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.

225

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

227

228 Section 1. Sections 409.961 through 409.992, Florida
229 Statutes, are designated as part IV of chapter 409, Florida
230 Statutes, entitled "Medicaid Managed Care."
231 Section 2. Section 409.961, Florida Statutes, is created
232 to read:
233 409.961 Statutory construction; applicability; rules.—It
234 is the intent of the Legislature that if any conflict exists
235 between the provisions contained in this part and provisions
236 contained in other parts of this chapter, the provisions
237 contained in this part shall control. The provisions of ss.
238 409.961-409.97 apply only to the Medicaid managed medical
239 assistance program, long-term care managed care program, and
240 managed long-term care for persons with developmental
241 disabilities program, as provided in this part. The agency shall
242 adopt any rules necessary to comply with or administer this part
243 and all rules necessary to comply with federal requirements. In
244 addition, the department shall adopt and accept the transfer of
245 any rules necessary to carry out the department's
246 responsibilities for receiving and processing Medicaid
247 applications and determining Medicaid eligibility and for
248 ensuring compliance with and administering this part, as those
249 rules relate to the department's responsibilities, and any other
250 provisions related to the department's responsibility for the
251 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

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

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

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.
472

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 for the same managed care program that have a business
477 relationship with each other. Failure to disclose any business
478 relationship shall result in disqualification from participation
479 in any region for the first full contract period after the
480 discovery of the business relationship by the agency. For the
481 purpose of this section, "business relationship" means an
482 ownership or controlling interest, an affiliate or subsidiary
483 relationship, a common parent, or any mutual interest in any
484 limited partnership, limited liability partnership, limited
485 liability company, or other entity or business association,
486 including all wholly or partially owned subsidiaries, majority-
487 owned subsidiaries, parent companies, or affiliates of such
488 entities, business associations, or other enterprises, that
489 exists for the purpose 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.

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. If a plan that is
513 awarded an additional contract pursuant to this paragraph is
514 subject to penalties pursuant to s. 409.967(2)(g) for activities
515 in Region I, the additional contract is automatically terminated
516 180 days after the imposition of the penalties. The plan shall
517 reimburse the agency for the cost of enrollment changes and
518 other transition activities, including the cost of additional
519 choice counseling services.
520 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that
521 participates in an invitation to negotiate in more than one
522 region and is selected in at least one region may not begin
523 serving Medicaid recipients in any region for which it was
524 selected until all administrative challenges to procurements
525 required by this section to which the eligible plan is a party
526 have been finalized. If the number of plans selected is less
527 than the maximum amount of plans permitted in the region, the
528 agency may contract with other selected plans in the region not

529 participating in the administrative challenge before resolution
530 of the administrative challenge. For purposes of this
531 subsection, an administrative challenge is finalized if an order
532 granting voluntary dismissal with prejudice has been entered by
533 any court established under Article V of the State Constitution
534 or by the Division of Administrative Hearings, a final order has
535 been entered into by the agency and the deadline for appeal has
536 expired, a final order has been entered by the First District
537 Court of Appeal and the time to seek any available review by the
538 Florida Supreme Court has expired, or a final order has been
539 entered by the Florida Supreme Court and a warrant has been
540 issued.
541 Section 8. Section 409.967, Florida Statutes, is created
542 to read:
543 409.967 Managed care plan accountability.—
544 (1) The agency shall establish a 5-year contract with each
545 managed care plan selected through the procurement process
546 described in s. 409.966. A plan contract may not be renewed;
547 however, the agency may extend the terms of a plan contract to
548 cover any delays in transition to a new plan.
549 (2) The agency shall establish such contract requirements
550 as are necessary for the operation of the statewide managed care
551 program. In addition to any other provisions the agency may deem
552 necessary, the contract shall require:
553 (a) Emergency services.—Managed care plans shall pay for
554 services required by ss. 395.1041 and 401.45 and rendered by a
555 noncontracted provider. The plans must comply with s. 641.3155.

556 Reimbursement for services under this paragraph shall be the
557 lesser of:
558 1. The provider's charges;
559 2. The usual and customary provider charges for similar
560 services in the community where the services were provided;
561 3. The charge mutually agreed to by the entity and the
562 provider within 60 days after submittal of the claim; or
563 4. The rate the agency would have paid on the most recent
564 October 1st.
565 (b) Access.—The agency shall establish specific standards
566 for the number, type, and regional distribution of providers in
567 managed care plan networks to ensure access to care for both
568 adults and children. Each plan must maintain a region-wide
569 network of providers in sufficient numbers to meet the access
570 standards for specific medical services for all recipients
571 enrolled in the plan. The exclusive use of mail-order pharmacies
572 shall not be sufficient to meet network access standards.
573 Consistent with the standards established by the agency,
574 provider networks may include providers located outside the
575 region. A plan may contract with a new hospital facility before
576 the date the hospital becomes operational if the hospital has
577 commenced construction, will be licensed and operational by
578 January 1, 2013, and a final order has issued in any civil or
579 administrative challenge. Each plan shall establish and maintain
580 an accurate and complete electronic database of contracted
581 providers, including information about licensure or
582 registration, locations and hours of operation, specialty
583 credentials and other certifications, specific performance

584 indicators, and such other information as the agency deems
585 necessary. The database shall be available online to both the
586 agency and the public and shall have the capability to compare
587 the availability of providers to network adequacy standards and
588 to accept and display feedback from each provider's patients.
589 Each plan shall submit quarterly reports to the agency
590 identifying the number of enrollees assigned to each primary
591 care provider.
592 (c) Encounter data.—The agency shall maintain and operate
593 a Medicaid Encounter Data System to collect, process, store, and
594 report on covered services provided to all Medicaid recipients
595 enrolled in prepaid plans.
596 1. Each prepaid plan must comply with the agency's
597 reporting requirements for the Medicaid Encounter Data System.
598 Prepaid plans must submit encounter data electronically in a
599 format that complies with the Health Insurance Portability and
600 Accountability Act provisions for electronic claims and in
601 accordance with deadlines established by the agency. Prepaid
602 plans must certify that the data reported is accurate and
603 complete.
604 2. The agency is responsible for validating the data
605 submitted by the plans. The agency shall develop methods and
606 protocols for ongoing analysis of the encounter data that
607 adjusts for differences in characteristics of prepaid plan
608 enrollees to allow comparison of service utilization among plans
609 and against expected levels of use. The analysis shall be used
610 to identify possible cases of systemic underutilization or
611 denials of claims and inappropriate service utilization such as

612 higher-than-expected emergency department encounters. The
613 analysis shall provide periodic feedback to the plans and enable
614 the agency to establish corrective action plans when necessary.
615 One of the focus areas for the analysis shall be the use of
616 prescription drugs.
617 3. The agency shall make encounter data available to those
618 plans accepting enrollees who are assigned to them from other
619 plans leaving a region.
620 (d) Continuous improvement.—The agency shall establish
621 specific performance standards and expected milestones or
622 timelines for improving performance over the term of the
623 contract. By the end of the fourth year of the first contract
624 term, the agency shall issue a request for information to
625 determine whether cost savings could be achieved by contracting
626 for plan oversight and monitoring, including analysis of
627 encounter data, assessment of performance measures, and
628 compliance with other contractual requirements. Each managed
629 care plan shall establish an internal health care quality
630 improvement system, including enrollee satisfaction and
631 disenrollment surveys. The quality improvement system shall
632 include incentives and disincentives for network providers.
633 (e) Program integrity.—Each managed care plan shall
634 establish program integrity functions and activities to reduce
635 the incidence of fraud and abuse, including, at a minimum:
636 1. A provider credentialing system and ongoing provider
637 monitoring;

638 2. An effective prepayment and postpayment review process
639 including, but not limited to, data analysis, system editing,
640 and auditing of network providers;
641 3. Procedures for reporting instances of fraud and abuse
642 pursuant to chapter 641;
643 4. Administrative and management arrangements or
644 procedures, including a mandatory compliance plan, designed to
645 prevent fraud and abuse; and
646 5. Designation of a program integrity compliance officer.
647 (f) Grievance resolution.—Consistent with federal law,
648 each managed care plan shall establish and the agency shall
649 approve an internal process for reviewing and responding to
650 grievances from enrollees. Each plan shall submit quarterly
651 reports on the number, description, and outcome of grievances
652 filed by enrollees.
653 (g) Penalties.—Managed care plans that reduce enrollment
654 levels or leave a region before the end of the contract term
655 shall reimburse the agency for the cost of enrollment changes
656 and other transition activities, including the cost of
657 additional choice counseling services. If more than one plan
658 leaves a region at the same time, costs shall be shared by the
659 departing plans proportionate to their enrollments. In addition
660 to the payment of costs, departing provider services networks
661 shall pay a per enrollee penalty not to exceed 3 month's payment
662 and shall continue to provide services to the enrollee for 90
663 days or until the enrollee is enrolled in another plan,
664 whichever is sooner. In addition to payment of costs, all other
665 plans shall pay a penalty equal to 25 percent of the minimum

666 surplus requirement pursuant to s. 641.225(1). Plans shall
667 provide the agency notice no less than 180 days before
668 withdrawing from a region.
669 (h) Prompt payment.—Managed care plans shall comply with
670 ss. 641.315, 641.3155, and 641.513.
671 (i) Electronic claims.—Managed care plans shall accept
672 electronic claims in compliance with federal standards.
673 (j) Fair payment.—Provider service networks must ensure
674 that no network provider with a controlling interest in the
675 network charges any Medicaid managed care plan more than the
676 amount paid to that provider by the provider service network for
677 the same service.
678 (3) ACHIEVED SAVINGS REBATE.—
679 (a) The agency shall establish and the prepaid plans shall
680 use a uniform method for annually reporting premium revenue,
681 medical and administrative costs, and income or losses, across
682 all Florida Medicaid prepaid plan lines of business in all
683 regions. The reports shall be due to the agency within 270 days
684 after the conclusion of the reporting period and the agency may
685 audit the reports. Achieved savings rebates shall be due within
686 30 days after the report is submitted. Except as provided in
687 paragraph (b), the achieved savings rebate will be established
688 by determining pretax income as a percentage of revenues and
689 applying the following income sharing ratios:
690 1. One hundred percent of income up to and including 5
691 percent of revenue shall be retained by the plan.

