CHAMBER ACTION

Senate	House

.

1 Representative Cummings offered the following:

2

3 **Amendment to Amendment (655868) (with title amendment)**

4 Remove everything after the enacting clause of the

5 amendment and insert:

6 Section 1. Section 409.964, Florida Statutes, is amended

7 to read:

8 409.964 Managed care program; state plan; waivers.—The

9 Medicaid program is established as a statewide, integrated

10 managed care program for all covered services, including long-

11 term care services. The agency shall apply for and implement

12 state plan amendments or waivers of applicable federal laws and

13 regulations necessary to implement the program. Before seeking a

14 waiver, the agency shall provide public notice and the
15 opportunity for public comment and include public feedback in
16 the waiver application. The agency shall hold one public meeting
17 in each of the regions described in s. 409.966(2), and the ~~time~~
18 period for public comment for each region shall end no sooner
19 than 30 days after the completion of the public meeting in that
20 region. ~~The agency shall submit any state plan amendments, new~~
21 ~~waiver requests, or requests for extensions or expansions for~~
22 ~~existing waivers, needed to implement the managed care program~~
23 ~~by August 1, 2011.~~
24 Section 2. Subsection (2) and paragraphs (a), (d), (e),
25 and (f) of subsection (3) of section 409.966, Florida Statutes,
26 are amended to read:
27 409.966 Eligible plans; selection.—
28 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a
29 limited number of eligible plans to participate in the Medicaid
30 program using invitations to negotiate in accordance with s.
31 287.057(1)(c). At least 90 days before issuing an invitation to
32 negotiate, the agency shall compile and publish a databook
33 consisting of a comprehensive set of utilization and spending
34 data consistent with actuarial rate-setting practices and
35 standards ~~for the 3 most recent contract years consistent with~~
36 ~~the rate-setting periods for all Medicaid recipients by region~~
37 ~~or county~~. The source of the data in the databook ~~report~~ must
38 include the 24 most recent months of ~~both historic fee-for-~~

39 ~~service claims and~~ validated data from the Medicaid Encounter
40 Data System. ~~The report must be available in electronic form and~~
41 ~~delineate utilization use by age, gender, eligibility group,~~
42 ~~geographic area, and aggregate clinical risk score~~. Separate and
43 simultaneous procurements shall be conducted in each of the
44 following regions:
45 (a) Region A ~~Region 1~~, which consists of Bay, Calhoun,
46 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,
47 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,
48 ~~and~~ Walton, and Washington Counties.
49 (b) Region B ~~Region 2~~, which consists of Alachua, Baker,
50 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,
51 Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion,
52 Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
53 ~~Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson,~~
54 ~~Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and~~
55 ~~Washington~~ Counties.
56 (c) Region C ~~Region 3~~, which consists of Hardee,
57 Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk
58 ~~Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton,~~
59 ~~Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter,~~
60 ~~Suwannee, and Union~~ Counties.
61 (d) Region D ~~Region 4~~, which consists of Brevard, Orange,
62 Osceola, and Seminole ~~Baker, Clay, Duval, Flagler, Nassau, St.~~
63 ~~Johns, and Volusia~~ Counties.

64 (e) Region E ~~Region 5~~, which consists of Charlotte,
65 Collier, DeSoto, Glades, Hendry, Lee, and Sarasota ~~Pasco and~~
66 ~~Pinellas~~ Counties.
67 (f) Region F ~~Region 6~~, which consists of Indian River,
68 Martin, Okeechobee, Palm Beach, and St. Lucie ~~Hardee, Highlands,~~
69 ~~Hillsborough, Manatee, and Polk~~ Counties.
70 (g) Region G ~~Region 7~~, which consists of Broward County
71 ~~Brevard, Orange, Osceola, and Seminole Counties~~.
72 (h) Region H ~~Region 8~~, which consists of Miami-Dade and
73 Monroe ~~Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and~~
74 ~~Sarasota~~ Counties.
75 ~~(i) Region 9, which consists of Indian River, Martin,~~
76 ~~Okeechobee, Palm Beach, and St. Lucie Counties.~~
77 ~~(j) Region 10, which consists of Broward County.~~
78 ~~(k) Region 11, which consists of Miami-Dade and Monroe~~
79 ~~Counties.~~
80 (3) QUALITY SELECTION CRITERIA.—
81 (a) The invitation to negotiate must specify the criteria
82 and the relative weight of the criteria that will be used for
83 determining the acceptability of the reply and guiding the
84 selection of the organizations with which the agency negotiates.
85 The agency shall give preference to plans that propose
86 establishing a comprehensive long-term care plan. In addition to
87 criteria established by the agency, the agency shall consider
88 the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has obtained signed contracts or written agreements ~~or signed contracts~~ or has made substantial progress in establishing relationships with providers before the plan submits ~~submitting~~ a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan

