Amendment No.

CHAMBER ACTION

Senate House

.

Representative Cruz offered the following:

Amendment

Remove lines 414-1494 and insert:

(a) Region I, which shall consist of Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington Counties.

(b) Region II, which shall consist of Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties.

(c) Region III, which shall consist of Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Putnam, Suwannee, and Union Counties.

(d) Region IV, which shall consist of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties Counties.

(e) Region V, which shall consist of Hernando, Hillsborough, Pasco, Pinellas, and Polk Counties.

(f) Region VI, which shall consist of Brevard, Lake, Orange, Osceola, Seminole, and Sumter Counties.

(g) Region VII, which shall consist of DeSoto, Hardee, Highlands, Manatee, and Sarasota Counties.

(h) Region VIII, which shall consist of Indian River, Martin, Okeechobee, Palm Beach, and St.Lucie Counties.

(i) Region IX, which shall consist of Charlotte, Collier, Glades, Hendry, and Lee Counties.

(j) Region X, which shall consist of Broward County.

(k) Region XI, which shall consist of Miami-Dade and Monroe Counties.

(3) QUALITY SELECTION CRITERIA.—

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

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

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

3. Availability and accessibility of primary care and specialty physicians in the provider network.

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

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

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

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

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

9. The business relationship a qualified plan has with any other qualified plan that responds to the invitation to negotiate.

A qualified plan must disclose any business relationship it has with any other qualified plan that responds to the invitation to negotiate. The agency may not select plans in the same region that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification from participation in any region for the first

full contract period after the discovery of the business relationship by the agency. For the purpose of this section, "business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.

(b) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that demonstrate the following:

1. Signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(b).

2. Well-defined programs for recognizing patient-centered medical homes or accountable care organizations, and providing for increased compensation for recognized medical homes or accountable care organizations, as defined by the plan.

3. Greater net economic benefit to Florida compared to other bidders through employment of, or subcontracting with firms that employ, Floridians in order to accomplish the contract requirements. Contracts with such bidders shall specify performance measures to evaluate the plan's employment-based

economic impact. Valuation of the net economic benefit may not include employment of or subcontracts with providers.

(c) To ensure managed care plan participation in Region I, the agency shall award an additional contract to each plan with a contract award in Region I. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency.

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate in more than one region and is selected in at least one region may not begin serving Medicaid recipients in any region for which it was selected until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

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

409.967 Managed care plan accountability.—

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

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

(a) Emergency services.—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider pursuant to s. 641.3155. Reimbursement for services under this paragraph shall be the lesser of:

1. The provider's charges;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

4. The rate the agency would have paid on the first day of the contract between the provider and the plan.

(b) Access.—The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a region-wide network of providers in sufficient numbers to meet the access

standards for specific medical services for all recipients enrolled in the plan. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database shall be available online to both the agency and the public and shall have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

(c) Encounter data.—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and

Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

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

(d) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and

compliance with other contractual requirements. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system shall include incentives and disincentives for network providers.

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

1. A provider credentialing system and ongoing provider monitoring;

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

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

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

5. Designation of a program integrity compliance officer.

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

(g) Penalties.—Managed care plans that reduce enrollment

levels or leave a region before the end of the contract term shall reimburse the agency for the cost of enrollment changes and other transition activities, including the cost of additional choice counseling services. If more than one plan leaves a region at the same time, costs shall be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks shall pay a per enrollee penalty not to exceed 3 month's payment and shall continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever is sooner. In addition to payment of costs, all other plans shall pay a penalty equal to 25 percent of the minimum surplus requirement pursuant to s. 641.225(1). Plans shall provide the agency notice no less than 180 days before withdrawing from a region.

(h) Prompt payment.—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(i) Electronic claims.—Managed care plans shall accept electronic claims in compliance with federal standards.

(j) Fair payment.—Provider service networks must ensure that no network provider with a controlling interest in the network charges any Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(3) ACHIEVED SAVINGS REBATE.—

(a) The agency shall establish and the prepaid plans shall use a uniform method for annually reporting premium revenue, medical and administrative costs, and income or losses, across

all Florida Medicaid prepaid plan lines of business in all regions. The reports shall be due to the agency within 270 days after the conclusion of the reporting period and the agency may audit the reports. Achieved savings rebates shall be due within 30 days after the report is submitted. Except as provided in paragraph (b), the achieved savings rebate will be established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.

2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, with the other 50 percent refunded to the state.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state.

(b) A plan that meets or exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue.

(c) The following expenses may not be included in calculating income to the plan:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state or federal governments.

4. Expenses associated with lobbying activities.

5. Administrative, reinsurance, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

6. Any payment made pursuant to paragraph (f).

(d) Prepaid plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.