692 2. Fifty percent of income above 5 percent and up to 10
693 percent shall be retained by the plan, with the other 50 percent
694 refunded to the state.
695 3. One hundred percent of income above 10 percent of
696 revenue shall be refunded to the state.
697 (b) A plan that meets or exceeds agency-defined quality
698 measures in the reporting period may retain an additional 1
699 percent of revenue.
700 (c) The following expenses may not be included in
701 calculating income to the plan:
702 1. Payment of achieved savings rebates.
703 2. Any financial incentive payments made to the plan
704 outside of the capitation rate.
705 3. Any financial disincentive payments levied by the state
706 or federal governments.
707 4. Expenses associated with lobbying activities.
708 5. Administrative, reinsurance, and outstanding claims
709 expenses in excess of actuarially sound maximum amounts set by
710 the agency.
711 6. Any payment made pursuant to paragraph (f).
712 (d) Prepaid plans that incur a loss in the first contract
713 year may apply the full amount of the loss as an offset to
714 income in the second contract year.
715 (e) If, after an audit or other reconciliation, the agency
716 determines that a prepaid plan owes an additional rebate, the
717 plan shall have 30 days after notification to make the payment.
718 Upon failure to timely pay the rebate, the agency shall withhold
719 future payments to the plan until the entire amount is recouped.

720 If the agency determines that a prepaid plan has made an
721 overpayment, the agency shall return the overpayment within 30
722 days.
723 (f) In addition to the reporting required by paragraph
724 (a), prepaid plans shall annually submit a report, consistent
725 with paragraph (a), which is specific to enrollees with
726 developmental disabilities. The agency shall compare each plan's
727 expenditures to the plan's aggregate premiums for this
728 population. The difference between aggregate premiums and
729 expenditures shall be shared equally between the plan and the
730 state. The state share shall be returned to the Medicaid
731 appropriation to serve people on the wait list for home and
732 community-based services provided through individual budgets.
733 Section 9. Section 409.968, Florida Statutes, is created
734 to read:
735 409.968 Managed care plan payments.—
736 (1) Prepaid plans shall receive per-member, per-month
737 payments negotiated pursuant to the procurements described in s.
738 409.966. Payments shall be risk-adjusted rates based on
739 historical utilization and spending data, projected forward, and
740 adjusted to reflect the eligibility category, geographic area,
741 and clinical risk profile of the recipients. In negotiating
742 rates with the plans, the agency shall consider any adjustments
743 necessary to encourage plans to use the most cost effective
744 modalities for treatment of chronic disease such as peritoneal
745 dialysis.
746 (2) Provider service networks may be prepaid plans and
747 receive per-member, per-month payments negotiated pursuant to

748 the procurement process described in s. 409.966. Provider
749 service networks that choose not to be prepaid plans shall
750 receive fee-for-service rates with a shared savings settlement.
751 The fee-for-service option shall be available to a provider
752 service network only for the first 3 years of its operation. The
753 agency shall annually conduct cost reconciliations to determine
754 the amount of cost savings achieved by fee-for-service provider
755 service networks for the dates of service within the period
756 being reconciled. Only payments for covered services for dates
757 of service within the reconciliation period and paid within 6
758 months after the last date of service in the reconciliation
759 period shall be included. The agency shall perform the necessary
760 adjustments for the inclusion of claims incurred but not
761 reported within the reconciliation period for claims that could
762 be received and paid by the agency after the 6-month claims
763 processing time lag. The agency shall provide the results of the
764 reconciliations to the fee-for-service provider service networks
765 within 45 days after the end of the reconciliation period. The
766 fee-for-service provider service networks shall review and
767 provide written comments or a letter of concurrence to the
768 agency within 45 days after receipt of the reconciliation
769 results. This reconciliation shall be considered final.
770 Section 10. Section 409.969, Florida Statutes, is created
771 to read:
772 409.969 Enrollment; choice counseling; automatic
773 assignment; disenrollment.—
774 (1) ENROLLMENT.—All Medicaid recipients shall be enrolled
775 in a managed care plan unless specifically exempted under this

776 part. Each recipient shall have a choice of plans and may select
777 any available plan unless that plan is restricted by contract to
778 a specific population that does not include the recipient.
779 Medicaid recipients shall have 30 days in which to make a choice
780 of plans. All recipients shall be offered choice counseling
781 services in accordance with this section.
782 (2) CHOICE COUNSELING.—The agency shall provide choice
783 counseling for Medicaid recipients. The agency may contract for
784 the provision for choice counseling. Except as provided in s.
785 409.984, any such contract shall be procured competitively. The
786 contract shall be with a vendor that employs Floridians to
787 accomplish the contract requirements, shall be for a period of 5
788 years, and shall comply with the provisions of 42 C.F.R. part
789 483, relating to enrollment brokers as defined in that part. The
790 agency may renew a contract for an additional 5-year period;
791 however, before renewal of the contract the agency shall hold at
792 least one public meeting in each of the regions covered by the
793 choice counseling vendor. The agency may extend the term of the
794 contract to cover any delays in transition to a new contractor.
795 Printed choice information and choice counseling shall be
796 offered in the native or preferred language of the recipient,
797 consistent with federal requirements. The manner and method of
798 choice counseling shall be modified as necessary to ensure
799 culturally competent, effective communication with people from
800 diverse cultural backgrounds. The agency shall maintain a record
801 of the recipients who receive such services, identifying the
802 scope and method of the services provided. The agency shall make

803 available clear and easily understandable choice information to
804 Medicaid recipients that includes:
805 (a) An explanation that each recipient has the right to
806 choose a managed care plan at the time of enrollment in Medicaid
807 and again at regular intervals set by the agency, and that if a
808 recipient does not choose a plan, the agency will assign the
809 recipient to a plan according to the criteria specified in this
810 section.
811 (b) A list and description of the benefits provided in
812 each managed care plan.
813 (c) An explanation of benefit limits.
814 (d) A current list of providers participating in the
815 network, including location and contact information.
816 (e) Managed care plan performance data.
817 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has
818 enrolled in a managed care plan, the recipient shall have 90
819 days to voluntarily disenroll and select another plan. After 90
820 days, no further changes may be made except for good cause. For
821 purposes of this section, the term "good cause" includes, but is
822 not limited to, poor quality of care, lack of access to
823 necessary specialty services, an unreasonable delay or denial of
824 service, or fraudulent enrollment. The agency must make a
825 determination as to whether good cause exists. The agency may
826 require a recipient to use the plan's grievance process before
827 the agency's determination of good cause, except in cases in
828 which immediate risk of permanent damage to the recipient's
829 health is alleged.

830 (a) The managed care plan internal grievance process, when
831 used, must be completed in time to permit the recipient to
832 disenroll by the first day of the second month after the month
833 the disenrollment request was made. If the result of the
834 grievance process is approval of an enrollee's request to
835 disenroll, the agency is not required to make a determination in
836 the case.
837 (b) The agency must make a determination and take final
838 action on a recipient's request so that disenrollment occurs no
839 later than the first day of the second month after the month the
840 request was made. If the agency fails to act within the
841 specified timeframe, the recipient's request to disenroll is
842 deemed to be approved as of the date agency action was required.
843 Recipients who disagree with the agency's finding that good
844 cause does not exist for disenrollment shall be advised of their
845 right to pursue a Medicaid fair hearing to dispute the agency's
846 finding.
847 (c) Medicaid recipients enrolled in a managed care plan
848 after the 90-day period shall remain in the plan for the
849 remainder of the 12-month period. After 12 months, the recipient
850 may select another plan. However, nothing shall prevent a
851 Medicaid recipient from changing providers within the plan
852 during that period.
853 (d) On the first day of the month after receiving notice
854 from a recipient that the recipient has moved to another region,
855 the agency shall automatically disenroll the recipient from the
856 managed care plan the recipient is currently enrolled in and
857 treat the recipient as if the recipient is a new Medicaid

858 enrollee. At that time, the recipient may choose another plan
859 pursuant to the enrollment process established in this section.
860 (e) The agency must monitor plan disenrollment throughout
861 the contract term to identify any discriminatory practices.
862 Section 11. Section 409.97, Florida Statutes, is created
863 to read:
864 409.97 State and local Medicaid partnerships.—
865 (1) INTERGOVERNMENTAL TRANSFERS.—In addition to the
866 contributions required pursuant to s. 409.915, beginning in the
867 2014-2015 fiscal year, the agency may accept voluntary transfers
868 of local taxes and other qualified revenue from counties,
869 municipalities, and special taxing districts. Such transfers
870 must be contributed to advance the general goals of the Florida
871 Medicaid program without restriction and must be executed
872 pursuant to a contract between the agency and the local funding
873 source. Contracts executed before October 31 shall result in
874 contributions to Medicaid for that same state fiscal year.
875 Contracts executed between November 1 and June 30 shall result
876 in contributions for the following state fiscal year. Based on
877 the date of the signed contracts, the agency shall allocate to
878 the low-income pool the first contributions received up to the
879 limit established by subsection (2). No more than 40 percent of
880 the low-income pool funding shall come from any single funding
881 source. Contributions in excess of the low-income pool shall be
882 allocated to the disproportionate share programs defined in ss.
883 409.911(3) and 409.9113 and to hospital rates pursuant to
884 subsection (4). The local funding source shall designate in the
885 contract which Medicaid providers ensure access to care for low-

886 income and uninsured people within the applicable jurisdiction
887 and are eligible for low-income pool funding. Eligible providers
888 may include hospitals, primary care providers, and primary care
889 access systems.
890 (2) LOW-INCOME POOL.—The agency shall establish and
891 maintain a low-income pool in a manner authorized by federal
892 waiver. The low-income pool is created to compensate a network
893 of providers designated pursuant to subsection (1). Funding of
894 the low-income pool shall be limited to the maximum amount
895 permitted by federal waiver minus a percentage specified in the
896 General Appropriations Act. The low-income pool must be used to
897 support enhanced access to services by offsetting shortfalls in
898 Medicaid reimbursement, paying for otherwise uncompensated care,
899 and financing coverage for the uninsured. The low-income pool
900 shall be distributed in periodic payments to the Access to Care
901 Partnership throughout the fiscal year. Distribution of low-
902 income pool funds by the Access to Care Partnership to
903 participating providers may be made through capitated payments,
904 fees for services, or contracts for specific deliverables. The
905 agency shall include the distribution amount for each provider
906 in the contract with the Access to Care Partnership pursuant to
907 subsection (3). Regardless of the method of distribution,
908 providers participating in the Access to Care Partnership shall
909 receive payments such that the aggregate benefit in the
910 jurisdiction of each local funding source, as defined in
911 subsection (1), equals the amount of the contribution plus a
912 factor specified in the General Appropriations Act.

