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LEGISLATIVE ACTION

Senate	.	House
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Floor: 1/AE/2R	.	Floor: SENA1/CA
05/03/2017 07:06 PM	.	05/05/2017 01:11 PM
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Senator Grimsley moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

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

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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. Subsection (2) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The

agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider

turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(2) The agency may contract with a provider service network~~, which may be reimbursed on a fee-for-service or prepaid basis~~. Prepaid provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary~~

~~adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

(a) A provider service network that ~~which~~ is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

(b) A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 3. 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, including state plan amendments or waivers required to implement chapter 2016-109, Laws of Florida. 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 4. 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. If the agency receives such a notification, the agency shall make a redetermination regarding the resident's exempt status pursuant to paragraph (c).

Section 5. Subsection (2) and paragraphs (a), (d), (e), and

(f) of subsection (3) of section 409.966, Florida Statutes, are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards ~~for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or county~~. The source of the data in the databook ~~report~~ must include the 24 most recent months of ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System. ~~The report must be available in electronic form and delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score~~. Separate and simultaneous procurements shall be conducted in each of the following regions:

(a) Region A ~~Region 1~~, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, ~~and~~ Walton, and Washington Counties.

(b) Region B ~~Region 2~~, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia ~~Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson,~~

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~~Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington~~ Counties.

(c) Region C ~~Region 3~~, which consists of Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk ~~Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union~~ Counties.

(d) Region D ~~Region 4~~, which consists of Brevard, Orange, Osceola, and Seminole ~~Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia~~ Counties.

(e) Region E ~~Region 5~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota ~~Pasco and Pinellas~~ Counties.

(f) Region F ~~Region 6~~, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie ~~Hardee, Highlands, Hillsborough, Manatee, and Polk~~ Counties.

(g) Region G ~~Region 7~~, which consists of Broward County ~~Brevard, Orange, Osceola, and Seminole Counties~~.

(h) Region H ~~Region 8~~, which consists of Miami-Dade and Monroe ~~Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota~~ Counties.

~~(i) Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.~~

~~(j) Region 10, which consists of Broward County.~~

~~(k) Region 11, which consists of Miami-Dade and Monroe Counties.~~

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for

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determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. The agency shall give preference to plans that propose establishing a comprehensive long-term care plan. In addition to criteria established by the agency, the agency shall consider 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 participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

~~(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.~~

~~1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.~~

~~2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.~~

(d) ~~(e)~~ To ensure managed care plan participation in Regions A and E ~~Regions 1 and 2~~, the agency shall award an additional contract to each plan with a contract award in Region A ~~Region 1~~ or Region E ~~Region 2~~. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a

rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region A ~~Region 1~~ or Region E ~~Region 2~~, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.

(e) ~~(f)~~ The agency may not execute contracts with managed care plans at payment rates not supported by the General Appropriations Act.

Section 6. Paragraphs (c) and (j) of subsection (2) of section 409.967, Florida Statutes, are 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:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the

hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract with a third party to conduct, systematic and ongoing testing of the provider network databases maintained by each plan to confirm database accuracy, to confirm that network providers are accepting enrollees, and to confirm that such enrollees have access to care.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who

have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(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 ss. 641.315, 641.3155, and 641.513 or s.

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409.982(5).

Section 7. Effective January 1, 2018, paragraph (p) is added to subsection (2) of section 409.967, Florida Statutes, 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:

(p) *Robust primary care networks.*—A health insurer or health maintenance organization selected as a managed care plan under this part may not, directly or indirectly, purchase, own, or otherwise have a controlling interest in any primary care group or practice in this state.

Section 8. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks shall ~~may~~ be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. ~~Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6~~

~~months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 9. Section 409.971, Florida Statutes, is amended to read:

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. ~~By January 1, 2013, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all regions by October 1, 2014.~~

Section 10. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans for the managed medical assistance program through the procurement process described in s. 409.966. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

(a) The agency shall procure at least three ~~two~~ plans and

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up to four plans for Region A ~~Region 1~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure at least four plans and up to eight ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure at least five ~~three~~ plans and up to 10 ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) The agency shall procure at least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(e) The agency shall procure at least three ~~two~~ plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) The agency shall procure at least three ~~four~~ plans and up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) The agency shall procure at least three plans and up to five ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) The agency shall procure at least five ~~two~~ plans and up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must

be a provider service network if any provider service networks submit a responsive bid.

