 (2) Payment rates for comprehensive long-term care plans
 1319 covering services described in s. 409.973 shall be combined with
 1320 rates for long-term care plans for services specified in s.
 1321 409.980.

1322 (3) Payment rates for plans shall reflect historic
 1323 utilization and spending for covered services projected forward
 1324 and adjusted to reflect the level of care profile for enrollees
 1325 of each plan. The payment shall be adjusted to provide an
 1326 incentive for reducing institutional placements and increasing
 1327 the utilization of home and community-based services.

1328 (4) The initial assessment of an enrollee's level of care
 1329 shall be made by the Comprehensive Assessment and Review for
 1330 Long-Term-Care Services (CARES) program, which shall assign the
 1331 recipient into one of the following levels of care:

1332 (a) Level of care 1 consists of recipients residing in

1333 nursing homes or needing immediate placement in a nursing home.

1334 (b) Level of care 2 consists of recipients who require the
1335 constant availability of routine medical and nursing treatment
1336 and care, and require extensive health-related care and services
1337 because of mental or physical incapacitation.

1338 (c) Level of care 3 consists of recipients who require the
1339 constant availability of routine medical and nursing treatment
1340 and care, have a limited need for health-related care and
1341 services, are mildly medically or physically incapacitated, and
1342 have a priority score of 5 or above.

1343
1344 The agency shall periodically adjust payment rates to account
1345 for changes in the level of care profile for each plan based on
1346 encounter data.

1347 (5) The incentive adjustment for reducing institutional
1348 placements shall be modified in each successive rate period
1349 during the contract in order to encourage a progressive
1350 rebalancing of the spending distribution for institutional and
1351 community services. The expected change toward more home and
1352 community-based services shall be at least a 3 percent, up to a
1353 5 percent, annual increase in the ratio of home and community-
1354 based service expenditures compared to nursing facility
1355 expenditures.

1356 (6) The agency shall establish nursing facility-specific
1357 payment rates for each licensed nursing home based on facility
1358 costs adjusted for inflation and other factors. Payments to
1359 long-term care managed care plans shall be reconciled to
1360 reimburse actual payments to nursing facilities.

1361 (7) The agency shall establish hospice payment rates.
1362 Payments to long-term care managed care plans shall be
1363 reconciled to reimburse actual payments to hospices.

1364 Section 25. Section 409.984, Florida Statutes, is created
1365 to read:

1366 409.984 Choice counseling; enrollment.—

1367 (1) CHOICE COUNSELING.—Before contracting with a vendor to
1368 provide choice counseling as authorized under s. 409.969, the
1369 agency shall offer to contract with aging resource centers
1370 established under s. 430.2053 for choice counseling services. If
1371 the aging resource center is determined not to be the vendor
1372 that provides choice counseling, the agency shall establish a
1373 memorandum of understanding with the aging resource center to
1374 coordinate staffing and collaborate with the choice counseling
1375 vendor.

1376 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
1377 enroll into a long-term care managed care plan those Medicaid
1378 recipients who do not voluntarily choose a plan pursuant to s.
1379 409.969. The agency shall automatically enroll recipients in
1380 plans that meet or exceed the performance or quality standards
1381 established pursuant to s. 409.967, and shall not automatically
1382 enroll recipients in a plan that is deficient in those
1383 performance or quality standards. The agency shall assign
1384 individuals who are deemed dually eligible for Medicaid and
1385 Medicare to a plan that provides both Medicaid and Medicare
1386 services. The agency may not engage in practices that are
1387 designed to favor one managed care plan over another. When

1388 automatically enrolling recipients in plans, the agency shall
 1389 take into account the following criteria:

1390 (a) Whether the plan has sufficient network capacity to
 1391 meet the needs of the recipients.

1392 (b) Whether the recipient has previously received services
 1393 from one of the plan's home and community-based service
 1394 providers.

1395 (c) Whether the home and community-based providers in one
 1396 plan are more geographically accessible to the recipient's
 1397 residence than those in other plans.

