

Amendment No.

CHAMBER ACTION

Senate

House

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1 Representative Schenck offered the following:

2
3 **Amendment (with title amendment)**

4 Remove everything after the enacting clause and insert:

5 Section 1. Paragraph (b) of subsection (4) and subsection
6 (21) of section 409.912, Florida Statutes, are amended to read:

7 409.912 Cost-effective purchasing of health care.—The
8 agency shall purchase goods and services for Medicaid recipients
9 in the most cost-effective manner consistent with the delivery
10 of quality medical care. To ensure that medical services are
11 effectively utilized, the agency may, in any case, require a
12 confirmation or second physician's opinion of the correct
13 diagnosis for purposes of authorizing future services under the
14 Medicaid program. This section does not restrict access to
15 emergency services or poststabilization care services as defined
16 in 42 C.F.R. part 438.114. Such confirmation or second opinion

504515

3/7/2012 6:01 PM

Amendment No.

17 shall be rendered in a manner approved by the agency. The agency
18 shall maximize the use of prepaid per capita and prepaid
19 aggregate fixed-sum basis services when appropriate and other
20 alternative service delivery and reimbursement methodologies,
21 including competitive bidding pursuant to s. 287.057, designed
22 to facilitate the cost-effective purchase of a case-managed
23 continuum of care. The agency shall also require providers to
24 minimize the exposure of recipients to the need for acute
25 inpatient, custodial, and other institutional care and the
26 inappropriate or unnecessary use of high-cost services. The
27 agency shall contract with a vendor to monitor and evaluate the
28 clinical practice patterns of providers in order to identify
29 trends that are outside the normal practice patterns of a
30 provider's professional peers or the national guidelines of a
31 provider's professional association. The vendor must be able to
32 provide information and counseling to a provider whose practice
33 patterns are outside the norms, in consultation with the agency,
34 to improve patient care and reduce inappropriate utilization.
35 The agency may mandate prior authorization, drug therapy
36 management, or disease management participation for certain
37 populations of Medicaid beneficiaries, certain drug classes, or
38 particular drugs to prevent fraud, abuse, overuse, and possible
39 dangerous drug interactions. The Pharmaceutical and Therapeutics
40 Committee shall make recommendations to the agency on drugs for
41 which prior authorization is required. The agency shall inform
42 the Pharmaceutical and Therapeutics Committee of its decisions
43 regarding drugs subject to prior authorization. The agency is
44 authorized to limit the entities it contracts with or enrolls as

504515

3/7/2012 6:01 PM

Amendment No.

45 Medicaid providers by developing a provider network through
46 provider credentialing. The agency may competitively bid single-
47 source-provider contracts if procurement of goods or services
48 results in demonstrated cost savings to the state without
49 limiting access to care. The agency may limit its network based
50 on the assessment of beneficiary access to care, provider
51 availability, provider quality standards, time and distance
52 standards for access to care, the cultural competence of the
53 provider network, demographic characteristics of Medicaid
54 beneficiaries, practice and provider-to-beneficiary standards,
55 appointment wait times, beneficiary use of services, provider
56 turnover, provider profiling, provider licensure history,
57 previous program integrity investigations and findings, peer
58 review, provider Medicaid policy and billing compliance records,
59 clinical and medical record audits, and other factors. Providers
60 are not entitled to enrollment in the Medicaid provider network.
61 The agency shall determine instances in which allowing Medicaid
62 beneficiaries to purchase durable medical equipment and other
63 goods is less expensive to the Medicaid program than long-term
64 rental of the equipment or goods. The agency may establish rules
65 to facilitate purchases in lieu of long-term rentals in order to
66 protect against fraud and abuse in the Medicaid program as
67 defined in s. 409.913. The agency may seek federal waivers
68 necessary to administer these policies.

69 (4) The agency may contract with:

70 (b) An entity that is providing comprehensive behavioral
71 health care services to certain Medicaid recipients through a
72 capitated, prepaid arrangement pursuant to the federal waiver

504515

3/7/2012 6:01 PM

Amendment No.

