

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

29 | creating s. 409.967, F.S.; providing for managed care plan  
30 | accountability; establishing contract terms; providing for  
31 | contract extension under certain circumstances;  
32 | establishing payments to noncontract providers;  
33 | establishing requirements for access; requiring plans to  
34 | establish and maintain an electronic database;  
35 | establishing requirements for the database; requiring  
36 | plans to provide encounter data; requiring the agency to  
37 | maintain an encounter data system; requiring the agency to  
38 | establish performance standards for plans; providing  
39 | program integrity requirements; establishing a grievance  
40 | resolution process; providing penalties for early  
41 | termination of contracts or reduction in enrollment  
42 | levels; establishing prompt payment requirements;  
43 | requiring plans to accept electronic claims; requiring  
44 | fair payment to providers with a controlling interest in a  
45 | provider service network by other plans; requiring the  
46 | agency and prepaid plans to use a uniform method for  
47 | certain financial reports; providing income-sharing  
48 | ratios; providing a timeframe for a plan to pay an  
49 | additional rebate under certain circumstances; requiring  
50 | the agency to return prepaid plan overpayments; creating  
51 | s. 409.968, F.S.; establishing managed care plan payments;  
52 | providing payment requirements for provider service  
53 | networks; requiring the agency to conduct annual cost  
54 | reconciliations to determine certain cost savings and  
55 | report the results of the reconciliations to the fee-for-  
56 | service provider; providing a timeframe for the provider

57 | service to respond to the report; creating s. 409.969,  
58 | F.S.; requiring enrollment in managed care plans by all  
59 | nonexempt Medicaid recipients; creating requirements for  
60 | plan selection by recipients; providing for choice  
61 | counseling; establishing choice counseling vendor  
62 | requirements; authorizing disenrollment under certain  
63 | circumstances; defining the term "good cause" for purposes  
64 | of disenrollment; providing time limits on an internal  
65 | grievance process; providing requirements for agency  
66 | determination regarding disenrollment; requiring  
67 | recipients to stay in plans for a specified time; creating  
68 | s. 409.97, F.S.; authorizing the agency to accept the  
69 | transfer of certain revenues from local governments;  
70 | requiring the agency to contract with a representative of  
71 | certain entities participating in the low-income pool for  
72 | the provision of enhanced access to care; providing for  
73 | support of these activities by the low-income pool as  
74 | authorized in the General Appropriations Act; establishing  
75 | the Access to Care Partnership; requiring the agency to  
76 | seek necessary waivers and plan amendments; providing  
77 | requirements for prepaid plans to submit data; authorizing  
78 | the agency to implement a tiered hospital rate system;  
79 | creating s. 409.971, F.S.; creating the managed medical  
80 | assistance program; providing deadlines to begin and  
81 | finalize implementation of the program; creating s.  
82 | 409.972, F.S.; providing eligibility requirements for  
83 | mandatory and voluntary enrollment; creating s. 409.973,  
84 | F.S.; establishing minimum benefits for managed care plans

85 | to cover; authorizing plans to customize benefit packages;  
86 | requiring plans to establish a program to encourage  
87 | healthy behaviors; requiring plans to establish a primary  
88 | care initiative; providing requirements for primary care  
89 | initiatives; requiring plans to report certain primary  
90 | care data to the agency; creating s. 409.974, F.S.;  
91 | establishing a deadline for issuing invitations to  
92 | negotiate; establishing a specified number or range of  
93 | eligible plans to be selected in each region; establishing  
94 | quality selection criteria; establishing requirements for  
95 | participation by specialty plans; establishing the  
96 | Children's Medical Service Network as an eligible plan;  
97 | creating s. 409.975, F.S.; providing for managed care plan  
98 | accountability; authorizing plans to limit providers in  
99 | networks; requiring plans to include essential Medicaid  
100 | providers in their networks unless an alternative  
101 | arrangement is approved by the agency; identifying  
102 | statewide essential providers; specifying provider  
103 | payments under certain circumstances; requiring plans to  
104 | include certain statewide essential providers in their  
105 | networks; requiring good faith negotiations; specifying  
106 | provider payments under certain circumstances; allowing  
107 | plans to exclude essential providers under certain  
108 | circumstances; requiring plans to offer a contract to home  
109 | medical equipment and supply providers under certain  
110 | circumstances; establishing the Florida medical school  
111 | quality network; requiring the agency to contract with a  
112 | representative of certain entities to establish a clinical

113 outcome improvement program in all plans; providing for  
114 support of these activities by certain expenditures and  
115 federal matching funds; requiring the agency to seek  
116 necessary waivers and plan amendments; providing for  
117 eligibility for the quality network; requiring plans to  
118 monitor the quality and performance history of providers;  
119 establishing the MomCare network; requiring the agency to  
120 contract with a representative of all Healthy Start  
121 Coalitions to provide certain services to recipients;  
122 providing for support of these activities by certain  
123 expenditures and federal matching funds; requiring plans  
124 to enter into agreements with local Healthy Start  
125 Coalitions for certain purposes; requiring specified  
126 programs and procedures be established by plans;  
127 establishing a screening standard for the Early and  
128 Periodic Screening, Diagnosis, and Treatment Service;  
129 requiring managed care plans and hospitals to negotiate  
130 rates, methods, and terms of payment; providing a limit on  
131 payments to hospitals; establishing plan requirements for  
132 medically needy recipients; creating s. 409.976, F.S.;  
133 providing for managed care plan payment; requiring the  
134 agency to establish payment rates for statewide inpatient  
135 psychiatric programs; requiring payments to managed care  
136 plans to be reconciled to reimburse actual payments to  
137 statewide inpatient psychiatric programs; creating s.  
138 409.977, F.S.; establishing choice counseling  
139 requirements; providing for automatic enrollment in a  
140 managed care plan for certain recipients; establishing

141 | opt-out opportunities for recipients; creating s. 409.978,  
142 | F.S.; requiring the agency to be responsible for  
143 | administering the long-term care managed care program;  
144 | providing implementation dates for the long-term care  
145 | managed care program; providing duties of the Department  
146 | of Elderly Affairs relating to assisting the agency in  
147 | implementing the program; creating s. 409.979, F.S.;  
148 | providing eligibility requirements for the long-term care  
149 | managed care program; creating s. 409.98, F.S.;  
150 | establishing the benefits covered under a managed care  
151 | plan participating in the long-term care managed care  
152 | program; creating s. 409.981, F.S.; providing criteria for  
153 | eligible plans; designating regions for plan  
154 | implementation throughout the state; providing criteria  
155 | for the selection of plans to participate in the long-term  
156 | care managed care program; providing that participation by  
157 | the Program of All-Inclusive Care for the Elderly is  
158 | pursuant to an agency contract; creating s. 409.982, F.S.;  
159 | requiring the agency to establish uniform accounting and  
160 | reporting methods for plans; providing for mandatory  
161 | participation in plans by certain service providers;  
162 | authorizing the exclusion of certain providers from plans  
163 | for failure to meet quality or performance criteria;  
164 | requiring plans to monitor participating providers using  
165 | specified criteria; requiring certain providers to be  
166 | included in plan networks; providing provider payment  
167 | specifications for nursing homes and hospices; creating s.  
168 | 409.983, F.S.; providing for negotiation of rates between

169 the agency and the plans participating in the long-term  
170 care managed care program; providing specific criteria for  
171 calculating and adjusting plan payments; allowing the  
172 CARES program to assign plan enrollees to a level of care;  
173 providing incentives for adjustments of payment rates;  
174 requiring the agency to establish nursing facility-  
175 specific and hospice services payment rates; creating s.  
176 409.984, F.S.; providing that before contracting with  
177 another vendor, the agency shall offer to contract with  
178 the aging resource centers to provide choice counseling  
179 for the long-term care managed care program; providing  
180 criteria for automatic assignments of plan enrollees who  
181 fail to choose a plan; providing for hospice selection  
182 within a specified timeframe; providing for a choice of  
183 residential setting under certain circumstances; creating  
184 s. 409.9841, F.S.; creating the long-term care managed  
185 care technical advisory workgroup; providing duties;  
186 providing membership; providing for reimbursement for per  
187 diem and travel expenses; providing for repeal by a  
188 specified date; creating s. 409.985, F.S.; providing that  
189 the agency shall operate the Comprehensive Assessment and  
190 Review for Long-Term Care Services program through an  
191 interagency agreement with the Department of Elderly  
192 Affairs; providing duties of the program; defining the  
193 term "nursing facility care"; creating s. 409.986, F.S.;  
194 providing authority and agency duties regarding long-term  
195 care programs for persons with developmental disabilities;  
196 authorizing the agency to delegate specific duties to and

197 collaborate with the Agency for Persons with Disabilities;  
198 requiring the agency to make payments for long-term care  
199 for persons with developmental disabilities under certain  
200 conditions; creating s. 409.987, F.S.; providing  
201 eligibility requirements for long-term care plans;  
202 creating s. 409.988, F.S.; specifying covered benefits for  
203 long-term care plans; creating s. 409.989, F.S.;  
204 establishing criteria for eligible plans; specifying  
205 minimum and maximum number of plans and selection  
206 criteria; authorizing participation by the Children's  
207 Medical Services Network in long-term care plans under  
208 certain conditions; creating s. 409.99, F.S.; providing  
209 requirements for managed care plan accountability;  
210 specifying limitations on providers in plan networks;  
211 providing for evaluation and payment of network providers;  
212 requiring managed care plans to establish family advisory  
213 committees and offer consumer-directed care services;  
214 creating s. 409.991, F.S.; providing for payment of  
215 managed care plans; providing duties for the Agency for  
216 Persons with Disabilities to assign plan enrollees into a  
217 payment-rate level of care; establishing level-of-care  
218 criteria; providing payment requirements for intensive  
219 behavior residential habilitation providers and  
220 intermediate care facilities for the developmentally  
221 disabled; creating s. 409.992, F.S.; providing  
222 requirements for enrollment and choice counseling;  
223 specifying enrollment exceptions for certain Medicaid  
224 recipients; providing an effective date.



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

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

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

409.961 Statutory construction; applicability; rules.—It is the intent of the Legislature that if any conflict exists between the provisions contained in this part and provisions contained in other parts of this chapter, the provisions contained in this part shall control. The provisions of ss. 409.961-409.97 apply only to the Medicaid managed medical assistance program, long-term care managed care program, and managed long-term care for persons with developmental disabilities program, as provided in this part. The agency shall adopt any rules necessary to comply with or administer this part and all rules necessary to comply with federal requirements. In addition, the department shall adopt and accept the transfer of any rules necessary to carry out the department's responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility and for ensuring compliance with and administering this part, as those rules relate to the department's responsibilities, and any other provisions related to the department's responsibility for the determination of Medicaid eligibility.

252 Section 3. Section 409.962, Florida Statutes, is created  
253 to read:

254 409.962 Definitions.—As used in this part, except as  
255 otherwise specifically provided, the term:

256 (1) "Agency" means the Agency for Health Care  
257 Administration.

258 (2) "Aging network service provider" means a provider that  
259 participated in a home and community-based waiver administered  
260 by the Department of Elderly Affairs or the community care  
261 service system pursuant to s. 430.205, as of October 1, 2013.

262 (3) "Comprehensive long-term care plan" means a managed  
263 care plan that provides services described in s. 409.973 and  
264 also provides the services described in s. 409.98 or s. 409.988.

265 (4) "Department" means the Department of Children and  
266 Family Services.

267 (5) "Developmental disability provider service network"  
268 means a provider service network, a controlling interest of  
269 which includes one or more entities licensed pursuant to s.  
270 393.067 or s. 400.962 with 18 or more licensed beds and the  
271 owner or owners of which have at least 10 years' experience  
272 serving persons with developmental disabilities.