(e) If, after an audit or other reconciliation, the agency determines that a prepaid plan owes an additional rebate, the plan shall have 30 days after notification to make the payment. Upon failure to timely pay the rebate, the agency shall withhold future payments to the plan until the entire amount is recouped. If the agency determines that a prepaid plan has made an overpayment, the agency shall return the overpayment within 30 days.

(f) In addition to the reporting required by paragraph (a), prepaid plans shall annually submit a report, consistent with paragraph (a), which is specific to enrollees with developmental disabilities. The agency shall compare each plan's expenditures to the plan's aggregate premiums for this population. The difference between aggregate premiums and expenditures shall be shared equally between the plan and the state. The state share shall be returned to the Medicaid appropriation to serve people on the wait list for home and community-based services provided through individual budgets.

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

409.968 Managed care plan payments.—

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

(2) Provider service networks may be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 5 years of its operation in a given region. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter

of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.

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

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

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

(2) CHOICE COUNSELING.—The agency shall provide choice counseling for Medicaid recipients. The agency may contract for the provision of choice counseling. Any such contract shall be with a vendor that employs Floridians to accomplish the contract requirements and shall be for a period of 5 years. The agency may renew a contract for an additional 5-year period; however, before renewal of the contract the agency shall hold at least one public meeting in each of the regions covered by the choice counseling vendor. The agency may extend the term of the contract to cover any delays in transition to a new contractor. Printed choice information and choice counseling shall be offered in the native or preferred language of the recipient, consistent with federal requirements. The manner and method of

choice counseling shall be modified as necessary to ensure culturally competent, effective communication with people from diverse cultural backgrounds. The agency shall maintain a record of the recipients who receive such services, identifying the scope and method of the services provided. The agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

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

(b) A list and description of the benefits provided in each managed care plan.

(c) An explanation of benefit limits.

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

(e) Managed care plan performance data.

(3) DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. For purposes of this section, the term "good cause" includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may

require a recipient to use the plan's grievance process before the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged.

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

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

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

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

(e) The agency must monitor plan disenrollment throughout the contract term to identify any discriminatory practices.

Section 11. Section 409.97, Florida Statutes, is created to read:

409.97 State and local Medicaid partnerships.—

(1) INTERGOVERNMENTAL TRANSFERS.—In addition to the contributions required pursuant to s. 409.915, beginning in the 2014-2015 fiscal year, the agency may accept voluntary transfers of local taxes and other qualified revenue from counties, municipalities, and special taxing districts. Such transfers must be contributed to advance the general goals of the Florida Medicaid program without restriction and must be executed pursuant to a contract between the agency and the local funding source. Contracts executed before October 31 shall result in contributions to Medicaid for that same state fiscal year. Contracts executed between November 1 and June 30 shall result in contributions for the following state fiscal year. Based on the date of the signed contracts, the agency shall allocate to the low-income pool the first contributions received up to the limit established by subsection (2). No more than 40 percent of the low-income pool funding shall come from any single funding

source. Contributions in excess of the low-income pool shall be allocated to the disproportionate share programs defined in ss. 409.911(3) and 409.9113 and to hospital rates pursuant to subsection (4). The local funding source shall designate in the contract which Medicaid providers ensure access to care for low-income and uninsured people within the applicable jurisdiction and are eligible for low-income pool funding. Eligible providers may include both hospitals and primary care providers.

(2) LOW-INCOME POOL.—The agency shall establish and maintain a low-income pool in a manner authorized by federal waiver. The low-income pool is created to compensate a network of providers designated pursuant to subsection (1). Funding of the low-income pool shall be limited to the maximum amount permitted by federal waiver minus a percentage specified in the General Appropriations Act. The low-income pool must be used to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement, paying for otherwise uncompensated care, and financing coverage for the uninsured. The low-income pool shall be distributed in periodic payments to the Access to Care Partnership throughout the fiscal year. Distribution of low-income pool funds by the Access to Care Partnership to participating providers may be made through capitated payments, fees for services, or contracts for specific deliverables. The agency shall include the distribution amount for each provider in the contract with the Access to Care Partnership pursuant to subsection (3). Regardless of the method of distribution, providers participating in the Access to Care Partnership shall receive payments such that the aggregate benefit in the

jurisdiction of each local funding source, as defined in subsection (1), equals the amount of the contribution plus a factor specified in the General Appropriations Act.

(3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract with an administrative services organization that has operating agreements with all health care facilities, programs, and providers supported with local taxes or certified public expenditures and designated pursuant to subsection (1). The contract shall provide for enhanced access to care for Medicaid, low-income, and uninsured Floridians. The partnership shall be responsible for an ongoing program of activities that provides needed, but uncovered or undercompensated, health services to Medicaid enrollees and persons receiving charity care, as defined in s. 409.911. Accountability for services rendered under this contract must be based on the number of services provided to unduplicated qualified beneficiaries, the total units of service provided to these persons, and the effectiveness of services provided as measured by specific standards of care. The agency shall seek such plan amendments or waivers as may be necessary to authorize the implementation of the low-income pool as the Access to Care Partnership pursuant to this section.