73 provided for by s. 409.905(5). Such entity must be licensed
74 under chapter 624, chapter 636, or chapter 641, or authorized
75 under paragraph (c) or paragraph (d), and must possess the
76 clinical systems and operational competence to manage risk and
77 provide comprehensive behavioral health care to Medicaid
78 recipients. As used in this paragraph, the term "comprehensive
79 behavioral health care services" means covered mental health and
80 substance abuse treatment services that are available to
81 Medicaid recipients. The secretary of the Department of Children
82 and Family Services shall approve provisions of procurements
83 related to children in the department's care or custody before
84 enrolling such children in a prepaid behavioral health plan. Any
85 contract awarded under this paragraph must be competitively
86 procured. In developing the behavioral health care prepaid plan
87 procurement document, the agency shall ensure that the
88 procurement document requires the contractor to develop and
89 implement a plan to ensure compliance with s. 394.4574 related
90 to services provided to residents of licensed assisted living
91 facilities that hold a limited mental health license. Except as
92 provided in subparagraph 5., and except in counties where the
93 Medicaid managed care pilot program is authorized pursuant to s.
94 409.91211, the agency shall seek federal approval to contract
95 with a single entity meeting these requirements to provide
96 comprehensive behavioral health care services to all Medicaid
97 recipients not enrolled in a Medicaid managed care plan
98 authorized under s. 409.91211, a provider service network
99 authorized under paragraph (d), or a Medicaid health maintenance
100 organization in an AHCA area. In an AHCA area where the Medicaid

504515

3/7/2012 6:01 PM

Amendment No.

101 managed care pilot program is authorized pursuant to s.
102 409.91211 in one or more counties, the agency may procure a
103 contract with a single entity to serve the remaining counties as
104 an AHCA area or the remaining counties may be included with an
105 adjacent AHCA area and are subject to this paragraph. Each
106 entity must offer a sufficient choice of providers in its
107 network to ensure recipient access to care and the opportunity
108 to select a provider with whom they are satisfied. The network
109 shall include all public mental health hospitals. To ensure
110 unimpaired access to behavioral health care services by Medicaid
111 recipients, all contracts issued pursuant to this paragraph must
112 require 80 percent of the capitation paid to the managed care
113 plan, including health maintenance organizations and capitated
114 provider service networks, to be expended for the provision of
115 behavioral health care services. If the managed care plan
116 expends less than 80 percent of the capitation paid for the
117 provision of behavioral health care services, the difference
118 shall be returned to the agency. The agency shall provide the
119 plan with a certification letter indicating the amount of
120 capitation paid during each calendar year for behavioral health
121 care services pursuant to this section. The agency may reimburse
122 for substance abuse treatment services on a fee-for-service
123 basis until the agency finds that adequate funds are available
124 for capitated, prepaid arrangements.

125 1. The agency shall modify the contracts with the entities
126 providing comprehensive inpatient and outpatient mental health
127 care services to Medicaid recipients in Hillsborough, Highlands,

504515

3/7/2012 6:01 PM

Amendment No.

128 Hardee, Manatee, and Polk Counties, to include substance abuse
129 treatment services.

130 2. Except as provided in subparagraph 5., the agency and
131 the Department of Children and Family Services shall contract
132 with managed care entities in each AHCA area except area 6 or
133 arrange to provide comprehensive inpatient and outpatient mental
134 health and substance abuse services through capitated prepaid
135 arrangements to all Medicaid recipients who are eligible to
136 participate in such plans under federal law and regulation. In
137 AHCA areas where eligible individuals number less than 150,000,
138 the agency shall contract with a single managed care plan to
139 provide comprehensive behavioral health services to all
140 recipients who are not enrolled in a Medicaid health maintenance
141 organization, a provider service network authorized under
142 paragraph (d), or a Medicaid capitated managed care plan
143 authorized under s. 409.91211. The agency may contract with more
144 than one comprehensive behavioral health provider to provide
145 care to recipients who are not enrolled in a Medicaid capitated
146 managed care plan authorized under s. 409.91211, a provider
147 service network authorized under paragraph (d), or a Medicaid
148 health maintenance organization in AHCA areas where the eligible
149 population exceeds 150,000. In an AHCA area where the Medicaid
150 managed care pilot program is authorized pursuant to s.
151 409.91211 in one or more counties, the agency may procure a
152 contract with a single entity to serve the remaining counties as
153 an AHCA area or the remaining counties may be included with an
154 adjacent AHCA area and shall be subject to this paragraph.