1398 (3) Notwithstanding the provisions of s. 409.969(3)(c),
 1399 when a recipient is referred for hospice services, the recipient
 1400 shall have a 30-day period during which the recipient may select
 1401 to enroll in another plan to access the hospice provider of the
 1402 recipient's choice.

1403 Section 26. Section 409.985, Florida Statutes, is created
 1404 to read:

1405 409.985 Comprehensive Assessment and Review for Long-Term
 1406 Care Services (CARES) Program.—

1407 (1) The agency shall operate the Comprehensive Assessment
 1408 and Review for Long-Term Care Services (CARES) preadmission
 1409 screening program to ensure that only individuals whose
 1410 conditions require long-term care services are enrolled in the
 1411 long-term care managed care program.

1412 (2) The agency shall operate the CARES program through an
 1413 interagency agreement with the Department of Elderly Affairs.
 1414 The agency, in consultation with the Department of Elderly
 1415 Affairs, may contract for any function or activity of the CARES

1416 program, including any function or activity required by 42
1417 C.F.R. part 483.20, relating to preadmission screening and
1418 review.

1419 (3) The CARES program shall determine if an individual
1420 requires nursing facility care and, if the individual requires
1421 such care, assign the individual to a level of care as described
1422 in s. 409.983(4). For the purposes of the long-term care managed
1423 care program, "nursing facility care" means the individual:

1424 (a) Requires the constant availability of routine medical
1425 and nursing treatment and care, and requires extensive health-
1426 related care and services because of mental or physical
1427 incapacitation; or

1428 (b) Requires the constant availability of routine medical
1429 and nursing treatment and care, has a limited need for health-
1430 related care and services, is mildly medically or physically
1431 incapacitated, and has a priority score of 5 or above.

1432 (4) For individuals whose nursing home stay is initially
1433 funded by Medicare and Medicare coverage is being terminated for
1434 lack of progress towards rehabilitation, CARES staff shall
1435 consult with the person making the determination of progress
1436 toward rehabilitation to ensure that the recipient is not being
1437 inappropriately disqualified from Medicare coverage. If, in
1438 their professional judgment, CARES staff believes that a
1439 Medicare beneficiary is still making progress toward
1440 rehabilitation, they may assist the Medicare beneficiary with an
1441 appeal of the disqualification from Medicare coverage. The use
1442 of CARES teams to review Medicare denials for coverage under
1443 this section is authorized only if it is determined that such

1444 reviews qualify for federal matching funds through Medicaid. The
1445 agency shall seek or amend federal waivers as necessary to
1446 implement this section.

1447 Section 27. Section 409.986, Florida Statutes, is created
1448 to read:

1449 409.986 Managed long-term care for persons with
1450 developmental disabilities.-

1451 (1) Pursuant to s. 409.963, the agency is responsible for
1452 administering the long-term care managed care program for
1453 persons with developmental disabilities described in ss.
1454 409.986-409.992, but may delegate specific duties and
1455 responsibilities for the program to the Agency for Persons with
1456 Disabilities and other state agencies. By January 1, 2014, the
1457 agency shall begin implementation of statewide long-term care
1458 managed care for persons with developmental disabilities, with
1459 full implementation in all regions by October 1, 2015.

1460 (2) The agency shall make payments for long-term care for
1461 persons with developmental disabilities, including home and
1462 community-based services, using a managed care model. Unless
1463 otherwise specified, the provisions of ss. 409.961-409.970 apply
1464 to the long-term care managed care program for persons with
1465 developmental disabilities.

1466 (3) The Agency for Persons with Disabilities shall assist
1467 the agency to develop the specifications for use in the
1468 invitations to negotiate and the model contract; determine
1469 clinical eligibility for enrollment in long-term care plans for
1470 persons with developmental disabilities; assist the agency to
1471 monitor plan performance and measure quality; assist clients and

1472 families to address complaints with the plans; facilitate
 1473 working relationships between plans and providers serving
 1474 persons with developmental disabilities; and perform other
 1475 functions specified in a memorandum of agreement.