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.~~

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider 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. The agency shall evaluate and

give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). The agency shall exercise a preference for plans with a provider network in which more than ~~over~~ 10 percent of the providers use electronic health records, as defined in s. 408.051. ~~When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.~~

Section 11. Subsection (1) of section 409.978, Florida Statutes, is amended to read:

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. ~~By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.~~

Section 12. 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 13. Subsection (2) and paragraphs (c), (d), and (e) of subsection (3) of section 409.981, Florida Statutes, are amended, present subsections (4) and (5) are redesignated as subsections (6) and (7), respectively, and new subsections (4) and (5) are added to that section, to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans for the long-term care managed care program through the procurement process described in s. 409.966. The agency shall procure:

(a) At least three ~~two~~ plans and up to four plans for Region A ~~Region 1~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(b) At least three ~~Two~~ plans and up to six plans for Region B ~~Region 2~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(c) At least five ~~three~~ plans and up to eight ~~five~~ plans for Region C ~~Region 3~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) At least three plans and up to six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be a provider service

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network if any provider service network submits a responsive bid.

(e) At least three ~~two~~ plans and up to four plans for Region E ~~Region 5~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) At least three ~~four~~ plans and up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) At least three plans and up to four ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) At least five ~~two~~ plans and up to 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~If no provider service network submits a responsive bid in a~~

~~region other than Region 1 or Region 2, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.~~

(3) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider the following factors in the selection of eligible plans:

~~(c) Whether a plan is proposing to establish a comprehensive long-term care plan and whether the eligible plan has a contract to provide managed medical assistance services in the same region.~~

(c) ~~(d)~~ Whether a plan offers consumer-directed care services to enrollees pursuant to s. 409.221.

(d) ~~(c)~~ Whether a plan is proposing to provide home and community-based services in addition to the minimum benefits required by s. 409.98.

(4) PLAN REQUIREMENTS.—An eligible plan must disclose any business relationship that it has with any other eligible plan that responds to the invitation to negotiate. The agency may not select plans in the same region for the same managed care program which have a business relationship with each other. The agency may not select a provider service network authorized under s. 409.912(2) in any region that has a business relationship with a health maintenance organization licensed under chapter 641, and may not select a provider service network in any region that has a business relationship with any entity

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that has an ownership or controlling interest in a health maintenance organization licensed under chapter 641 or a common parent of a health maintenance organization licensed under chapter 641. An eligible plan that fails to comply with this subsection is disqualified from participation in any region for the first full contract period after the discovery of the business relationship by the agency. For the purpose of this section, the term "business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, which exists for the purpose of making a profit. The term does not include subcontract arrangements, unless the subcontract is between a plan and an entity that is a parent, affiliate or subsidiary of the plan.

(5) PLAN REQUIREMENTS.—An eligible plan must disclose any business relationship that it has with any other eligible plan that responds to the invitation to negotiate. The agency may not select plans in the same region for the same managed care program which have a business relationship with each other. The agency may not select a long-term care provider service network authorized under s. 409.912(2) in any region that has a business relationship with a health maintenance organization licensed under chapter 641, and may not select a long-term care provider service network in any region that has a business relationship


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with any entity that has a controlling interest in a health maintenance organization licensed under chapter 641 or a common parent of a health maintenance organization licensed under chapter 641. An eligible plan that fails to comply with this subsection is disqualified from participation in any region for the first full contract period after the agency discovers the business relationship. For the purpose of this section, the term "business relationship" means a controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, which exists for the purpose of making a profit. The term does not include subcontract arrangements unless the subcontract is between a plan and an entity that is a parent, affiliate, or subsidiary of the plan.