155 Contracts for comprehensive behavioral health providers awarded
504515

3/7/2012 6:01 PM

Amendment No.

156 pursuant to this section shall be competitively procured. Both
157 for-profit and not-for-profit corporations are eligible to
158 compete. Managed care plans contracting with the agency under
159 subsection (3) or paragraph (d) shall provide and receive
160 payment for the same comprehensive behavioral health benefits as
161 provided in AHCA rules, including handbooks incorporated by
162 reference. In AHCA area 11, the agency shall contract with at
163 least two comprehensive behavioral health care providers to
164 provide behavioral health care to recipients in that area who
165 are enrolled in, or assigned to, the MediPass program. One of
166 the behavioral health care contracts must be with the existing
167 provider service network pilot project, as described in
168 paragraph (d), for the purpose of demonstrating the cost-
169 effectiveness of the provision of quality mental health services
170 through a public hospital-operated managed care model. Payment
171 shall be at an agreed-upon capitated rate to ensure cost
172 savings. Of the recipients in area 11 who are assigned to
173 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
174 MediPass-enrolled recipients shall be assigned to the existing
175 provider service network in area 11 for their behavioral care.

176 3. Children residing in a statewide inpatient psychiatric
177 program, or in a Department of Juvenile Justice or a Department
178 of Children and Family Services residential program approved as
179 a Medicaid behavioral health overlay services provider may not
180 be included in a behavioral health care prepaid health plan or
181 any other Medicaid managed care plan pursuant to this paragraph.

182 4. Traditional community mental health providers under
183 contract with the Department of Children and Family Services

504515

3/7/2012 6:01 PM

Amendment No.

184 pursuant to part IV of chapter 394, child welfare providers
185 under contract with the Department of Children and Family
186 Services in areas 1 and 6, and inpatient mental health providers
187 licensed pursuant to chapter 395 must be offered an opportunity
188 to accept or decline a contract to participate in any provider
189 network for prepaid behavioral health services.

190 5. All Medicaid-eligible children, except children in area
191 1 and children in Highlands County, Hardee County, Polk County,
192 or Manatee County of area 6, that are open for child welfare
193 services in the statewide automated child welfare information
194 system, shall receive their behavioral health care services
195 through a specialty prepaid plan operated by community-based
196 lead agencies through a single agency or formal agreements among
197 several agencies. The agency shall work with the specialty plan
198 to develop clinically effective, evidence-based alternatives as
199 a downward substitution for the statewide inpatient psychiatric
200 program and similar residential care and institutional services.
201 The specialty prepaid plan must result in savings to the state
202 comparable to savings achieved in other Medicaid managed care
203 and prepaid programs. Such plan must provide mechanisms to
204 maximize state and local revenues. The specialty prepaid plan
205 shall be developed by the agency and the Department of Children
206 and Family Services. The agency may seek federal waivers to
207 implement this initiative. Medicaid-eligible children whose
208 cases are open for child welfare services in the statewide
209 automated child welfare information system and who reside in
210 AHCA area 10 shall be enrolled in a capitated provider service
211 network or other capitated managed care plan, which, in

504515

3/7/2012 6:01 PM

Amendment No.

212 coordination with available community-based care providers
213 specified in s. 409.1671, shall provide sufficient medical,
214 developmental, and behavioral health services to meet the needs
215 of these children.

