1
2 An act relating to Medicaid managed care; amending s.
3 408.7056, F.S.; specifying which health plan entities
4 are subject to the subscriber assistance program;
5 amending s. 409.912, F.S.; authorizing the Agency for
6 Health Care Administration to extend or modify certain
7 contracts with behavioral health care providers under
8 specified circumstances; removing the expiration of
9 the authority of the agency to impose fines against
10 entities under contract with the department under
11 specified circumstances; amending s. 409.9122, F.S.;
12 directing the agency to calculate a medical loss ratio
13 for managed care plans under specified circumstances
14 and providing the method of calculation; amending s.
15 409.961, F.S.; specifying that contracts necessary to
16 administer the Medicaid program are not rules and are
17 not subject to ch. 120, F.S., the Administrative
18 Procedure Act; amending s. 409.962, F.S.; including
19 certain Medicare plans in the definition of the term
20 “comprehensive long-term care plan”; including certain
21 Medicare plans in the managed medical assistance
22 program by amending the definition of the term
23 “eligible plan”; amending s. 409.966, F.S.; modifying
24 a preference for plans with in-state operations;
25 revising a definition; amending s. 409.967, F.S.;
26 limiting the penalty that a plan must pay if it leaves
27 a region before the end of the contract term;
28 directing the agency to calculate a medical loss ratio
29 for managed care plans under specified circumstances

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30 and providing the method of calculation; amending s.
31 409.973, F.S.; requiring a managed care plan to inform
32 the enrollee of the importance of having a primary
33 care provider; amending s. 409.974, F.S.; revising
34 requirements for participation by specialty plans;
35 revising requirements for participation by certain
36 Medicare plans; requiring contracts to meet certain
37 standards; setting enrollment requirements; amending
38 s. 409.981, F.S.; modifying requirements for
39 participation by Medicare Advantage Special Needs
40 Plans; requiring contracts to meet certain standards;
41 establishing enrollment requirements; amending s.
42 627.602, F.S.; applying federal internal grievance
43 procedures to certain health insurance policies;
44 providing exceptions; creating s. 627.6513, F.S.;
45 applying federal internal grievance procedures to
46 certain group health insurance policies; providing
47 exceptions; creating s. 641.312, F.S.; authorizing the
48 Office of Insurance Regulation to adopt rules to
49 administer the federal procedures; providing effective
50 dates.
51
52 Be It Enacted by the Legislature of the State of Florida:
53
54 Section 1. Effective May 12, 2012, subsection (15) is added
55 to section 408.7056, Florida Statutes, to read:
56 408.7056 Subscriber Assistance Program.—
57 (15) This section applies only to prepaid health clinics
58 certified under chapter 641, Florida Healthy Kids plans, and

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59 health plan health insurance policies or health maintenance
60 contracts that meet the requirements of 45 C.F.R. s. 147.140,
61 but only if the health plan does not elect to have all of its
62 health insurance policies or health maintenance contracts
63 subject to applicable internal grievance and external review
64 processes by an independent review organization. A health plan
65 must notify the agency in writing if it elects to have all of
66 its health insurance policies or health maintenance contracts
67 subject to such external review.
68 Section 2. Paragraph (b) of subsection (4) and subsection
69 (21) of section 409.912, Florida Statutes, are amended to read:
70 409.912 Cost-effective purchasing of health care.—The
71 agency shall purchase goods and services for Medicaid recipients
72 in the most cost-effective manner consistent with the delivery
73 of quality medical care. To ensure that medical services are
74 effectively utilized, the agency may, in any case, require a
75 confirmation or second physician's opinion of the correct
76 diagnosis for purposes of authorizing future services under the
77 Medicaid program. This section does not restrict access to
78 emergency services or poststabilization care services as defined
79 in 42 C.F.R. part 438.114. Such confirmation or second opinion
80 shall be rendered in a manner approved by the agency. The agency
81 shall maximize the use of prepaid per capita and prepaid
82 aggregate fixed-sum basis services when appropriate and other
83 alternative service delivery and reimbursement methodologies,
84 including competitive bidding pursuant to s. 287.057, designed
85 to facilitate the cost-effective purchase of a case-managed
86 continuum of care. The agency shall also require providers to
87 minimize the exposure of recipients to the need for acute

