Amendment No.

CHAMBER ACTION

Senate House

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1 Representative Pafford offered the following:

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3 **Amendment (with title amendment)**

4 Remove everything after the enacting clause and insert:

5 Section 1. It is the intent of the Legislature to ensure
6 that all Medicaid recipients receive medically necessary,
7 quality care through the provider of their choice. In Florida's
8 medical marketplace, managed care plans are responsible for the
9 health care of almost 50 percent of Medicaid recipients.
10 Therefore, the Legislature finds it is in the state's interest
11 to ensure managed care plans are delivering appropriate quality
12 services and are held accountable for the proper use of taxpayer
13 dollars.

14 Section 2. Sections 409.961 through 409.697, Florida
15 Statutes, are designated as part IV of chapter 409, Florida
16 Statutes, entitled "Medicaid Managed Care Accountability Act."

17 Section 3. Section 409.961, Florida Statutes, is created
18 to read:
19 409.961 Definitions.—As used in this part, except as
20 otherwise specifically provided, the term:
21 (1) "Agency" means the Agency for Health Care
22 Administration.
23 (2) "Department" means the Department of Children and
24 Family Services.
25 (3) "Direct care management" means care management
26 activities that involve direct interaction with Medicaid
27 recipients.
28 (4) "Eligible plan" means a health insurer authorized
29 under chapter 624, an exclusive provider organization authorized
30 under chapter 627, a health maintenance organization authorized
31 under chapter 641, or a provider service network authorized
32 under s. 409.912(4)(d).
33 (5) "Managed care plan" means an eligible plan under
34 contract with the agency to provide services in the Medicaid
35 program.
36 (6) "Medicaid" means the medical assistance program
37 authorized by Title XIX of the Social Security Act, 42 U.S.C. 81
38 ss. 1396 et seq., and regulations thereunder, as administered in
39 this state by the agency.
40 (7) "Medicaid recipient" or "recipient" means an
41 individual who the department or, for Supplemental Security
42 Income, the Social Security Administration, determines is
43 eligible pursuant to federal and state law to receive medical
44 assistance and related services for which the agency may make

45 payments under the Medicaid program. For the purposes of
46 determining third-party liability, the term includes an
47 individual formerly determined to be eligible for Medicaid, an
48 individual who has received medical assistance under the
49 Medicaid program, or an individual on whose behalf Medicaid has
50 become obligated.
51 (8) "Prepaid plan" means a managed care plan that is
52 licensed or certified as a risk-bearing entity, or qualified
53 pursuant to s. 409.912(4)(d), in the state and is paid a
54 prospective per-member, per-month payment by the agency.
55 (9) "Provider service network" means an entity qualified
56 pursuant to s. 409.912(4)(d) of which a controlling interest is
57 owned by a health care provider, or group of affiliated
58 providers, or a public agency or entity that delivers health
59 services. Health care providers include Florida-licensed health
60 care professionals or licensed health care facilities, federally
61 qualified health care centers, and home health care agencies.
62 (10) "Specialty plan" means a managed care plan that
63 serves Medicaid recipients who meet specified criteria based on
64 age, medical condition, or diagnosis.
65 Section 4. Section 409.962, Florida Statutes, is created
66 to read:
67 409.962 Single state agency.—The Agency for Health Care
68 Administration is designated as the single state agency
69 authorized to manage, operate, and make payments for medical
70 assistance and related services under Title XIX of the Social
71 Security Act. Subject to any limitations or directions provided
72 for in the General Appropriations Act, these payments may be

73 made only for services included in the program, only on behalf
74 of eligible individuals, and only to qualified providers in
75 accordance with federal requirements for Title XIX of the Social
76 Security Act and the provisions of state law. This program of
77 medical assistance is designated as the "Medicaid program." The
78 department is responsible for Medicaid eligibility
79 determinations, including, but not limited to, policy, rules,
80 and the agreement with the Social Security Administration for
81 Medicaid eligibility determinations for Supplemental Security
82 Income recipients, as well as the actual determination of
83 eligibility. As a condition of Medicaid eligibility, subject to
84 federal approval, the agency and the department shall ensure
85 that each Medicaid recipient consents to the release of her or
86 his medical records to the agency and the Medicaid Fraud Control
87 Unit of the Department of Legal Affairs.
88 Section 5. Section 409.963, Florida Statutes, is created
89 to read:
90 409.963 Medicaid managed care contracting accountability.—
91 (1) The agency shall establish such contract requirements
92 as are necessary for the operation of the managed care program.
93 In addition to any other provisions the agency may deem
94 necessary, the contract shall require:
95 (a) Emergency services.—Managed care plans shall pay for
96 services required by ss. 395.1041 and 401.45 and rendered by a
97 noncontracted provider pursuant to s. 641.3155. Reimbursement
98 for services under this paragraph shall be the lesser of:
99 1. The provider's charges;

