**By** the Committee on Health Policy; and Senator Stargel

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1 A bill to be entitled
2 An act relating to Medicaid managed care; amending s.
3 400.141, F.S.; requiring that nursing home facilities
4 be prepared to provide confirmation within a specified
5 timeframe to the Agency for Health Care Administration
6 as to whether certain nursing home facility residents
7 are candidates for certain services; amending s.
8 409.964, F.S.; providing that covered services for
9 long-term care under the Medicaid managed care program
10 are those specified in part IV of ch. 409, F.S.;
11 deleting an obsolete provision; amending s. 409.965,
12 F.S.; providing that certain residents of nursing
13 facilities are exempt from participation in the long-
14 term care managed care program; providing for
15 application of the exemption; providing that
16 eligibility for the Medicaid managed medical
17 assistance program is not affected by such provisions;
18 providing conditions under which the exemption does
19 not apply; requiring the agency to confirm whether
20 certain persons have been identified as candidates for
21 home and community-based services; requiring a certain
22 notice to the agency by nursing facility
23 administrators; amending s. 409.967, F.S.; requiring
24 the agency to impose fines and authorizing other
25 sanctions for willful failure to comply with specified
26 payment provisions; amending s. 409.979, F.S.;
27 providing that certain exempt Medicaid recipients are
28 not required to receive long-term care services
29 through the long-term care managed care program;



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30 amending s. 409.982, F.S.; revising parameters under
31 which a long-term care managed care plan must contract
32 with nursing homes and hospices; specifying that the
33 agency must require certain plans to report
34 information on the quality or performance criteria
35 used in making a certain determination; providing
36 effective dates.
37
38 Be It Enacted by the Legislature of the State of Florida:
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40 Section 1. Effective October 1, 2018, paragraph (v) is
41 added to subsection (1) of section 400.141, Florida Statutes, to
42 read:
43 400.141 Administration and management of nursing home
44 facilities.—
45 (1) Every licensed facility shall comply with all
46 applicable standards and rules of the agency and shall:
47 <u>(v) Be prepared to confirm for the agency whether a nursing</u>
48 <u>home facility resident who is a Medicaid recipient, or whose</u>
49 <u>Medicaid eligibility is pending, is a candidate for home and</u>
50 <u>community-based services under s. 409.965(3)(c), no later than</u>
51 <u>the resident's 50th consecutive day of residency in the nursing</u>
52 <u>home facility.</u>
53 Section 2. Section 409.964, Florida Statutes, is amended to
54 read:
55 409.964 Managed care program; state plan; waivers.—The
56 Medicaid program is established as a statewide, integrated
57 managed care program for all covered services, including long-
58 term care services <u>as specified under this part</u>. The agency



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59 shall apply for and implement state plan amendments or waivers
60 of applicable federal laws and regulations necessary to
61 implement the program. Before seeking a waiver, the agency shall
62 provide public notice and the opportunity for public comment and
63 include public feedback in the waiver application. The agency
64 shall hold one public meeting in each of the regions described
65 in s. 409.966(2), and the time period for public comment for
66 each region shall end no sooner than 30 days after the
67 completion of the public meeting in that region. ~~The agency~~
68 ~~shall submit any state plan amendments, new waiver requests, or~~
69 ~~requests for extensions or expansions for existing waivers,~~
70 ~~needed to implement the managed care program by August 1, 2011.~~
71 Section 3. Effective October 1, 2018, section 409.965,
72 Florida Statutes, is amended to read:
73 409.965 Mandatory enrollment.—All Medicaid recipients shall
74 receive covered services through the statewide managed care
75 program, except as provided by this part pursuant to an approved
76 federal waiver.
77 (1) The following Medicaid recipients are exempt from
78 participation in the statewide managed care program:
79 (a) ~~(1)~~ Women who are eligible only for family planning
80 services.
81 (b) ~~(2)~~ Women who are eligible only for breast and cervical
82 cancer services.
83 (c) ~~(3)~~ Persons who are eligible for emergency Medicaid for
84 aliens.
85 (2)(a) Persons who are assigned into level of care 1 under
86 s. 409.983(4) and have resided in a nursing facility for 60 or
87 more consecutive days are exempt from participation in the long-

88 term care managed care program. For a person who becomes exempt
89 under this paragraph while enrolled in the long-term care
90 managed care program, the exemption shall take effect on the
91 first day of the first month after the person meets the criteria
92 for the exemption. This paragraph does not affect a person's
93 eligibility for the Medicaid managed medical assistance program.
94 (b) Persons receiving hospice care while residing in a
95 nursing facility are exempt from participation in the long-term
96 care managed care program. For a person who becomes exempt under
97 this paragraph while enrolled in the long-term care managed care
98 program, the exemption takes effect on the first day of the
99 first month after the person meets the criteria for the
100 exemption. This paragraph does not affect a person's eligibility
101 for the Medicaid managed medical assistance program.
102 (3) Notwithstanding subsection (2):
103 (a) A Medicaid recipient who is otherwise eligible for the
104 long-term care managed care program, who is 18 years of age or
105 older, and who is eligible for Medicaid by reason of a
106 disability is not exempt from the long-term care managed care
107 program under subsection (2).
108 (b) A person who is afforded priority enrollment for home
109 and community-based services under s. 409.979(3)(f) is not
110 exempt from the long-term care managed care program under
111 subsection (2).
112 (c) A nursing facility resident is not exempt from the
113 long-term care managed care program under paragraph (2)(a) if
114 the resident has been identified as a candidate for home and
115 community-based services by the nursing facility administrator
116 and any long-term care plan case manager assigned to the