Section 14. 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~~

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~~October 1, 2013, and September 30, 2014, each~~ selected for a region encompassing a county that the plan was not serving immediately prior to the procurement, the plan must offer a network contract to all nursing homes in that county which meet the recredentialing requirements and to all hospices in that county 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

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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 15. Section 456.0625, Florida Statutes, is created to read:

456.0625 Direct primary care agreements.—

(1) As used in this section, the term:

(a) "Direct primary care agreement" means a contract between a primary care provider and a patient, the patient's legal representative, or an employer which meets the requirements specified under subsection (3) and which does not indemnify for services provided by a third party.

(b) "Primary care provider" means a health care practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 464 or a primary care group practice that provides medical services to patients which are commonly provided without referral from another health care provider.

(c) "Primary care service" means the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

(2) A primary care provider or an agent of the primary care provider may enter into a direct primary care agreement for

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providing primary care services. Section 624.27 applies to a direct primary care agreement.

(3) A direct primary care agreement must:

(a) Be in writing.

(b) Be signed by the primary care provider or an agent of the primary care provider and the patient, the patient's legal representative, or an employer.

(c) Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.

(d) Describe the scope of primary care services that are covered by the monthly fee.

(e) Specify the monthly fee and any fees for primary care services not covered by the monthly fee.

(f) Specify the duration of the agreement and any automatic renewal provisions.

(g) Offer a refund to the patient of monthly fees paid in advance if the primary care provider ceases to offer primary care services for any reason.

(h) Contain, in contrasting color and in not less than 12-point type, the following statements on the same page as the applicant's signature:

1. This agreement is not health insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by this agreement.

2. This agreement does not qualify as minimum essential

coverage to satisfy the individual shared responsibility provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

3. This agreement is not workers' compensation insurance and may not replace the employer's obligations under chapter 440, Florida Statutes.

Section 16. Section 624.27, Florida Statutes, is created to read:

624.27 Application of code as to direct primary care agreements.—

(1) A direct primary care agreement, as defined in s. 456.0625, does not constitute insurance and is not subject to any chapter of the Florida Insurance Code. The act of entering into a direct primary care agreement does not constitute the business of insurance and is not subject to any chapter of the Florida Insurance Code.

(2) A primary care provider or an agent of a primary care provider is not required to obtain a certificate of authority or license under any chapter of the Florida Insurance Code to market, sell, or offer to sell a direct primary care agreement pursuant to s. 456.0625.

Section 17. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(11) A health insurer may not retroactively deny a claim because of insured ineligibility:

(a) At any time, if the health insurer verified the eligibility of an insured at the time of treatment and provided an authorization number. This paragraph applies to policies

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entered into or renewed on or after January 1, 2018.

(b) More than 1 year after the date of payment of the claim.

Section 18. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility:

(a) At any time, if the health maintenance organization verified the eligibility of a subscriber at the time of treatment and provided an authorization number. This paragraph applies to contracts entered into or renewed on or after January 1, 2018. This paragraph does not apply to Medicaid managed care plans pursuant to part IV of chapter 409.

(b) More than 1 year after the date of payment of the claim.

Section 19. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term:

(a) "Health insurer" means an authorized insurer offering an individual or group insurance policy that provides major medical or similar comprehensive coverage ~~health insurance as defined in s. 624.603~~, a managed care plan as defined in s. 409.962(10) ~~s. 409.962(9)~~, or a health maintenance organization as defined in s. 641.19(12).

(b) "Urgent care situation" has the same meaning as in s. 627.42393.

(2) Notwithstanding any other provision of law, effective

January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not provide an electronic prior authorization process for use by its contracted providers, shall only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the health insurer to make a decision. At a minimum, the form must include: (1) sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number; (2) provider name, address and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; (4) any laboratory documentation required; and (5) an attestation that all information provided is true and accurate. The form, whether in electronic or paper format, may not require information that is not necessary for the determination of medical necessity of, or coverage for, the requested medical procedure, course of treatment, or prescription drug.

(3) The Financial Services Commission in consultation with the Agency for Health Care Administration shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(4) Electronic prior authorization approvals do not

preclude benefit verification or medical review by the insurer under either the medical or pharmacy benefits.