913 (3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract
914 with an administrative services organization that has operating
915 agreements with all health care facilities, programs, and
916 providers supported with local taxes or certified public
917 expenditures and designated pursuant to subsection (1). The
918 contract shall provide for enhanced access to care for Medicaid,
919 low-income, and uninsured Floridians. The partnership shall be
920 responsible for an ongoing program of activities that provides
921 needed, but uncovered or undercompensated, health services to
922 Medicaid enrollees and persons receiving charity care, as
923 defined in s. 409.911. Accountability for services rendered
924 under this contract must be based on the number of services
925 provided to unduplicated qualified beneficiaries, the total
926 units of service provided to these persons, and the
927 effectiveness of services provided as measured by specific
928 standards of care. The agency shall seek such plan amendments or
929 waivers as may be necessary to authorize the implementation of
930 the low-income pool as the Access to Care Partnership pursuant
931 to this section.
932 (4) HOSPITAL RATE DISTRIBUTION.—
933 (a) The agency is authorized to implement a tiered
934 hospital rate system to enhance Medicaid payments to all
935 hospitals when resources for the tiered rates are available from
936 general revenue and such contributions pursuant to subsection
937 (1) as are authorized under the General Appropriations Act.
938 1. Tier 1 hospitals are statutory rural hospitals as
939 defined in s. 395.602, statutory teaching hospitals as defined

940 in s. 408.07(45), and specialty children's hospitals as defined
941 in s. 395.002(28).
942 2. Tier 2 hospitals are community hospitals not included
943 in Tier 1 that provided more than 9 percent of the hospital's
944 total inpatient days to Medicaid patients and charity patients,
945 as defined in s. 409.911, and are located in the jurisdiction of
946 a local funding source pursuant to subsection (1).
947 3. Tier 3 hospitals include all community hospitals.
948 (b) When rates are increased pursuant to this section, the
949 Total Tier Allocation (TTA) shall be distributed as follows:
950 1. Tier 1 (T1A) = 0.35 x TTA.
951 2. Tier 2 (T2A) = 0.35 x TTA.
952 3. Tier 3 (T3A) = 0.30 x TTA.
953 (c) The tier allocation shall be distributed as a
954 percentage increase to the hospital specific base rate (HSBR)
955 established pursuant to s. 409.905(5)(c). The increase in each
956 tier shall be calculated according to the proportion of tier-
957 specific allocation to the total estimated inpatient spending
958 (TEIS) for all hospitals in each tier:
959 1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total
960 estimated inpatient spending (T1TEIS).
961 2. Tier 2 percent increase (T2PI) = T2A /Tier 2 total
962 estimated inpatient spending (T2TEIS).
963 3. Tier 3 percent increase (T3PI) = T3A/ Tier 3 total
964 estimated inpatient spending (T3TEIS).
965 (d) The hospital-specific tiered rate (HSTR) shall be
966 calculated as follows:
967 1. For hospitals in Tier 3: HSTR = (1 + T3PI) x HSBR.

968 2. For hospitals in Tier 2: HSTR = (1 + T2PI) x HSBR.
969 3. For hospitals in Tier 1: HSTR = (1 + T1PI) x HSBR.
970 Section 12. Section 409.971, Florida Statutes, is created
971 to read:
972 409.971 Managed medical assistance program.—The agency
973 shall make payments for primary and acute medical assistance and
974 related services using a managed care model. By January 1, 2013,
975 the agency shall begin implementation of the statewide managed
976 medical assistance program, with full implementation in all
977 regions by October 1, 2014.
978 Section 13. Section 409.972, Florida Statutes, is created
979 to read:
980 409.972 Mandatory and voluntary enrollment.—
981 (1) Persons eligible for the program known as "medically
982 needy" pursuant to s. 409.904(2)(a) shall enroll in managed care
983 plans. Medically needy recipients shall meet the share of the
984 cost by paying the plan premium, up to the share of the cost
985 amount, contingent upon federal approval.
986 (2) The following Medicaid-eligible persons are exempt
987 from mandatory managed care enrollment required by s. 409.965,
988 and may voluntarily choose to participate in the managed medical
989 assistance program:
990 (a) Medicaid recipients who have other creditable health
991 care coverage, excluding Medicare.
992 (b) Medicaid recipients residing in residential commitment
993 facilities operated through the Department of Juvenile Justice
994 or mental health treatment facilities as defined by s.
995 394.455(32).

996 (c) Persons eligible for refugee assistance.
997 (d) Medicaid recipients who are residents of a
998 developmental disability center, including Sunland Center in
999 Marianna and Tacachale in Gainesville.
1000 (3) Persons eligible for Medicaid but exempt from
1001 mandatory participation who do not choose to enroll in managed
1002 care shall be served in the Medicaid fee-for-service program as
1003 provided in part III of this chapter.
1004 Section 14. Section 409.973, Florida Statutes, is created
1005 to read:
1006 409.973 Benefits.—
1007 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a
1008 minimum, the following services:
1009 (a) Advanced registered nurse practitioner services.
1010 (b) Ambulatory surgical treatment center services.
1011 (c) Birthing center services.
1012 (d) Chiropractic services.
1013 (e) Dental services.
1014 (f) Early periodic screening diagnosis and treatment
1015 services for recipients under age 21.
1016 (g) Emergency services.
1017 (h) Family planning services and supplies.
1018 (i) Healthy start services, except as provided in s.
1019 409.975(4).
1020 (j) Hearing services.
1021 (k) Home health agency services.
1022 (l) Hospice services.
1023 (m) Hospital inpatient services.

1024 (n) Hospital outpatient services.
1025 (o) Laboratory and imaging services.
1026 (p) Medical supplies, equipment, prostheses, and orthoses.
1027 (q) Mental health services.
1028 (r) Nursing care.
1029 (s) Optical services and supplies.
1030 (t) Optometrist services.
1031 (u) Physical, occupational, respiratory, and speech
1032 therapy services.
1033 (v) Physician services, including physician assistant
1034 services.
1035 (w) Podiatric services.
1036 (x) Prescription drugs.
1037 (y) Renal dialysis services.
1038 (z) Respiratory equipment and supplies.
1039 (aa) Rural health clinic services.
1040 (bb) Substance abuse treatment services.
1041 (cc) Transportation to access covered services, except as
1042 provided in s. 409.975(5).
1043 (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
1044 benefit packages for nonpregnant adults, vary cost-sharing
1045 provisions, and provide coverage for additional services. The
1046 agency shall evaluate the proposed benefit packages to ensure
1047 services are sufficient to meet the needs of the plan's
1048 enrollees and to verify actuarial equivalence.
1049 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed
1050 medical assistance program shall establish a program to
1051 encourage and reward healthy behaviors.

1052 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the
1053 managed medical assistance program shall establish a program to
1054 encourage enrollees to establish a relationship with their
1055 primary care provider. Each plan shall:
1056 (a) Within 30 days after enrollment, provide information
1057 to each enrollee on the importance of and procedure for
1058 selecting a primary care physician, and thereafter automatically
1059 assign to a primary care provider any enrollee who fails to
1060 choose a primary care provider.
1061 (b) Within 90 days after selection of or assignment to a
1062 primary care provider, provide information to each enrollee on
1063 the importance of scheduling a wellness screening with the
1064 enrollee's primary care physician.
1065 (c) Report to the agency the number of enrollees assigned
1066 to each primary care provider within the plan's network.
1067 (d) Report to the agency the number of enrollees who have
1068 not had an appointment with their primary care provider within
1069 their first year of enrollment.
1070 (e) Report to the agency the number of emergency room
1071 visits by enrollees who have not had a least one appointment
1072 with their primary care provider.
1073 Section 15. Section 409.974, Florida Statutes, is created
1074 to read:
1075 409.974 Eligible plans.—
1076 (1) ELIGIBLE PLAN SELECTION.—The agency shall select
1077 eligible plans through the procurement process described in s.
1078 409.966. The agency shall notice invitations to negotiate no
1079 later than January 1, 2013.