273 (6) "Direct care management" means care management  
274 activities that involve direct interaction with Medicaid  
275 recipients.

276 (7) "Eligible plan" means a health insurer authorized  
277 under chapter 624, an exclusive provider organization authorized  
278 under chapter 627, a health maintenance organization authorized  
279 under chapter 641, or a provider service network authorized

280 under s. 409.912(4)(d). For purposes of the managed medical  
 281 assistance program, the term also includes the Children's  
 282 Medical Services Network authorized under chapter 391. For  
 283 purposes of the long-term care managed care program, the term  
 284 also includes entities qualified under 42 C.F.R. part 422 as  
 285 Medicare Advantage Preferred Provider Organizations, Medicare  
 286 Advantage Provider-sponsored Organizations, and Medicare  
 287 Advantage Special Needs Plans, and the Program of All-Inclusive  
 288 Care for the Elderly.

289 (8) "Long-term care plan" means a managed care plan that  
 290 provides the services described in s. 409.98 for the long-term  
 291 care managed care program or the services described in s.  
 292 409.988 for the long-term care managed care program for persons  
 293 with developmental disabilities.

294 (9) "Long-term care provider service network" means a  
 295 provider service network a controlling interest of which is  
 296 owned by one or more licensed nursing homes, assisted living  
 297 facilities with 17 or more beds, home health agencies, community  
 298 care for the elderly lead agencies, or hospices.

299 (10) "Managed care plan" means an eligible plan under  
 300 contract with the agency to provide services in the Medicaid  
 301 program.

302 (11) "Medicaid" means the medical assistance program  
 303 authorized by Title XIX of the Social Security Act, 42 U.S.C.  
 304 ss. 1396 et seq., and regulations thereunder, as administered in  
 305 this state by the agency.

306 (12) "Medicaid recipient" or "recipient" means an  
 307 individual who the department or, for Supplemental Security

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308 Income, the Social Security Administration determines is  
309 eligible pursuant to federal and state law to receive medical  
310 assistance and related services for which the agency may make  
311 payments under the Medicaid program. For the purposes of  
312 determining third-party liability, the term includes an  
313 individual formerly determined to be eligible for Medicaid, an  
314 individual who has received medical assistance under the  
315 Medicaid program, or an individual on whose behalf Medicaid has  
316 become obligated.

317 (13) "Prepaid plan" means a managed care plan that is  
318 licensed or certified as a risk-bearing entity, or qualified  
319 pursuant to s. 409.912(4)(d), in the state and is paid a  
320 prospective per-member, per-month payment by the agency.

321 (14) "Provider service network" means an entity qualified  
322 pursuant to s. 409.912(4)(d) of which a controlling interest is  
323 owned by a health care provider, or group of affiliated  
324 providers, or a public agency or entity that delivers health  
325 services. Health care providers include Florida-licensed health  
326 care professionals or licensed health care facilities, federally  
327 qualified health care centers, and home health care agencies.

328 (15) "Specialty plan" means a managed care plan that  
329 serves Medicaid recipients who meet specified criteria based on  
330 age, medical condition, or diagnosis.

331 Section 4. Section 409.963, Florida Statutes, is created  
332 to read:

333 409.963 Single state agency.—The Agency for Health Care  
334 Administration is designated as the single state agency  
335 authorized to manage, operate, and make payments for medical

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336 assistance and related services under Title XIX of the Social  
337 Security Act. Subject to any limitations or directions provided  
338 for in the General Appropriations Act, these payments may be  
339 made only for services included in the program, only on behalf  
340 of eligible individuals, and only to qualified providers in  
341 accordance with federal requirements for Title XIX of the Social  
342 Security Act and the provisions of state law. This program of  
343 medical assistance is designated as the "Medicaid program." The  
344 department is responsible for Medicaid eligibility  
345 determinations, including, but not limited to, policy, rules,  
346 and the agreement with the Social Security Administration for  
347 Medicaid eligibility determinations for Supplemental Security  
348 Income recipients, as well as the actual determination of  
349 eligibility. As a condition of Medicaid eligibility, subject to  
350 federal approval, the agency and the department shall ensure  
351 that each Medicaid recipient consents to the release of her or  
352 his medical records to the agency and the Medicaid Fraud Control  
353 Unit of the Department of Legal Affairs.

354 Section 5. Section 409.964, Florida Statutes is created to  
355 read:

356 409.964 Managed care program; state plan; waivers.—The  
357 Medicaid program is established as a statewide, integrated  
358 managed care program for all covered services, including long-  
359 term care services. The agency shall apply for and implement  
360 state plan amendments or waivers of applicable federal laws and  
361 regulations necessary to implement the program. Before seeking a  
362 waiver, the agency shall provide public notice and the  
363 opportunity for public comment and shall include public feedback

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364 in the waiver application. The agency shall hold one public  
 365 meeting in each of the regions described in s. 409.966(2) and  
 366 the time period for public comment for each region shall end no  
 367 sooner than 30 days after the completion of the public meeting  
 368 in that region.

369 Section 6. Section 409.965, Florida Statutes, is created  
 370 to read:

371 409.965 Mandatory enrollment.—All Medicaid recipients  
 372 shall receive covered services through the statewide managed  
 373 care program, except as provided by this part pursuant to an  
 374 approved federal waiver. The following Medicaid recipients are  
 375 exempt from participation in the statewide managed care program:

376 (1) Women who are only eligible for family planning  
 377 services.

378 (2) Women who are only eligible for breast and cervical  
 379 cancer services.

380 (3) Persons who are eligible for emergency Medicaid for  
 381 aliens.

382 Section 7. Section 409.966, Florida Statutes, is created  
 383 to read:

384 409.966 Eligible plans; selection.—

385 (1) ELIGIBLE PLANS.—Services in the Medicaid managed care  
 386 program shall be provided by eligible plans. A provider service  
 387 network must be capable of providing all covered services to a  
 388 mandatory Medicaid managed care enrollee or may limit the  
 389 provision of services to a specific target population based on  
 390 the age, chronic disease state, or medical condition of the  
 391 enrollee to whom the network will provide services. A specialty

392 provider service network must be capable of coordinating care  
393 and delivering or arranging for the delivery of all covered  
394 services to the target population. A provider service network  
395 may partner with an insurer licensed under chapter 627 or a  
396 health maintenance organization licensed under chapter 641 to  
397 meet the requirements of a Medicaid contract.

398 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a  
399 limited number of eligible plans to participate in the Medicaid  
400 program using invitations to negotiate in accordance with s.  
401 287.057(3) (a). At least 90 days before issuing an invitation to  
402 negotiate, the agency shall compile and publish a databook  
403 consisting of a comprehensive set of utilization and spending  
404 data for the 3 most recent contract years consistent with the  
405 rate-setting periods for all Medicaid recipients by region or  
406 county. The source of the data in the report shall include both  
407 historic fee-for-service claims and validated data from the  
408 Medicaid Encounter Data System. The report shall be made  
409 available in electronic form and shall delineate utilization use  
410 by age, gender, eligibility group, geographic area, and  
411 aggregate clinical risk score. Separate and simultaneous  
412 procurements shall be conducted in each of the following  
413 regions:

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

418 (b) Region II, which shall consist of Alachua, Baker,  
419 Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton,

420 Lafayette, Lake, Levy, Marion, Sumter, Suwannee, and Union  
 421 Counties.

422 (c) Region III, which shall consist of Clay, Duval,  
 423 Flagler, Nassau, Putman, St. Johns, and Volusia Counties.

424 (d) Region IV, which shall consist of Brevard, Indian  
 425 River, Okeechobee, Orange, Osceola, Seminole, and St. Lucie  
 426 Counties.

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

429 (f) Region VI, which shall consist of Charlotte, Collier,  
 430 DeSoto, Hardee, Highlands, Lee, Manatee, and Sarasota Counties.

431 (g) Region VII, which shall consist of Broward, Glades,  
 432 Hendry, Martin, and Palm Beach Counties.

433 (h) Region VIII, which shall consist of Miami-Dade and  
 434 Monroe Counties.

435 (3) QUALITY SELECTION CRITERIA.—

436 (a) The invitation to negotiate must specify the criteria  
 437 and the relative weight of the criteria that will be used for  
 438 determining the acceptability of the reply and guiding the  
 439 selection of the organizations with which the agency negotiates.

440 In addition to criteria established by the agency, the agency  
 441 shall consider the following factors in the selection of  
 442 eligible plans:

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



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

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

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

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

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

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

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

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

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473 A qualified plan must disclose any business relationship it has  
 474 with any other qualified plan that responds to the invitation to  
 475 negotiate. The agency may not select plans in the same region  
 476 that have a business relationship with each other. Failure to  
 477 disclose any business relationship shall result in  
 478 disqualification from participation in any region for the first  
 479 full contract period after the discovery of the business  
 480 relationship by the agency. For the purpose of this section,  
 481 "business relationship" means an ownership or controlling  
 482 interest, an affiliate or subsidiary relationship, a common  
 483 parent, or any mutual interest in any limited partnership,  
 484 limited liability partnership, limited liability company, or  
 485 other entity or business association, including all wholly or  
 486 partially owned subsidiaries, majority-owned subsidiaries,  
 487 parent companies, or affiliates of such entities, business  
 488 associations, or other enterprises, that exists for the purpose  
 489 of making a profit.

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

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

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

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501 3. Greater net economic benefit to Florida compared to  
502 other bidders through employment of, or subcontracting with  
503 firms that employ, Floridians in order to accomplish the  
504 contract requirements. Contracts with such bidders shall specify  
505 performance measures to evaluate the plan's employment-based  
506 economic impact. Valuation of the net economic benefit may not  
507 include employment of or subcontracts with providers.

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

513 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that  
514 participates in an invitation to negotiate in more than one  
515 region and is selected in at least one region may not begin  
516 servicing Medicaid recipients in any region for which it was  
517 selected until all administrative challenges to procurements  
518 required by this section to which the eligible plan is a party  
519 have been finalized. If the number of plans selected is less  
520 than the maximum amount of plans permitted in the region, the  
521 agency may contract with other selected plans in the region not  
522 participating in the administrative challenge before resolution  
523 of the administrative challenge. For purposes of this  
524 subsection, an administrative challenge is finalized if an order  
525 granting voluntary dismissal with prejudice has been entered by  
526 any court established under Article V of the State Constitution  
527 or by the Division of Administrative Hearings, a final order has  
528 been entered into by the agency and the deadline for appeal has

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529 expired, a final order has been entered by the First District  
530 Court of Appeal and the time to seek any available review by the  
531 Florida Supreme Court has expired, or a final order has been  
532 entered by the Florida Supreme Court and a warrant has been  
533 issued.

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

536 409.967 Managed care plan accountability.-

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

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

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

550 1. The provider's charges;

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

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

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

557        (b) Access.—The agency shall establish specific standards  
558 for the number, type, and regional distribution of providers in  
559 managed care plan networks to ensure access to care for both  
560 adults and children. Each plan must maintain a region-wide  
561 network of providers in sufficient numbers to meet the access  
562 standards for specific medical services for all recipients  
563 enrolled in the plan. Consistent with the standards established  
564 by the agency, provider networks may include providers located  
565 outside the region. A plan may contract with a new hospital  
566 facility before the date the hospital becomes operational if the  
567 hospital has commenced construction, will be licensed and  
568 operational by January 1, 2013, and a final order has issued in  
569 any civil or administrative challenge. Each plan shall establish  
570 and maintain an accurate and complete electronic database of  
571 contracted providers, including information about licensure or  
572 registration, locations and hours of operation, specialty  
573 credentials and other certifications, specific performance  
574 indicators, and such other information as the agency deems  
575 necessary. The database shall be available online to both the  
576 agency and the public and shall have the capability to compare  
577 the availability of providers to network adequacy standards and  
578 to accept and display feedback from each provider's patients.  
579 Each plan shall submit quarterly reports to the agency  
580 identifying the number of enrollees assigned to each primary  
581 care provider.