(5) A health insurer or a pharmacy benefits manager on behalf of the health insurer must provide the following information in writing or in an electronic format upon request, and on a publicly accessible Internet website:

(a) Detailed descriptions of requirements and restrictions to obtain prior authorization for coverage of a medical procedure, course of treatment, or prescription drug in clear, easily understandable language. Clinical criteria must be described in language easily understandable by a health care provider.

(b) Prior authorization forms.

(6) A health insurer or a pharmacy benefits manager on behalf of the health insurer may not implement any new requirements or restrictions or make changes to existing requirements or restrictions to obtain prior authorization unless:

(a) The changes have been available on a publicly accessible Internet website at least 60 days before the implementation of the changes.

(b) Policyholders and health care providers who are affected by the new requirements and restrictions or changes to the requirements and restrictions are provided with a written notice of the changes at least 60 days before the changes are implemented. Such notice may be delivered electronically or by other means as agreed to by the insured or health care provider.

This subsection does not apply to expansion of health care

services coverage.

(7) A health insurer or a pharmacy benefits manager on behalf of the health insurer must authorize or deny a prior authorization request and notify the patient and the patient's treating health care provider of the decision within:

(a) Seventy-two hours of obtaining a completed prior authorization form for nonurgent care situations.

(b) Twenty-four hours of obtaining a completed prior authorization form for urgent care situations.

Section 20. Section 627.42393, Florida Statutes, is created to read:

627.42393 Fail-first protocols.—

(1) As used in this section, the term:

(a) "Fail-first protocol" means a written protocol that specifies the order in which a certain medical procedure, course of treatment, or prescription drug must be used to treat an insured's condition.

(b) "Health insurer" has the same meaning as provided in s. 627.42392.

(c) "Preceding prescription drug or medical treatment" means a medical procedure, course of treatment, or prescription drug that must be used pursuant to a health insurer's fail-first protocol as a condition of coverage under a health insurance policy or a health maintenance contract to treat an insured's condition.

(d) "Protocol exception" means a determination by a health insurer that a fail-first protocol is not medically appropriate or indicated for treatment of an insured's condition and the health insurer authorizes the use of another medical procedure,

course of treatment, or prescription drug prescribed or recommended by the treating health care provider for the insured's condition.

(e) "Urgent care situation" means an injury or condition of an insured which, if medical care and treatment is not provided earlier than the time generally considered by the medical profession to be reasonable for a nonurgent situation, in the opinion of the insured's treating physician, would:

1. Seriously jeopardize the insured's life, health, or ability to regain maximum function; or

2. Subject the insured to severe pain that cannot be adequately managed.

(2) A health insurer must publish on its website, and provide to an insured in writing, a procedure for an insured and health care provider to request a protocol exception. The procedure must include:

(a) A description of the manner in which an insured or health care provider may request a protocol exception.

(b) The manner and timeframe in which the health insurer is required to authorize or deny a protocol exception request or respond to an appeal to a health insurer's authorization or denial of a request.

(c) The conditions in which the protocol exception request must be granted.

(3)(a) The health insurer must authorize or deny a protocol exception request or respond to an appeal to a health insurer's authorization or denial of a request within:

1. Seventy-two hours of obtaining a completed prior authorization form for nonurgent care situations.

2. Twenty-four hours of obtaining a completed prior authorization form for urgent care situations.

(b) An authorization of the request must specify the approved medical procedure, course of treatment, or prescription drug benefits.

(c) A denial of the request must include a detailed, written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure to appeal the health insurer's determination.

(4) A health insurer must grant a protocol exception request if:

(a) A preceding prescription drug or medical treatment is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(b) A preceding prescription drug is expected to be ineffective, based on the medical history of the insured and the clinical evidence of the characteristics of the preceding prescription drug or medical treatment;

(c) The insured has previously received a preceding prescription drug or medical treatment that is in the same pharmacologic class or has the same mechanism of action, and such drug or treatment lacked efficacy or effectiveness or adversely affected the insured; or

(d) A preceding prescription drug or medical treatment is not in the best interest of the insured because the insured's use of such drug or treatment is expected to:

1. Cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care;

2. Worsen an insured's medical condition that exists

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simultaneously but independently with the condition under treatment; or

3. Decrease the insured's ability to achieve or maintain his or her ability to perform daily activities.

(5) The health insurer may request a copy of relevant documentation from the insured's medical record in support of a protocol exception request.