216
217 Effective July, 1, 2012, in order to ensure continuity of care,
218 the agency is authorized to extend or modify current contracts
219 based on current service areas or on a regional basis, as
220 determined appropriate by the agency, with comprehensive
221 behavioral health care providers as described in this paragraph
222 during the period prior to its expiration. This paragraph
223 expires October 1, 2014.

224 (21) The agency may impose a fine for a violation of this
225 section or the contract with the agency by a person or entity
226 that is under contract with the agency. With respect to any
227 nonwillful violation, such fine shall not exceed \$2,500 per
228 violation. In no event shall such fine exceed an aggregate
229 amount of \$10,000 for all nonwillful violations arising out of
230 the same action. With respect to any knowing and willful
231 violation of this section or the contract with the agency, the
232 agency may impose a fine upon the entity in an amount not to
233 exceed \$20,000 for each such violation. In no event shall such
234 fine exceed an aggregate amount of \$100,000 for all knowing and
235 willful violations arising out of the same action. ~~This~~
236 ~~subsection expires October 1, 2014.~~

237 Section 2. Subsection (21) is added to section 409.9122,
238 Florida Statutes, to read:

504515
3/7/2012 6:01 PM

Amendment No.

239 409.9122 Mandatory Medicaid managed care enrollment;
240 programs and procedures.—

241 (21) If required as a condition of a waiver, the agency
242 may calculate a medical loss ratio for managed care plans. The
243 calculation shall utilize uniform financial data collected from
244 all plans and shall be computed for each plan on a statewide
245 basis. The method for calculating the medical loss ratio shall
246 meet the following criteria:

247 (a) Except as provided in paragraphs (b) and (c),
248 expenditures shall be classified in a manner consistent with 45
249 C.F.R. part 158.

250 (b) Funds provided by plans to graduate medical education
251 institutions to underwrite the costs of residency positions
252 shall be classified as medical expenditures, provided the
253 funding is sufficient to sustain the position for the number of
254 years necessary to complete the residency requirements and the
255 residency positions funded by the plans are active providers of
256 care to Medicaid and uninsured patients.

257 (c) Prior to final determination of the medical loss ratio
258 for any period, a plan may contribute to a designated state
259 trust fund for the purpose of supporting Medicaid and indigent
260 care and have the contribution counted as a medical expenditure
261 for the period.

262 Section 3. Section 409.961, Florida Statutes, is amended
263 to read:

264 409.961 Statutory construction; applicability; rules.—It
265 is the intent of the Legislature that if any conflict exists
266 between the provisions contained in this part and in other parts

504515
3/7/2012 6:01 PM

Amendment No.

267 of this chapter, the provisions in this part control. Sections
268 409.961-409.985 apply only to the Medicaid managed medical
269 assistance program and long-term care managed care program, as
270 provided in this part. The agency shall adopt any rules
271 necessary to comply with or administer this part and all rules
272 necessary to comply with federal requirements. In addition, the
273 department shall adopt and accept the transfer of any rules
274 necessary to carry out the department's responsibilities for
275 receiving and processing Medicaid applications and determining
276 Medicaid eligibility and for ensuring compliance with and
277 administering this part, as those rules relate to the
278 department's responsibilities, and any other provisions related
279 to the department's responsibility for the determination of
280 Medicaid eligibility. Contracts with the agency and a person or
281 entity, including Medicaid providers and managed care plans,
282 necessary to administer the Medicaid program are not rules and
283 are not subject to chapter 120.

284 Section 4. Subsections (4) and (6) of section 409.962,
285 Florida Statutes, are amended to read:

286 409.962 Definitions.—As used in this part, except as
287 otherwise specifically provided, the term:

288 (4) "Comprehensive long-term care plan" means a managed
289 care plan, including a Medicare Advantage Special Needs Plan
290 organized as a preferred provider organization, provider-
291 sponsored organization, health maintenance organization, or
292 coordinated care plan, that provides services described in s.
293 409.973 and also provides the services described in s. 409.98.

504515
3/7/2012 6:01 PM

Amendment No.