1080 (a) The agency shall procure three plans for Region I. At
1081 least one plan shall be a provider service network, if any
1082 provider service network submits a responsive bid.
1083 (b) The agency shall procure three plans for Region II. At
1084 least one plan shall be a provider service network, if any
1085 provider service network submits a responsive bid.
1086 (c) The agency shall procure at least three plans and no
1087 more than four plans for Region III. At least two plans shall be
1088 provider service networks, if any two provider service networks
1089 submit responsive bids.
1090 (d) The agency shall procure at least four plans and no
1091 more than seven plans for Region IV. At least two plans shall be
1092 provider service networks if any two provider service networks
1093 submit responsive bids.
1094 (e) The agency shall procure at least five plans and no
1095 more than eight plans for Region V. At least two plans shall be
1096 provider service networks, if any two provider service networks
1097 submit responsive bids.
1098 (f) The agency shall procure at least three plans and no
1099 more than four plans for Region VI. At least one plan shall be a
1100 provider service network, if any provider service network
1101 submits a responsive bid.
1102 (g) The agency shall procure at least four plans and no
1103 more than seven plans for Region VII. At least two plans shall
1104 be provider service networks, if any two provider service
1105 networks submit a responsive bid.
1106 (h) The agency shall procure at least six plans and no
1107 more than ten plans for Region VIII. At least two plans shall be

1108 provider service networks, if any two provider service networks
1109 submit a responsive bid.
1110
1111 If no provider service network submits a responsive bid, the
1112 agency shall procure no more than one less than the maximum
1113 number of eligible plans permitted in that region. Within 12
1114 months after the initial invitation to negotiate, the agency
1115 shall attempt to procure a provider service network. The agency
1116 shall notice another invitation to negotiate only with provider
1117 service networks in such region where no provider service
1118 network has been selected.
1119 (2) QUALITY SELECTION CRITERIA.—In addition to the
1120 criteria established in s. 409.966, the agency shall consider
1121 evidence that an eligible plan has written agreements or signed
1122 contracts or has made substantial progress in establishing
1123 relationships with providers before the plan submitting a
1124 response. The agency shall evaluate and give special weight to
1125 evidence of signed contracts with essential providers as defined
1126 by the agency pursuant to s. 409.975(2). The agency shall
1127 exercise a preference for plans with a provider network in which
1128 over 10 percent of the providers use electronic health records,
1129 as defined in s. 408.051. When all other factors are equal, the
1130 agency shall consider whether the organization has a contract to
1131 provide managed long-term care services in the same region and
1132 shall exercise a preference for such plans.
1133 (3) SPECIALTY PLANS.—Participation by specialty plans
1134 shall be subject to the procurement requirements and regional
1135 plan number limits of this section. However, a specialty plan

1136 whose target population includes no more than 10 percent of the
1137 enrollees of that region is not subject to the regional plan
1138 number limits of this section.
1139 (4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by
1140 the Children's Medical Services Network shall be pursuant to a
1141 single, statewide contract with the agency that is not subject
1142 to the procurement requirements or regional plan number limits
1143 of this section. The Children's Medical Services Network must
1144 meet all other plan requirements for the managed medical
1145 assistance program.
1146 Section 16. Section 409.975, Florida Statutes, is created
1147 to read:
1148 409.975 Managed care plan accountability.—In addition to
1149 the requirements of s. 409.967, plans and providers
1150 participating in the managed medical assistance program shall
1151 comply with the requirements of this section.
1152 (1) PROVIDER NETWORKS.—Managed care plans must develop and
1153 maintain provider networks that meet the medical needs of their
1154 enrollees in accordance with standards established pursuant to
1155 409.967(2)(b). Except as provided in this section, managed care
1156 plans may limit the providers in their networks based on
1157 credentials, quality indicators, and price.
1158 (a) Plans must include all providers in the region that
1159 are classified by the agency as essential Medicaid providers,
1160 unless the agency approves, in writing, an alternative
1161 arrangement for securing the types of services offered by the
1162 essential providers. Providers are essential for serving
1163 Medicaid enrollees if they offer services that are not available

1164 from any other provider within a reasonable access standard, or
1165 if they provided a substantial share of the total units of a
1166 particular service used by Medicaid patients within the region
1167 during the last 3 years and the combined capacity of other
1168 service providers in the region is insufficient to meet the
1169 total needs of the Medicaid patients. The agency may not
1170 classify physicians and other practitioners as essential
1171 providers. The agency, at a minimum, shall determine which
1172 providers in the following categories are essential Medicaid
1173 providers:
1174 1. Federally qualified health centers.
1175 2. Statutory teaching hospitals as defined in s.
1176 408.07(45).
1177 3. Hospitals that are trauma centers as defined in s.
1178 395.4001(14).
1179 4. Hospitals located at least 25 miles from any other
1180 hospital with similar services.
1181
1182 Managed care plans that have not contracted with all essential
1183 providers in the region as of the first date of recipient
1184 enrollment, or with whom an essential provider has terminated
1185 its contract, must negotiate in good faith with such essential
1186 providers for 1 year or until an agreement is reached, whichever
1187 is first. Payments for services rendered by a nonparticipating
1188 essential provider shall be made at the applicable Medicaid rate
1189 as of the first day of the contract between the agency and the
1190 plan. A rate schedule for all essential providers shall be
1191 attached to the contract between the agency and the plan. After

1192 1 year, managed care plans that are unable to contract with
1193 essential providers shall notify the agency and propose an
1194 alternative arrangement for securing the essential services for
1195 Medicaid enrollees. The arrangement must rely on contracts with
1196 other participating providers, regardless of whether those
1197 providers are located within the same region as the
1198 nonparticipating essential service provider. If the alternative
1199 arrangement is approved by the agency, payments to
1200 nonparticipating essential providers after the date of the
1201 agency's approval shall equal 90 percent of the applicable
1202 Medicaid rate. If the alternative arrangement is not approved by
1203 the agency, payment to nonparticipating essential providers
1204 shall equal 110 percent of the applicable Medicaid rate.
1205 (b) Certain providers are statewide resources and
1206 essential providers for all managed care plans in all regions.
1207 All managed care plans must include these essential providers in
1208 their networks. Statewide essential providers include:
1209 1. Faculty plans of Florida medical schools.
1210 2. Regional perinatal intensive care centers as defined in
1211 s. 383.16(2).
1212 3. Hospitals licensed as specialty children's hospitals as
1213 defined in s. 395.002(28).
1214 4. Accredited and integrated systems serving medically
1215 complex children that are comprised of separately licensed, but
1216 commonly owned, health care providers delivering at least the
1217 following services: medical group home, in-home and outpatient
1218 nursing care and therapies, pharmacy services, durable medical
1219 equipment, and Prescribed Pediatric Extended Care.

1220

1221 Managed care plans that have not contracted with all statewide
1222 essential providers in all regions as of the first date of
1223 recipient enrollment must continue to negotiate in good faith.
1224 Payments to physicians on the faculty of nonparticipating
1225 Florida medical schools shall be made at the applicable Medicaid
1226 rate. Payments for services rendered by a regional perinatal
1227 intensive care centers shall be made at the applicable Medicaid
1228 rate as of the first day of the contract between the agency and
1229 the plan. Payments to nonparticipating specialty children's
1230 hospitals shall equal the highest rate established by contract
1231 between that provider and any other Medicaid managed care plan.
1232 (c) After 12 months of active participation in a plan's
1233 network, the plan may exclude any essential provider from the
1234 network for failure to meet quality or performance criteria. If
1235 the plan excludes an essential provider from the plan, the plan
1236 must provide written notice to all recipients who have chosen
1237 that provider for care. The notice shall be provided at least 30
1238 days before the effective date of the exclusion.
1239 (d) Each managed care plan must offer a network contract
1240 to each home medical equipment and supplies provider in the
1241 region which meets quality and fraud prevention and detection
1242 standards established by the plan and which agrees to accept the
1243 lowest price previously negotiated between the plan and another
1244 such provider.
1245 (2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency
1246 shall contract with a single organization representing medical
1247 schools and graduate medical education programs in the state for

1248 the purpose of establishing an active and ongoing program to
1249 improve clinical outcomes in all managed care plans. Contracted
1250 activities must support greater clinical integration for
1251 Medicaid enrollees through interdependent and cooperative
1252 efforts of all providers participating in managed care plans.
1253 The agency shall support these activities with certified public
1254 expenditures and any earned federal matching funds and shall
1255 seek any plan amendments or waivers necessary to comply with
1256 this subsection. To be eligible to participate in the quality
1257 network, a medical school must contract with each managed care
1258 plan in its region.
1259 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
1260 monitor the quality and performance of each participating
1261 provider. At the beginning of the contract period, each plan
1262 shall notify all its network providers of the metrics used by
1263 the plan for evaluating the provider's performance and
1264 determining continued participation in the network.
1265 (4) MOMCARE NETWORK.—
1266 (a) The agency shall contract with an administrative
1267 services organization representing all Healthy Start Coalitions
1268 providing risk appropriate care coordination and other services
1269 in accordance with a federal waiver and pursuant to s. 409.906.
1270 The contract shall require the network of coalitions to provide
1271 choice counseling, education, risk-reduction and case management
1272 services, and quality assurance for all enrollees of the waiver.
1273 The agency shall evaluate the impact of the MomCare network by
1274 monitoring each plan's performance on specific measures to
1275 determine the adequacy, timeliness, and quality of services for

1276 pregnant women and infants. The agency shall support this
1277 contract with certified public expenditures of general revenue
1278 appropriated for Healthy Start services and any earned federal
1279 matching funds.
1280 (b) Each managed care plan shall establish specific
1281 programs and procedures to improve pregnancy outcomes and infant
1282 health, including, but not limited to, coordination with the
1283 Healthy Start program, immunization programs, and referral to
1284 the Special Supplemental Nutrition Program for Women, Infants,
1285 and Children, and the Children's Medical Services program for
1286 children with special health care needs. Each plan's programs
1287 and procedures shall include agreements with each local Healthy
1288 Start Coalition in the region to provide risk-appropriate care
1289 coordination for pregnant women and infants, consistent with
1290 agency policies and the MomCare network.
1291 (5) TRANSPORTATION.—Nonemergency transportation services
1292 shall be provided pursuant to a single, statewide contract
1293 between the agency and the Commission for the Transportation
1294 Disadvantaged. The agency shall establish performance standards
1295 in the contract and shall evaluate the performance of the
1296 Commission for the Transportation Disadvantaged. For the
1297 purposes of this subsection, the term "nonemergency
1298 transportation" does not include transportation by ambulance and
1299 any medical services received during transport.
1300 (6) SCREENING RATE.—After the end of the second contract
1301 year, each managed care plan shall achieve an annual Early and
1302 Periodic Screening, Diagnosis, and Treatment Service screening

1303 rate of at least 80 percent of those recipients continuously
1304 enrolled for at least 8 months.
1305 (7) PROVIDER PAYMENT.—Managed care plan and hospitals
1306 shall negotiate mutually acceptable rates, methods, and terms of
1307 payment. For rates, methods, and terms of payment negotiated
1308 after the contract between the agency and the plan is executed,
1309 plans shall pay hospitals, at a minimum, the rate the agency
1310 would have paid on the first day of the contract between the
1311 provider and the plan. Such payments to hospitals may not exceed
1312 120 percent of the rate the agency would have paid on the first
1313 day of the contract between the provider and the plan, unless
1314 specifically approved by the agency. Payment rates may be
1315 updated periodically.
1316 (8) MEDICALLY NEEDY ENROLLEES.—Each managed care plan
1317 shall accept any medically needy recipient who selects or is
1318 assigned to the plan and provide that recipient with continuous
1319 enrollment for 12 months. After the first month of qualifying as
1320 a medically needy recipient and enrolling in a plan, and
1321 contingent upon federal approval, the enrollee shall pay the
1322 plan a portion of the monthly premium equal to the enrollee's
1323 share of the cost as determined by the department. The agency
1324 shall pay any remaining portion of the monthly premium. Plans
1325 are not obligated to pay claims for medically needy patients for
1326 services provided before enrollment in the plan. Medically needy
1327 patients are responsible for payment of incurred claims that are
1328 used to determine eligibility. Plans must provide a grace period
1329 of at least 90 days before disenrolling recipients who fail to
1330 pay their shares of the premium.