582        (c) Encounter data.—The agency shall maintain and operate  
583 a Medicaid Encounter Data System to collect, process, store, and

584 report on covered services provided to all Medicaid recipients  
585 enrolled in prepaid plans.

586 1. Each prepaid plan must comply with the agency's  
587 reporting requirements for the Medicaid Encounter Data System.  
588 Prepaid plans must submit encounter data electronically in a  
589 format that complies with the Health Insurance Portability and  
590 Accountability Act provisions for electronic claims and in  
591 accordance with deadlines established by the agency. Prepaid  
592 plans must certify that the data reported is accurate and  
593 complete.

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

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

610 (d) Continuous improvement.—The agency shall establish  
611 specific performance standards and expected milestones or

612 timelines for improving performance over the term of the  
613 contract. By the end of the fourth year of the first contract  
614 term, the agency shall issue a request for information to  
615 determine whether cost savings could be achieved by contracting  
616 for plan oversight and monitoring, including analysis of  
617 encounter data, assessment of performance measures, and  
618 compliance with other contractual requirements. Each managed  
619 care plan shall establish an internal health care quality  
620 improvement system, including enrollee satisfaction and  
621 disenrollment surveys. The quality improvement system shall  
622 include incentives and disincentives for network providers.

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

626 1. A provider credentialing system and ongoing provider  
627 monitoring;

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

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

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

636 5. Designation of a program integrity compliance officer.

637 (f) Grievance resolution.—Each managed care plan shall  
638 establish and the agency shall approve an internal process for  
639 reviewing and responding to grievances from enrollees consistent

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640 with the requirements of s. 641.511. Each plan shall submit  
641 quarterly reports on the number, description, and outcome of  
642 grievances filed by enrollees. The agency shall maintain a  
643 process for provider service networks consistent with s.  
644 408.7056.

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

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

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

665 (j) Fair payment.—Provider service networks must ensure  
666 that no network provider with a controlling interest in the  
667 network charges any Medicaid managed care plan more than the



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668 amount paid to that provider by the provider service network for  
669 the same service.

670 (3) ACHIEVED SAVINGS REBATE.—

671 (a) The agency shall establish and the prepaid plans shall  
672 use a uniform method for annually reporting premium revenue,  
673 medical and administrative costs, and income or losses, across  
674 all Florida Medicaid prepaid plan lines of business in all  
675 regions. The reports shall be due to the agency within 270 days  
676 after the conclusion of the reporting period and the agency may  
677 audit the reports. Achieved savings rebates shall be due within  
678 30 days after the report is submitted. Except as provided in  
679 paragraph (b), the achieved savings rebate will be established  
680 by determining pretax income as a percentage of revenues and  
681 applying the following income sharing ratios:

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

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

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

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

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

694 1. Payment of achieved savings rebates.

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

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

699 4. Expenses associated with lobbying activities.

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

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

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

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

715 (f) In addition to the reporting required by paragraph  
 716 (a), prepaid plans shall annually submit a report, consistent  
 717 with paragraph (a), which is specific to enrollees with  
 718 developmental disabilities. The agency shall compare each plan's  
 719 expenditures to the plan's aggregate premiums for this  
 720 population. The difference between aggregate premiums and  
 721 expenditures shall be shared equally between the plan and the  
 722 state. The state share shall be returned to the Medicaid

723 appropriation to serve people on the wait list for home and  
724 community-based services provided through individual budgets.

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

727 409.968 Managed care plan payments.-

728 (1) Prepaid plans shall receive per-member, per-month  
729 payments negotiated pursuant to the procurements described in s.  
730 409.966. Payments shall be risk-adjusted rates based on  
731 historical utilization and spending data, projected forward, and  
732 adjusted to reflect the eligibility category, geographic area,  
733 and clinical risk profile of the recipients.

734 (2) Provider service networks may be prepaid plans and  
735 receive per-member, per-month payments negotiated pursuant to  
736 the procurement process described in s. 409.966. Provider  
737 service networks that choose not to be prepaid plans shall  
738 receive fee-for-service rates with a shared savings settlement.  
739 The fee-for-service option shall be available to a provider  
740 service network only for the first 5 years of its operation in a  
741 given region. The agency shall annually conduct cost  
742 reconciliations to determine the amount of cost savings achieved  
743 by fee-for-service provider service networks for the dates of  
744 service within the period being reconciled. Only payments for  
745 covered services for dates of service within the reconciliation  
746 period and paid within 6 months after the last date of service  
747 in the reconciliation period shall be included. The agency shall  
748 perform the necessary adjustments for the inclusion of claims  
749 incurred but not reported within the reconciliation period for  
750 claims that could be received and paid by the agency after the

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751 6-month claims processing time lag. The agency shall provide the  
752 results of the reconciliations to the fee-for-service provider  
753 service networks within 45 days after the end of the  
754 reconciliation period. The fee-for-service provider service  
755 networks shall review and provide written comments or a letter  
756 of concurrence to the agency within 45 days after receipt of the  
757 reconciliation results. This reconciliation shall be considered  
758 final.

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

761 409.969 Enrollment; choice counseling; automatic  
762 assignment; disenrollment.-

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

771 (2) CHOICE COUNSELING.-The agency shall provide choice  
772 counseling for Medicaid recipients. The agency may contract for  
773 the provision of choice counseling. Any such contract shall be  
774 with a vendor that employs Floridians to accomplish the contract  
775 requirements and shall be for a period of 5 years. The agency  
776 may renew a contract for an additional 5-year period; however,  
777 before renewal of the contract the agency shall hold at least  
778 one public meeting in each of the regions covered by the choice

779 counseling vendor. The agency may extend the term of the  
780 contract to cover any delays in transition to a new contractor.  
781 Printed choice information and choice counseling shall be  
782 offered in the native or preferred language of the recipient,  
783 consistent with federal requirements. The manner and method of  
784 choice counseling shall be modified as necessary to ensure  
785 culturally competent, effective communication with people from  
786 diverse cultural backgrounds. The agency shall maintain a record  
787 of the recipients who receive such services, identifying the  
788 scope and method of the services provided. The agency shall make  
789 available clear and easily understandable choice information to  
790 Medicaid recipients that includes:

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

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

799 (c) An explanation of benefit limits.

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

802 (e) Managed care plan performance data.

803 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has  
804 enrolled in a managed care plan, the recipient shall have 90  
805 days to voluntarily disenroll and select another plan. After 90  
806 days, no further changes may be made except for good cause. For

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807 purposes of this section, the term "good cause" includes, but is  
808 not limited to, poor quality of care, lack of access to  
809 necessary specialty services, an unreasonable delay or denial of  
810 service, or fraudulent enrollment. The agency must make a  
811 determination as to whether good cause exists. The agency may  
812 require a recipient to use the plan's grievance process before  
813 the agency's determination of good cause, except in cases in  
814 which immediate risk of permanent damage to the recipient's  
815 health is alleged.

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

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

833 (c) Medicaid recipients enrolled in a managed care plan  
834 after the 90-day period shall remain in the plan for the

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835 remainder of the 12-month period. After 12 months, the recipient  
836 may select another plan. However, nothing shall prevent a  
837 Medicaid recipient from changing providers within the plan  
838 during that period.

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

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

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

850 409.97 State and local Medicaid partnerships.-

851 (1) INTERGOVERNMENTAL TRANSFERS.-In addition to the  
852 contributions required pursuant to s. 409.915, beginning in the  
853 2014-2015 fiscal year, the agency may accept voluntary transfers  
854 of local taxes and other qualified revenue from counties,  
855 municipalities, and special taxing districts. Such transfers  
856 must be contributed to advance the general goals of the Florida  
857 Medicaid program without restriction and must be executed  
858 pursuant to a contract between the agency and the local funding  
859 source. Contracts executed before October 31 shall result in  
860 contributions to Medicaid for that same state fiscal year.  
861 Contracts executed between November 1 and June 30 shall result  
862 in contributions for the following state fiscal year. Based on

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863 the date of the signed contracts, the agency shall allocate to  
864 the low-income pool the first contributions received up to the  
865 limit established by subsection (2). No more than 40 percent of  
866 the low-income pool funding shall come from any single funding  
867 source. Contributions in excess of the low-income pool shall be  
868 allocated to the disproportionate share programs defined in ss.  
869 409.911(3) and 409.9113 and to hospital rates pursuant to  
870 subsection (4). The local funding source shall designate in the  
871 contract which Medicaid providers ensure access to care for low-  
872 income and uninsured people within the applicable jurisdiction  
873 and are eligible for low-income pool funding. Eligible providers  
874 may include both hospitals and primary care providers.

875 (2) LOW-INCOME POOL.—The agency shall establish and  
876 maintain a low-income pool in a manner authorized by federal  
877 waiver. The low-income pool is created to compensate a network  
878 of providers designated pursuant to subsection (1). Funding of  
879 the low-income pool shall be limited to the maximum amount  
880 permitted by federal waiver minus a percentage specified in the  
881 General Appropriations Act. The low-income pool must be used to  
882 support enhanced access to services by offsetting shortfalls in  
883 Medicaid reimbursement, paying for otherwise uncompensated care,  
884 and financing coverage for the uninsured. The low-income pool  
885 shall be distributed in periodic payments to the Access to Care  
886 Partnership throughout the fiscal year. Distribution of low-  
887 income pool funds by the Access to Care Partnership to  
888 participating providers may be made through capitated payments,  
889 fees for services, or contracts for specific deliverables. The  
890 agency shall include the distribution amount for each provider



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891 in the contract with the Access to Care Partnership pursuant to  
892 subsection (3). Regardless of the method of distribution,  
893 providers participating in the Access to Care Partnership shall  
894 receive payments such that the aggregate benefit in the  
895 jurisdiction of each local funding source, as defined in  
896 subsection (1), equals the amount of the contribution plus a  
897 factor specified in the General Appropriations Act.

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

917 (4) HOSPITAL RATE DISTRIBUTION.—

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

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

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

932 3. Tier 3 hospitals include all community hospitals.

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

- 935 1. Tier 1 (T1A) = 0.35 x TTA.
- 936 2. Tier 2 (T2A) = 0.35 x TTA.
- 937 3. Tier 3 (T3A) = 0.30 x TTA.

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

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

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

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

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

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

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

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

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

957           409.971 Managed medical assistance program.—The agency  
 958 shall make payments for primary and acute medical assistance and  
 959 related services using a managed care model. By January 1, 2013,  
 960 the agency shall begin implementation of the statewide managed  
 961 medical assistance program, with full implementation in all  
 962 regions by October 1, 2014.

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

965           409.972 Mandatory and voluntary enrollment.—

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

971           (2) The following Medicaid-eligible persons are exempt  
 972 from mandatory managed care enrollment required by s. 409.965,

973 and may voluntarily choose to participate in the managed medical  
 974 assistance program:

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

977 (b) Medicaid recipients residing in residential commitment  
 978 facilities operated through the Department of Juvenile Justice  
 979 or mental health treatment facilities as defined by s.  
 980 394.455(32).

981 (c) Persons eligible for refugee assistance.

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

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

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

991 409.973 Benefits.—

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

994 (a) Advanced registered nurse practitioner services.

995 (b) Ambulatory surgical treatment center services.