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88 inpatient, custodial, and other institutional care and the
89 inappropriate or unnecessary use of high-cost services. The
90 agency shall contract with a vendor to monitor and evaluate the
91 clinical practice patterns of providers in order to identify
92 trends that are outside the normal practice patterns of a
93 provider’s professional peers or the national guidelines of a
94 provider’s professional association. The vendor must be able to
95 provide information and counseling to a provider whose practice
96 patterns are outside the norms, in consultation with the agency,
97 to improve patient care and reduce inappropriate utilization.
98 The agency may mandate prior authorization, drug therapy
99 management, or disease management participation for certain
100 populations of Medicaid beneficiaries, certain drug classes, or
101 particular drugs to prevent fraud, abuse, overuse, and possible
102 dangerous drug interactions. The Pharmaceutical and Therapeutics
103 Committee shall make recommendations to the agency on drugs for
104 which prior authorization is required. The agency shall inform
105 the Pharmaceutical and Therapeutics Committee of its decisions
106 regarding drugs subject to prior authorization. The agency is
107 authorized to limit the entities it contracts with or enrolls as
108 Medicaid providers by developing a provider network through
109 provider credentialing. The agency may competitively bid single-
110 source-provider contracts if procurement of goods or services
111 results in demonstrated cost savings to the state without
112 limiting access to care. The agency may limit its network based
113 on the assessment of beneficiary access to care, provider
114 availability, provider quality standards, time and distance
115 standards for access to care, the cultural competence of the
116 provider network, demographic characteristics of Medicaid

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117 beneficiaries, practice and provider-to-beneficiary standards,
118 appointment wait times, beneficiary use of services, provider
119 turnover, provider profiling, provider licensure history,
120 previous program integrity investigations and findings, peer
121 review, provider Medicaid policy and billing compliance records,
122 clinical and medical record audits, and other factors. Providers
123 are not entitled to enrollment in the Medicaid provider network.
124 The agency shall determine instances in which allowing Medicaid
125 beneficiaries to purchase durable medical equipment and other
126 goods is less expensive to the Medicaid program than long-term
127 rental of the equipment or goods. The agency may establish rules
128 to facilitate purchases in lieu of long-term rentals in order to
129 protect against fraud and abuse in the Medicaid program as
130 defined in s. 409.913. The agency may seek federal waivers
131 necessary to administer these policies.
132 (4) The agency may contract with:
133 (b) An entity that is providing comprehensive behavioral
134 health care services to certain Medicaid recipients through a
135 capitated, prepaid arrangement pursuant to the federal waiver
136 provided for by s. 409.905(5). Such entity must be licensed
137 under chapter 624, chapter 636, or chapter 641, or authorized
138 under paragraph (c) or paragraph (d), and must possess the
139 clinical systems and operational competence to manage risk and
140 provide comprehensive behavioral health care to Medicaid
141 recipients. As used in this paragraph, the term "comprehensive
142 behavioral health care services" means covered mental health and
143 substance abuse treatment services that are available to
144 Medicaid recipients. The secretary of the Department of Children
145 and Family Services shall approve provisions of procurements

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146 related to children in the department's care or custody before
147 enrolling such children in a prepaid behavioral health plan. Any
148 contract awarded under this paragraph must be competitively
149 procured. In developing the behavioral health care prepaid plan
150 procurement document, the agency shall ensure that the
151 procurement document requires the contractor to develop and
152 implement a plan to ensure compliance with s. 394.4574 related
153 to services provided to residents of licensed assisted living
154 facilities that hold a limited mental health license. Except as
155 provided in subparagraph 5., and except in counties where the
156 Medicaid managed care pilot program is authorized pursuant to s.
157 409.91211, the agency shall seek federal approval to contract
158 with a single entity meeting these requirements to provide
159 comprehensive behavioral health care services to all Medicaid
160 recipients not enrolled in a Medicaid managed care plan
161 authorized under s. 409.91211, a provider service network
162 authorized under paragraph (d), or a Medicaid health maintenance
163 organization in an AHCA area. In an AHCA area where the Medicaid
164 managed care pilot program is authorized pursuant to s.
165 409.91211 in one or more counties, the agency may procure a
166 contract with a single entity to serve the remaining counties as
167 an AHCA area or the remaining counties may be included with an
168 adjacent AHCA area and are subject to this paragraph. Each
169 entity must offer a sufficient choice of providers in its
170 network to ensure recipient access to care and the opportunity
171 to select a provider with whom they are satisfied. The network
172 shall include all public mental health hospitals. To ensure
173 unimpaired access to behavioral health care services by Medicaid
174 recipients, all contracts issued pursuant to this paragraph must