100 2. The usual and customary provider charges for similar
101 services in the community where the services were provided;
102 3. The charge mutually agreed to by the entity and the
103 provider within 60 days after submittal of the claim; or
104 4. The rate the agency would have paid on the first day of
105 the contract between the provider and the plan.
106 (b) Access.—The agency shall establish specific standards
107 for the number, type, and distribution of providers in managed
108 care plan networks to ensure access to care for both adults and
109 children. Each plan must maintain a network of providers in
110 sufficient numbers to meet the access standards for specific
111 medical services for all recipients enrolled in the plan.
112 Consistent with the standards established by the agency,
113 provider networks may include providers located throughout the
114 state. Plans may contract with a new hospital facility before
115 the date it becomes operational if the hospital has commenced
116 construction, will be licensed and operational by January 1,
117 2013, and a final order has issued in any civil or
118 administrative challenge. Each plan shall establish and maintain
119 an accurate and complete electronic database of contracted
120 providers, including information about licensure or
121 registration, locations and hours of operation, specialty
122 credentials and other certifications, specific performance
123 indicators, including complaints as defined by s. 641.47 and
124 action taken on such complaints, and such other information as
125 the agency deems necessary. The database shall be available
126 online to both the agency and the public and compare the
127 availability of providers to network adequacy standards and

128 shall display feedback from each provider's patients. Each plan
129 shall submit quarterly reports to the agency identifying the
130 number of enrollees assigned to each primary care provider.
131 (c) Encounter data.—The agency shall maintain and operate
132 a Medicaid Encounter Data System to collect, process, store, and
133 report on covered services provided to all Medicaid recipients.
134 The system shall provide a standard consistent methodology for
135 reporting such data.
136 1. Each prepaid plan must comply with the agency's
137 reporting requirements for the Medicaid Encounter Data System.
138 Prepaid plans must submit encounter data electronically in a
139 format that complies with the Health Insurance Portability and
140 Accountability Act provisions for electronic claims and in
141 accordance with deadlines established by the agency. Prepaid
142 plans must certify that the data reported is accurate and
143 complete.
144 2. The agency is responsible for validating the data
145 submitted by the plans. The agency shall develop methods and
146 protocols for ongoing analysis of the encounter data that
147 adjusts for differences in characteristics of prepaid plan
148 enrollees to allow comparison of service utilization among plans
149 and other Medicaid providers such as MediPass and other non-
150 prepaid Medicaid providers against expected levels of use. The
151 analysis shall be used to identify possible cases of systemic
152 underutilization or denials of claims and inappropriate service
153 utilization such as higher-than-expected emergency department
154 encounters. The analysis shall provide quarterly feedback to the
155 plans and enable the agency to establish corrective action plans

156 when necessary. One of the focus areas for the analysis shall be
157 the use of prescription drugs.
158 3. The agency shall make encounter data available to those
159 plans accepting enrollees who are assigned to them from other
160 plans.
161 (d) Continuous improvement.—The agency shall establish
162 specific performance standards and expected milestones or
163 timelines for improving performance over the term of the
164 contract. By the end of the first year of the first contract
165 term, the agency shall issue a request for information to
166 determine whether cost savings could be achieved by contracting
167 for plan oversight and monitoring, including analysis of
168 encounter data, assessment of performance measures, and
169 compliance with other contractual requirements. Each managed
170 care plan shall establish an internal health care quality
171 improvement system, including enrollee satisfaction and
172 disenrollment surveys. The quality improvement system shall
173 include incentives and disincentives for network providers.
174 (e) Program integrity.—Each managed care plan shall
175 establish program integrity functions and activities to reduce
176 the incidence of fraud and abuse, including, at a minimum:
177 1. A provider credentialing system and ongoing provider
178 monitoring;
179 2. An effective prepayment and postpayment review process
180 including, but not limited to, data analysis, system editing,
181 and auditing of network providers;
182 3. Procedures for reporting instances of fraud and abuse
183 pursuant to chapter 641;