996 (c) Birthing center services.

997 (d) Chiropractic services.

998 (e) Dental services.

999 (f) Early periodic screening diagnosis and treatment  
 1000 services for recipients under age 21.

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- 1001        (g) Emergency services.
- 1002        (h) Family planning services and supplies.
- 1003        (i) Healthy start services.
- 1004        (j) Hearing services.
- 1005        (k) Home health agency services.
- 1006        (l) Hospice services.
- 1007        (m) Hospital inpatient services.
- 1008        (n) Hospital outpatient services.
- 1009        (o) Laboratory and imaging services.
- 1010        (p) Medical supplies, equipment, prostheses, and orthoses.
- 1011        (q) Mental health services.
- 1012        (r) Nursing care.
- 1013        (s) Optical services and supplies.
- 1014        (t) Optometrist services.
- 1015        (u) Physical, occupational, respiratory, and speech  
 1016 therapy services.
- 1017        (v) Physician services, including physician assistant  
 1018 services.
- 1019        (w) Podiatric services.
- 1020        (x) Prescription drugs.
- 1021        (y) Renal dialysis services.
- 1022        (z) Respiratory equipment and supplies.
- 1023        (aa) Rural health clinic services.
- 1024        (bb) Substance abuse treatment services.
- 1025        (cc) Transportation to access covered services.
- 1026        (2) CUSTOMIZED BENEFITS.—Managed care plans may customize  
 1027 benefit packages for nonpregnant adults, vary cost-sharing  
 1028 provisions, and provide coverage for additional services. The

1029 agency shall evaluate the proposed benefit packages to ensure  
 1030 services are sufficient to meet the needs of the plan's  
 1031 enrollees and to verify actuarial equivalence.

1032 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed  
 1033 medical assistance program shall establish a program to  
 1034 encourage and reward healthy behaviors.

1035 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the  
 1036 managed medical assistance program shall establish a program to  
 1037 encourage enrollees to establish a relationship with their  
 1038 primary care provider. Each plan shall:

1039 (a) Within 30 days after enrollment, provide information  
 1040 to each enrollee on the importance of and procedure for  
 1041 selecting a primary care physician, and thereafter automatically  
 1042 assign to a primary care provider any enrollee who fails to  
 1043 choose a primary care provider.

1044 (b) Within 90 days after selection of or assignment to a  
 1045 primary care provider, provide information to each enrollee on  
 1046 the importance of scheduling a wellness screening with the  
 1047 enrollee's primary care physician.

1048 (c) Report to the agency the number of enrollees assigned  
 1049 to each primary care provider within the plan's network.

1050 (d) Report to the agency the number of enrollees who have  
 1051 not had an appointment with their primary care provider within  
 1052 their first year of enrollment.

1053 (e) Report to the agency the number of emergency room  
 1054 visits by enrollees who have not had a least one appointment  
 1055 with their primary care provider.

1056 Section 15. Section 409.974, Florida Statutes, is created  
 1057 to read:

1058 409.974 Eligible plans.—

1059 (1) ELIGIBLE PLAN SELECTION.—The agency shall select  
 1060 eligible plans through the procurement process described in s.  
 1061 409.966. The agency shall notice invitations to negotiate no  
 1062 later than January 1, 2013.

1063 (a) The agency shall procure three plans for Region I. At  
 1064 least one plan shall be a provider service network, if any  
 1065 provider service network submits a responsive bid.

1066 (b) The agency shall procure three plans for Region II. At  
 1067 least one plan shall be a provider service network, if any  
 1068 provider service network submits a responsive bid.

1069 (c) The agency shall procure at least three plans and no  
 1070 more than four plans for Region III. At least two plans shall be  
 1071 provider service networks, if any two provider service networks  
 1072 submit responsive bids.

1073 (d) The agency shall procure at least four plans and no  
 1074 more than seven plans for Region IV. At least two plans shall be  
 1075 provider service networks if any two provider service networks  
 1076 submit responsive bids.

1077 (e) The agency shall procure at least five plans and no  
 1078 more than eight plans for Region V. At least two plans shall be  
 1079 provider service networks, if any two provider service networks  
 1080 submit responsive bids.

1081 (f) The agency shall procure at least three plans and no  
 1082 more than four plans for Region VI. At least one plan shall be a

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1083 provider service network, if any provider service network  
1084 submits a responsive bid.

1085 (g) The agency shall procure at least four plans and no  
1086 more than seven plans for Region VII. At least two plans shall  
1087 be provider service networks, if any two provider service  
1088 networks submit a responsive bid.

1089 (h) The agency shall procure at least six plans and no  
1090 more than ten plans for Region VIII. At least two plans shall be  
1091 provider service networks, if any two provider service networks  
1092 submit a responsive bid.

1093  
1094 If no provider service network submits a responsive bid, the  
1095 agency shall procure no more than one less than the maximum  
1096 number of eligible plans permitted in that region. Within 12  
1097 months after the initial invitation to negotiate, the agency  
1098 shall attempt to procure a provider service network. The agency  
1099 shall notice another invitation to negotiate only with provider  
1100 service networks in such region where no provider service  
1101 network has been selected.

1102 (2) QUALITY SELECTION CRITERIA.—In addition to the  
1103 criteria established in s. 409.966, the agency shall consider  
1104 evidence that an eligible plan has written agreements or signed  
1105 contracts or has made substantial progress in establishing  
1106 relationships with providers before the plan submitting a  
1107 response. The agency shall evaluate and give special weight to  
1108 evidence of signed contracts with essential providers as defined  
1109 by the agency pursuant to s. 409.975(2). The agency shall  
1110 exercise a preference for plans with a provider network in which



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1111 over 10 percent of the providers use electronic health records,  
1112 as defined in s. 408.051. When all other factors are equal, the  
1113 agency shall consider whether the organization has a contract to  
1114 provide managed long-term care services in the same region and  
1115 shall exercise a preference for such plans.

1116 (3) SPECIALTY PLANS.—Participation by specialty plans  
1117 shall be subject to the procurement requirements and regional  
1118 plan number limits of this section. However, a specialty plan  
1119 whose target population includes no more than 10 percent of the  
1120 enrollees of that region is not subject to the regional plan  
1121 number limits of this section.

1122 (4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by  
1123 the Children's Medical Services Network shall be pursuant to a  
1124 single, statewide contract with the agency that is not subject  
1125 to the procurement requirements or regional plan number limits  
1126 of this section. The Children's Medical Services Network must  
1127 meet all other plan requirements for the managed medical  
1128 assistance program.

1129 Section 16. Section 409.975, Florida Statutes, is created  
1130 to read:

1131 409.975 Managed care plan accountability.—In addition to  
1132 the requirements of s. 409.967, plans and providers  
1133 participating in the managed medical assistance program shall  
1134 comply with the requirements of this section.

1135 (1) PROVIDER NETWORKS.—Managed care plans must develop and  
1136 maintain provider networks that meet the medical needs of their  
1137 enrollees in accordance with standards established pursuant to  
1138 409.967(2)(b). Except as provided in this section, managed care

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1139 plans may limit the providers in their networks based on  
1140 credentials, quality indicators, and price.

1141 (a) Plans must include all providers in the region that  
1142 are classified by the agency as essential Medicaid providers,  
1143 unless the agency approves, in writing, an alternative  
1144 arrangement for securing the types of services offered by the  
1145 essential providers. Providers are essential for serving  
1146 Medicaid enrollees if they offer services that are not available  
1147 from any other provider within a reasonable access standard, or  
1148 if they provided a substantial share of the total units of a  
1149 particular service used by Medicaid patients within the region  
1150 during the last 3 years and the combined capacity of other  
1151 service providers in the region is insufficient to meet the  
1152 total needs of the Medicaid patients. The agency may not  
1153 classify physicians and other practitioners as essential  
1154 providers. The agency, at a minimum, shall determine which  
1155 providers in the following categories are essential Medicaid  
1156 providers:

1157 1. Federally qualified health centers.

1158 2. Statutory teaching hospitals as defined in s.  
1159 408.07(45).

1160 3. Hospitals that are trauma centers as defined in s.  
1161 395.4001(14).

1162 4. Hospitals located at least 25 miles from any other  
1163 hospital with similar services.

1164

1165 Managed care plans that have not contracted with all essential  
1166 providers in the region as of the first date of recipient

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1167 enrollment, or with whom an essential provider has terminated  
1168 its contract, must negotiate in good faith with such essential  
1169 providers for 1 year or until an agreement is reached, whichever  
1170 is first. Payments for services rendered by a nonparticipating  
1171 essential provider shall be made at the applicable Medicaid rate  
1172 as of the first day of the contract between the agency and the  
1173 plan. A rate schedule for all essential providers shall be  
1174 attached to the contract between the agency and the plan. After  
1175 1 year, managed care plans that are unable to contract with  
1176 essential providers shall notify the agency and propose an  
1177 alternative arrangement for securing the essential services for  
1178 Medicaid enrollees. The arrangement must rely on contracts with  
1179 other participating providers, regardless of whether those  
1180 providers are located within the same region as the  
1181 nonparticipating essential service provider. If the alternative  
1182 arrangement is approved by the agency, payments to  
1183 nonparticipating essential providers after the date of the  
1184 agency's approval shall equal 90 percent of the applicable  
1185 Medicaid rate. If the alternative arrangement is not approved by  
1186 the agency, payment to nonparticipating essential providers  
1187 shall equal 110 percent of the applicable Medicaid rate.

1188 (b) Certain providers are statewide resources and  
1189 essential providers for all managed care plans in all regions.  
1190 All managed care plans must include these essential providers in  
1191 their networks. Statewide essential providers include:

- 1192 1. Faculty plans of Florida medical schools.
- 1193 2. Regional perinatal intensive care centers as defined in  
1194 s. 383.16(2).

1195 3. Hospitals licensed as specialty children's hospitals as  
 1196 defined in s. 395.002(28).

1197  
 1198 Managed care plans that have not contracted with all statewide  
 1199 essential providers in all regions as of the first date of  
 1200 recipient enrollment must continue to negotiate in good faith.  
 1201 Payments to physicians on the faculty of nonparticipating  
 1202 Florida medical schools shall be made at the applicable Medicaid  
 1203 rate. Payments for services rendered by a regional perinatal  
 1204 intensive care centers shall be made at the applicable Medicaid  
 1205 rate as of the first day of the contract between the agency and  
 1206 the plan. Payments to nonparticipating specialty children's  
 1207 hospitals shall equal the highest rate established by contract  
 1208 between that provider and any other Medicaid managed care plan.

1209 (c) After 12 months of active participation in a plan's  
 1210 network, the plan may exclude any essential provider from the  
 1211 network for failure to meet quality or performance criteria. If  
 1212 the plan excludes an essential provider from the plan, the plan  
 1213 must provide written notice to all recipients who have chosen  
 1214 that provider for care. The notice shall be provided at least 30  
 1215 days before the effective date of the exclusion.

1216 (d) Each managed care plan must offer a network contract  
 1217 to each home medical equipment and supplies provider in the  
 1218 region which meets quality and fraud prevention and detection  
 1219 standards established by the plan and which agrees to accept the  
 1220 lowest price previously negotiated between the plan and another  
 1221 such provider.

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1222        (2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency  
1223 shall contract with a single organization representing medical  
1224 schools and graduate medical education programs in the state for  
1225 the purpose of establishing an active and ongoing program to  
1226 improve clinical outcomes in all managed care plans. Contracted  
1227 activities must support greater clinical integration for  
1228 Medicaid enrollees through interdependent and cooperative  
1229 efforts of all providers participating in managed care plans.  
1230 The agency shall support these activities with certified public  
1231 expenditures and any earned federal matching funds and shall  
1232 seek any plan amendments or waivers necessary to comply with  
1233 this subsection. To be eligible to participate in the quality  
1234 network, a medical school must contract with each managed care  
1235 plan in its region.