(4) HOSPITAL RATE DISTRIBUTION.—

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized under the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in s. 408.07(45), and specialty children's hospitals as defined in s. 395.002(28).

2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients, as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).

3. Tier 3 hospitals include all community hospitals.

(b) When rates are increased pursuant to this section, the Total Tier Allocation (TTA) shall be distributed as follows:

1. Tier 1 (T1A) = 0.35 x TTA.

2. Tier 2 (T2A) = 0.35 x TTA.

3. Tier 3 (T3A) = 0.30 x TTA.

(c) The tier allocation shall be distributed as a percentage increase to the hospital specific base rate (HSBR) established pursuant to s. 409.905(5)(c). The increase in each tier shall be calculated according to the proportion of tier-specific allocation to the total estimated inpatient spending (TEIS) for all hospitals in each tier:

1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total estimated inpatient spending (T1TEIS).

2. Tier 2 percent increase (T2PI) = T2A /Tier 2 total estimated inpatient spending (T2TEIS).

3. Tier 3 percent increase (T3PI) = T3A/ Tier 3 total estimated inpatient spending (T3TEIS).

(d) The hospital-specific tiered rate (HSTR) shall be calculated as follows:

1. For hospitals in Tier 3: HSTR = (1 + T3PI) x HSBR.

2. For hospitals in Tier 2: HSTR = (1 + T2PI) x HSBR.

3. For hospitals in Tier 1: HSTR = (1 + T1PI) x HSBR.

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

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

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

409.972 Mandatory and voluntary enrollment.—

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

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

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

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).

(c) Persons eligible for refugee assistance.

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

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

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

409.973 Benefits.—

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

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

(e) Dental services.

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

(g) Emergency services.

(h) Family planning services and supplies.

(i) Healthy start services.

(j) Hearing services.

(k) Home health agency services.

(l) Hospice services.

(m) Hospital inpatient services.

(n) Hospital outpatient services.

(o) Laboratory and imaging services.

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

(q) Mental health services.

(r) Nursing care.

(s) Optical services and supplies.

(t) Optometrist services.

(u) Physical, occupational, respiratory, and speech therapy services.

(v) Physician services, including physician assistant services.

(w) Podiatric services.

(x) Prescription drugs.

(y) Renal dialysis services.

(z) Respiratory equipment and supplies.

(aa) Rural health clinic services.

(bb) Substance abuse treatment services.

(cc) Transportation to access covered services.

(2) CUSTOMIZED BENEFITS.—Managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plan's enrollees and to verify actuarial equivalence.

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors.

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Within 30 days after enrollment, provide information to each enrollee on the importance of and procedure for selecting a primary care physician, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) Within 90 days after selection of or assignment to a primary care provider, provide information to each enrollee on the importance of scheduling a wellness screening with the enrollee's primary care physician.

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had a least one appointment with their primary care provider.

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

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2013.

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

(b) The agency shall procure two plans for Region II. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(c) The agency shall procure at least two plans and no more than four plans for Region III. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

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

(e) The agency shall procure at least four plans and no more than eight plans for Region V. At least two plans shall be provider service networks, if any two provider service networks submit responsive bids.

(f) The agency shall procure at least four plans and no more than seven plans for Region VI. At least two plans shall be provider service networks, if any two provider service networks submit responsive bids.

(g) The agency shall procure two plans for Region VII. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(h) The agency shall procure at least two plans and no more than four plans for Region VIII. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

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

(j) The agency shall procure at least two plans and no more than four plans for Region X. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(k) The agency shall procure at least five plans and no more than nine plans for Region XI. At least two plans shall be provider service networks, if any two provider service networks submit a responsive bid.

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

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

(3) SPECIALTY PLANS.—Participation by specialty plans shall be subject to the procurement requirements and regional plan number limits of this section. However, a specialty plan whose target population includes no more than 10 percent of the enrollees of that region is not subject to the regional plan number limits of this section.

(4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

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

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

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to 409.967(2)(b). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(45).

3. Hospitals that are trauma centers as defined in s. 395.4001(14).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable

Medicaid rate. If the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by a regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

(c) After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan

must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion.

(d) Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency shall contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans. The agency shall support these activities with certified public expenditures and any earned federal matching funds and shall seek any plan amendments or waivers necessary to comply with this subsection. To be eligible to participate in the quality network, a medical school must contract with each managed care plan in its region.

(3) PERFORMANCE MEASUREMENT.—Each managed care plan shall monitor the quality and performance of each participating provider. At the beginning of the contract period, each plan shall notify all its network providers of the metrics used by

the plan for evaluating the provider's performance and determining continued participation in the network.