113 participating in the procurement in the same region as the
114 submitting provider.
115 9. Documentation of policies and procedures for preventing
116 fraud and abuse.
117 10. The business relationship an eligible plan has with
118 any other eligible plan that responds to the invitation to
119 negotiate.
120 ~~(d) For the first year of the first contract term, the~~
121 ~~agency shall negotiate capitation rates or fee for service~~
122 ~~payments with each plan in order to guarantee aggregate savings~~
123 ~~of at least 5 percent.~~
124 ~~1. For prepaid plans, determination of the amount of~~
125 ~~savings shall be calculated by comparison to the Medicaid rates~~
126 ~~that the agency paid managed care plans for similar populations~~
127 ~~in the same areas in the prior year. In regions containing no~~
128 ~~prepaid plans in the prior year, determination of the amount of~~
129 ~~savings shall be calculated by comparison to the Medicaid rates~~
130 ~~established and certified for those regions in the prior year.~~
131 ~~2. For provider service networks operating on a fee-for-~~
132 ~~service basis, determination of the amount of savings shall be~~
133 ~~calculated by comparison to the Medicaid rates that the agency~~
134 ~~paid on a fee-for-service basis for the same services in the~~
135 ~~prior year.~~
136 <u>(d)</u>~~(e)~~ To ensure managed care plan participation in
137 <u>Regions A and E</u> ~~Regions 1 and 2~~, the agency shall award an

138 additional contract to each plan with a contract award in Region
139 A ~~Region 1~~ or Region E ~~Region 2~~. Such contract shall be in any
140 other region in which the plan submitted a responsive bid and
141 negotiates a rate acceptable to the agency. If a plan that is
142 awarded an additional contract pursuant to this paragraph is
143 subject to penalties pursuant to s. 409.967(2)(i) for activities
144 in Region A ~~Region 1~~ or Region E ~~Region 2~~, the additional
145 contract is automatically terminated 180 days after the
146 imposition of the penalties. The plan must reimburse the agency
147 for the cost of enrollment changes and other transition
148 activities.
149 (e) ~~(f)~~ The agency may not execute contracts with managed
150 care plans at payment rates not supported by the General
151 Appropriations Act.
152 Section 3. Paragraphs (c) and (j) of subsection (2) of
153 section 409.967, Florida Statutes, are amended to read:
154 409.967 Managed care plan accountability.—
155 (2) The agency shall establish such contract requirements
156 as are necessary for the operation of the statewide managed care
157 program. In addition to any other provisions the agency may deem
158 necessary, the contract must require:
159 (c) *Access.*—
160 1. The agency shall establish specific standards for the
161 number, type, and regional distribution of providers in managed
162 care plan networks to ensure access to care for both adults and

163 children. Each plan must maintain a regionwide network of
164 providers in sufficient numbers to meet the access standards for
165 specific medical services for all recipients enrolled in the
166 plan. The exclusive use of mail-order pharmacies may not be
167 sufficient to meet network access standards. Consistent with the
168 standards established by the agency, provider networks may
169 include providers located outside the region. A plan may
170 contract with a new hospital facility before the date the
171 hospital becomes operational if the hospital has commenced
172 construction, will be licensed and operational by January 1,
173 2013, and a final order has issued in any civil or
174 administrative challenge. Each plan shall establish and maintain
175 an accurate and complete electronic database of contracted
176 providers, including information about licensure or
177 registration, locations and hours of operation, specialty
178 credentials and other certifications, specific performance
179 indicators, and such other information as the agency deems
180 necessary. The database must be available online to both the
181 agency and the public and have the capability to compare the
182 availability of providers to network adequacy standards and to
183 accept and display feedback from each provider's patients. Each
184 plan shall submit quarterly reports to the agency identifying
185 the number of enrollees assigned to each primary care provider.
186 The agency shall conduct, or contract with a third party to
187 conduct, systematic and ongoing testing of the provider network