1236        (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall  
1237 monitor the quality and performance of each participating  
1238 provider. At the beginning of the contract period, each plan  
1239 shall notify all its network providers of the metrics used by  
1240 the plan for evaluating the provider's performance and  
1241 determining continued participation in the network.

1242        (4) MOMCARE NETWORK.—

1243        (a) The agency shall contract with an administrative  
1244 services organization representing all Healthy Start Coalitions  
1245 providing risk appropriate care coordination and other services  
1246 in accordance with a federal waiver and pursuant to s. 409.906.  
1247 The contract shall require the network of coalitions to provide  
1248 choice counseling, education, risk-reduction and case management  
1249 services, and quality assurance for all enrollees of the waiver.

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1250 The agency shall evaluate the impact of the MomCare network by  
1251 monitoring each plan's performance on specific measures to  
1252 determine the adequacy, timeliness, and quality of services for  
1253 pregnant women and infants. The agency shall support this  
1254 contract with certified public expenditures of general revenue  
1255 appropriated for Healthy Start services and any earned federal  
1256 matching funds.

1257 (b) Each managed care plan shall establish specific  
1258 programs and procedures to improve pregnancy outcomes and infant  
1259 health, including, but not limited to, coordination with the  
1260 Healthy Start program, immunization programs, and referral to  
1261 the Special Supplemental Nutrition Program for Women, Infants,  
1262 and Children, and the Children's Medical Services program for  
1263 children with special health care needs. Each plan's programs  
1264 and procedures shall include agreements with each local Healthy  
1265 Start Coalition in the region to provide risk-appropriate care  
1266 coordination for pregnant women and infants, consistent with  
1267 agency policies and the MomCare network.

1268 (5) TRANSPORTATION.—Nonemergency transportation services  
1269 shall be provided pursuant to a single, statewide contract  
1270 between the agency and the Commission for the Transportation  
1271 Disadvantaged. The agency shall establish performance standards  
1272 in the contract and shall evaluate the performance of the  
1273 Commission for the Transportation Disadvantaged. For the  
1274 purposes of this subsection, the term "nonemergency  
1275 transportation" does not include transportation by ambulance and  
1276 any medical services received during transport.

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1277        (6) SCREENING RATE.—After the end of the second contract  
1278 year, each managed care plan shall achieve an annual Early and  
1279 Periodic Screening, Diagnosis, and Treatment Service screening  
1280 rate of at least 80 percent of those recipients continuously  
1281 enrolled for at least 8 months.

1282        (7) PROVIDER PAYMENT.—Managed care plan and hospitals  
1283 shall negotiate mutually acceptable rates, methods, and terms of  
1284 payment. For rates, methods, and terms of payment negotiated  
1285 after the contract between the agency and the plan is executed,  
1286 plans shall pay hospitals, at a minimum, the rate the agency  
1287 would have paid on the first day of the contract between the  
1288 provider and the plan. Such payments to hospitals may not exceed  
1289 120 percent of the rate the agency would have paid on the first  
1290 day of the contract between the provider and the plan, unless  
1291 specifically approved by the agency. Payment rates may be  
1292 updated periodically.

1293        (8) MEDICALLY NEEDED ENROLLEES.—Each managed care plan  
1294 shall accept any medically needy recipient who selects or is  
1295 assigned to the plan and provide that recipient with continuous  
1296 enrollment for 12 months. After the first month of qualifying as  
1297 a medically needy recipient and enrolling in a plan, and  
1298 contingent upon federal approval, the enrollee shall pay the  
1299 plan a portion of the monthly premium equal to the enrollee's  
1300 share of the cost as determined by the department. The agency  
1301 shall pay any remaining portion of the monthly premium. Plans  
1302 are not obligated to pay claims for medically needy patients for  
1303 services provided before enrollment in the plan. Medically needy  
1304 patients are responsible for payment of incurred claims that are

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1305 used to determine eligibility. Plans must provide a grace period  
 1306 of at least 90 days before disenrolling recipients who fail to  
 1307 pay their shares of the premium.

1308 Section 17. Section 409.976, Florida Statutes, is created  
 1309 to read:

1310 409.976 Managed care plan payment.—In addition to the  
 1311 payment provisions of s. 409.968, the agency shall provide  
 1312 payment to plans in the managed medical assistance program  
 1313 pursuant to this section.

1314 (1) Prepaid payment rates shall be negotiated between the  
 1315 agency and the eligible plans as part of the procurement process  
 1316 described in s. 409.966.

1317 (2) The agency shall establish payment rates for statewide  
 1318 inpatient psychiatric programs. Payments to managed care plans  
 1319 shall be reconciled to reimburse actual payments to statewide  
 1320 inpatient psychiatric programs.

1321 Section 18. Section 409.977, Florida Statutes, is created  
 1322 to read:

1323 409.977 Choice counseling and enrollment.—

1324 (1) CHOICE COUNSELING.—In addition to the choice  
 1325 counseling information required by s. 409.969, the agency shall  
 1326 make available clear and easily understandable choice  
 1327 information to Medicaid recipients that includes information  
 1328 about the cost-sharing requirements of each managed care plan.

1329 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically  
 1330 enroll into a managed care plan those Medicaid recipients who do  
 1331 not voluntarily choose a plan pursuant to s. 409.969. The agency  
 1332 shall automatically enroll recipients in plans that meet or



1333 exceed the performance or quality standards established pursuant  
 1334 to s. 409.967 and may not automatically enroll recipients in a  
 1335 plan that is deficient in those performance or quality  
 1336 standards. When a specialty plan is available to accommodate a  
 1337 specific condition or diagnosis of a recipient, the agency shall  
 1338 assign the recipient to that plan. In the first year of the  
 1339 first contract term only, if a recipient was previously enrolled  
 1340 in a plan that is still available in the region, the agency  
 1341 shall automatically enroll the recipient in that plan unless an  
 1342 applicable specialty plan is available. Except as otherwise  
 1343 provided in this part, the agency may not engage in practices  
 1344 that are designed to favor one managed care plan over another.  
 1345 When automatically enrolling recipients in managed care plans,  
 1346 the agency shall automatically enroll based on the following  
 1347 criteria:

1348 (a) Whether the plan has sufficient network capacity to  
 1349 meet the needs of the recipients.

1350 (b) Whether the recipient has previously received services  
 1351 from one of the plan's primary care providers.

1352 (c) Whether primary care providers in one plan are more  
 1353 geographically accessible to the recipient's residence than  
 1354 those in other plans.

1355 (3) OPT-OUT OPTION.—The agency shall develop a process to  
 1356 enable any recipient with access to employer-sponsored health  
 1357 care coverage to opt out of all managed care plans and to use  
 1358 Medicaid financial assistance to pay for the recipient's share  
 1359 of the cost in such employer-sponsored coverage. Contingent upon  
 1360 federal approval, the agency shall also enable recipients with

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1361 access to other insurance or related products providing access  
1362 to health care services created pursuant to state law, including  
1363 any product available under the Florida Health Choices Program,  
1364 or any health exchange, to opt out. The amount of financial  
1365 assistance provided for each recipient may not exceed the amount  
1366 of the Medicaid premium that would have been paid to a managed  
1367 care plan for that recipient.

1368 Section 19. Section 409.978, Florida Statutes, is created  
1369 to read:

1370 409.978 Long-term care managed care program.—

1371 (1) Pursuant to s. 409.963, the agency shall administer  
1372 the long-term care managed care program described in ss.  
1373 409.978-409.985, but may delegate specific duties and  
1374 responsibilities for the program to the Department of Elderly  
1375 Affairs and other state agencies. By July 1, 2012, the agency  
1376 shall begin implementation of the statewide long-term care  
1377 managed care program, with full implementation in all regions by  
1378 October 1, 2013.

1379 (2) The agency shall make payments for long-term care,  
1380 including home and community-based services, using a managed  
1381 care model. Unless otherwise specified, the provisions of ss.  
1382 409.961-409.97 apply to the long-term care managed care program.

1383 (3) The Department of Elderly Affairs shall assist the  
1384 agency to develop specifications for use in the invitation to  
1385 negotiate and the model contract, determine clinical eligibility  
1386 for enrollment in managed long-term care plans, monitor plan  
1387 performance and measure quality of service delivery, assist  
1388 clients and families to address complaints with the plans,

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1389 facilitate working relationships between plans and providers  
 1390 serving elders and disabled adults, and perform other functions  
 1391 specified in a memorandum of agreement.

1392 Section 20. Section 409.979, Florida Statutes, is created  
 1393 to read:

1394 409.979 Eligibility.-

1395 (1) Medicaid recipients who meet all of the following  
 1396 criteria are eligible to receive long-term care services and  
 1397 must receive long-term care services by participating in the  
 1398 long-term care managed care program. The recipient must be:

1399 (a) Sixty-five years of age or older or eligible for  
 1400 Medicaid by reason of a disability.

1401 (b) Determined by the Comprehensive Assessment Review and  
 1402 Evaluation for Long-Term Care Services (CARES) Program to  
 1403 require nursing facility care as defined in s. 409.985(3).

1404 (2) Medicaid recipients who, on the date long-term care  
 1405 managed care plans become available in their region, reside in a  
 1406 nursing home facility or are enrolled in one of the following  
 1407 long-term care Medicaid waiver programs are eligible to  
 1408 participate in the long-term care managed care program for up to  
 1409 24 months without being reevaluated for their need of nursing  
 1410 facility care as defined in s. 409.985(3):

1411 (a) The Assisted Living for the Frail Elderly Waiver.

1412 (b) The Aged and Disabled Adult Waiver.

1413 (c) The Adult Day Health Care Waiver.

1414 (d) The Consumer-Directed Care Plus Program as described  
 1415 in s. 409.221.

1416 (e) The Program of All-inclusive Care for the Elderly.

1417        (f) The long-term care community-based diversion pilot  
 1418 project as described in s. 430.705.

1419        (g) The Channeling Services Waiver for Frail Elders.

1420        (3) The Department of Elderly Affairs shall make offers  
 1421 for enrollment to eligible individuals based on a wait-list  
 1422 prioritization and subject to availability of funds. Before  
 1423 enrollment offers, the department shall determine that  
 1424 sufficient funds exist to support additional enrollment into  
 1425 plans.

1426        Section 21. Section 409.98, Florida Statutes, is created  
 1427 to read:

1428        409.98 Benefits.—Long-term care plans shall cover, at a  
 1429 minimum, the following:

1430        (1) Nursing facility care.

1431        (2) Services provided in assisted living facilities.

1432        (3) Hospice.

1433        (4) Adult day care.

1434        (5) Medical equipment and supplies, including incontinence  
 1435 supplies.

1436        (6) Personal care.

1437        (7) Home accessibility adaptation.

1438        (8) Behavior management.

1439        (9) Home-delivered meals.

1440        (10) Case management.

1441        (11) Therapies:

1442        (a) Occupational therapy.

1443        (b) Speech therapy.

1444        (c) Respiratory therapy.

- 1445        (d) Physical therapy.
- 1446        (12) Intermittent and skilled nursing.
- 1447        (13) Medication administration.
- 1448        (14) Medication management.
- 1449        (15) Nutritional assessment and risk reduction.
- 1450        (16) Caregiver training.
- 1451        (17) Respite care.
- 1452        (18) Transportation.
- 1453        (19) Personal emergency response system.