1476 Section 28. Section 409.987, Florida Statutes, is created
 1477 to read:

1478 409.987 Eligibility.-

1479 (1) Medicaid recipients who meet all of the following
 1480 criteria are eligible to be enrolled in a developmental
 1481 disabilities comprehensive long-term care plan or developmental
 1482 disabilities long-term care plan:

1483 (a) Medicaid eligible pursuant to income and asset tests
 1484 in state and federal law.

1485 (b) A Florida resident who has a developmental disability
 1486 as defined in s. 393.063.

1487 (c) Meets the level of care need including:

1488 1. The recipient's intelligence quotient is 59 or less;

1489 2. The recipient's intelligence quotient is 60-69,

1490 inclusive, and the recipient has a secondary handicapping

1491 condition that includes cerebral palsy, spina bifida, Prader-

1492 Willi syndrome, epilepsy, or autism; or ambulation, sensory,

1493 chronic health, and behavioral problems;

1494 3. The recipient's intelligence quotient is 60-69,

1495 inclusive, and the recipient has severe functional limitations

1496 in at least three major life activities including self-care,

1497 learning, mobility, self-direction, understanding and use of

1498 language, and capacity for independent living; or

1499 4. The recipient is eligible under a primary disability of
 1500 autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.
 1501 In addition, the condition must result in substantial functional
 1502 limitations in three or more major life activities, including
 1503 self-care, learning, mobility, self-direction, understanding and
 1504 use of language, and capacity for independent living.

1505 (d) Meets the level of care need for services in an
 1506 intermediate care facility for the developmentally disabled.

1507 (e) Is enrolled or has been offered enrollment in one of
 1508 the four tier waivers established in s. 393.0661(3) or the
 1509 recipient is a Medicaid-funded resident of a private
 1510 intermediate care facility for the developmentally disabled on
 1511 the date the managed long-term care plans for persons with
 1512 disabilities become available in the recipient's region or the
 1513 recipient has been offered enrollment in a developmental
 1514 disabilities comprehensive long-term care plan or developmental
 1515 disabilities long-term care plan.

1516 (2) Unless specifically exempted, all eligible persons
 1517 must be enrolled in a developmental disabilities comprehensive
 1518 long-term care plan or a developmental disabilities long-term
 1519 care plan. Medicaid recipients who are residents of a
 1520 developmental disability center, including Sunland Center in
 1521 Marianna and Tacachale Center in Gainesville, are exempt from
 1522 mandatory enrollment but may voluntarily enroll in a long-term
 1523 care plan.

1524 Section 29. Section 409.988, Florida Statutes, is created
 1525 to read:

1526 409.988 Benefits.-Managed care plans shall cover, at a

1527 minimum, the services in this section. Plans may customize
 1528 benefit packages or offer additional benefits to meet the needs
 1529 of enrollees in the plan.

1530 (1) Intermediate care for the developmentally disabled.

1531 (2) Alternative residential services, including, but not
 1532 limited to:

1533 (a) Group homes and foster care homes licensed pursuant to
 1534 chapters 393 and 409.

1535 (b) Comprehensive transitional education programs licensed
 1536 pursuant to chapter 393.

1537 (c) Residential habilitation centers licensed pursuant to
 1538 chapter 393.

1539 (d) Assisted living facilities, and transitional living
 1540 facilities licensed pursuant to chapters 400 and 429.

1541 (3) Adult day training.

1542 (4) Behavior analysis services.

1543 (5) Companion services.

1544 (6) Consumable medical supplies.

1545 (7) Durable medical equipment and supplies.

1546 (8) Environmental accessibility adaptations.

1547 (9) In-home support services.

1548 (10) Therapies, including occupational, speech,
 1549 respiratory, and physical therapy.

1550 (11) Personal care assistance.

1551 (12) Residential habilitation services.

1552 (13) Intensive behavioral residential habilitation
 1553 services.

1554 (14) Behavior focus residential habilitation services.

1555 (15) Residential nursing services.

1556 (16) Respite care.

1557 (17) Case management.

1558 (18) Supported employment.

1559 (19) Supported living coaching.

1560 (20) Transportation.