(4) MOMCARE NETWORK.—

(a) The agency shall contract with an administrative services organization representing all Healthy Start Coalitions providing risk appropriate care coordination and other services in accordance with a federal waiver and pursuant to s. 409.906. The contract shall require the network of coalitions to provide choice counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver. The agency shall evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. The agency shall support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

(b) Each managed care plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs. Each plan's programs and procedures shall include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with agency policies and the MomCare network.

(5) TRANSPORTATION.—Nonemergency transportation services shall be provided pursuant to a single, statewide contract between the agency and the Commission for the Transportation Disadvantaged. The agency shall establish performance standards in the contract and shall evaluate the performance of the Commission for the Transportation Disadvantaged. For the purposes of this subsection, the term "nonemergency transportation" does not include transportation by ambulance and any medical services received during transport.

(6) SCREENING RATE.—After the end of the second contract year, each managed care plan shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent of those recipients continuously enrolled for at least 8 months.

(7) PROVIDER PAYMENT.—Managed care plan and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. For rates, methods, and terms of payment negotiated after the contract between the agency and the plan is executed, plans shall pay hospitals, at a minimum, the rate the agency would have paid on the first day of the contract between the provider and the plan. Such payments to hospitals may not exceed 120 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

(8) MEDICALLY NEEDY ENROLLEES.—Each managed care plan shall accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous

enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the department. The agency shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for medically needy patients for services provided before enrollment in the plan. Medically needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.

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

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

(1) Prepaid payment rates shall be negotiated between the agency and the eligible plans as part of the procurement process described in s. 409.966.

(2) The agency shall establish payment rates for statewide inpatient psychiatric programs. Payments to managed care plans shall be reconciled to reimburse actual payments to statewide inpatient psychiatric programs.

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

409.977 Choice counseling and enrollment.—

(1) CHOICE COUNSELING.—In addition to the choice counseling information required by s. 409.969, the agency shall make available clear and easily understandable choice information to Medicaid recipients that includes information about the cost-sharing requirements of each managed care plan.

(2) AUTOMATIC ENROLLMENT.—The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria:

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

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

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

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

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

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.

(2) The agency shall make payments for long-term care,

including home and community-based services, using a managed care model. Unless otherwise specified, the provisions of ss. 409.961-409.97 apply to the long-term care managed care program.

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

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

409.979 Eligibility.—

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

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

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

(2) Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to

participate in the long-term care managed care program for up to 24 months without being reevaluated for their need of nursing facility care as defined in s. 409.985(3):

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

(b) The Aged and Disabled Adult Waiver.

(c) The Adult Day Health Care Waiver.

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

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

(f) The long-term care community-based diversion pilot project as described in s. 430.705.

(g) The Channeling Services Waiver for Frail Elders.

(3) The Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before enrollment offers, the department shall determine that sufficient funds exist to support additional enrollment into plans.

Section 21. Section 409.98, Florida Statutes, is created to read:

409.98 Benefits.—Long-term care plans shall cover, at a minimum, the following:

(1) Nursing facility care.

(2) Services provided in assisted living facilities.

(3) Hospice.

(4) Adult day care.

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

(6) Personal care.

(7) Home accessibility adaptation.

(8) Behavior management.

(9) Home-delivered meals.

(10) Case management.

(11) Therapies:

(a) Occupational therapy.

(b) Speech therapy.

(c) Respiratory therapy.

(d) Physical therapy.

(12) Intermittent and skilled nursing.

(13) Medication administration.

(14) Medication management.

(15) Nutritional assessment and risk reduction.

(16) Caregiver training.

(17) Respite care.

(18) Transportation.

(19) Personal emergency response system.

Section 22. Section 409.981, Florida Statutes, is created to read:

409.981 Eligible plans.—

(1) ELIGIBLE PLANS.—Provider service networks must be long-term care provider service networks. Other eligible plans may either be long-term care plans or comprehensive long-term care plans.

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

409.966. The agency shall provide notice of invitations to negotiate no later than July 1, 2012.

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

(b) The agency shall procure two plans for Region II. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(c) The agency shall procure at least two plans and no more than four plans for Region III. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

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

(e) The agency shall procure at least four plans and no more than eight plans for Region V. At least two plans shall be provider service networks, if any two provider service networks submit responsive bids.

(f) The agency shall procure at least four plans and no more than seven plans for Region VI. At least two plans shall be provider service networks, if any two provider service networks submit responsive bids.

(g) The agency shall procure two plans for Region VII. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(h) The agency shall procure at least two plans and no more than four plans for Region VIII. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

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

(j) The agency shall procure at least two plans and no more than four plans for Region X. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

(k) The agency shall procure at least five plans and no more than nine plans for Region XI. At least two plans shall be provider service networks, if any two provider service networks submit a responsive bid.