1454        Section 22. Section 409.981, Florida Statutes, is created  
 1455 to read:

1456        409.981 Eligible plans.—

1457        (1) ELIGIBLE PLANS.—Provider service networks must be  
 1458 long-term care provider service networks. Other eligible plans  
 1459 may either be long-term care plans or comprehensive long-term  
 1460 care plans.

1461        (2) ELIGIBLE PLAN SELECTION.—The agency shall select  
 1462 eligible plans through the procurement process described in s.  
 1463 409.966. The agency shall provide notice of invitations to  
 1464 negotiate no later than July 1, 2012.

1465        (a) The agency shall procure three plans for Region I. At  
 1466 least one plan shall be a provider service network, if any  
 1467 submit a responsive bid.

1468        (b) The agency shall procure three plans for Region II. At  
 1469 least one plan shall be a provider service network, if any  
 1470 provider service network submits a responsive bid.

1471        (c) The agency shall procure at least three plans and no  
 1472 more than four plans for Region III. At least two plans shall be

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1473 provider service networks, if any two provider service networks  
1474 submit responsive bids.

1475 (d) The agency shall procure at least four plans and no  
1476 more than seven plans for Region IV. At least two plans shall be  
1477 provider service networks if any two provider service networks  
1478 submit responsive bids.

1479 (e) The agency shall procure at least five plans and no  
1480 more than eight plans for Region V. At least two plans shall be  
1481 provider service networks, if any two provider service networks  
1482 submit responsive bids.

1483 (f) The agency shall procure at least three plans and no  
1484 more than four plans for Region VI. At least one plan shall be a  
1485 provider service network, if any provider service network  
1486 submits a responsive bid.

1487 (g) The agency shall procure at least four plans and no  
1488 more than seven plans for Region VII. At least two plans shall  
1489 be provider service networks, if any two provider service  
1490 networks submit responsive bids.

1491 (h) The agency shall procure at least five plans and no  
1492 more than nine plans for Region VIII. At least two plans shall  
1493 be provider service networks, if any two provider service  
1494 networks submit a responsive bid.

1495  
1496 If no provider service network submits a responsive bid, the  
1497 agency shall procure one fewer eligible plan in each of the  
1498 regions. Within 12 months after the initial invitation to  
1499 negotiate, the agency shall attempt to procure an eligible plan  
1500 that is a provider service network. The agency shall notice

1501 another invitation to negotiate only with provider service  
 1502 networks in a region where no provider service network has been  
 1503 selected.

1504 (3) QUALITY SELECTION CRITERIA.—In addition to the  
 1505 criteria established in s. 409.966, the agency shall consider  
 1506 the following factors in the selection of eligible plans:

1507 (a) Evidence of the employment of executive managers with  
 1508 expertise and experience in serving aged and disabled persons  
 1509 who require long-term care.

1510 (b) Whether a plan has established a network of service  
 1511 providers dispersed throughout the region and in sufficient  
 1512 numbers to meet specific service standards established by the  
 1513 agency for specialty services for persons receiving home and  
 1514 community-based care.

1515 (c) Whether a plan is proposing to establish a  
 1516 comprehensive long-term care plan and whether the eligible plan  
 1517 has a contract to provide managed medical assistance services in  
 1518 the same region.

1519 (d) Whether a plan offers consumer-directed care services  
 1520 to enrollees pursuant to s. 409.221.

1521 (e) Whether a plan is proposing to provide home and  
 1522 community-based services in addition to the minimum benefits  
 1523 required by s. 409.98.

1524 (4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—  
 1525 Participation by the Program of All-Inclusive Care for the  
 1526 Elderly (PACE) shall be pursuant to a contract with the agency  
 1527 and not subject to the procurement requirements or regional plan  
 1528 number limits of this section. PACE plans may continue to

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1529 provide services to individuals at such levels and enrollment  
1530 caps as authorized by the General Appropriations Act.

1531 Section 23. Section 409.982, Florida Statutes, is created  
1532 to read:

1533 409.982 Managed care plan accountability.—In addition to  
1534 the requirements of s. 409.967, plans and providers  
1535 participating in the long-term care managed care program shall  
1536 comply with the requirements of this section.

1537 (1) PROVIDER NETWORKS.—Managed care plans may limit the  
1538 providers in their networks based on credentials, quality  
1539 indicators, and price. For the period between October 1, 2013,  
1540 and September 30, 2014, each selected plan must offer a network  
1541 contract to all the following providers in the region:

1542 (a) Nursing homes.

1543 (b) Hospices.

1544 (c) Aging network service providers that have previously  
1545 participated in home and community-based waivers serving elders  
1546 or community-service programs administered by the Department of  
1547 Elderly Affairs.

1548  
1549 After 12 months of active participation in a managed care plan's  
1550 network, the plan may exclude any of the providers named in this  
1551 subsection from the network for failure to meet quality or  
1552 performance criteria. If the plan excludes a provider from the  
1553 plan, the plan must provide written notice to all recipients who  
1554 have chosen that provider for care. The notice shall be provided  
1555 at least 30 days before the effective date of the exclusion. The



1556 agency shall establish contract provisions governing the  
 1557 transfer of recipients from excluded residential providers.

1558 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in  
 1559 this subsection, providers may limit the managed care plans they  
 1560 join. Nursing homes and hospices that are enrolled Medicaid  
 1561 providers must participate in all eligible plans selected by the  
 1562 agency in the region in which the provider is located.

1563 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall  
 1564 monitor the quality and performance of each participating  
 1565 provider using measures adopted by and collected by the agency  
 1566 and any additional measures mutually agreed upon by the provider  
 1567 and the plan

1568 (4) PROVIDER NETWORK STANDARDS.—The agency shall establish  
 1569 and each managed care plan must comply with specific standards  
 1570 for the number, type, and regional distribution of providers in  
 1571 the plan's network, which must include:

- 1572 (a) Adult day care centers.
- 1573 (b) Adult family-care homes.
- 1574 (c) Assisted living facilities.
- 1575 (d) Health care services pools.
- 1576 (e) Home health agencies.
- 1577 (f) Homemaker and companion services.
- 1578 (g) Hospices.
- 1579 (h) Community care for the elderly lead agencies.
- 1580 (i) Nurse registries.
- 1581 (j) Nursing homes.

1582 (5) PROVIDER PAYMENT.—Managed care plans and providers  
 1583 shall negotiate mutually acceptable rates, methods, and terms of

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1584 payment. Plans shall pay nursing homes an amount equal to the  
 1585 nursing facility-specific payment rates set by the agency;  
 1586 however, mutually acceptable higher rates may be negotiated for  
 1587 medically complex care. Plans shall pay hospice providers an  
 1588 amount equal to the per diem rate set by the agency. For  
 1589 recipients residing in a nursing facility and receiving hospice  
 1590 services, the plan shall pay the hospice provider the per diem  
 1591 rate set by the agency minus the nursing facility component and  
 1592 shall pay the nursing facility the applicable state rate. Plans  
 1593 shall ensure that electronic nursing home and hospice claims  
 1594 that contain sufficient information for processing are paid  
 1595 within 10 business days after receipt.

1596 Section 24. Section 409.983, Florida Statutes, is created  
 1597 to read:

1598 409.983 Managed care plan payment.—In addition to the  
 1599 payment provisions of s. 409.968, the agency shall provide  
 1600 payment to plans in the long-term care managed care program  
 1601 pursuant to this section.

1602 (1) Prepaid payment rates for long-term care managed care  
 1603 plans shall be negotiated between the agency and the eligible  
 1604 plans as part of the procurement process described in s.  
 1605 409.966.

1606 (2) Payment rates for comprehensive long-term care plans  
 1607 covering services described in s. 409.973 shall be blended with  
 1608 rates for long-term care plans for services specified in s.  
 1609 409.98.

1610 (3) Payment rates for plans shall reflect historic  
 1611 utilization and spending for covered services projected forward

1612 and adjusted to reflect the level of care profile for enrollees  
 1613 in each plan. The payment shall be adjusted to provide an  
 1614 incentive for reducing institutional placements and increasing  
 1615 the utilization of home and community-based services.

1616 (4) The initial assessment of an enrollee's level of care  
 1617 shall be made by the Comprehensive Assessment and Review for  
 1618 Long-Term-Care Services (CARES) program, which shall assign the  
 1619 recipient into one of the following levels of care:

1620 (a) Level of care 1 consists of recipients residing in or  
 1621 who must be placed in a nursing home.

1622 (b) Level of care 2 consists of recipients at imminent  
 1623 risk of nursing home placement, as evidenced by the need for the  
 1624 constant availability of routine medical and nursing treatment  
 1625 and care, and require extensive health-related care and services  
 1626 because of mental or physical incapacitation.

1627 (c) Level of care 3 consists of recipients at imminent  
 1628 risk of nursing home placement, as evidenced by the need for the  
 1629 constant availability of routine medical and nursing treatment  
 1630 and care, who have a limited need for health-related care and  
 1631 services and are mildly medically or physically incapacitated.

1632  
 1633 The agency shall periodically adjust payment rates to account  
 1634 for changes in the level of care profile for each managed care  
 1635 plan based on encounter data.

1636 (5) The agency shall make an incentive adjustment in  
 1637 payment rates to encourage the increased utilization of home and  
 1638 community-based services and a commensurate reduction of  
 1639 institutional placement. The incentive adjustment shall be

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1640 modified in each successive rate period during the first  
1641 contract period, as follows:

1642 (a) A 2 percentage point shift in the first rate-setting  
1643 period;

1644 (b) A 2 percentage point shift in the second rate-setting  
1645 period, as compared to the utilization mix at the end of the  
1646 first rate-setting period;

1647 (c) A 3 percentage point shift in the third rate-setting  
1648 period, and in each subsequent rate-setting period during the  
1649 first contract period, as compared to the utilization mix at the  
1650 end of the immediately preceding rate-setting period.

1651  
1652 The incentive adjustment shall continue in subsequent contract  
1653 periods, at a rate of 3 percentage points per year as compared  
1654 to the utilization mix at the end of the immediately preceding  
1655 rate-setting period, until no more than 35 percent of the plan's  
1656 enrollees are placed in institutional settings. The agency shall  
1657 annually report to the Legislature the actual change in the  
1658 utilization mix of home and community-based services compared to  
1659 institutional placements and provide a recommendation for  
1660 utilization mix requirements for future contracts.

1661 (6) The agency shall establish nursing-facility-specific  
1662 payment rates for each licensed nursing home based on facility  
1663 costs adjusted for inflation and other factors as authorized in  
1664 the General Appropriations Act. Payments to long-term care  
1665 managed care plans shall be reconciled to reimburse actual  
1666 payments to nursing facilities.

1667 (7) The agency shall establish hospice payment rates.

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1668 Payments to long-term care managed care plans shall be  
 1669 reconciled to reimburse actual payments to hospices.

1670 Section 25. Section 409.984, Florida Statutes, is created  
 1671 to read:

1672 409.984 Choice counseling; enrollment.—

1673 (1) CHOICE COUNSELING.—Before contracting with a vendor to  
 1674 provide choice counseling as authorized under s. 409.969, the  
 1675 agency shall offer to contract with aging resource centers  
 1676 established under s. 430.2053 for choice counseling services. If  
 1677 the aging resource center is determined not to be the vendor  
 1678 that provides choice counseling, the agency shall establish a  
 1679 memorandum of understanding with the aging resource center to  
 1680 coordinate staffing and collaborate with the choice counseling  
 1681 vendor. In addition to the requirements of s. 409.969, any  
 1682 contract to provide choice counseling for the long-term care  
 1683 managed care program shall provide that each recipient be given  
 1684 the option of having in-person choice counseling.