188 databases maintained by each plan to confirm database accuracy,
189 to confirm that network providers are accepting enrollees, and
190 to confirm that such enrollees have access to care.
191 2. Each managed care plan must publish any prescribed drug
192 formulary or preferred drug list on the plan's website in a
193 manner that is accessible to and searchable by enrollees and
194 providers. The plan must update the list within 24 hours after
195 making a change. Each plan must ensure that the prior
196 authorization process for prescribed drugs is readily accessible
197 to health care providers, including posting appropriate contact
198 information on its website and providing timely responses to
199 providers. For Medicaid recipients diagnosed with hemophilia who
200 have been prescribed anti-hemophilic-factor replacement
201 products, the agency shall provide for those products and
202 hemophilia overlay services through the agency's hemophilia
203 disease management program.
204 3. Managed care plans, and their fiscal agents or
205 intermediaries, must accept prior authorization requests for any
206 service electronically.
207 4. Managed care plans serving children in the care and
208 custody of the Department of Children and Families must maintain
209 complete medical, dental, and behavioral health encounter
210 information and participate in making such information available
211 to the department or the applicable contracted community-based
212 care lead agency for use in providing comprehensive and

213 coordinated case management. The agency and the department shall
214 establish an interagency agreement to provide guidance for the
215 format, confidentiality, recipient, scope, and method of
216 information to be made available and the deadlines for
217 submission of the data. The scope of information available to
218 the department shall be the data that managed care plans are
219 required to submit to the agency. The agency shall determine the
220 plan's compliance with standards for access to medical, dental,
221 and behavioral health services; the use of medications; and
222 followup on all medically necessary services recommended as a
223 result of early and periodic screening, diagnosis, and
224 treatment.
225 (j) *Prompt payment.*—Managed care plans shall comply with
226 ss. 641.315, 641.3155, and 641.513, and the agency shall impose
227 fines, and may impose other sanctions, on a plan that willfully
228 fails to comply with ss. 641.315, 641.3155, and 641.513 or s.
229 409.982(5).
230 Section 4. Section 409.971, Florida Statutes, is amended
231 to read:
232 409.971 Managed medical assistance program.—The agency
233 shall make payments for primary and acute medical assistance and
234 related services using a managed care model. ~~By January 1, 2013,~~
235 ~~the agency shall begin implementation of the statewide managed~~
236 ~~medical assistance program, with full implementation in all~~
237 ~~regions by October 1, 2014.~~

238 Section 5. Subsections (1) and (2) of section 409.974,
239 Florida Statutes, are amended to read:
240 409.974 Eligible plans.—
241 (1) ELIGIBLE PLAN SELECTION.—The agency shall select
242 eligible plans for the managed medical assistance program
243 through the procurement process described in s. 409.966. ~~The~~
244 ~~agency shall notice invitations to negotiate no later than~~
245 ~~January 1, 2013.~~
246 (a) The agency shall procure at least three ~~two~~ plans and
247 up to four plans for Region A ~~Region 1~~. At least one plan shall
248 be a provider service network if any provider service networks
249 submit a responsive bid.
250 (b) The agency shall procure at least four plans and up to
251 eight ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall
252 be a provider service network if any provider service networks
253 submit a responsive bid.
254 (c) The agency shall procure at least five ~~three~~ plans and
255 up to 10 ~~five~~ plans for Region C ~~Region 3~~. At least one plan
256 must be a provider service network if any provider service
257 networks submit a responsive bid.
258 (d) The agency shall procure at least three plans and up
259 to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must
260 be a provider service network if any provider service networks
261 submit a responsive bid.