1561 Section 30. Section 409.989, Florida Statutes, is created
1562 to read:

1563 409.989 Qualified plans.—

1564 (1) QUALIFIED PLANS.—Qualified plans that are a provider
1565 service network or the Children's Medical Services Network
1566 authorized under chapter 391 may be either developmental
1567 disabilities long-term care plans that cover benefits pursuant
1568 to s. 409.988, or developmental disabilities comprehensive long-
1569 term care plans that cover benefits pursuant to ss. 409.973 and
1570 409.988. Other qualified plans may only be developmental
1571 disabilities comprehensive long-term care plans that cover
1572 benefits pursuant to ss. 409.973 and 409.988.

1573 (2) SPECIALTY PROVIDER SERVICE NETWORKS.—Provider service
1574 networks targeted to serve persons with disabilities must
1575 include one or more owners licensed pursuant to s. 393.067 or s.
1576 400.962 and with at least 10 years experience in serving this
1577 population.

1578 (3) QUALIFIED PLAN SELECTION.—The agency shall select
1579 qualified plans through the procurement described in s. 409.966.
1580 The agency shall notice invitations to negotiate no later than
1581 January 1, 2014.

1582 (a) The agency shall procure two plans for Region I. At
1583 least one plan shall be a provider service network, if any
1584 submit a responsive bid.

1585 (b) The agency shall procure at least two and no more than
1586 five plans for Region II. At least one plan shall be a provider
1587 service network, if any submit a responsive bid.

1588 (c) The agency shall procure at least three plans and no
1589 more than six plans for Region III. At least one plan shall be a
1590 provider service network, if any submit a responsive bid.

1591 (d) The agency shall procure at least three plans and no
1592 more than six plans for Region IV. At least one plan shall be a
1593 provider service network if any submit a responsive bid.

1594 (e) The agency shall procure at least three plans and no
1595 more than six plans for Region V. At least one plan shall be a
1596 provider service network, if any submit a responsive bid.

1597 (f) The agency shall procure at least three plans and no
1598 more than six plans for Region VI. At least one plan shall be a
1599 provider service network, if any submit a responsive bid.

1600 If no provider service network submits a responsive bid, the
1601 agency shall procure no more than one less than the maximum
1602 number of qualified plans permitted in that region. Within 12
1603 months after the initial invitation to negotiate, the agency
1604 shall attempt to procure a qualified plan that is a provider
1605 service network. The agency shall notice another invitation to
1606 negotiate only with provider service networks in such region
1607 where no provider service network has been selected.

1608 (4) QUALITY SELECTION CRITERIA.—In addition to the
 1609 criteria established in s. 409.966, the agency shall consider
 1610 the following factors in the selection of qualified plans:

1611 (a) Specialized staffing. Plan employment of executive
 1612 managers with expertise and experience in serving persons with
 1613 developmental disabilities.

1614 (b) Network qualifications. Plan establishment of a
 1615 network of service providers dispersed throughout the region and
 1616 in sufficient numbers to meet specific accessibility standards
 1617 established by the agency for specialty services for persons
 1618 with developmental disabilities.

1619 (c) Whether the plan has proposed to be a developmental
 1620 disabilities comprehensive long-term care plan and has a
 1621 contract to provide managed medical assistance services in the
 1622 same region. The agency shall exercise a preference for such
 1623 plans.

1624 (d) Whether the plan offers consumer-directed care
 1625 services to enrollees pursuant to s. 409.221. Consumer-directed
 1626 care services provide a flexible budget which is managed by
 1627 enrolled individuals and their families or representatives and
 1628 allows them to choose providers of services, determine provider
 1629 rates of payment and direct the delivery of services to best
 1630 meet their special long-term care needs. When all other factors
 1631 are equal among competing qualified plans, the agency shall
 1632 exercise a preference for such plans.

1633 (e) Evidence that a qualified plan has written agreements
 1634 or signed contracts or has made substantial progress in
 1635 establishing relationships with providers prior to the plan

1636 submitting a response. The agency shall evaluate and give
 1637 special weight to evidence of signed contracts with providers of
 1638 critical services pursuant to s. 409.990(2)a)-(b).