294 (6) "Eligible plan" means a health insurer authorized
295 under chapter 624, an exclusive provider organization authorized
296 under chapter 627, a health maintenance organization authorized
297 under chapter 641, or a provider service network authorized
298 under s. 409.912(4) (d) or an accountable care organization
299 authorized under federal law. For purposes of the managed
300 medical assistance program, the term also includes the
301 Children's Medical Services Network authorized under chapter 391
302 ~~and. For purposes of the long-term care managed care program,~~
303 ~~the term also includes~~ entities qualified under 42 C.F.R. part
304 422 as Medicare Advantage Preferred Provider Organizations,
305 Medicare Advantage Provider-sponsored Organizations, Medicare
306 Advantage Health Maintenance Organizations, Medicare Advantage
307 Coordinated Care Plans, and Medicare Advantage Special Needs
308 Plans, and the Program of All-inclusive Care for the Elderly.

309 Section 5. Paragraph (c) of subsection (3) of section
310 409.966, Florida Statutes, is amended to read:

311 409.966 Eligible plans; selection.—

312 (3) QUALITY SELECTION CRITERIA.—

313 (c) After negotiations are conducted, the agency shall
314 select the eligible plans that are determined to be responsive
315 and provide the best value to the state. Preference shall be
316 given to plans that:

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

Amendment No.

320 2. Have well-defined programs for recognizing patient-
321 centered medical homes and providing for increased compensation
322 for recognized medical homes, as defined by the plan.

323 3. Are organizations that are based in and perform
324 operational functions in this state, in-house or through
325 contractual arrangements, by staff located in this state. Using
326 a tiered approach, the highest number of points shall be awarded
327 to a plan that has all or substantially all of its operational
328 functions performed in the state. The second highest number of
329 points shall be awarded to a plan that has a majority of its
330 operational functions performed in the state. The agency may
331 establish a third tier; however, preference points may not be
332 awarded to plans that perform only community outreach, medical
333 director functions, and state administrative functions in the
334 state. For purposes of this subparagraph, operational functions
335 include corporate headquarters, claims processing, member
336 services, provider relations, utilization and prior
337 authorization, case management, disease and quality functions,
338 and finance and administration. For purposes of this
339 subparagraph, the term "corporate headquarters" ~~"based in this~~
340 ~~state"~~ means ~~that~~ the ~~entity's~~ principal office of ~~is in this~~
341 ~~state and~~ the organization, which may not be ~~plan is not~~ a
342 subsidiary, directly or indirectly through one or more
343 subsidiaries of, or a joint venture with, any other entity whose
344 principal office is not located in the state.

345 4. Have contracts or other arrangements for cancer disease
346 management programs that have a proven record of clinical
347 efficiencies and cost savings.

504515

3/7/2012 6:01 PM

Amendment No.

348 5. Have contracts or other arrangements for diabetes
349 disease management programs that have a proven record of
350 clinical efficiencies and cost savings.

351 6. Have a claims payment process that ensures that claims
352 that are not contested or denied will be promptly paid pursuant
353 to s. 641.3155.

354 Section 6. Paragraph (h) of subsection (2) of section
355 409.967, Florida Statutes, is amended, and subsection (4) is
356 added to that section, to read:

357 409.967 Managed care plan accountability.—

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

362 (h) Penalties.—

363 1. Withdrawal and enrollment reduction.—Managed care plans
364 that reduce enrollment levels or leave a region before the end
365 of the contract term must reimburse the agency for the cost of
366 enrollment changes and other transition activities. If more than
367 one plan leaves a region at the same time, costs must be shared
368 by the departing plans proportionate to their enrollments. In
369 addition to the payment of costs, departing provider services
370 networks must pay a per-enrollee ~~per-enrollee~~ penalty of up to 3
371 months' payment and continue to provide services to the enrollee
372 for 90 days or until the enrollee is enrolled in another plan,
373 whichever occurs first. In addition to payment of costs, all
374 other departing plans must pay a penalty of 25 percent of that
375 portion of the minimum surplus maintained ~~requirement~~ pursuant

504515

3/7/2012 6:01 PM

Amendment No.