CODING: Words stricken are deletions; words underlined are additions.

1331 Section 17. Section 409.976, Florida Statutes, is created
1332 to read:
1333 409.976 Managed care plan payment.—In addition to the
1334 payment provisions of s. 409.968, the agency shall provide
1335 payment to plans in the managed medical assistance program
1336 pursuant to this section.
1337 (1) Prepaid payment rates shall be negotiated between the
1338 agency and the eligible plans as part of the procurement process
1339 described in s. 409.966.
1340 (2) The agency shall establish payment rates for statewide
1341 inpatient psychiatric programs. Payments to managed care plans
1342 shall be reconciled to reimburse actual payments to statewide
1343 inpatient psychiatric programs.
1344 Section 18. Section 409.977, Florida Statutes, is created
1345 to read:
1346 409.977 Choice counseling and enrollment.—
1347 (1) CHOICE COUNSELING.—In addition to the choice
1348 counseling information required by s. 409.969, the agency shall
1349 make available clear and easily understandable choice
1350 information to Medicaid recipients that includes information
1351 about the cost-sharing requirements of each managed care plan.
1352 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
1353 enroll into a managed care plan those Medicaid recipients who do
1354 not voluntarily choose a plan pursuant to s. 409.969. The agency
1355 shall automatically enroll recipients in plans that meet or
1356 exceed the performance or quality standards established pursuant
1357 to s. 409.967 and may not automatically enroll recipients in a
1358 plan that is deficient in those performance or quality

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1359 standards. When a specialty plan is available to accommodate a
1360 specific condition or diagnosis of a recipient, the agency shall
1361 assign the recipient to that plan. In the first year of the
1362 first contract term only, if a recipient was previously enrolled
1363 in a plan that is still available in the region, the agency
1364 shall automatically enroll the recipient in that plan unless an
1365 applicable specialty plan is available. Except as otherwise
1366 provided in this part, the agency may not engage in practices
1367 that are designed to favor one managed care plan over another.
1368 When automatically enrolling recipients in managed care plans,
1369 the agency shall automatically enroll based on the following
1370 criteria:
1371 (a) Whether the plan has sufficient network capacity to
1372 meet the needs of the recipients.
1373 (b) Whether the recipient has previously received services
1374 from one of the plan's primary care providers.
1375 (c) Whether primary care providers in one plan are more
1376 geographically accessible to the recipient's residence than
1377 those in other plans.
1378 (3) OPT-OUT OPTION.—The agency shall develop a process to
1379 enable any recipient with access to employer-sponsored health
1380 care coverage to opt out of all managed care plans and to use
1381 Medicaid financial assistance to pay for the recipient's share
1382 of the cost in such employer-sponsored coverage. Contingent upon
1383 federal approval, the agency shall also enable recipients with
1384 access to other insurance or related products providing access
1385 to health care services created pursuant to state law, including
1386 any product available under the Florida Health Choices Program,

1387 or any health exchange, to opt out. The amount of financial
1388 assistance provided for each recipient may not exceed the amount
1389 of the Medicaid premium that would have been paid to a managed
1390 care plan for that recipient.
1391 Section 19. Section 409.978, Florida Statutes, is created
1392 to read:
1393 409.978 Long-term care managed care program.—
1394 (1) Pursuant to s. 409.963, the agency shall administer
1395 the long-term care managed care program described in ss.
1396 409.978-409.985, but may delegate specific duties and
1397 responsibilities for the program to the Department of Elderly
1398 Affairs and other state agencies. By July 1, 2012, the agency
1399 shall begin implementation of the statewide long-term care
1400 managed care program, with full implementation in all regions by
1401 October 1, 2013.
1402 (2) The agency shall make payments for long-term care,
1403 including home and community-based services, using a managed
1404 care model. Unless otherwise specified, the provisions of ss.
1405 409.961-409.97 apply to the long-term care managed care program.
1406 (3) The Department of Elderly Affairs shall assist the
1407 agency to develop specifications for use in the invitation to
1408 negotiate and the model contract, determine clinical eligibility
1409 for enrollment in managed long-term care plans, monitor plan
1410 performance and measure quality of service delivery, assist
1411 clients and families to address complaints with the plans,
1412 facilitate working relationships between plans and providers
1413 serving elders and disabled adults, and perform other functions
1414 specified in a memorandum of agreement.

1415 Section 20. Section 409.979, Florida Statutes, is created
1416 to read:
1417 409.979 Eligibility.—
1418 (1) Medicaid recipients who meet all of the following
1419 criteria are eligible to receive long-term care services and
1420 must receive long-term care services by participating in the
1421 long-term care managed care program. The recipient must be:
1422 (a) Sixty-five years of age or older, or age 18 or older
1423 and eligible for Medicaid by reason of a disability.
1424 (b) Determined by the Comprehensive Assessment Review and
1425 Evaluation for Long-Term Care Services (CARES) Program to
1426 require nursing facility care as defined in s. 409.985(3).
1427 (2) Medicaid recipients who, on the date long-term care
1428 managed care plans become available in their region, reside in a
1429 nursing home facility or are enrolled in one of the following
1430 long-term care Medicaid waiver programs are eligible to
1431 participate in the long-term care managed care program for up to
1432 12 months without being reevaluated for their need for nursing
1433 facility care as defined in s. 409.985(3):
1434 (a) The Assisted Living for the Frail Elderly Waiver.
1435 (b) The Aged and Disabled Adult Waiver.
1436 (c) The Adult Day Health Care Waiver.
1437 (d) The Consumer-Directed Care Plus Program as described
1438 in s. 409.221.
1439 (e) The Program of All-inclusive Care for the Elderly.
1440 (f) The long-term care community-based diversion pilot
1441 project as described in s. 430.705.
1442 (g) The Channeling Services Waiver for Frail Elders.

1443 (3) The Department of Elderly Affairs shall make offers
1444 for enrollment to eligible individuals based on a wait-list
1445 prioritization and subject to availability of funds. Before
1446 enrollment offers, the department shall determine that
1447 sufficient funds exist to support additional enrollment into
1448 plans.
1449 Section 21. Section 409.98, Florida Statutes, is created
1450 to read:
1451 409.98 Benefits.—Long-term care plans shall cover, at a
1452 minimum, the following:
1453 (1) Nursing facility care.
1454 (2) Services provided in assisted living facilities.
1455 (3) Hospice.
1456 (4) Adult day care.
1457 (5) Medical equipment and supplies, including incontinence
1458 supplies.
1459 (6) Personal care.
1460 (7) Home accessibility adaptation.
1461 (8) Behavior management.
1462 (9) Home-delivered meals.
1463 (10) Case management.
1464 (11) Therapies:
1465 (a) Occupational therapy.
1466 (b) Speech therapy.
1467 (c) Respiratory therapy.
1468 (d) Physical therapy.
1469 (12) Intermittent and skilled nursing.
1470 (13) Medication administration.

1471 (14) Medication management.
1472 (15) Nutritional assessment and risk reduction.
1473 (16) Caregiver training.
1474 (17) Respite care.
1475 (18) Transportation.
1476 (19) Personal emergency response system.
1477 Section 22. Section 409.981, Florida Statutes, is created
1478 to read:
1479 409.981 Eligible plans.—
1480 (1) ELIGIBLE PLANS.—Provider service networks must be
1481 long-term care provider service networks. Other eligible plans
1482 may either be long-term care plans or comprehensive long-term
1483 care plans.
1484 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
1485 eligible plans through the procurement process described in s.
1486 409.966. The agency shall provide notice of invitations to
1487 negotiate no later than July 1, 2012.
1488 (a) The agency shall procure three plans for Region I. At
1489 least one plan shall be a provider service network, if any
1490 submit a responsive bid.
1491 (b) The agency shall procure three plans for Region II. At
1492 least one plan shall be a provider service network, if any
1493 provider service network submits a responsive bid.
1494 (c) The agency shall procure at least three plans and no
1495 more than four plans for Region III. At least two plans shall be
1496 provider service networks, if any two provider service networks
1497 submit responsive bids.
1498 (d) The agency shall procure at least four plans and no

1499 more than seven plans for Region IV. At least two plans shall be
1500 provider service networks if any two provider service networks
1501 submit responsive bids.
1502 (e) The agency shall procure at least five plans and no
1503 more than eight plans for Region V. At least two plans shall be
1504 provider service networks, if any two provider service networks
1505 submit responsive bids.
1506 (f) The agency shall procure at least three plans and no
1507 more than four plans for Region VI. At least one plan shall be a
1508 provider service network, if any provider service network
1509 submits a responsive bid.
1510 (g) The agency shall procure at least four plans and no
1511 more than seven plans for Region VII. At least two plans shall
1512 be provider service networks, if any two provider service
1513 networks submit responsive bids.
1514 (h) The agency shall procure at least five plans and no
1515 more than nine plans for Region VIII. At least two plans shall
1516 be provider service networks, if any two provider service
1517 networks submit a responsive bid.
1518
1519 If no provider service network submits a responsive bid, the
1520 agency shall procure one fewer eligible plan in each of the
1521 regions. Within 12 months after the initial invitation to
1522 negotiate, the agency shall attempt to procure an eligible plan
1523 that is a provider service network. The agency shall notice
1524 another invitation to negotiate only with provider service
1525 networks in a region where no provider service network has been
1526 selected.