184 4. Administrative and management arrangements or
185 procedures, including a mandatory compliance plan, designed to
186 prevent fraud and abuse; and
187 5. Designation of a program integrity compliance officer.
188 (f) Complaint and grievance resolution.—Each managed care
189 plan shall establish and the agency shall approve an internal
190 process for reviewing and responding to complaints and
191 grievances from enrollees consistent with the requirements of
192 ss. 641.47 and 641.511. Each plan shall submit quarterly reports
193 on the number, description, and outcome of complaints and
194 grievances filed by enrollees. The agency shall maintain a
195 process for provider service networks consistent with s.
196 408.7056. Such reports from each plan shall be posted online
197 through the agency website in an easily accessible location.
198 (g) Penalties.—Managed care plans that reduce enrollment
199 levels before the end of the contract term shall reimburse the
200 agency for the cost of enrollment changes and other transition
201 activities, including the cost of additional choice counseling
202 services. If more than one plan leaves at the same time, costs
203 shall be shared by the departing plans proportionate to their
204 enrollments. In addition to the payment of costs, departing
205 provider services networks shall pay a per-enrollee penalty not
206 to exceed 3 months' payment and shall continue to provide
207 services to the enrollee for 90 days or until the enrollee is
208 enrolled in another plan, whichever is sooner. In addition to
209 payment of costs, all other plans shall pay a penalty equal to
210 25 percent of the minimum surplus requirement pursuant to s.

211 641.225(1). Plans shall provide the agency notice no less than
212 180 days before withdrawing.
213 (h) Prompt payment.—Managed care plans shall comply with
214 ss. 641.315, 641.3155, and 641.513.
215 (i) Electronic claims.—Managed care plans shall accept
216 electronic claims in compliance with federal standards.
217 (j) Fair payment.—Provider service networks must ensure
218 that no network provider with a controlling interest in the
219 network charges any Medicaid managed care plan more than the
220 amount paid to that provider by the provider service network for
221 the same service.
222 (k) Medical loss ratio.—The agency shall implement the
223 following thresholds and consequences regarding various spending
224 patterns for qualified plans under the managed medical
225 assistance component of the Medicaid managed care program:
226 1. The minimum medical loss ratio shall be 90 percent.
227 2. A plan that spends less than 90 percent of its Medicaid
228 capitation revenue on medical services and direct care
229 management, as determined by the agency, must pay back to the
230 agency a share of the dollar difference between the plan's
231 actual medical loss ratio and the minimum medical loss ratio, as
232 follows:
233 a. If the plan's actual medical loss ratio is not lower
234 than 87 percent, the plan must pay back 50 percent of the dollar
235 difference between the actual medical loss ratio and the minimum
236 medical loss ratio of 90 percent.
237 b. If the plan's actual medical loss ratio is lower than
238 87 percent, the plan must pay back 50 percent of the dollar

239 difference between a medical loss ratio of 87 percent and the
240 minimum medical loss ratio of 90 percent, plus 100 percent of
241 the dollar difference between the actual medical loss ratio and
242 a medical loss ratio of 87 percent.
243 (2) The agency shall adopt rules that specify a
244 methodology for calculating medical loss ratios and the
245 requirements for plans to annually report information related to
246 medical loss ratios. Repayments required under this section must
247 be made annually.
248 Section 6. Section 409.964, Florida Statutes, is created
249 to read:
250 409.964 Enrollment; choice counseling; automatic
251 assignment; disenrollment.—
252 (1) ENROLLMENT.—Medicaid recipients may enroll in a
253 managed care plan. Each recipient shall have a choice of plans
254 including MediPass and may select any available plan unless that
255 plan is restricted by contract to a specific population that
256 does not include the recipient. Medicaid recipients shall have
257 30 days in which to make a choice of plans. All recipients shall
258 be offered choice counseling services in accordance with this
259 section. For any month during which the choice counseling vendor
260 described in subsection (3) is found to be out of compliance
261 with its contract with the agency, the 30-day limit shall be
262 suspended.
263 (2) AUTOMATIC ASSIGNMENT.—The agency shall automatically
264 enroll into a managed care plan 50 percent of those Medicaid
265 recipients who do not voluntarily choose a plan. The remaining
266 50 percent shall be enrolled in the MediPass program. The agency

