576-03814-17

Proposed Committee Substitute by the Committee on Appropriations
(Appropriations Subcommittee on Health and Human Services)

A bill to be entitled

An act relating to Medicaid managed care; amending s. 400.141, F.S.; requiring that nursing home facilities be prepared to provide confirmation within a specified timeframe to the Agency for Health Care Administration as to whether certain nursing home facility residents are candidates for certain services; amending s. 409.964, F.S.; providing that covered services for long-term care under the Medicaid managed care program are those specified in part IV of ch. 409, F.S.; deleting an obsolete provision; amending s. 409.965, F.S.; providing that certain residents of nursing facilities are exempt from participation in the long-term care managed care program; providing for application of the exemption; providing that eligibility for the Medicaid managed medical assistance program is not affected by such provisions; providing conditions under which the exemption does not apply; requiring the agency to confirm whether certain persons have been identified as candidates for home and community-based services; requiring a certain notice to the agency by nursing facility administrators; amending s. 409.967, F.S.; requiring the agency to impose fines and authorizing other sanctions for willful failure to comply with specified payment provisions; amending s. 409.979, F.S.; providing that certain exempt Medicaid recipients are

not required to receive long-term care services through the long-term care managed care program; amending s. 409.982, F.S.; revising parameters under which a long-term care managed care plan must contract with nursing homes and hospices; specifying that the agency must require certain plans to report information on the quality or performance criteria used in making a certain determination; providing effective dates.

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

Section 1. Effective October 1, 2018, paragraph (v) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(v) Be prepared to confirm for the agency whether a nursing home facility resident who is a Medicaid recipient, or whose Medicaid eligibility is pending, is a candidate for home and community-based services under s. 409.965(3)(c), no later than the resident’s 50th consecutive day of residency in the nursing home facility.

Section 2. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated

managed care program for all covered services, including long-term care services as specified under this part. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region. ~~The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.~~

Section 3. Effective October 1, 2018, section 409.965, Florida Statutes, is amended to read:

409.965 Mandatory enrollment.—All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver.

(1) The following Medicaid recipients are exempt from participation in the statewide managed care program:

(a) ~~(1)~~ Women who are eligible only for family planning services.

(b) ~~(2)~~ Women who are eligible only for breast and cervical cancer services.

(c) ~~(3)~~ Persons who are eligible for emergency Medicaid for aliens.

(2)(a) Persons who are assigned into level of care 1 under

s. 409.983(4) and have resided in a nursing facility for 60 or more consecutive days are exempt from participation in the long-term care managed care program. For a person who becomes exempt under this paragraph while enrolled in the long-term care managed care program, the exemption shall take effect on the first day of the first month after the person meets the criteria for the exemption. This paragraph does not affect a person's eligibility for the Medicaid managed medical assistance program.

(b) Persons receiving hospice care while residing in a nursing facility are exempt from participation in the long-term care managed care program. For a person who becomes exempt under this paragraph while enrolled in the long-term care managed care program, the exemption takes effect on the first day of the first month after the person meets the criteria for the exemption. This paragraph does not affect a person's eligibility for the Medicaid managed medical assistance program.

(3) Notwithstanding subsection (2):

(a) A Medicaid recipient who is otherwise eligible for the long-term care managed care program, who is 18 years of age or older, and who is eligible for Medicaid by reason of a disability is not exempt from the long-term care managed care program under subsection (2).

(b) A person who is afforded priority enrollment for home and community-based services under s. 409.979(3)(f) is not exempt from the long-term care managed care program under subsection (2).

(c) A nursing facility resident is not exempt from the long-term care managed care program under paragraph (2)(a) if the resident has been identified as a candidate for home and

community-based services by the nursing facility administrator and any long-term care plan case manager assigned to the resident. Such identification must be made in consultation with the following persons:

1. The resident or the resident's legal representative or designee;

2. The resident's personal physician or, if the resident does not have a personal physician, the facility's medical director; and

3. A registered nurse who has participated in developing, maintaining, or reviewing the individual's resident care plan as defined in s. 400.021.

(d) Before determining that a person is exempt from the long-term care managed care program under paragraph (2)(a), the agency shall confirm whether the person has been identified as a candidate for home and community-based services under paragraph (c). If a nursing facility resident who has been determined exempt is later identified as a candidate for home and community-based services, the nursing facility administrator shall promptly notify the agency.

Section 4. Paragraph (j) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

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

(j) *Prompt payment.*—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513, and the agency shall impose

fines, and may impose other sanctions, on a plan that willfully fails to comply with those sections or s. 409.982(5).

Section 5. Subsection (1) of section 409.979, Florida Statutes, is amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and, unless exempt under s. 409.965, must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

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

Section 6. Subsections (1) and (2) of section 409.982, Florida Statutes, are amended to read:

409.982 Long-term care managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the long-term care managed care program must comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price. For the first 12 months of a contract period following a procurement for the long-term care managed care program under s. 409.981, if a plan has been ~~period between October 1, 2013, and September 30, 2014, each~~ selected for a


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region that the plan was not serving immediately prior to the procurement, the plan must offer a network contract to all nursing homes in that region which meet the recredentialing requirements and to all hospices in that region which meet the credentialing requirements specified in the plan's contract with the agency ~~the following providers in the region:~~

~~(a) Nursing homes.~~

~~(b) Hospices.~~

~~(c) Aging network service providers that have previously participated in home and community-based waivers serving elders or community-service programs administered by the Department of Elderly Affairs~~. After a provider specified in this subsection has actively participated in a managed care plan's network for 12 months ~~of active participation in a managed care plan's network~~, the plan may exclude the provider ~~any of the providers named in this subsection~~ from the plan's network for failure to meet quality or performance criteria. If a ~~the~~ plan excludes a provider from its network under this subsection ~~the plan~~, the plan must provide written notice to all recipients who have chosen that provider for care. The notice must be provided at least 30 days before the effective date of the exclusion. The agency shall establish contract provisions governing the transfer of recipients from excluded residential providers. The agency shall require a plan that excludes a provider from its network or that fails to renew the plan's contract with a provider under this subsection to report to the agency the quality or performance criteria the plan used in deciding to exclude the provider and to demonstrate how the provider failed to meet those criteria.

(2) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the managed care plans they join. Nursing homes and hospices that are enrolled Medicaid providers must participate in all eligible plans selected by the agency in the region in which the provider is located, with the exception of plans from which the provider has been excluded under subsection (1).

Section 7. Except as otherwise provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2017.