117 resident. Such identification must be made in consultation with
118 the following persons:
119 1. The resident or the resident's legal representative or
120 designee;
121 2. The resident's personal physician or, if the resident
122 does not have a personal physician, the facility's medical
123 director; and
124 3. A registered nurse who has participated in developing,
125 maintaining, or reviewing the individual's resident care plan as
126 defined in s. 400.021.
127 (d) Before determining that a person is exempt from the
128 long-term care managed care program under paragraph (2)(a), the
129 agency shall confirm whether the person has been identified as a
130 candidate for home and community-based services under paragraph
131 (c). If a nursing facility resident who has been determined
132 exempt is later identified as a candidate for home and
133 community-based services, the nursing facility administrator
134 shall promptly notify the agency.
135 Section 4. Paragraph (j) of subsection (2) of section
136 409.967, Florida Statutes, is amended to read:
137 409.967 Managed care plan accountability.—
138 (2) The agency shall establish such contract requirements
139 as are necessary for the operation of the statewide managed care
140 program. In addition to any other provisions the agency may deem
141 necessary, the contract must require:
142 (j) *Prompt payment.*—Managed care plans shall comply with
143 ss. 641.315, 641.3155, and 641.513, and the agency shall impose
144 fines, and may impose other sanctions, on a plan that willfully
145 fails to comply with those sections or s. 409.982(5).


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146 Section 5. Subsection (1) of section 409.979, Florida
147 Statutes, is amended to read:
148 409.979 Eligibility.—
149 (1) PREREQUISITE CRITERIA FOR ELIGIBILITY.—Medicaid
150 recipients who meet all of the following criteria are eligible
151 to receive long-term care services and, unless exempt under s.
152 409.965, must receive long-term care services by participating
153 in the long-term care managed care program. The recipient must
154 be:
155 (a) Sixty-five years of age or older, or age 18 or older
156 and eligible for Medicaid by reason of a disability.
157 (b) Determined by the Comprehensive Assessment Review and
158 Evaluation for Long-Term Care Services (CARES) preadmission
159 screening program to require nursing facility care as defined in
160 s. 409.985(3).
161 Section 6. Subsections (1) and (2) of section 409.982,
162 Florida Statutes, are amended to read:
163 409.982 Long-term care managed care plan accountability.—In
164 addition to the requirements of s. 409.967, plans and providers
165 participating in the long-term care managed care program must
166 comply with the requirements of this section.
167 (1) PROVIDER NETWORKS.—Managed care plans may limit the
168 providers in their networks based on credentials, quality
169 indicators, and price. For the first 12 months of a contract
170 period following a procurement for the long-term care managed
171 care program under s. 409.981, if a plan is ~~period between~~
172 ~~October 1, 2013, and September 30, 2014, each~~ selected for a
173 region and that region was not served by the plan after the most
174 recent procurement, the plan must offer a network contract to



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175 all nursing homes in that region which meet the recredentialing
176 requirements and to all hospices in that region which meet the
177 credentialing requirements specified in the plan’s contract with
178 the agency ~~the following providers in the region:~~
179 ~~(a) Nursing homes.~~
180 ~~(b) Hospices.~~
181 ~~(c) Aging network service providers that have previously~~
182 ~~participated in home and community-based waivers serving elders~~
183 ~~or community-service programs administered by the Department of~~
184 ~~Elderly Affairs~~. After a provider specified in this subsection
185 has actively participated in a managed care plan’s network for
186 12 months ~~of active participation in a managed care plan’s~~
187 ~~network~~, the plan may exclude the provider ~~any of the providers~~
188 ~~named in this subsection~~ from the plan’s network for failure to
189 meet quality or performance criteria. If a ~~the~~ plan excludes a
190 provider from its network under this subsection ~~the plan~~, the
191 plan must provide written notice to all recipients who have
192 chosen that provider for care. The notice must be provided at
193 least 30 days before the effective date of the exclusion. The
194 agency shall establish contract provisions governing the
195 transfer of recipients from excluded residential providers. The
196 agency shall require a plan that excludes a provider from its
197 network or that fails to renew the plan’s contract with a
198 provider under this subsection to report to the agency the
199 quality or performance criteria the plan used in deciding to
200 exclude the provider and to demonstrate how the provider failed
201 to meet those criteria.
202 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in
203 this subsection, providers may limit the managed care plans they

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204 join. Nursing homes and hospices that are enrolled Medicaid
205 providers must participate in all eligible plans selected by the
206 agency in the region in which the provider is located, with the
207 exception of plans from which the provider has been excluded
208 under subsection (1).
209 Section 7. Except as otherwise provided in this act and
210 except for this section, which shall take effect upon this act
211 becoming a law, this act shall take effect July 1, 2017.



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