262 (e) The agency shall procure at least three ~~two~~ plans and
263 up to four plans for Region E ~~Region 5~~. At least one plan must
264 be a provider service network if any provider service networks
265 submit a responsive bid.
266 (f) The agency shall procure at least three ~~four~~ plans and
267 up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan
268 must be a provider service network if any provider service
269 networks submit a responsive bid.
270 (g) The agency shall procure at least three plans and up
271 to five ~~six~~ plans for Region G ~~Region 7~~. At least one plan must
272 be a provider service network if any provider service networks
273 submit a responsive bid.
274 (h) The agency shall procure at least five ~~two~~ plans and
275 up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan
276 must be a provider service network if any provider service
277 networks submit a responsive bid.
278 ~~(i) The agency shall procure at least two plans and up to~~
279 ~~four plans for Region 9. At least one plan must be a provider~~
280 ~~service network if any provider service networks submit a~~
281 ~~responsive bid.~~
282 ~~(j) The agency shall procure at least two plans and up to~~
283 ~~four plans for Region 10. At least one plan must be a provider~~
284 ~~service network if any provider service networks submit a~~
285 ~~responsive bid.~~

286 ~~(k) The agency shall procure at least five plans and up to~~
287 ~~10 plans for Region 11. At least one plan must be a provider~~
288 ~~service network if any provider service networks submit a~~
289 ~~responsive bid.~~
290
291 ~~If no provider service network submits a responsive bid, the~~
292 ~~agency shall procure no more than one less than the maximum~~
293 ~~number of eligible plans permitted in that region. Within 12~~
294 ~~months after the initial invitation to negotiate, the agency~~
295 ~~shall attempt to procure a provider service network. The agency~~
296 ~~shall notice another invitation to negotiate only with provider~~
297 ~~service networks in those regions where no provider service~~
298 ~~network has been selected.~~
299 (2) QUALITY SELECTION CRITERIA.—In addition to the
300 criteria established in s. 409.966, the agency shall consider
301 evidence that an eligible plan has obtained signed contracts or
302 written agreements ~~or signed contracts~~ or has made substantial
303 progress in establishing relationships with providers before the
304 plan submits ~~submitting~~ a response. The agency shall evaluate
305 and give special weight to evidence of signed contracts with
306 essential providers as defined by the agency pursuant to s.
307 409.975(1). The agency shall exercise a preference for plans
308 with a provider network in which more than ~~over~~ 10 percent of
309 the providers use electronic health records, as defined in s.
310 408.051. ~~When all other factors are equal, the agency shall~~

311 consider whether the organization has a contract to provide
312 managed long-term care services in the same region and shall
313 exercise a preference for such plans.
314 Section 6. Subsection (1) of section 409.978, Florida
315 Statutes, is amended to read:
316 409.978 Long-term care managed care program.—
317 (1) Pursuant to s. 409.963, the agency shall administer
318 the long-term care managed care program described in ss.
319 409.978-409.985, but may delegate specific duties and
320 responsibilities for the program to the Department of Elderly
321 Affairs and other state agencies. By July 1, 2012, the agency
322 shall begin implementation of the statewide long-term care
323 managed care program, with full implementation in all regions by
324 October 1, 2013.
325 Section 7. Subsection (2) and paragraphs (c), (d), and (e)
326 of subsection (3) of section 409.981, Florida Statutes, are
327 amended to read:
328 409.981 Eligible long-term care plans.—
329 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
330 eligible plans for the long-term care managed care program
331 through the procurement process described in s. 409.966. The
332 agency shall procure:
333 (a) At least three two plans and up to four plans for
334 Region A Region 1. At least one plan must be a provider service

335 network if any provider service networks submit a responsive
336 bid.
337 (b) At least three ~~Two~~ plans and up to six plans for
338 Region B ~~Region 2~~. At least one plan must be a provider service
339 network if any provider service networks submit a responsive
340 bid.
341 (c) At least five ~~three~~ plans and up to eight ~~five~~ plans
342 for Region C ~~Region 3~~. At least one plan must be a provider
343 service network if any provider service networks submit a
344 responsive bid.
345 (d) At least three plans and up to six ~~five~~ plans for
346 Region D ~~Region 4~~. At least one plan must be a provider service
347 network if any provider service network submits a responsive
348 bid.
349 (e) At least three ~~two~~ plans and up to four plans for
350 Region E ~~Region 5~~. At least one plan must be a provider service
351 network if any provider service networks submit a responsive
352 bid.
353 (f) At least three ~~four~~ plans and up to five ~~seven~~ plans
354 for Region F ~~Region 6~~. At least one plan must be a provider
355 service network if any provider service networks submit a
356 responsive bid.
357 (g) At least three plans and up to four ~~six~~ plans for
358 Region G ~~Region 7~~. At least one plan must be a provider service