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175 require 80 percent of the capitation paid to the managed care
176 plan, including health maintenance organizations and capitated
177 provider service networks, to be expended for the provision of
178 behavioral health care services. If the managed care plan
179 expends less than 80 percent of the capitation paid for the
180 provision of behavioral health care services, the difference
181 shall be returned to the agency. The agency shall provide the
182 plan with a certification letter indicating the amount of
183 capitation paid during each calendar year for behavioral health
184 care services pursuant to this section. The agency may reimburse
185 for substance abuse treatment services on a fee-for-service
186 basis until the agency finds that adequate funds are available
187 for capitated, prepaid arrangements.
188 1. The agency shall modify the contracts with the entities
189 providing comprehensive inpatient and outpatient mental health
190 care services to Medicaid recipients in Hillsborough, Highlands,
191 Hardee, Manatee, and Polk Counties, to include substance abuse
192 treatment services.
193 2. Except as provided in subparagraph 5., the agency and
194 the Department of Children and Family Services shall contract
195 with managed care entities in each AHCA area except area 6 or
196 arrange to provide comprehensive inpatient and outpatient mental
197 health and substance abuse services through capitated prepaid
198 arrangements to all Medicaid recipients who are eligible to
199 participate in such plans under federal law and regulation. In
200 AHCA areas where eligible individuals number less than 150,000,
201 the agency shall contract with a single managed care plan to
202 provide comprehensive behavioral health services to all
203 recipients who are not enrolled in a Medicaid health maintenance

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204 organization, a provider service network authorized under
205 paragraph (d), or a Medicaid capitated managed care plan
206 authorized under s. 409.91211. The agency may contract with more
207 than one comprehensive behavioral health provider to provide
208 care to recipients who are not enrolled in a Medicaid capitated
209 managed care plan authorized under s. 409.91211, a provider
210 service network authorized under paragraph (d), or a Medicaid
211 health maintenance organization in AHCA areas where the eligible
212 population exceeds 150,000. In an AHCA area where the Medicaid
213 managed care pilot program is authorized pursuant to s.
214 409.91211 in one or more counties, the agency may procure a
215 contract with a single entity to serve the remaining counties as
216 an AHCA area or the remaining counties may be included with an
217 adjacent AHCA area and shall be subject to this paragraph.
218 Contracts for comprehensive behavioral health providers awarded
219 pursuant to this section shall be competitively procured. Both
220 for-profit and not-for-profit corporations are eligible to
221 compete. Managed care plans contracting with the agency under
222 subsection (3) or paragraph (d) shall provide and receive
223 payment for the same comprehensive behavioral health benefits as
224 provided in AHCA rules, including handbooks incorporated by
225 reference. In AHCA area 11, the agency shall contract with at
226 least two comprehensive behavioral health care providers to
227 provide behavioral health care to recipients in that area who
228 are enrolled in, or assigned to, the MediPass program. One of
229 the behavioral health care contracts must be with the existing
230 provider service network pilot project, as described in
231 paragraph (d), for the purpose of demonstrating the cost-
232 effectiveness of the provision of quality mental health services