267 shall automatically enroll recipients in plans that meet or
268 exceed the performance or quality standards established in this
269 part and may not automatically enroll recipients in a plan that
270 is deficient in those performance or quality standards. When a
271 specialty plan is available to accommodate a specific condition
272 or diagnosis of a recipient, the agency shall assign the
273 recipient to that plan. In the first year of the first contract
274 term only, if a recipient was previously enrolled in a plan that
275 is still available, the agency shall automatically enroll the
276 recipient in that plan unless an applicable specialty plan is
277 available. Except as otherwise provided in this part, the agency
278 may not engage in practices that are designed to favor one
279 managed care plan over another. When automatically enrolling
280 recipients in managed care plans, the agency shall automatically
281 enroll based on the following criteria:
282 (a) Whether the plan has sufficient network capacity to
283 meet the needs of the recipients.
284 (b) Whether the recipient has previously received services
285 from one of the plan's primary care providers.
286 (c) Whether primary care providers in one plan are more
287 geographically accessible to the recipient's residence than
288 those in other plans.
289 (3) CHOICE COUNSELING.—The agency shall provide choice
290 counseling for Medicaid recipients. The agency may contract for
291 the provision of choice counseling. Any such contract shall be
292 with a vendor that employs Floridians to accomplish the contract
293 requirements and shall be for a period of 2 years. The agency
294 may renew a contract for an additional 2-year period; however,

295 before renewal of the contract the agency shall hold at least
296 one public meeting in each of the areas covered by the choice
297 counseling vendor. The agency may extend the term of the
298 contract to cover any delays in transition to a new contractor.
299 Printed choice information and choice counseling shall be
300 offered in the native or preferred language of the recipient,
301 consistent with federal requirements. The manner and method of
302 choice counseling shall be modified as necessary to ensure
303 culturally competent, effective communication with people from
304 diverse cultural backgrounds. The agency shall maintain a record
305 of the recipients who receive such services, identifying the
306 scope and method of the services provided. The agency shall make
307 available clear and easily understandable choice information to
308 Medicaid recipients that includes:
309 (a) An explanation that each recipient has the right to
310 choose a managed care plan including MediPass at the time of
311 enrollment in Medicaid and again at regular intervals set by the
312 agency, and that if a recipient does not choose a plan, the
313 agency shall assign the recipient according to the criteria
314 specified in this section.
315 (b) A list and description of the benefits provided and
316 excluded by each managed care plan.
317 (c) An explanation of benefit limits.
318 (d) A current list of providers participating in the
319 network, including location and contact information. Such lists
320 shall be updated monthly.
321 (e) Managed care plan performance and encounter data.
322 (f) A list of complaints filed and action taken.

323 (4) DISENROLLMENT.—After a recipient has enrolled in a
324 managed care plan, the recipient may change providers within the
325 plan. The recipient may disenroll and select another plan with a
326 30-day notice to the agency and the plan from which the
327 recipient is disenrolling. The agency must monitor plan
328 disenrollment throughout the contract term to identify any
329 discriminatory practices.
330 Section 7. Section 409.965, Florida Statutes, is created
331 to read:
332 409.965 Benefits.—
333 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a
334 minimum, the following services:
335 (a) Advanced registered nurse practitioner services.
336 (b) Ambulatory surgical treatment center services.
337 (c) Birthing center services.
338 (d) Chiropractic services.
339 (e) Dental services.
340 (f) Early periodic screening diagnosis and treatment
341 services for recipients under age 21.
342 (g) Emergency services.
343 (h) Family planning services and supplies.
344 (i) Healthy start services.
345 (j) Hearing services.
346 (k) Home health agency services.
347 (l) Hospice services.
348 (m) Hospital inpatient services.
349 (n) Hospital outpatient services.
350 (o) Laboratory and imaging services.