359 network if any provider service networks submit a responsive
360 bid.
361 (h) At least five ~~two~~ plans and up to 10 ~~four~~ plans for
362 Region H ~~Region 8~~. At least one plan must be a provider service
363 network if any provider service networks submit a responsive
364 bid.
365 ~~(i) At least two plans and up to four plans for Region 9.~~
366 ~~At least one plan must be a provider service network if any~~
367 ~~provider service networks submit a responsive bid.~~
368 ~~(j) At least two plans and up to four plans for Region 10.~~
369 ~~At least one plan must be a provider service network if any~~
370 ~~provider service networks submit a responsive bid.~~
371 ~~(k) At least five plans and up to 10 plans for Region 11.~~
372 ~~At least one plan must be a provider service network if any~~
373 ~~provider service networks submit a responsive bid.~~
374
375 ~~If no provider service network submits a responsive bid in a~~
376 ~~region other than Region 1 or Region 2, the agency shall procure~~
377 ~~no more than one less than the maximum number of eligible plans~~
378 ~~permitted in that region. Within 12 months after the initial~~
379 ~~invitation to negotiate, the agency shall attempt to procure a~~
380 ~~provider service network. The agency shall notice another~~
381 ~~invitation to negotiate only with provider service networks in~~
382 ~~regions where no provider service network has been selected.~~

383 (3) QUALITY SELECTION CRITERIA.—In addition to the
384 criteria established in s. 409.966, the agency shall consider
385 the following factors in the selection of eligible plans:
386 ~~(c) Whether a plan is proposing to establish a~~
387 ~~comprehensive long-term care plan and whether the eligible plan~~
388 ~~has a contract to provide managed medical assistance services in~~
389 ~~the same region.~~
390 <u>(c)</u>~~(d)~~ Whether a plan offers consumer-directed care
391 services to enrollees pursuant to s. 409.221.
392 <u>(d)</u>~~(e)~~ Whether a plan is proposing to provide home and
393 community-based services in addition to the minimum benefits
394 required by s. 409.98.
395 Section 8. This act shall take effect July 1, 2017.
396
397
398 ---
399 **T I T L E A M E N D M E N T**
400 Remove everything before the enacting clause of the
401 amendment and insert:
402 A bill to be entitled
403 An act relating to the statewide Medicaid managed care
404 program; amending s. 409.964, F.S.; deleting an
405 obsolete provision; amending s. 409.966, F.S.;
406 revising requirements relating to the compilation and
407 publication of certain Medicaid data by the Agency for

408 Health Care Administration; revising the designation
409 and county makeup of regions for procurement of health
410 plans eligible to participate in the program;
411 requiring the agency to give preference to plans that
412 propose establishing a comprehensive long-term care
413 plan; deleting provisions relating to capitation rate
414 and fee-for-service payment calculations; amending s.
415 409.967, F.S.; requiring the agency to test provider
416 network databases maintained by Medicaid managed care
417 plans; requiring the agency to impose fines, and
418 authorizing the agency to impose other sanctions, on
419 plans that fail to comply with certain claim payment
420 requirements; amending s. 409.971, F.S.; deleting an
421 obsolete provision; amending s. 409.974, F.S.;
422 deleting an obsolete provision; revising the number of
423 eligible plans the agency must procure for certain
424 regions; deleting provisions that require the agency
425 to issue an invitation to negotiate and to give
426 preference to certain plans; amending s. 409.978,
427 F.S.; deleting an obsolete provision; amending s.
428 409.981, F.S.; revising the number of eligible plans
429 that the agency must procure for certain regions;
430 deleting provisions that require the agency to issue
431 an invitation to negotiate and to consider a specific
432 factor relating to the selection of eligible plans;

433 amending s. 409.982, F.S.; deleting a provision that
434 requires long-term care managed care plans to pay
435 nursing homes at the payment rate set by the agency;
436 providing an effective date.