233 through a public hospital-operated managed care model. Payment
234 shall be at an agreed-upon capitated rate to ensure cost
235 savings. Of the recipients in area 11 who are assigned to
236 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
237 MediPass-enrolled recipients shall be assigned to the existing
238 provider service network in area 11 for their behavioral care.
239 3. Children residing in a statewide inpatient psychiatric
240 program, or in a Department of Juvenile Justice or a Department
241 of Children and Family Services residential program approved as
242 a Medicaid behavioral health overlay services provider may not
243 be included in a behavioral health care prepaid health plan or
244 any other Medicaid managed care plan pursuant to this paragraph.
245 4. Traditional community mental health providers under
246 contract with the Department of Children and Family Services
247 pursuant to part IV of chapter 394, child welfare providers
248 under contract with the Department of Children and Family
249 Services in areas 1 and 6, and inpatient mental health providers
250 licensed pursuant to chapter 395 must be offered an opportunity
251 to accept or decline a contract to participate in any provider
252 network for prepaid behavioral health services.
253 5. All Medicaid-eligible children, except children in area
254 1 and children in Highlands County, Hardee County, Polk County,
255 or Manatee County of area 6, that are open for child welfare
256 services in the statewide automated child welfare information
257 system, shall receive their behavioral health care services
258 through a specialty prepaid plan operated by community-based
259 lead agencies through a single agency or formal agreements among
260 several agencies. The agency shall work with the specialty plan
261 to develop clinically effective, evidence-based alternatives as

262 a downward substitution for the statewide inpatient psychiatric
263 program and similar residential care and institutional services.
264 The specialty prepaid plan must result in savings to the state
265 comparable to savings achieved in other Medicaid managed care
266 and prepaid programs. Such plan must provide mechanisms to
267 maximize state and local revenues. The specialty prepaid plan
268 shall be developed by the agency and the Department of Children
269 and Family Services. The agency may seek federal waivers to
270 implement this initiative. Medicaid-eligible children whose
271 cases are open for child welfare services in the statewide
272 automated child welfare information system and who reside in
273 AHCA area 10 shall be enrolled in a capitated provider service
274 network or other capitated managed care plan, which, in
275 coordination with available community-based care providers
276 specified in s. 409.1671, shall provide sufficient medical,
277 developmental, and behavioral health services to meet the needs
278 of these children.
279
280 Effective July, 1, 2012, in order to ensure continuity of care,
281 the agency is authorized to extend or modify current contracts
282 based on current service areas or on a regional basis, as
283 determined appropriate by the agency, with comprehensive
284 behavioral health care providers as described in this paragraph
285 during the period prior to its expiration. This paragraph
286 expires October 1, 2014.
287 (21) The agency may impose a fine for a violation of this
288 section or the contract with the agency by a person or entity
289 that is under contract with the agency. With respect to any
290 nonwillful violation, such fine shall not exceed $2,500 per

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291 violation. In no event shall such fine exceed an aggregate
292 amount of $10,000 for all nonwillful violations arising out of
293 the same action. With respect to any knowing and willful
294 violation of this section or the contract with the agency, the
295 agency may impose a fine upon the entity in an amount not to
296 exceed $20,000 for each such violation. In no event shall such
297 fine exceed an aggregate amount of $100,000 for all knowing and
298 willful violations arising out of the same action. ~~This~~
299 ~~subsection expires October 1, 2014.~~
300 Section 3. Subsection (21) is added to section 409.9122,
301 Florida Statutes, to read:
302 409.9122 Mandatory Medicaid managed care enrollment;
303 programs and procedures.—
304 (21) If required as a condition of a waiver, the agency may
305 calculate a medical loss ratio for managed care plans. The
306 calculation shall utilize uniform financial data collected from
307 all plans and shall be computed for each plan on a statewide
308 basis. The method for calculating the medical loss ratio shall
309 meet the following criteria:
310 (a) Except as provided in paragraphs (b) and (c),
311 expenditures shall be classified in a manner consistent with 45
312 C.F.R. part 158.
313 (b) Funds provided by plans to graduate medical education
314 institutions to underwrite the costs of residency positions
315 shall be classified as medical expenditures, provided the
316 funding is sufficient to sustain the position for the number of
317 years necessary to complete the residency requirements and the
318 residency positions funded by the plans are active providers of
319 care to Medicaid and uninsured patients.