1527 (3) QUALITY SELECTION CRITERIA.—In addition to the
1528 criteria established in s. 409.966, the agency shall consider
1529 the following factors in the selection of eligible plans:
1530 (a) Evidence of the employment of executive managers with
1531 expertise and experience in serving aged and disabled persons
1532 who require long-term care.
1533 (b) Whether a plan has established a network of service
1534 providers dispersed throughout the region and in sufficient
1535 numbers to meet specific service standards established by the
1536 agency for specialty services for persons receiving home and
1537 community-based care.
1538 (c) Whether a plan is proposing to establish a
1539 comprehensive long-term care plan and whether the eligible plan
1540 has a contract to provide managed medical assistance services in
1541 the same region.
1542 (d) Whether a plan offers consumer-directed care services
1543 to enrollees pursuant to s. 409.221.
1544 (e) Whether a plan is proposing to provide home and
1545 community-based services in addition to the minimum benefits
1546 required by s. 409.98.
1547 (4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—
1548 Participation by the Program of All-Inclusive Care for the
1549 Elderly (PACE) shall be pursuant to a contract with the agency
1550 and not subject to the procurement requirements or regional plan
1551 number limits of this section. PACE plans may continue to
1552 provide services to individuals at such levels and enrollment
1553 caps as authorized by the General Appropriations Act.
1554 Section 23. Section 409.982, Florida Statutes, is created

1555 to read:
1556 409.982 Managed care plan accountability.—In addition to
1557 the requirements of s. 409.967, plans and providers
1558 participating in the long-term care managed care program shall
1559 comply with the requirements of this section.
1560 (1) PROVIDER NETWORKS.—Managed care plans may limit the
1561 providers in their networks based on credentials, quality
1562 indicators, and price. For the period between October 1, 2013,
1563 and September 30, 2014, each selected plan must offer a network
1564 contract to all the following providers in the region:
1565 (a) Nursing homes.
1566 (b) Hospices.
1567 (c) Aging network service providers that have previously
1568 participated in home and community-based waivers serving elders
1569 or community-service programs administered by the Department of
1570 Elderly Affairs.
1571
1572 After 12 months of active participation in a managed care plan's
1573 network, the plan may exclude any of the providers named in this
1574 subsection from the network for failure to meet quality or
1575 performance criteria. If the plan excludes a provider from the
1576 plan, the plan must provide written notice to all recipients who
1577 have chosen that provider for care. The notice shall be provided
1578 at least 30 days before the effective date of the exclusion. The
1579 agency shall establish contract provisions governing the
1580 transfer of recipients from excluded residential providers.
1581 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in
1582 this subsection, providers may limit the managed care plans they

1583 join. Nursing homes and hospices that are enrolled Medicaid
1584 providers must participate in all eligible plans selected by the
1585 agency in the region in which the provider is located.
1586 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
1587 monitor the quality and performance of each participating
1588 provider using measures adopted by and collected by the agency
1589 and any additional measures mutually agreed upon by the provider
1590 and the plan
1591 (4) PROVIDER NETWORK STANDARDS.—The agency shall establish
1592 and each managed care plan must comply with specific standards
1593 for the number, type, and regional distribution of providers in
1594 the plan's network, which must include:
1595 (a) Adult day care centers.
1596 (b) Adult family-care homes.
1597 (c) Assisted living facilities.
1598 (d) Health care services pools.
1599 (e) Home health agencies.
1600 (f) Homemaker and companion services.
1601 (g) Hospices.
1602 (h) Community care for the elderly lead agencies.
1603 (i) Nurse registries.
1604 (j) Nursing homes.
1605 (5) PROVIDER PAYMENT.—Managed care plans and providers
1606 shall negotiate mutually acceptable rates, methods, and terms of
1607 payment. Plans shall pay nursing homes an amount equal to the
1608 nursing facility-specific payment rates set by the agency;
1609 however, mutually acceptable higher rates may be negotiated for
1610 medically complex care. Plans shall pay hospice providers

1611 through a prospective system for each enrollee an amount equal
1612 to the per diem rate set by the agency. For recipients residing
1613 in a nursing facility and receiving hospice services, the plan
1614 shall pay the hospice provider the per diem rate set by the
1615 agency minus the nursing facility component and shall pay the
1616 nursing facility the applicable state rate. Plans shall ensure
1617 that electronic nursing home and hospice claims that contain
1618 sufficient information for processing are paid within 10
1619 business days after receipt.
1620 Section 24. Section 409.983, Florida Statutes, is created
1621 to read:
1622 409.983 Managed care plan payment.—In addition to the
1623 payment provisions of s. 409.968, the agency shall provide
1624 payment to plans in the long-term care managed care program
1625 pursuant to this section.
1626 (1) Prepaid payment rates for long-term care managed care
1627 plans shall be negotiated between the agency and the eligible
1628 plans as part of the procurement process described in s.
1629 409.966.
1630 (2) Payment rates for comprehensive long-term care plans
1631 covering services described in s. 409.973 shall be blended with
1632 rates for long-term care plans for services specified in s.
1633 409.98.
1634 (3) Payment rates for plans shall reflect historic
1635 utilization and spending for covered services projected forward
1636 and adjusted to reflect the level of care profile for enrollees
1637 in each plan. The payment shall be adjusted to provide an
1638 incentive for reducing institutional placements and increasing

1639 the utilization of home and community-based services.
1640 (4) The initial assessment of an enrollee's level of care
1641 shall be made by the Comprehensive Assessment and Review for
1642 Long-Term-Care Services (CARES) program, which shall assign the
1643 recipient into one of the following levels of care:
1644 (a) Level of care 1 consists of recipients residing in or
1645 who must be placed in a nursing home.
1646 (b) Level of care 2 consists of recipients at imminent
1647 risk of nursing home placement, as evidenced by the need for the
1648 constant availability of routine medical and nursing treatment
1649 and care, and require extensive health-related care and services
1650 because of mental or physical incapacitation.
1651 (c) Level of care 3 consists of recipients at imminent
1652 risk of nursing home placement, as evidenced by the need for the
1653 constant availability of routine medical and nursing treatment
1654 and care, who have a limited need for health-related care and
1655 services and are mildly medically or physically incapacitated.
1656
1657 The agency shall periodically adjust payment rates to account
1658 for changes in the level of care profile for each managed care
1659 plan based on encounter data.
1660 (5) The agency shall make an incentive adjustment in
1661 payment rates to encourage the increased utilization of home and
1662 community-based services and a commensurate reduction of
1663 institutional placement. The incentive adjustment shall be
1664 modified in each successive rate period during the first
1665 contract period, as follows:
1666 (a) A 2 percentage point shift in the first rate-setting

1667 period;
1668 (b) A 2 percentage point shift in the second rate-setting
1669 period, as compared to the utilization mix at the end of the
1670 first rate-setting period;
1671 (c) A 3 percentage point shift in the third rate-setting
1672 period, and in each subsequent rate-setting period during the
1673 first contract period, as compared to the utilization mix at the
1674 end of the immediately preceding rate-setting period.
1675
1676 The incentive adjustment shall continue in subsequent contract
1677 periods, at a rate of 3 percentage points per year as compared
1678 to the utilization mix at the end of the immediately preceding
1679 rate-setting period, until no more than 35 percent of the plan's
1680 enrollees are placed in institutional settings. The agency shall
1681 annually report to the Legislature the actual change in the
1682 utilization mix of home and community-based services compared to
1683 institutional placements and provide a recommendation for
1684 utilization mix requirements for future contracts.
1685 (6) The agency shall establish nursing-facility-specific
1686 payment rates for each licensed nursing home based on facility
1687 costs adjusted for inflation and other factors as authorized in
1688 the General Appropriations Act. Payments to long-term care
1689 managed care plans shall be reconciled to reimburse actual
1690 payments to nursing facilities.
1691 (7) The agency shall establish hospice payment rates
1692 pursuant to Title XVIII of the Social Security Act. Payments to
1693 long-term care managed care plans shall be reconciled to
1694 reimburse actual payments to hospices.

1695 Section 25. Section 409.984, Florida Statutes, is created
1696 to read:
1697 409.984 Choice counseling; enrollment.—
1698 (1) CHOICE COUNSELING.—Before contracting with a vendor to
1699 provide choice counseling as authorized under s. 409.969, the
1700 agency shall offer to contract with aging resource centers
1701 established under s. 430.2053 for choice counseling services. If
1702 the aging resource center is determined not to be the vendor
1703 that provides choice counseling, the agency shall establish a
1704 memorandum of understanding with the aging resource center to
1705 coordinate staffing and collaborate with the choice counseling
1706 vendor. In addition to the requirements of s. 409.969, any
1707 contract to provide choice counseling for the long-term care
1708 managed care program shall provide that each recipient be given
1709 the option of having in-person choice counseling.
1710 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
1711 enroll into a long-term care managed care plan those Medicaid
1712 recipients who do not voluntarily choose a plan pursuant to s.
1713 409.969. The agency shall automatically enroll recipients in
1714 plans that meet or exceed the performance or quality standards
1715 established pursuant to s. 409.967 and may not automatically
1716 enroll recipients in a plan that is deficient in those
1717 performance or quality standards. If a recipient is deemed
1718 dually eligible for Medicaid and Medicare services and is
1719 currently receiving Medicare services from an entity qualified
1720 under 42 C.F.R. part 422 as a Medicare Advantage Preferred
1721 Provider Organization, Medicare Advantage Provider-sponsored
1722 Organization, or Medicare Advantage Special Needs Plan, the

1723 agency shall automatically enroll the recipient in such plan for
1724 Medicaid services if the plan is currently participating in the
1725 long-term care managed care program. Except as otherwise
1726 provided in this part, the agency may not engage in practices
1727 that are designed to favor one managed care plan over another.
1728 When automatically enrolling recipients in plans, the agency
1729 shall take into account the following criteria:
1730 (a) Whether the plan has sufficient network capacity to
1731 meet the needs of the recipients.
1732 (b) Whether the recipient has previously received services
1733 from one of the plan's home and community-based service
1734 providers.
1735 (c) Whether the home and community-based providers in one
1736 plan are more geographically accessible to the recipient's
1737 residence than those in other plans.
1738 (3) HOSPICE SELECTION.—Notwithstanding the provisions of
1739 s. 409.969(3)(c), when a recipient is referred for hospice
1740 services, the recipient shall have a 30-day period during which
1741 the recipient may select to enroll in another managed care plan
1742 to access the hospice provider of the recipient's choice.
1743 (4) CHOICE OF RESIDENTIAL SETTING.—When a recipient is
1744 referred for placement in a nursing home or assisted living
1745 facility, the plan shall inform the recipient of any facilities
1746 within the plan that have specific cultural or religious
1747 affiliations and, if requested by the recipient, make a
1748 reasonable effort to place the recipient in the facility of the
1749 recipient's choice.
1750 Section 26. Section 409.9841, Florida Statutes, is created