376 to s. 641.225(1) which is attributable to the provision of
377 coverage to Medicaid enrollees. Plans shall provide at least 180
378 days' notice to the agency before withdrawing from a region. If
379 a managed care plan leaves a region before the end of the
380 contract term, the agency shall terminate all contracts with
381 that plan in other regions, pursuant to the termination
382 procedures in subparagraph 3.

383 2. Encounter data.—If a plan fails to comply with the
384 encounter data reporting requirements of this section for 30
385 days, the agency must assess a fine of \$5,000 per day for each
386 day of noncompliance beginning on the 31st day. On the 31st day,
387 the agency must notify the plan that the agency will initiate
388 contract termination procedures on the 90th day unless the plan
389 comes into compliance before that date.

390 3. Termination.—If the agency terminates more than one
391 regional contract with the same managed care plan due to
392 noncompliance with the requirements of this section, the agency
393 shall terminate all the regional contracts held by that plan.
394 When terminating multiple contracts, the agency must develop a
395 plan to provide for the transition of enrollees to other plans,
396 and phase in ~~phase in~~ the terminations over a time period
397 sufficient to ensure a smooth transition.

398 (4) MEDICAL LOSS RATIO.—If required as a condition of a
399 waiver, the agency may calculate a medical loss ratio for
400 managed care plans. The calculation shall use uniform financial
401 data collected from all plans and shall be computed for each
402 plan on a statewide basis. The method for calculating the
403 medical loss ratio shall meet the following criteria:

504515

3/7/2012 6:01 PM

Amendment No.

404 (a) Except as provided in paragraphs (b) and (c),
405 expenditures shall be classified in a manner consistent with 45
406 C.F.R. part 158.

407 (b) Funds provided by plans to graduate medical education
408 institutions to underwrite the costs of residency positions
409 shall be classified as medical expenditures, provided the
410 funding is sufficient to sustain the position for the number of
411 years necessary to complete the residency requirements and the
412 residency positions funded by the plans are active providers of
413 care to Medicaid and uninsured patients.

414 (c) Prior to final determination of the medical loss ratio
415 for any period, a plan may contribute to a designated state
416 trust fund for the purpose of supporting Medicaid and indigent
417 care and have the contribution counted as a medical expenditure
418 for the period.

419 Section 7. Subsection (4) of section 409.973, Florida
420 Statutes, is amended to read:

421 409.973 Benefits.—

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

426 (a) Provide information to each enrollee on the importance
427 of and procedure for selecting a primary care provider
428 ~~physician~~, and thereafter automatically assign to a primary care
429 provider any enrollee who fails to choose a primary care
430 provider.

504515
3/7/2012 6:01 PM

Amendment No.

431 (b) If the enrollee was not a Medicaid recipient before
432 enrollment in the plan, assist the enrollee in scheduling an
433 appointment with the primary care provider. If possible the
434 appointment should be made within 30 days after enrollment in
435 the plan. For enrollees who become eligible for Medicaid between
436 January 1, 2014, and December 31, 2015, the appointment should
437 be scheduled within 6 months after enrollment in the plan.

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

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

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

446 Section 8. Subsection (3) of section 409.974, Florida
447 Statutes, is amended, and subsection (5) is added to that
448 section, to read:

449 409.974 Eligible plans.—

450 (3) SPECIALTY PLANS.—Participation by specialty plans
451 shall be subject to the procurement requirements ~~and regional~~
452 ~~plan number limits~~ of this section. The aggregate enrollment of
453 all specialty plans in a region may not exceed 10 percent of the
454 total enrollees of that region. ~~However, a specialty plan whose~~
455 ~~target population includes no more than 10 percent of the~~
456 ~~enrollees of that region is not subject to the regional plan~~
457 ~~number limits of this section.~~

504515

3/7/2012 6:01 PM

Amendment No.