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320 (c) Prior to final determination of the medical loss ratio
321 for any period, a plan may contribute to a designated state
322 trust fund for the purpose of supporting Medicaid and indigent
323 care and have the contribution counted as a medical expenditure
324 for the period.
325 Section 4. Section 409.961, Florida Statutes, is amended to
326 read:
327 409.961 Statutory construction; applicability; rules.—It is
328 the intent of the Legislature that if any conflict exists
329 between the provisions contained in this part and in other parts
330 of this chapter, the provisions in this part control. Sections
331 409.961-409.985 apply only to the Medicaid managed medical
332 assistance program and long-term care managed care program, as
333 provided in this part. The agency shall adopt any rules
334 necessary to comply with or administer this part and all rules
335 necessary to comply with federal requirements. In addition, the
336 department shall adopt and accept the transfer of any rules
337 necessary to carry out the department's responsibilities for
338 receiving and processing Medicaid applications and determining
339 Medicaid eligibility and for ensuring compliance with and
340 administering this part, as those rules relate to the
341 department's responsibilities, and any other provisions related
342 to the department's responsibility for the determination of
343 Medicaid eligibility. Contracts with the agency and a person or
344 entity, including Medicaid providers and managed care plans,
345 necessary to administer the Medicaid program are not rules and
346 are not subject to chapter 120.
347 Section 5. Subsections (4) and (6) of section 409.962,
348 Florida Statutes, are amended to read:

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

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

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

Section 6. Paragraph (c) of subsection (3) of section 409.966, Florida Statutes, is amended to read:

409.966 Eligible plans; selection.—

(3) QUALITY SELECTION CRITERIA.—

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive

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378 and provide the best value to the state. Preference shall be
379 given to plans that:
380 1. Have signed contracts with primary and specialty
381 physicians in sufficient numbers to meet the specific standards
382 established pursuant to s. 409.967(2)(b).
383 2. Have well-defined programs for recognizing patient-
384 centered medical homes and providing for increased compensation
385 for recognized medical homes, as defined by the plan.
386 3. Are organizations that are based in and perform
387 operational functions in this state, in-house or through
388 contractual arrangements, by staff located in this state. Using
389 a tiered approach, the highest number of points shall be awarded
390 to a plan that has all or substantially all of its operational
391 functions performed in the state. The second highest number of
392 points shall be awarded to a plan that has a majority of its
393 operational functions performed in the state. The agency may
394 establish a third tier; however, preference points may not be
395 awarded to plans that perform only community outreach, medical
396 director functions, and state administrative functions in the
397 state. For purposes of this subparagraph, operational functions
398 include <u>corporate headquarters,</u> claims processing, member
399 services, provider relations, utilization and prior
400 authorization, case management, disease and quality functions,
401 and finance and administration. For purposes of this
402 subparagraph, the term <u>"corporate headquarters"</u> ~~"based in this~~
403 ~~state"~~ means ~~that~~ the ~~entity's~~ principal office <u>of</u> ~~is in this~~
404 ~~state and~~ the <u>organization, which may not be</u> ~~plan is not~~ a
405 subsidiary, directly or indirectly through one or more
406 subsidiaries of, or a joint venture with, any other entity whose

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407 principal office is not located in the state.
408 4. Have contracts or other arrangements for cancer disease
409 management programs that have a proven record of clinical
410 efficiencies and cost savings.
411 5. Have contracts or other arrangements for diabetes
412 disease management programs that have a proven record of
413 clinical efficiencies and cost savings.
414 6. Have a claims payment process that ensures that claims
415 that are not contested or denied will be promptly paid pursuant
416 to s. 641.3155.
417 Section 7. Paragraph (h) of subsection (2) of section
418 409.967, Florida Statutes, is amended, and subsection (4) is
419 added to that section, to read:
420 409.967 Managed care plan accountability.—
421 (2) The agency shall establish such contract requirements
422 as are necessary for the operation of the statewide managed care
423 program. In addition to any other provisions the agency may deem
424 necessary, the contract must require:
425 (h) *Penalties.*—
426 1. Withdrawal and enrollment reduction.—Managed care plans
427 that reduce enrollment levels or leave a region before the end
428 of the contract term must reimburse the agency for the cost of
429 enrollment changes and other transition activities. If more than
430 one plan leaves a region at the same time, costs must be shared
431 by the departing plans proportionate to their enrollments. In
432 addition to the payment of costs, departing provider services
433 networks must pay a per-enrollee ~~per enrollee~~ penalty of up to 3
434 months' payment and continue to provide services to the enrollee
435 for 90 days or until the enrollee is enrolled in another plan,