Section 21. Except as otherwise provided in this act, this act shall take effect July 1, 2017.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care services; 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. 409.912, F.S.; deleting the fee-for-service option as a basis for the reimbursement of Medicaid provider service networks; 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.; requiring the agency to apply for and implement state plan amendments or waivers of applicable federal laws in order to

implement specified Florida law; 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. 409.966, F.S.; requiring that a required databook consist of data that is consistent with actuarial rate-setting practices and standards; requiring that the source of such data include the 24 most recent months of validated data from the Medicaid Encounter Data System; deleting provisions relating to a report and report requirements; revising the designation and county makeup of regions of the state for purposes of procuring health plans that may participate in the Medicaid program; adding a factor that the agency must consider in the selection of eligible plans; deleting a provision for certain additional benefits to receive particular consideration; deleting an obsolete provision; amending s. 409.967, F.S.; requiring the agency to test provider network databases maintained by Medicaid managed care plans; requiring the agency

to impose fines, and authorizing the agency to impose other sanctions, on plans that fail to comply with certain claim payment requirements; prohibiting certain health insurers or health maintenance organizations from owning or having a controlling interest in any primary care group or practice in the state; amending s. 409.968, F.S.; requiring provider service networks to be prepaid plans; deleting a fee-for-service option for Medicaid reimbursement for provider service networks; amending s. 409.971, F.S.; deleting an obsolete provision; amending s. 409.974, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state; deleting provisions that require the agency to issue an invitation to negotiate under certain circumstances; deleting preference for certain plans; deleting an obsolete provision; amending s. 409.978, F.S.; deleting an obsolete provision; 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. 409.981, F.S.; revising the number of eligible Medicaid health care plans the agency must procure for certain regions in the state; deleting provisions that require the agency to issue an invitation to negotiate under certain circumstances; deleting a requirement that the agency consider a specific factor relating to the selection of managed medical assistance plans; requiring a plan

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to disclose any business relationships it has with other eligible plans that respond to an invitation to negotiate; prohibiting the agency from selecting plans under certain circumstances; providing for disqualification from participation in any region under certain circumstances; defining the term "business relationship"; requiring an eligible plan to disclose any business relationships it has with other eligible plans that respond to an invitation to negotiate; prohibiting the agency from selecting plans under certain circumstances; providing for disqualification of an eligible plan from participation in any region under certain circumstances; defining the term "business relationship"; 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; creating s. 456.0625, F.S.; defining terms; authorizing primary care providers or their agents to enter into direct primary care agreements for providing primary care services; providing applicability; specifying requirements for direct primary care agreements; creating s. 624.27, F.S.; providing construction and applicability of the Florida Insurance Code as to direct primary care agreements; providing an exception for primary care

providers or their agents from certain requirements under the code under certain circumstances; amending s. 627.6131, F.S.; prohibiting a health insurer from retroactively denying a claim under specified circumstances; providing applicability; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from retroactively denying a claim under specified circumstances; providing applicability; exempting certain Medicaid managed care plans; amending s. 627.42392, F.S.; revising and providing definitions; revising criteria for prior authorization forms; requiring health insurers and pharmacy benefits managers on behalf of health insurers to provide certain information relating to prior authorization in a specified manner; prohibiting such insurers and pharmacy benefits managers from implementing or making changes to requirements or restrictions to obtain prior authorization, except under certain circumstances; providing applicability; requiring such insurers and pharmacy benefits managers to authorize or deny prior authorization requests and provide certain notices within specified timeframes; creating s. 627.42393, F.S.; providing definitions; requiring health insurers to publish on their websites and provide in writing to insureds a specified procedure to obtain protocol exceptions; specifying timeframes in which health insurers must authorize or deny protocol exception requests and respond to an appeal to a health insurer’s authorization or denial of a

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request; requiring authorizations or denials to specify certain information; providing circumstances in which health insurers must grant a protocol exception request; authorizing health insurers to request documentation in support of a protocol exception request; providing effective dates.