1685 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically  
 1686 enroll into a long-term care managed care plan those Medicaid  
 1687 recipients who do not voluntarily choose a plan pursuant to s.  
 1688 409.969. The agency shall automatically enroll recipients in  
 1689 plans that meet or exceed the performance or quality standards  
 1690 established pursuant to s. 409.967 and may not automatically  
 1691 enroll recipients in a plan that is deficient in those  
 1692 performance or quality standards. If a recipient is deemed  
 1693 dually eligible for Medicaid and Medicare services and is  
 1694 currently receiving Medicare services from an entity qualified  
 1695 under 42 C.F.R. part 422 as a Medicare Advantage Preferred

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1696 Provider Organization, Medicare Advantage Provider-sponsored  
 1697 Organization, or Medicare Advantage Special Needs Plan, the  
 1698 agency shall automatically enroll the recipient in such plan for  
 1699 Medicaid services if the plan is currently participating in the  
 1700 long-term care managed care program. Except as otherwise  
 1701 provided in this part, the agency may not engage in practices  
 1702 that are designed to favor one managed care plan over another.  
 1703 When automatically enrolling recipients in plans, the agency  
 1704 shall take into account the following criteria:

1705 (a) Whether the plan has sufficient network capacity to  
 1706 meet the needs of the recipients.

1707 (b) Whether the recipient has previously received services  
 1708 from one of the plan's home and community-based service  
 1709 providers.

1710 (c) Whether the home and community-based providers in one  
 1711 plan are more geographically accessible to the recipient's  
 1712 residence than those in other plans.

1713 (3) HOSPICE SELECTION.—Notwithstanding the provisions of  
 1714 s. 409.969(3)(c), when a recipient is referred for hospice  
 1715 services, the recipient shall have a 30-day period during which  
 1716 the recipient may select to enroll in another managed care plan  
 1717 to access the hospice provider of the recipient's choice.

1718 (4) CHOICE OF RESIDENTIAL SETTING.—When a recipient is  
 1719 referred for placement in a nursing home or assisted living  
 1720 facility, the plan shall inform the recipient of any facilities  
 1721 within the plan that have specific cultural or religious  
 1722 affiliations and, if requested by the recipient, make a  
 1723 reasonable effort to place the recipient in the facility of the

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1724 recipient's choice.

1725 Section 26. Section 409.9841, Florida Statutes, is created  
1726 to read:

1727 409.9841 Long-term care managed care technical advisory  
1728 workgroup.—

1729 (1) Before August 1, 2011, the agency shall establish a  
1730 technical advisory workgroup to assist in developing:

1731 (a) The method of determining Medicaid eligibility  
1732 pursuant to s. 409.985(3).

1733 (b) The requirements for provider payments to nursing  
1734 homes under s. 409.983(6).

1735 (c) The method for managing Medicare coinsurance crossover  
1736 claims.

1737 (d) Uniform requirements for claims submissions and  
1738 payments, including electronic funds transfers and claims  
1739 processing.

1740 (e) The process for enrollment of and payment for  
1741 individuals pending determination of Medicaid eligibility.

1742 (2) The advisory workgroup shall include, but is not  
1743 limited to, representatives of providers and plans who could  
1744 potentially participate in long-term care managed care. Members  
1745 of the workgroup shall serve without compensation but may be  
1746 reimbursed for per diem and travel expenses as provided in s.  
1747 112.061.

1748 (3) This section is repealed on June 30, 2013.

1749 Section 27. Section 409.985, Florida Statutes, is created  
1750 to read:

1751 409.985 Comprehensive Assessment and Review for Long-Term

1752 Care Services (CARES) Program.—

1753 (1) The agency shall operate the Comprehensive Assessment  
 1754 and Review for Long-Term Care Services (CARES) preadmission  
 1755 screening program to ensure that only individuals whose  
 1756 conditions require long-term care services are enrolled in the  
 1757 long-term care managed care program.

1758 (2) The agency shall operate the CARES program through an  
 1759 interagency agreement with the Department of Elderly Affairs.  
 1760 The agency, in consultation with the Department of Elderly  
 1761 Affairs, may contract for any function or activity of the CARES  
 1762 program, including any function or activity required by 42  
 1763 C.F.R. part 483.20, relating to preadmission screening and  
 1764 review.

1765 (3) The CARES program shall determine if an individual  
 1766 requires nursing facility care and, if the individual requires  
 1767 such care, assign the individual to a level of care as described  
 1768 in s. 409.983(4). When determining the need for nursing facility  
 1769 care, consideration shall be given to the nature of the services  
 1770 prescribed and which level of nursing or other health care  
 1771 personnel meets the qualifications necessary to provide such  
 1772 services and the availability to and access by the individual of  
 1773 community or alternative resources. For the purposes of the  
 1774 long-term care managed care program, the term "nursing facility  
 1775 care" means the individual:

1776 (a) Requires nursing home placement as evidenced by the  
 1777 need for medical observation throughout a 24-hour period and  
 1778 care required to be performed on a daily basis by, or under the  
 1779 direct supervision of, a registered nurse or other health care



1780 professional and requires services that are sufficiently  
 1781 medically complex to require supervision, assessment, planning,  
 1782 or intervention by a registered nurse because of a mental or  
 1783 physical incapacitation by the individual;

1784 (b) Requires or is at imminent risk of nursing home  
 1785 placement as evidenced by the need for observation throughout a  
 1786 24-hour period and care and the constant availability of medical  
 1787 and nursing treatment and requires services on a daily or  
 1788 intermittent basis that are to be performed under the  
 1789 supervision of licensed nursing or other health professionals  
 1790 because the individual who is incapacitated mentally or  
 1791 physically; or

1792 (c) Requires or is at imminent risk of nursing home  
 1793 placement as evidenced by the need for observation throughout a  
 1794 24-hour period and care and the constant availability of medical  
 1795 and nursing treatment and requires limited services that are to  
 1796 be performed under the supervision of licensed nursing or other  
 1797 health professionals because the individual is mildly  
 1798 incapacitated mentally or physically.

1799 (4) For individuals whose nursing home stay is initially  
 1800 funded by Medicare and Medicare coverage and is being terminated  
 1801 for lack of progress towards rehabilitation, CARES staff shall  
 1802 consult with the person making the determination of progress  
 1803 toward rehabilitation to ensure that the recipient is not being  
 1804 inappropriately disqualified from Medicare coverage. If, in  
 1805 their professional judgment, CARES staff believe that a Medicare  
 1806 beneficiary is still making progress toward rehabilitation, they  
 1807 may assist the Medicare beneficiary with an appeal of the

1808 disqualification from Medicare coverage. The use of CARES teams  
 1809 to review Medicare denials for coverage under this section is  
 1810 authorized only if it is determined that such reviews qualify  
 1811 for federal matching funds through Medicaid. The agency shall  
 1812 seek or amend federal waivers as necessary to implement this  
 1813 section.

1814 Section 28. Section 409.986, Florida Statutes, is created  
 1815 to read:

1816 409.986 Managed long-term care for persons with  
 1817 developmental disabilities.-

1818 (1) Pursuant to s. 409.963, the agency is responsible for  
 1819 administering the long-term care managed care program for  
 1820 persons with developmental disabilities described in ss.  
 1821 409.986-409.992, but may delegate specific duties and  
 1822 responsibilities for the program to the Agency for Persons with  
 1823 Disabilities and other state agencies. By January 1, 2015, the  
 1824 agency shall begin implementation of statewide long-term care  
 1825 managed care for persons with developmental disabilities, with  
 1826 full implementation in all regions by October 1, 2016.

1827 (2) The agency shall make payments for long-term care for  
 1828 persons with developmental disabilities, including home and  
 1829 community-based services, using a managed care model. Unless  
 1830 otherwise specified, the provisions of ss. 409.961-409.97 apply  
 1831 to the long-term care managed care program for persons with  
 1832 developmental disabilities.

1833 (3) The Agency for Persons with Disabilities shall assist  
 1834 the agency to develop the specifications for use in the  
 1835 invitations to negotiate and the model contract, determine

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1836 clinical eligibility for enrollment in long-term care plans for  
 1837 persons with developmental disabilities, assist the agency to  
 1838 monitor plan performance and measure quality, assist clients and  
 1839 families to address complaints with the plans, facilitate  
 1840 working relationships between plans and providers serving  
 1841 persons with developmental disabilities, and perform other  
 1842 functions specified in a memorandum of agreement.

1843 Section 29. Section 409.987, Florida Statutes, is created  
 1844 to read:

1845 409.987 Eligibility.—

1846 (1) Medicaid recipients who meet all of the following  
 1847 criteria are eligible and shall be enrolled in a comprehensive  
 1848 long-term care plan or long-term care plan:

1849 (a) Is Medicaid eligible pursuant to s. 409.904.

1850 (b) Is a Florida resident who has a developmental  
 1851 disability as defined in s. 393.063.

1852 (c) Meets the level of care need, including:

1853 1. The recipient's intelligence quotient is 59 or less;

1854 2. The recipient's intelligence quotient is 60-69,  
 1855 inclusive, and the recipient has a secondary condition that  
 1856 includes cerebral palsy, spina bifida, Prader-Willi syndrome,  
 1857 epilepsy, or autistic disorder or has ambulation, sensory,  
 1858 chronic health, and behavioral problems;

1859 3. The recipient's intelligence quotient is 60-69,  
 1860 inclusive, and the recipient has severe functional limitations  
 1861 in at least three major life activities, including self-care,  
 1862 learning, mobility, self-direction, understanding and use of  
 1863 language, and capacity for independent living; or

1864           4. The recipient is eligible under a primary disability of  
 1865 autistic disorder, cerebral palsy, spina bifida, or Prader-Willi  
 1866 syndrome. In addition, the condition must result in substantial  
 1867 functional limitations in three or more major life activities,  
 1868 including self-care, learning, mobility, self-direction,  
 1869 understanding and use of language, and capacity for independent  
 1870 living.

1871           (d) Meets the level of care need to receive services in an  
 1872 intermediate care facility for the developmentally disabled.

1873           (e) Is enrolled in a home and community-based Medicaid  
 1874 waiver established in chapter 393 or the Consumer Directed Care  
 1875 Plus program for persons with developmental disabilities under  
 1876 the Medicaid state plan, is a Medicaid-funded resident of a  
 1877 private intermediate care facility for the developmentally  
 1878 disabled on the date the managed long-term care plans for  
 1879 persons with disabilities becomes available in the recipient's  
 1880 region, or has been offered enrollment in a comprehensive long-  
 1881 term care plan or a long-term care plan.

1882           (2) The Agency for Persons with Disabilities shall make  
 1883 offers for enrollment to eligible individuals based on the wait-  
 1884 list prioritization in s. 393.065(5) and subject to availability  
 1885 of funds. Before enrollment offers, the agency shall determine  
 1886 that sufficient funds exist to support additional enrollment  
 1887 into plans.

1888           (3) Unless specifically exempted, all eligible persons  
 1889 must be enrolled in a comprehensive long-term care plan or a  
 1890 long-term care plan. Medicaid recipients who are residents of a  
 1891 developmental disability center, including Sunland Center in

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1892 Marianna and Tacachale Center in Gainesville, are exempt from  
 1893 mandatory enrollment but may voluntarily enroll in a long-term  
 1894 care plan.

1895 Section 30. Section 409.988, Florida Statutes, is created  
 1896 to read:

1897 409.988 Benefits.—Managed care plans shall cover, at a  
 1898 minimum, the services in this section. Plans may customize  
 1899 benefit packages or offer additional benefits to meet the needs  
 1900 of enrollees in the plan.

1901 (1) Intermediate care for the developmentally disabled.