458 (5) MEDICARE PLANS.—Participation by a Medicare Advantage
459 Preferred Provider Organization, Medicare Advantage Provider-
460 sponsored Organization, Medicare Advantage Health Maintenance
461 Organization, Medicare Advantage Coordinated Care Plan, or
462 Medicare Advantage Special Needs Plan shall be pursuant to a
463 contract with the agency that is consistent with the Medicare
464 Improvement for Patients and Providers Act of 2008, Pub. L. No.
465 110-275. Such plans are not subject to the procurement
466 requirements if the plan's Medicaid enrollees consist
467 exclusively of dually eligible recipients who are enrolled in
468 the plan in order to receive Medicare benefits as of the date
469 that the invitation to negotiate is issued. Otherwise, such
470 plans are subject to all procurement requirements.

471 Section 9. Subsection (5) of section 409.981, Florida
472 Statutes, is amended to read:

473 409.981 Eligible long-term care plans.—

474 (5) MEDICARE ADVANTAGE SPECIAL NEEDS PLANS.—Participation
475 by a ~~Medicare Advantage Preferred Provider Organization,~~
476 ~~Medicare Advantage Provider-sponsored Organization, or Medicare~~
477 Advantage Special Needs Plan shall be pursuant to a contract
478 with the agency that is consistent with the Medicare Improvement
479 for Patients and Providers Act of 2008, Pub. L. No. 110-275.
480 Such plans are ~~and~~ not subject to the procurement requirements
481 if the plan's Medicaid enrollees consist exclusively of dually
482 eligible recipients who are enrolled in the plan in order to
483 receive Medicare benefits as of the date the invitation to
484 negotiate is issued ~~deemed dually eligible for Medicaid and~~
485 ~~Medicare services.~~ Otherwise, ~~Medicare Advantage Preferred~~

504515

3/7/2012 6:01 PM

Amendment No.

486 ~~Provider Organizations, Medicare Advantage Provider-sponsored~~
487 ~~Organizations, and Medicare Advantage Special Needs Plans~~ are
488 subject to all procurement requirements.

489 Section 10. This act shall take effect July 1, 2012.

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492 -----

493 **T I T L E A M E N D M E N T**

494 Remove the entire title and insert:

495 A bill to be entitled

496 An act relating to Medicaid managed care; amending s.
497 409.912, F.S.; authorizing the Agency for Health Care
498 Administration to extend or modify certain contracts
499 with behavioral health care providers under specified
500 circumstances; removing the expiration of the
501 authority of the agency to impose fines against
502 entities under contract with the department under
503 specified circumstances; amending s. 409.9122, F.S.;
504 directing the agency to calculate a medical loss ratio
505 for managed care plans under specified circumstances
506 and providing the method of calculation; amending s.
507 409.961, F.S.; specifying that contracts necessary to
508 administer the Medicaid program are not rules and are
509 not subject to ch. 120, F.S., the Administrative
510 Procedure Act; amending s. 409.962, F.S.; including
511 certain Medicare plans in the definition of the term
512 "comprehensive long-term care plan"; including certain
513 Medicare plans in the managed medical assistance

504515

3/7/2012 6:01 PM

Amendment No.

514 program by amending the definition of the term
515 "eligible plan"; amending s. 409.966, F.S.; modifying
516 a preference for plans with in-state operations;
517 revising a definition; amending s. 409.967, F.S.;
518 limiting the penalty that a plan must pay if it leaves
519 a region before the end of the contract term;
520 directing the agency to calculate a medical loss ratio
521 for managed care plans under specified circumstances
522 and providing the method of calculation; amending s.
523 409.973, F.S.; requiring a managed care plan to inform
524 the enrollee of the importance of having a primary
525 care provider; amending s. 409.974, F.S.; revising
526 requirements for participation by specialty plans;
527 revising requirements for participation by certain
528 Medicare plans; requiring contracts to meet certain
529 standards; setting enrollment requirements; amending
530 s. 409.981, F.S.; modifying requirements for
531 participation by Medicare Advantage Special Needs
532 Plans; requiring contracts to meet certain standards;
533 establishing enrollment requirements; providing an
534 effective date.