1639 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's
 1640 Medical Services Network authorized under chapter 391 is a
 1641 qualified plan for purposes of the developmental disabilities
 1642 long-term care plans and developmental disabilities
 1643 comprehensive long-term care plans. Participation by the
 1644 Children's Medical Services Network shall be pursuant to a
 1645 single, statewide contract with the agency not subject to the
 1646 procurement requirements or regional plan number limits of this
 1647 section. The Children's Medical Services Network must meet all
 1648 other plan requirements.

1649 Section 31. Section 409.990, Florida Statutes, is created
 1650 to read:

1651 409.990 Managed care plan accountability.—In addition to
 1652 the requirements of s. 409.967, qualified plans and providers
 1653 shall comply with the requirements of this section.

1654 (1) MEDICAL LOSS RATIO.—The agency shall establish and
 1655 plans shall use a uniform method of accounting and reporting
 1656 long-term care service costs, direct care management costs, and
 1657 administrative costs. The agency shall evaluate plan spending
 1658 patterns beginning after the plan completes 2 full years of
 1659 operation and at least annually thereafter. The agency shall
 1660 implement the following thresholds and consequences of various
 1661 spending patterns:

1662 (a) Plans that spend less than 75 percent of Medicaid
 1663 premium revenue on long-term care services, including direct

1664 care management as determined by the agency shall be excluded
 1665 from automatic enrollments and shall be required to pay back the
 1666 amount between actual spending and 92 percent of the Medicaid
 1667 premium revenue.

1668 (b) Plans that spend less than 92 percent of Medicaid
 1669 premium revenue on long-term care services, including direct
 1670 care management as determined by the agency shall be required to
 1671 pay back the amount between actual spending and 92 percent of
 1672 the Medicaid premium revenue.

1673 (2) PROVIDER NETWORKS.—Plans may limit the providers in
 1674 their networks based on credentials, quality indicators, and
 1675 price. However, in the first contract period after a qualified
 1676 plan is selected in a region by the agency, the plan must offer
 1677 a network contract to the following providers in the region:

1678 (a) Providers with licensed institutional care facilities
 1679 for the developmentally disabled.

1680 (b) Providers of alternative residential facilities
 1681 specified in s.409.988.

1682
 1683 After 12 months of active participation in a plan's network, the
 1684 plan may exclude any of the above-named providers from the
 1685 network for failure to meet quality or performance criteria. If
 1686 the plan excludes a provider from the plan, the plan must
 1687 provide written notice to all recipients who have chosen that
 1688 provider for care. The notice shall be issued at least 90 days
 1689 before the effective date of the exclusion.

1690 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
 1691 this subsection, providers may limit the plans they join.

1692 Licensed institutional care facilities for the developmentally
 1693 disabled with an active Medicaid provider agreement must agree
 1694 to participate in any qualified plan selected by the agency in
 1695 the region in which the provider is located.

1696 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
 1697 quality and performance of each participating provider. At the
 1698 beginning of the contract period, each plan shall notify all its
 1699 network providers of the metrics used by the plan for evaluating
 1700 the provider's performance and determining continued
 1701 participation in the network.

1702 (5) PROVIDER PAYMENT.—Plans and providers shall negotiate
 1703 mutually acceptable rates, methods, and terms of payment. Plans
 1704 shall pay intermediate care facilities for the developmentally
 1705 disabled an amount equal to the facility-specific payment rate
 1706 set by the agency.

1707 (6) CONSUMER AND FAMILY INVOLVEMENT.—Plans must establish
 1708 a family advisory committee to participate in program design and
 1709 oversight.

1710 Section 32. Section 409.991, Florida Statutes, is created
 1711 to read:

1712 409.991 Managed care plan payment.—In addition to the
 1713 payment provisions of s. 409.968, the agency shall provide
 1714 payment to developmental disabilities comprehensive long-term
 1715 care plans and developmental disabilities long-term care plans
 1716 pursuant to this section.

1717 (1) Prepaid payment rates shall be negotiated between the
 1718 agency and the qualified plans as part of the procurement
 1719 described in s. 409.966.