1902 (2) Services in alternative residential settings,  
 1903 including, but not limited to:

1904 (a) Group homes licensed under chapter 393 and foster care  
 1905 homes licensed under chapter 409.

1906 (b) Comprehensive transitional education programs licensed  
 1907 under chapter 393.

1908 (c) Residential habilitation centers licensed under  
 1909 chapter 393.

1910 (d) Assisted living facilities licensed under chapter 429  
 1911 and transitional living facilities licensed under part V of  
 1912 chapter 400.

1913 (3) Adult day training.

1914 (4) Behavior analysis services.

1915 (5) Companion services.

1916 (6) Consumable medical supplies.

1917 (7) Durable medical equipment and supplies.

1918 (8) Environmental accessibility adaptations.

1919 (9) In-home support services.

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- 1920           (10) Therapies, including occupational, speech,
- 1921 respiratory, and physical therapy.
- 1922           (11) Personal care assistance.
- 1923           (12) Residential habilitation services.
- 1924           (13) Intensive behavioral residential habilitation
- 1925 services.
- 1926           (14) Behavior focus residential habilitation services.
- 1927           (15) Residential nursing services.
- 1928           (16) Respite care.
- 1929           (17) Support coordination.
- 1930           (18) Supported employment.
- 1931           (19) Supported living coaching.
- 1932           (20) Transportation.

1933           Section 31. Section 409.989, Florida Statutes, is created  
 1934 to read:

1935           409.989 Eligible plans.—

1936           (1) ELIGIBLE PLANS.—Provider service networks may be  
 1937 either long-term care plans or comprehensive long-term care  
 1938 plans. Other plans must be comprehensive long-term care plans  
 1939 and under contract to provide services pursuant to s. 409.973 or  
 1940 s. 409.98 in any of the regions that form the combined region as  
 1941 defined in this section.

1942           (2) PROVIDER SERVICE NETWORKS.—Provider service networks  
 1943 targeted to serve persons with disabilities must include one or  
 1944 more owners licensed pursuant to s. 393.067 or s. 400.962 and  
 1945 with at least 10 years' experience in serving this population.

1946           (3) ELIGIBLE PLAN SELECTION.—The agency shall select  
 1947 eligible plans through the procurement process described in s.

1948 409.966. The agency shall notice invitations to negotiate no  
 1949 later than January 1, 2015.

1950 (a) The agency shall procure at least two plans and no  
 1951 more than three plans for services in combined Regions I, II,  
 1952 and III. At least one plan shall be a provider service network,  
 1953 if any submit a responsive bid.

1954 (b) The agency shall procure at least two plans and no  
 1955 more than three plans for services in combined Regions IV and V.  
 1956 At least one plan shall be a provider service network, if any  
 1957 submit a responsive bid.

1958 (c) The agency shall procure at least two plans and no  
 1959 more than four plans for services in combined Regions VI, VII,  
 1960 and VIII. At least one plan shall be a provider service network,  
 1961 if any submit a responsive bid.

1962  
 1963 If no provider service network submits a responsive bid, the  
 1964 agency shall procure no more than one less than the maximum  
 1965 number of eligible plans permitted in the combined region.  
 1966 Within 12 months after the initial invitation to negotiate, the  
 1967 agency shall attempt to procure an eligible plan that is a  
 1968 provider service network. The agency shall notice another  
 1969 invitation to negotiate only with provider service networks in  
 1970 such combined region where no provider service network has been  
 1971 selected.

1972 (4) QUALITY SELECTION CRITERIA.—In addition to the  
 1973 criteria established in s. 409.966, the agency shall consider  
 1974 the following factors in the selection of eligible plans:

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1975 (a) Whether the plan has sufficient specialized staffing,  
 1976 including employment of executive managers with expertise and  
 1977 experience in serving persons with developmental disabilities.

1978 (b) Whether the plan has sufficient network  
 1979 qualifications, including establishment of a network of service  
 1980 providers dispersed throughout the combined region and in  
 1981 sufficient numbers to meet specific accessibility standards  
 1982 established by the agency for specialty services for persons  
 1983 with developmental disabilities.

1984 (c) Whether the plan has written agreements or signed  
 1985 contracts or has made substantial progress in establishing  
 1986 relationships with providers before the plan submitting a  
 1987 response. The agency shall give preference to plans with  
 1988 evidence of signed contracts with providers listed in s.  
 1989 409.99(1).

1990 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's  
 1991 Medical Services Network may provide either long-term care plans  
 1992 or comprehensive long-term care plans. Participation by the  
 1993 Children's Medical Services Network shall be pursuant to a  
 1994 single, statewide contract with the agency not subject to the  
 1995 procurement requirements or regional plan number limits of this  
 1996 section. The Children's Medical Services Network must meet all  
 1997 other plan requirements.

1998 Section 32. Section 409.99, Florida Statutes, is created  
 1999 to read:

2000 409.99 Managed care plan accountability.—In addition to  
 2001 the requirements of s. 409.967, managed care plans and providers  
 2002 shall comply with the requirements of this section.



2003           (1) PROVIDER NETWORKS.—Managed care plans may limit the  
 2004 providers in their networks based on credentials, quality  
 2005 indicators, and price. However, in the first contract period  
 2006 after an eligible plan is selected in a region by the agency,  
 2007 the plan must offer a network contract to the following  
 2008 providers in the region:

2009           (a) Providers with licensed institutional care facilities  
 2010 for the developmentally disabled.

2011           (b) Providers of alternative residential facilities  
 2012 specified in s. 409.988.

2013  
 2014 After 12 months of active participation in a managed care plan  
 2015 network, the plan may exclude any of the above-named providers  
 2016 from the network for failure to meet quality or performance  
 2017 criteria. If the plan excludes a provider from the plan, the  
 2018 plan must provide written notice to all recipients who have  
 2019 chosen that provider for care. The notice shall be issued at  
 2020 least 90 days before the effective date of the exclusion.

2021           (2) SELECT PROVIDER PARTICIPATION.—Except as provided in  
 2022 this subsection, providers may limit the managed care plans they  
 2023 join. Licensed institutional care facilities for the  
 2024 developmentally disabled and licensed residential settings  
 2025 providing Intensive Behavioral Residential Habilitation services  
 2026 with an active Medicaid provider agreement must agree to  
 2027 participate in any eligible plan selected by the agency.

2028           (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall  
 2029 monitor the quality and performance of each participating  
 2030 provider. At the beginning of the contract period, each plan

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2031 shall notify all its network providers of the metrics used by  
 2032 the plan for evaluating the provider's performance and  
 2033 determining continued participation in the network.

2034 (4) PROVIDER PAYMENT.—Managed care plans and providers  
 2035 shall negotiate mutually acceptable rates, methods, and terms of  
 2036 payment. Plans shall pay intermediate care facilities for the  
 2037 developmentally disabled and intensive behavior residential  
 2038 habilitation providers an amount equal to the facility-specific  
 2039 payment rate set by the agency.

2040 (5) CONSUMER AND FAMILY INVOLVEMENT.—Each managed care  
 2041 plan must establish a family advisory committee to participate  
 2042 in program design and oversight.

2043 (6) CONSUMER-DIRECTED CARE.—Each managed care plan must  
 2044 offer consumer-directed care services to enrollees pursuant to  
 2045 s. 409.221.

2046 Section 33. Section 409.991, Florida Statutes, is created  
 2047 to read:

2048 409.991 Managed care plan payment.—In addition to the  
 2049 payment provisions of s. 409.968, the agency shall provide  
 2050 payment to comprehensive long-term care plans and long-term care  
 2051 plans pursuant to this section.

2052 (1) Prepaid payment rates shall be negotiated between the  
 2053 agency and the eligible plans as part of the procurement process  
 2054 described in s. 409.966.

2055 (2) Payment for comprehensive long-term care plans  
 2056 covering services pursuant to s. 409.973 shall be blended with  
 2057 payments for long-term care plans for services specified in s.  
 2058 409.988.

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2059 (3) Payment rates for plans covering services specified in  
2060 s. 409.988 shall be based on historical utilization and spending  
2061 for covered services projected forward and adjusted to reflect  
2062 the level-of-care profile of each plan's enrollees.

2063 (4) The Agency for Persons with Disabilities shall conduct  
2064 the initial assessment of an enrollee's level of care. The  
2065 evaluation of level of care shall be based on assessment and  
2066 service utilization information from the most recent version of  
2067 the Questionnaire for Situational Information and encounter  
2068 data.

2069 (5) The agency shall assign enrollees of developmental  
2070 disabilities long-term care plans into one of five levels of  
2071 care to account for variations in risk status and service needs  
2072 among enrollees.

2073 (a) Level of care 1 consists of individuals receiving  
2074 services in an intermediate care facility for the  
2075 developmentally disabled.

2076 (b) Level of care 2 consists of individuals with intensive  
2077 medical or adaptive needs and who require essential services to  
2078 avoid institutionalization or who possess behavioral problems  
2079 that are exceptional in intensity, duration, or frequency and  
2080 present a substantial risk of harm to themselves or others.

2081 (c) Level of care 3 consists of individuals with service  
2082 needs, including a licensed residential facility and a moderate  
2083 level of support for standard residential habilitation services  
2084 or a minimal level of support for behavior focus residential  
2085 habilitation services, or individuals in supported living who  
2086 require more than 6 hours a day of in-home support services.

2087 (d) Level of care 4 consists of individuals requiring less  
 2088 than a moderate level of residential habilitation support in a  
 2089 residential placement or individuals in supported living who  
 2090 require 6 hours a day or less of in-home support services.

2091 (e) Level of care 5 consists of individuals who do not  
 2092 receive in-home support services and need minimal support  
 2093 services while living in independent or supported living  
 2094 situations or in their family home.

2095  
 2096 The agency shall periodically adjust aggregate payments to plans  
 2097 based on encounter data to account for variations in risk levels  
 2098 among plans' enrollees.

2099 (6) The agency shall establish intensive behavior  
 2100 residential habilitation rates for providers approved by the  
 2101 agency to provide this service. The agency shall also establish  
 2102 intermediate care facility for the developmentally disabled-  
 2103 specific payment rates for each licensed intermediate care  
 2104 facility. Payments to intermediate care facilities for the  
 2105 developmentally disabled and providers of intensive behavior  
 2106 residential habilitation services shall be reconciled to  
 2107 reimburse the plan's actual payments to the facilities.

2108 Section 34. Section 409.992, Florida Statutes, is created  
 2109 to read:

2110 409.992 Automatic enrollment.—The agency shall  
 2111 automatically enroll into a comprehensive long-term care plan or  
 2112 a long-term care plan those Medicaid recipients who do not  
 2113 voluntarily choose a plan pursuant to s. 409.969. The agency  
 2114 shall automatically enroll recipients in plans that meet or

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2115 exceed the performance or quality standards established pursuant  
2116 to s. 409.967 and shall not automatically enroll recipients in a  
2117 plan that is deficient in those performance or quality  
2118 standards. Except as otherwise provided in this part, the agency  
2119 shall assign individuals who are deemed dually eligible for  
2120 Medicaid and Medicare to a plan that provides both Medicaid and  
2121 Medicare services. The agency may not engage in practices that  
2122 are designed to favor one managed care plan over another. When  
2123 automatically enrolling recipients in plans, the agency shall  
2124 take into account the following criteria:

2125 (1) Whether the plan has sufficient network capacity to  
2126 meet the needs of the recipients.

2127 (2) Whether the recipient has previously received services  
2128 from one of the plan's home and community-based service  
2129 providers.

2130 (3) Whether home and community-based providers in one plan  
2131 are more geographically accessible to the recipient's residence  
2132 than those in other plans.

2133 Section 35. This act shall take effect July 1, 2011.