1751 to read:
1752 409.9841 Long-term care managed care technical advisory
1753 workgroup.—
1754 (1) Before August 1, 2011, the agency shall establish a
1755 technical advisory workgroup to assist in developing:
1756 (a) The method of determining Medicaid eligibility
1757 pursuant to s. 409.985(3).
1758 (b) The requirements for provider payments to nursing
1759 homes under s. 409.983(6).
1760 (c) The method for managing Medicare coinsurance crossover
1761 claims.
1762 (d) Uniform requirements for claims submissions and
1763 payments, including electronic funds transfers and claims
1764 processing.
1765 (e) The process for enrollment of and payment for
1766 individuals pending determination of Medicaid eligibility.
1767 (2) The advisory workgroup shall include, but is not
1768 limited to, representatives of providers and plans who could
1769 potentially participate in long-term care managed care. Members
1770 of the workgroup shall serve without compensation but may be
1771 reimbursed for per diem and travel expenses as provided in s.
1772 112.061.
1773 (3) This section is repealed on June 30, 2013.
1774 Section 27. Section 409.985, Florida Statutes, is created
1775 to read:
1776 409.985 Comprehensive Assessment and Review for Long-Term
1777 Care Services (CARES) Program.—
1778 (1) The agency shall operate the Comprehensive Assessment

1779 and Review for Long-Term Care Services (CARES) preadmission
1780 screening program to ensure that only individuals whose
1781 conditions require long-term care services are enrolled in the
1782 long-term care managed care program.
1783 (2) The agency shall operate the CARES program through an
1784 interagency agreement with the Department of Elderly Affairs.
1785 The agency, in consultation with the Department of Elderly
1786 Affairs, may contract for any function or activity of the CARES
1787 program, including any function or activity required by 42
1788 C.F.R. part 483.20, relating to preadmission screening and
1789 review.
1790 (3) The CARES program shall determine if an individual
1791 requires nursing facility care and, if the individual requires
1792 such care, assign the individual to a level of care as described
1793 in s. 409.983(4). When determining the need for nursing facility
1794 care, consideration shall be given to the nature of the services
1795 prescribed and which level of nursing or other health care
1796 personnel meets the qualifications necessary to provide such
1797 services and the availability to and access by the individual of
1798 community or alternative resources. For the purposes of the
1799 long-term care managed care program, the term "nursing facility
1800 care" means the individual:
1801 (a) Requires nursing home placement as evidenced by the
1802 need for medical observation throughout a 24-hour period and
1803 care required to be performed on a daily basis by, or under the
1804 direct supervision of, a registered nurse or other health care
1805 professional and requires services that are sufficiently
1806 medically complex to require supervision, assessment, planning,

1807 or intervention by a registered nurse because of a mental or
1808 physical incapacitation by the individual;
1809 (b) Requires or is at imminent risk of nursing home
1810 placement as evidenced by the need for observation throughout a
1811 24-hour period and care and the constant availability of medical
1812 and nursing treatment and requires services on a daily or
1813 intermittent basis that are to be performed under the
1814 supervision of licensed nursing or other health professionals
1815 because the individual who is incapacitated mentally or
1816 physically; or
1817 (c) Requires or is at imminent risk of nursing home
1818 placement as evidenced by the need for observation throughout a
1819 24-hour period and care and the constant availability of medical
1820 and nursing treatment and requires limited services that are to
1821 be performed under the supervision of licensed nursing or other
1822 health professionals because the individual is mildly
1823 incapacitated mentally or physically.
1824 (4) For individuals whose nursing home stay is initially
1825 funded by Medicare and Medicare coverage and is being terminated
1826 for lack of progress towards rehabilitation, CARES staff shall
1827 consult with the person making the determination of progress
1828 toward rehabilitation to ensure that the recipient is not being
1829 inappropriately disqualified from Medicare coverage. If, in
1830 their professional judgment, CARES staff believe that a Medicare
1831 beneficiary is still making progress toward rehabilitation, they
1832 may assist the Medicare beneficiary with an appeal of the
1833 disqualification from Medicare coverage. The use of CARES teams
1834 to review Medicare denials for coverage under this section is

1835 authorized only if it is determined that such reviews qualify
1836 for federal matching funds through Medicaid. The agency shall
1837 seek or amend federal waivers as necessary to implement this
1838 section.
1839 Section 28. Section 409.986, Florida Statutes, is created
1840 to read:
1841 409.986 Managed long-term care for persons with
1842 developmental disabilities.—
1843 (1) Pursuant to s. 409.963, the agency is responsible for
1844 administering the long-term care managed care program for
1845 persons with developmental disabilities described in ss.
1846 409.986-409.992, but may delegate specific duties and
1847 responsibilities for the program to the Agency for Persons with
1848 Disabilities and other state agencies. By January 1, 2015, the
1849 agency shall begin implementation of statewide long-term care
1850 managed care for persons with developmental disabilities, with
1851 full implementation in all regions by October 1, 2016.
1852 (2) The agency shall make payments for long-term care for
1853 persons with developmental disabilities, including home and
1854 community-based services, using a managed care model. Unless
1855 otherwise specified, the provisions of ss. 409.961-409.97 apply
1856 to the long-term care managed care program for persons with
1857 developmental disabilities.
1858 (3) The Agency for Persons with Disabilities shall assist
1859 the agency to develop the specifications for use in the
1860 invitations to negotiate and the model contract, determine
1861 clinical eligibility for enrollment in long-term care plans for
1862 persons with developmental disabilities, assist the agency to

1863 monitor plan performance and measure quality, assist clients and
1864 families to address complaints with the plans, facilitate
1865 working relationships between plans and providers serving
1866 persons with developmental disabilities, and perform other
1867 functions specified in a memorandum of agreement.
1868 Section 29. Section 409.987, Florida Statutes, is created
1869 to read:
1870 409.987 Eligibility.—
1871 (1) Medicaid recipients who meet all of the following
1872 criteria are eligible and shall be enrolled in a comprehensive
1873 long-term care plan or long-term care plan:
1874 (a) Is Medicaid eligible pursuant to s. 409.904.
1875 (b) Is a Florida resident who has a developmental
1876 disability as defined in s. 393.063.
1877 (c) Meets the level of care need, including:
1878 1. The recipient's intelligence quotient is 59 or less;
1879 2. The recipient's intelligence quotient is 60-69,
1880 inclusive, and the recipient has a secondary condition that
1881 includes cerebral palsy, spina bifida, Prader-Willi syndrome,
1882 epilepsy, or autistic disorder or has ambulation, sensory,
1883 chronic health, and behavioral problems;
1884 3. The recipient's intelligence quotient is 60-69,
1885 inclusive, and the recipient has severe functional limitations
1886 in at least three major life activities, including self-care,
1887 learning, mobility, self-direction, understanding and use of
1888 language, and capacity for independent living; or
1889 4. The recipient is eligible under a primary disability of
1890 autistic disorder, cerebral palsy, spina bifida, or Prader-Willi

1891 syndrome. In addition, the condition must result in substantial
1892 functional limitations in three or more major life activities,
1893 including self-care, learning, mobility, self-direction,
1894 understanding and use of language, and capacity for independent
1895 living.
1896 (d) Meets the level of care need to receive services in an
1897 intermediate care facility for the developmentally disabled.
1898 (e) Is enrolled in a home and community-based Medicaid
1899 waiver established in chapter 393 or the Consumer Directed Care
1900 Plus program for persons with developmental disabilities under
1901 the Medicaid state plan, is a Medicaid-funded resident of a
1902 private intermediate care facility for the developmentally
1903 disabled on the date the managed long-term care plans for
1904 persons with disabilities becomes available in the recipient's
1905 region, or has been offered enrollment in a comprehensive long-
1906 term care plan or a long-term care plan.
1907 (2) The Agency for Persons with Disabilities shall make
1908 offers for enrollment to eligible individuals based on the wait-
1909 list prioritization in s. 393.065(5) and subject to availability
1910 of funds. Before enrollment offers, the agency shall determine
1911 that sufficient funds exist to support additional enrollment
1912 into plans.
1913 (3) Unless specifically exempted, all eligible persons
1914 must be enrolled in a comprehensive long-term care plan or a
1915 long-term care plan. Medicaid recipients who are residents of a
1916 developmental disability center, including Sunland Center in
1917 Marianna and Tacachale Center in Gainesville, are exempt from
1918 mandatory enrollment but may voluntarily enroll in a long-term

1919 care plan.
1920 Section 30. Section 409.988, Florida Statutes, is created
1921 to read:
1922 409.988 Benefits.—Managed care plans shall cover, at a
1923 minimum, the services in this section. Plans may customize
1924 benefit packages or offer additional benefits to meet the needs
1925 of enrollees in the plan.
1926 (1) Intermediate care for the developmentally disabled.
1927 (2) Services in alternative residential settings,
1928 including, but not limited to:
1929 (a) Group homes licensed under chapter 393 and foster care
1930 homes licensed under chapter 409.
1931 (b) Comprehensive transitional education programs licensed
1932 under chapter 393.
1933 (c) Residential habilitation centers licensed under
1934 chapter 393.
1935 (d) Assisted living facilities licensed under chapter 429
1936 and transitional living facilities licensed under part V of
1937 chapter 400.
1938 (3) Adult day training.
1939 (4) Behavior analysis services.
1940 (5) Companion services.
1941 (6) Consumable medical supplies.
1942 (7) Durable medical equipment and supplies.
1943 (8) Environmental accessibility adaptations.
1944 (9) In-home support services.
1945 (10) Therapies, including occupational, speech,
1946 respiratory, and physical therapy.