351 (p) Medical supplies, equipment, prostheses, and orthoses.
352 (q) Mental health services.
353 (r) Nursing care.
354 (s) Optical services and supplies.
355 (t) Optometrist services.
356 (u) Physical, occupational, respiratory, and speech
357 therapy services.
358 (v) Physician services, including physician assistant
359 services.
360 (w) Podiatric services.
361 (x) Prescription drugs.
362 (y) Renal dialysis services.
363 (z) Respiratory equipment and supplies.
364 (aa) Rural health clinic services.
365 (bb) Substance abuse treatment services.
366 (cc) Transportation to access-covered services.
367 (2) AMOUNT, DURATION AND SCOPE.—Benefits and services
368 shall be provided in the amount and for the period of time
369 needed to achieve the health outcomes sought by the treating
370 health care provider.
371 Section 8. Section 409.966, Florida Statutes, is created
372 to read:
373 409.966 Managed care plan accountability.—In addition to
374 the requirements of s. 409.963, plans and providers
375 participating in the managed care program shall comply with the
376 requirements of this section.
377 (1) PROVIDER NETWORKS.—Plan provider networks must be
378 adequate to meet the needs of all recipients. To that end, plans

379 must enroll any willing provider in good standing with the
380 Medicaid program. For purposes of this subsection, a plan
381 provider network is adequate if any recipient in need of a
382 medically necessary service can access such service without
383 facing time, travel, or administrative constraints more
384 burdensome than would apply if such recipient were enrolled in
385 MediPass.
386 (2) COMPLAINT AND GRIEVANCE PROCESS.—Each plan must have
387 in place a process to address complaints and grievances
388 submitted by network providers. Such complaints and grievances
389 and their outcomes shall be posted on the plan's website.
390 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
391 monitor the quality and performance of each participating
392 provider. At the beginning of the contract period, each plan
393 shall notify all its network providers of the metrics used by
394 the plan for evaluating the provider's performance and
395 determining continued participation in the network.
396 (4) TRANSPORTATION.—Nonemergency transportation services
397 shall be provided pursuant to a single, statewide contract
398 between the agency and the Commission for the Transportation
399 Disadvantaged. The agency shall establish performance standards
400 in the contract and shall evaluate the performance of the
401 Commission for the Transportation Disadvantaged. For the
402 purposes to this subsection, nonemergency transportation does
403 not include transportation by ambulance and any medical services
404 received during transport.
405 (5) SCREENING RATE.—Each managed care plan shall achieve
406 an annual Early and Periodic Screening, Diagnosis, and Treatment

407 Service screening rate of at least 90 percent of those
408 recipients continuously enrolled for at least 8 months.
409 Section 9. Section 409.967, Florida Statutes, is created
410 to read:
411 409.967 Statutory construction; rules.—It is the intent of
412 the Legislature that if any conflict exists between the
413 provisions contained in ss. 409.962-409.967 and other provisions
414 of this chapter, the provisions contained in ss. 409.962-409.967
415 shall control. The agency shall adopt any rules necessary to
416 comply with or administer this part and all rules necessary to
417 comply with federal requirements.
418 Section 10. This act shall take effect July 1, 2011.
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421 ---
422 **T I T L E A M E N D M E N T**
423 Remove the entire title and insert:
424 A bill to be entitled
425 An act relating to Medicaid managed care; providing
426 legislative intent; creating pt. IV of ch. 409, F.S.,
427 entitled the "Medicaid Managed Care Accountability Act";
428 creating s. 409.961, F.S.; providing definitions; creating
429 s. 409.962, F.S.; designating the Agency for Health Care
430 Administration as the single state agency to administer
431 the Medicaid program; providing for specified agency
432 responsibilities; requiring client consent for release of
433 medical records; creating s. 409.963, F.S.; providing for
434 Medicaid managed care contracting accountability;

435 requiring plans to establish and maintain an electronic
436 database; establishing requirements for the database;
437 requiring plans to provide encounter data; requiring the
438 agency to maintain an encounter data system; requiring the
439 agency to establish performance standards for plans;
440 providing penalties for departing provider service
441 networks under certain circumstances; authorizing the
442 agency to adopt rules; requiring certain plans to make
443 repayments to based on medical loss ratios as determined
444 by the agency; creating s. 409.964, F.S.; providing for
445 enrollment, choice counseling, automatic assignment, and
446 disenrollment; creating s. 409.965, F.S.; providing for
447 minimum benefits and the amount, scope, and duration
448 thereof; creating s. 409.966, F.S.; providing for managed
449 care plan accountability; establishing a complaint and
450 grievance resolution process; requiring managed care plans
451 to monitor the quality and performance of participating
452 providers; providing for nonemergency transportation
453 services; providing screening rate standards; creating s.
454 409.967, F.S.; providing for statutory construction;
455 providing for the agency to adopt rules; providing an
456 effective date.