1720 (2) Payment for developmental disabilities comprehensive
1721 long-term care plans covering services pursuant to s. 409.973
1722 shall be combined with payments for developmental disabilities
1723 long-term care plans for services specified in s. 409.988.

1724 (3) Payment rates for plans covering service specified in
1725 s. 409.988 shall be based on historical utilization and spending
1726 for covered services projected forward and adjusted to reflect
1727 the level of care profile of each plan's enrollees.

1728 (4) The Agency for Persons with Disabilities shall conduct
1729 the initial assessment of an enrollee's level of care. The
1730 evaluation of level of care shall be based on assessment and
1731 service utilization information from the most recent version of
1732 the Questionnaire for Situational Information and encounter
1733 data.

1734 (5) Payment rates for developmental disabilities long-term
1735 care plans shall be classified into five levels of care to
1736 account for variations in risk status and service needs among
1737 enrollees.

1738 (a) Level of care 1 consists of individuals receiving
1739 services in an intermediate care facility for the
1740 developmentally disabled.

1741 (b) Level of care 2 consists of individuals with intensive
1742 medical or adaptive needs and that are essential for avoiding
1743 institutionalization, or who possess behavioral problems that
1744 are exceptional in intensity, duration, or frequency and present
1745 a substantial risk of harm to themselves or others.

1746 (c) Level of care 3 consists of individuals with service
1747 needs, including a licensed residential facility and a moderate

1748 level of support for standard residential habilitation services
 1749 or a minimal level of support for behavior focus residential
 1750 habilitation services, or individuals in supported living who
 1751 require more than 6 hours a day of in-home support services.

1752 (d) Level of care 4 consists of individuals requiring less
 1753 than moderate level of residential habilitation support in a
 1754 residential placement, or individuals in independent or
 1755 supported living situations, or who live in their family home.

1756 (e) Level of care 5 consists of individuals requiring
 1757 minimal support services while living in independent or
 1758 supported living situations and individuals who live in their
 1759 family home.

1760
 1761 The agency shall periodically adjust payment rates to account
 1762 for changes in the level of care profile of each plan's
 1763 enrollees based on encounter data.

1764 (6) The agency shall establish intensive behavior
 1765 residential habilitation rates for providers approved by the
 1766 agency to provide this service. The agency shall also establish
 1767 intermediate care facility for the developmentally disabled-
 1768 specific payment rates for each licensed intermediate care
 1769 facility based on facility costs adjusted for inflation and
 1770 other factors. Payments to intermediate care facilities for the
 1771 developmentally disabled and providers of intensive behavior
 1772 residential habilitation service shall be reconciled to
 1773 reimburse the plan's actual payments to the facilities.

1774 Section 33. Section 409.992, Florida Statutes, is created
 1775 to read:

1776 409.992 Automatic enrollment.—
1777 (1) The agency shall automatically enroll into a
1778 developmental disabilities comprehensive long-term care plan or
1779 a developmental disabilities long-term care plan those Medicaid
1780 recipients who do not voluntarily choose a plan pursuant to s.
1781 409.969. The agency shall automatically enroll recipients in
1782 plans that meet or exceed the performance or quality standards
1783 established pursuant to s. 409.967, and shall not automatically
1784 enroll recipients in a plan that is deficient in those
1785 performance or quality standards. The agency shall assign
1786 individuals who are deemed dually eligible for Medicaid and
1787 Medicare, to a plan that provides both Medicaid and Medicare
1788 services. The agency may not engage in practices that are
1789 designed to favor one managed care plan over another. When
1790 automatically enrolling recipients in plans, the agency shall
1791 take into account the following criteria:
1792 (a) Whether the plan has sufficient network capacity to
1793 meet the needs of the recipients.
1794 (b) Whether the recipient has previously received services
1795 from one of the plan's home and community-based service
1796 providers.
1797 (c) Whether home and community-based providers in one plan
1798 are more geographically accessible to the recipient's residence
1799 than those in other plans.
1800 Section 34. This act shall take effect July 1, 2010.