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436 whichever occurs first. In addition to payment of costs, all
437 other departing plans must pay a penalty of 25 percent of that
438 portion of the minimum surplus maintained requirement pursuant
439 to s. 641.225(1) which is attributable to the provision of
440 coverage to Medicaid enrollees. Plans shall provide at least 180
441 days' notice to the agency before withdrawing from a region. If
442 a managed care plan leaves a region before the end of the
443 contract term, the agency shall terminate all contracts with
444 that plan in other regions, pursuant to the termination
445 procedures in subparagraph 3.
446 2. Encounter data.—If a plan fails to comply with the
447 encounter data reporting requirements of this section for 30
448 days, the agency must assess a fine of $5,000 per day for each
449 day of noncompliance beginning on the 31st day. On the 31st day,
450 the agency must notify the plan that the agency will initiate
451 contract termination procedures on the 90th day unless the plan
452 comes into compliance before that date.
453 3. Termination.—If the agency terminates more than one
454 regional contract with the same managed care plan due to
455 noncompliance with the requirements of this section, the agency
456 shall terminate all the regional contracts held by that plan.
457 When terminating multiple contracts, the agency must develop a
458 plan to provide for the transition of enrollees to other plans,
459 and phase in phase-in the terminations over a time period
460 sufficient to ensure a smooth transition.
461 (4) MEDICAL LOSS RATIO.—If required as a condition of a
462 waiver, the agency may calculate a medical loss ratio for
463 managed care plans. The calculation shall use uniform financial
464 data collected from all plans and shall be computed for each

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465 plan on a statewide basis. The method for calculating the
466 medical loss ratio shall meet the following criteria:
467 (a) Except as provided in paragraphs (b) and (c),
468 expenditures shall be classified in a manner consistent with 45
469 C.F.R. part 158.
470 (b) Funds provided by plans to graduate medical education
471 institutions to underwrite the costs of residency positions
472 shall be classified as medical expenditures, provided the
473 funding is sufficient to sustain the position for the number of
474 years necessary to complete the residency requirements and the
475 residency positions funded by the plans are active providers of
476 care to Medicaid and uninsured patients.
477 (c) Prior to final determination of the medical loss ratio
478 for any period, a plan may contribute to a designated state
479 trust fund for the purpose of supporting Medicaid and indigent
480 care and have the contribution counted as a medical expenditure
481 for the period.
482 Section 8. Subsection (4) of section 409.973, Florida
483 Statutes, is amended to read:
484 409.973 Benefits.—
485 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the
486 managed medical assistance program shall establish a program to
487 encourage enrollees to establish a relationship with their
488 primary care provider. Each plan shall:
489 (a) Provide information to each enrollee on the importance
490 of and procedure for selecting a primary care provider
491 ~~physician~~, and thereafter automatically assign to a primary care
492 provider any enrollee who fails to choose a primary care
493 provider.

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494 (b) If the enrollee was not a Medicaid recipient before
495 enrollment in the plan, assist the enrollee in scheduling an
496 appointment with the primary care provider. If possible the
497 appointment should be made within 30 days after enrollment in
498 the plan. For enrollees who become eligible for Medicaid between
499 January 1, 2014, and December 31, 2015, the appointment should
500 be scheduled within 6 months after enrollment in the plan.
501 (c) Report to the agency the number of enrollees assigned
502 to each primary care provider within the plan's network.
503 (d) Report to the agency the number of enrollees who have
504 not had an appointment with their primary care provider within
505 their first year of enrollment.
506 (e) Report to the agency the number of emergency room
507 visits by enrollees who have not had at least one appointment
508 with their primary care provider.
509 Section 9. Subsection (3) of section 409.974, Florida
510 Statutes, is amended, and subsection (5) is added to that
511 section, to read:
512 409.974 Eligible plans.—
513 (3) SPECIALTY PLANS.—Participation by specialty plans shall
514 be subject to the procurement requirements ~~and regional plan~~
515 ~~number limits~~ of this section. The aggregate enrollment of all
516 specialty plans in a region may not exceed 10 percent of the
517 total enrollees of that region. ~~However, a specialty plan whose~~
518 ~~target population includes no more than 10 percent of the~~
519 ~~enrollees of that region is not subject to the regional plan~~
520 ~~number limits of this section.~~
521 (5) MEDICARE PLANS.—Participation by a Medicare Advantage
522 Preferred Provider Organization, Medicare Advantage Provider-