1947 (11) Personal care assistance.
1948 (12) Residential habilitation services.
1949 (13) Intensive behavioral residential habilitation
1950 services.
1951 (14) Behavior focus residential habilitation services.
1952 (15) Residential nursing services.
1953 (16) Respite care.
1954 (17) Support coordination.
1955 (18) Supported employment.
1956 (19) Supported living coaching.
1957 (20) Transportation.
1958 Section 31. Section 409.989, Florida Statutes, is created
1959 to read:
1960 409.989 Eligible plans.—
1961 (1) ELIGIBLE PLANS.—Provider service networks may be
1962 either long-term care plans or comprehensive long-term care
1963 plans. Other plans must be comprehensive long-term care plans
1964 and under contract to provide services pursuant to s. 409.973 or
1965 s. 409.98 in any of the regions that form the combined region as
1966 defined in this section.
1967 (2) PROVIDER SERVICE NETWORKS.—Provider service networks
1968 targeted to serve persons with disabilities must include one or
1969 more owners licensed pursuant to s. 393.067 or s. 400.962 and
1970 with at least 10 years' experience in serving this population.
1971 (3) ELIGIBLE PLAN SELECTION.—The agency shall select
1972 eligible plans through the procurement process described in s.
1973 409.966. The agency shall notice invitations to negotiate no
1974 later than January 1, 2015.

1975 (a) The agency shall procure at least two plans and no
1976 more than three plans for services in combined Regions I, II,
1977 and III. At least one plan shall be a provider service network,
1978 if any submit a responsive bid.
1979 (b) The agency shall procure at least two plans and no
1980 more than three plans for services in combined Regions IV and V.
1981 At least one plan shall be a provider service network, if any
1982 submit a responsive bid.
1983 (c) The agency shall procure at least two plans and no
1984 more than four plans for services in combined Regions VI, VII,
1985 and VIII. At least one plan shall be a provider service network,
1986 if any submit a responsive bid.
1987
1988 If no provider service network submits a responsive bid, the
1989 agency shall procure no more than one less than the maximum
1990 number of eligible plans permitted in the combined region.
1991 Within 12 months after the initial invitation to negotiate, the
1992 agency shall attempt to procure an eligible plan that is a
1993 provider service network. The agency shall notice another
1994 invitation to negotiate only with provider service networks in
1995 such combined region where no provider service network has been
1996 selected.
1997 (4) QUALITY SELECTION CRITERIA.—In addition to the
1998 criteria established in s. 409.966, the agency shall consider
1999 the following factors in the selection of eligible plans:
2000 (a) Whether the plan has sufficient specialized staffing,
2001 including employment of executive managers with expertise and
2002 experience in serving persons with developmental disabilities.

2003 (b) Whether the plan has sufficient network
2004 qualifications, including establishment of a network of service
2005 providers dispersed throughout the combined region and in
2006 sufficient numbers to meet specific accessibility standards
2007 established by the agency for specialty services for persons
2008 with developmental disabilities.
2009 (c) Whether the plan has written agreements or signed
2010 contracts or has made substantial progress in establishing
2011 relationships with providers before the plan submitting a
2012 response. The agency shall give preference to plans with
2013 evidence of signed contracts with providers listed in s.
2014 409.99(1).
2015 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's
2016 Medical Services Network may provide either long-term care plans
2017 or comprehensive long-term care plans. Participation by the
2018 Children's Medical Services Network shall be pursuant to a
2019 single, statewide contract with the agency not subject to the
2020 procurement requirements or regional plan number limits of this
2021 section. The Children's Medical Services Network must meet all
2022 other plan requirements.
2023 Section 32. Section 409.99, Florida Statutes, is created
2024 to read:
2025 409.99 Managed care plan accountability.—In addition to
2026 the requirements of s. 409.967, managed care plans and providers
2027 shall comply with the requirements of this section.
2028 (1) PROVIDER NETWORKS.—Managed care plans may limit the
2029 providers in their networks based on credentials, quality
2030 indicators, and price. However, in the first contract period

2031 after an eligible plan is selected in a region by the agency,
2032 the plan must offer a network contract to the following
2033 providers in the region:
2034 (a) Providers with licensed institutional care facilities
2035 for the developmentally disabled.
2036 (b) Providers of alternative residential facilities
2037 specified in s. 409.988.
2038
2039 After 12 months of active participation in a managed care plan
2040 network, the plan may exclude any of the above-named providers
2041 from the network for failure to meet quality or performance
2042 criteria. If the plan excludes a provider from the plan, the
2043 plan must provide written notice to all recipients who have
2044 chosen that provider for care. The notice shall be issued at
2045 least 90 days before the effective date of the exclusion.
2046 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in
2047 this subsection, providers may limit the managed care plans they
2048 join. Licensed institutional care facilities for the
2049 developmentally disabled and licensed residential settings
2050 providing Intensive Behavioral Residential Habilitation services
2051 with an active Medicaid provider agreement must agree to
2052 participate in any eligible plan selected by the agency.
2053 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
2054 monitor the quality and performance of each participating
2055 provider. At the beginning of the contract period, each plan
2056 shall notify all its network providers of the metrics used by
2057 the plan for evaluating the provider's performance and
2058 determining continued participation in the network.

2059 (4) PROVIDER PAYMENT.—Managed care plans and providers
2060 shall negotiate mutually acceptable rates, methods, and terms of
2061 payment. Plans shall pay intermediate care facilities for the
2062 developmentally disabled and intensive behavior residential
2063 habilitation providers an amount equal to the facility-specific
2064 payment rate set by the agency.
2065 (5) CONSUMER AND FAMILY INVOLVEMENT.—Each managed care
2066 plan must establish a family advisory committee to participate
2067 in program design and oversight.
2068 (6) CONSUMER-DIRECTED CARE.—Each managed care plan must
2069 offer consumer-directed care services to enrollees pursuant to
2070 s. 409.221.
2071 Section 33. Section 409.991, Florida Statutes, is created
2072 to read:
2073 409.991 Managed care plan payment.—In addition to the
2074 payment provisions of s. 409.968, the agency shall provide
2075 payment to comprehensive long-term care plans and long-term care
2076 plans pursuant to this section.
2077 (1) Prepaid payment rates shall be negotiated between the
2078 agency and the eligible plans as part of the procurement process
2079 described in s. 409.966.
2080 (2) Payment for comprehensive long-term care plans
2081 covering services pursuant to s. 409.973 shall be blended with
2082 payments for long-term care plans for services specified in s.
2083 409.988.
2084 (3) Payment rates for plans covering services specified in
2085 s. 409.988 shall be based on historical utilization and spending

2086 for covered services projected forward and adjusted to reflect
2087 the level-of-care profile of each plan's enrollees.
2088 (4) The Agency for Persons with Disabilities shall conduct
2089 the initial assessment of an enrollee's level of care. The
2090 evaluation of level of care shall be based on assessment and
2091 service utilization information from the most recent version of
2092 the Questionnaire for Situational Information and encounter
2093 data.
2094 (5) The agency shall assign enrollees of developmental
2095 disabilities long-term care plans into one of five levels of
2096 care to account for variations in risk status and service needs
2097 among enrollees.
2098 (a) Level of care 1 consists of individuals receiving
2099 services in an intermediate care facility for the
2100 developmentally disabled.
2101 (b) Level of care 2 consists of individuals with intensive
2102 medical or adaptive needs and who require essential services to
2103 avoid institutionalization or who possess behavioral problems
2104 that are exceptional in intensity, duration, or frequency and
2105 present a substantial risk of harm to themselves or others.
2106 (c) Level of care 3 consists of individuals with service
2107 needs, including a licensed residential facility and a moderate
2108 level of support for standard residential habilitation services
2109 or a minimal level of support for behavior focus residential
2110 habilitation services, or individuals in supported living who
2111 require more than 6 hours a day of in-home support services.
2112 (d) Level of care 4 consists of individuals requiring less
2113 than a moderate level of residential habilitation support in a

2114 residential placement or individuals in supported living who
2115 require 6 hours a day or less of in-home support services.
2116 (e) Level of care 5 consists of individuals who do not
2117 receive in-home support services and need minimal support
2118 services while living in independent or supported living
2119 situations or in their family home.
2120
2121 The agency shall periodically adjust aggregate payments to plans
2122 based on encounter data to account for variations in risk levels
2123 among plans' enrollees.
2124 (6) The agency shall establish intensive behavior
2125 residential habilitation rates for providers approved by the
2126 agency to provide this service. The agency shall also establish
2127 intermediate care facility for the developmentally disabled-
2128 specific payment rates for each licensed intermediate care
2129 facility. Payments to intermediate care facilities for the
2130 developmentally disabled and providers of intensive behavior
2131 residential habilitation services shall be reconciled to
2132 reimburse the plan's actual payments to the facilities.
2133 Section 34. Section 409.992, Florida Statutes, is created
2134 to read:
2135 409.992 Automatic enrollment.—The agency shall
2136 automatically enroll into a comprehensive long-term care plan or
2137 a long-term care plan those Medicaid recipients who do not
2138 voluntarily choose a plan pursuant to s. 409.969. The agency
2139 shall automatically enroll recipients in plans that meet or
2140 exceed the performance or quality standards established pursuant
2141 to s. 409.967 and shall not automatically enroll recipients in a

2142 plan that is deficient in those performance or quality
2143 standards. Except as otherwise provided in this part, the agency
2144 shall assign individuals who are deemed dually eligible for
2145 Medicaid and Medicare to a plan that provides both Medicaid and
2146 Medicare services. The agency may not engage in practices that
2147 are designed to favor one managed care plan over another. When
2148 automatically enrolling recipients in plans, the agency shall
2149 take into account the following criteria:
2150 (1) Whether the plan has sufficient network capacity to
2151 meet the needs of the recipients.
2152 (2) Whether the recipient has previously received services
2153 from one of the plan's home and community-based service
2154 providers.
2155 (3) Whether home and community-based providers in one plan
2156 are more geographically accessible to the recipient's residence
2157 than those in other plans.
2158 Section 35. This act shall take effect July 1, 2011.