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523 sponsored Organization, Medicare Advantage Health Maintenance
524 Organization, Medicare Advantage Coordinated Care Plan, or
525 Medicare Advantage Special Needs Plan shall be pursuant to a
526 contract with the agency that is consistent with the Medicare
527 Improvement for Patients and Providers Act of 2008, Pub. L. No.
528 110-275. Such plans are not subject to the procurement
529 requirements if the plan's Medicaid enrollees consist
530 exclusively of dually eligible recipients who are enrolled in
531 the plan in order to receive Medicare benefits as of the date
532 that the invitation to negotiate is issued. Otherwise, such
533 plans are subject to all procurement requirements.
534 Section 10. Subsection (5) of section 409.981, Florida
535 Statutes, is amended to read:
536 409.981 Eligible long-term care plans.—
537 (5) MEDICARE ADVANTAGE SPECIAL NEEDS PLANS.—Participation
538 by a ~~Medicare Advantage Preferred Provider Organization,~~
539 ~~Medicare Advantage Provider-sponsored Organization, or~~ Medicare
540 Advantage Special Needs Plan shall be pursuant to a contract
541 with the agency that is consistent with the Medicare Improvement
542 for Patients and Providers Act of 2008, Pub. L. No. 110-275.
543 Such plans are ~~and~~ not subject to the procurement requirements
544 if the plan's Medicaid enrollees consist exclusively of dually
545 eligible recipients who are enrolled in the plan in order to
546 receive Medicare benefits as of the date the invitation to
547 negotiate is issued ~~deemed dually eligible for Medicaid and~~
548 ~~Medicare services~~. Otherwise, ~~Medicare Advantage Preferred~~
549 ~~Provider Organizations, Medicare Advantage Provider-sponsored~~
550 ~~Organizations, and~~ Medicare Advantage Special Needs Plans are
551 subject to all procurement requirements.

552 Section 11. Effective May 12, 2012, paragraph (h) is added
553 to subsection (1) of section 627.602, Florida Statutes, to read:
554 627.602 Scope, format of policy.—
555 (1) Each health insurance policy delivered or issued for
556 delivery to any person in this state must comply with all
557 applicable provisions of this code and all of the following
558 requirements:
559 (h) Section 641.312 and the provisions of the Employee
560 Retirement Income Security Act of 1974, as implemented by 29
561 C.F.R. s. 2560.503-1, relating to internal grievances. This
562 paragraph does not apply to a health insurance policy that is
563 subject to the subscriber assistance program under s. 408.7056
564 or to the types of benefits or coverages provided under s.
565 627.6561(5)(b)-(e) issued in any market.
566 Section 12. Effective May 12, 2012, section 627.6513,
567 Florida Statutes, is created to read:
568 627.6513 Scope.—Section 641.312 and the provisions of the
569 Employee Retirement Income Security Act of 1974, as implemented
570 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
571 apply to all group health insurance policies issued under this
572 part. This section does not apply to a group health insurance
573 policy that is subject to the subscriber assistance program in
574 s. 408.7056 or to the types of benefits or coverages provided
575 under s. 627.6561(5)(b)-(e) issued in any market.
576 Section 13. Effective May 12, 2012, section 641.312,
577 Florida Statutes, is created to read:
578 641.312 Scope.—The Office of Insurance Regulation may adopt
579 rules to administer the provisions of the National Association
580 of Insurance Commissioners' Uniform Health Carrier External

581 Review Model Act, issued by the National Association of
582 Insurance Commissioners and dated April 2010. This section does
583 not apply to a health maintenance contract that is subject to
584 the subscriber assistance program under s. 408.7056 or to the
585 types of benefits or coverages provided under s. 625.6561(5)(b)-
586 (e) issued in any market.
587 Section 14. Except as otherwise expressly provided in this
588 act and except for this section, which shall take effect upon
589 this act becoming a law, this act shall take effect July 1,
590 2012.

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