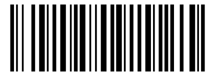
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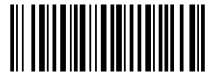
Proposed Committee Substitute by the Committee on Appropriations (Appropriations Subcommittee on Health and Human Services)

1 A bill to be entitled
2 An act relating to the statewide Medicaid managed care
3 program; amending s. 409.912, F.S.; requiring, rather
4 than authorizing, that the reimbursement method for
5 provider service networks be on a prepaid basis;
6 deleting the authority to reimburse provider service
7 networks on a fee-for-service basis; conforming
8 provisions to changes made by the act; providing that
9 provider service networks are subject to and exempt
10 from certain requirements; providing construction;
11 repealing s. 409.9124, F.S., relating to managed care
12 reimbursement; amending s. 409.964, F.S.; deleting a
13 requirement that the Agency for Health Care
14 Administration provide the opportunity for public
15 feedback on a certain waiver application; amending s.
16 409.966, F.S.; revising requirements relating to the
17 databook published by the agency consisting of
18 Medicaid utilization and spending data; reallocating
19 regions within the statewide managed care program;
20 deleting a requirement that the agency negotiate plan
21 rates or payments to guarantee a certain savings
22 amount; deleting a requirement for the agency to award
23 additional contracts to plans in specified regions for
24 certain purposes; revising a limitation on when plans
25 may begin serving Medicaid recipients to apply to any
26 eligible plan that participates in an invitation to
27 negotiate, rather than plans participating in certain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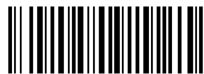
28 regions; making technical changes; amending s.
29 409.967, F.S.; deleting obsolete provisions; amending
30 s. 409.968, F.S.; conforming provisions to changes
31 made by the act; amending s. 409.973, F.S.; revising
32 requirements for healthy behaviors programs
33 established by plans; deleting an obsolete provision;
34 amending s. 409.974, F.S.; requiring the agency to
35 select plans for the managed medical assistance
36 program through a single statewide procurement;
37 authorizing the agency to award contracts to plans on
38 a regional or statewide basis; specifying requirements
39 for minimum numbers of plans which the agency must
40 procure for each specified region; conforming
41 provisions to changes made by the act; deleting a
42 requirement for the agency to exercise a preference
43 for certain plans; amending s. 409.975, F.S.;
44 providing that cancer hospitals meeting certain
45 criteria are statewide essential providers; amending
46 s. 409.977, F.S.; revising the circumstances for
47 maintaining a recipient’s enrollment in a plan;
48 deleting obsolete language; authorizing specialty
49 plans to serve certain children who receive
50 guardianship assistance payments under the
51 Guardianship Assistance Program; amending s. 409.981,
52 F.S.; requiring the agency to select plans for the
53 long-term care managed medical assistance program
54 through a single statewide procurement; authorizing
55 the agency to award contracts to plans on a regional
56 or statewide basis; specifying requirements for

 625186

57 minimum numbers of plans which the agency must procure
58 for each specified region; conforming provisions to
59 changes made by the act; amending s. 409.8132, F.S.;
60 conforming a cross-reference; reenacting ss.
61 409.962(1), (7), (13), and (14) and 641.19(22)
62 relating to definitions, to incorporate the amendments
63 made by this act to s. 409.912, F.S., in references
64 thereto; reenacting s. 430.2053(3)(h), (i), and (j)
65 and (11), relating to aging resource centers, to
66 incorporate the amendments made by this act to s.
67 409.981, F.S., in references thereto; providing an
68 effective date.
69
70 Be It Enacted by the Legislature of the State of Florida:
71
72 Section 1. Subsection (1) of section 409.912, Florida
73 Statutes, is amended to read:
74 409.912 Cost-effective purchasing of health care.—The
75 agency shall purchase goods and services for Medicaid recipients
76 in the most cost-effective manner consistent with the delivery
77 of quality medical care. To ensure that medical services are
78 effectively utilized, the agency may, in any case, require a
79 confirmation or second physician's opinion of the correct
80 diagnosis for purposes of authorizing future services under the
81 Medicaid program. This section does not restrict access to
82 emergency services or poststabilization care services as defined
83 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
84 shall be rendered in a manner approved by the agency. The agency
85 shall maximize the use of prepaid per capita and prepaid

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86 aggregate fixed-sum basis services when appropriate and other
87 alternative service delivery and reimbursement methodologies,
88 including competitive bidding pursuant to s. 287.057, designed
89 to facilitate the cost-effective purchase of a case-managed
90 continuum of care. The agency shall also require providers to
91 minimize the exposure of recipients to the need for acute
92 inpatient, custodial, and other institutional care and the
93 inappropriate or unnecessary use of high-cost services. The
94 agency shall contract with a vendor to monitor and evaluate the
95 clinical practice patterns of providers in order to identify
96 trends that are outside the normal practice patterns of a
97 provider’s professional peers or the national guidelines of a
98 provider’s professional association. The vendor must be able to
99 provide information and counseling to a provider whose practice
100 patterns are outside the norms, in consultation with the agency,
101 to improve patient care and reduce inappropriate utilization.
102 The agency may mandate prior authorization, drug therapy
103 management, or disease management participation for certain
104 populations of Medicaid beneficiaries, certain drug classes, or
105 particular drugs to prevent fraud, abuse, overuse, and possible
106 dangerous drug interactions. The Pharmaceutical and Therapeutics
107 Committee shall make recommendations to the agency on drugs for
108 which prior authorization is required. The agency shall inform
109 the Pharmaceutical and Therapeutics Committee of its decisions
110 regarding drugs subject to prior authorization. The agency is
111 authorized to limit the entities it contracts with or enrolls as
112 Medicaid providers by developing a provider network through
113 provider credentialing. The agency may competitively bid single-
114 source-provider contracts if procurement of goods or services

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115 results in demonstrated cost savings to the state without
116 limiting access to care. The agency may limit its network based
117 on the assessment of beneficiary access to care, provider
118 availability, provider quality standards, time and distance
119 standards for access to care, the cultural competence of the
120 provider network, demographic characteristics of Medicaid
121 beneficiaries, practice and provider-to-beneficiary standards,
122 appointment wait times, beneficiary use of services, provider
123 turnover, provider profiling, provider licensure history,
124 previous program integrity investigations and findings, peer
125 review, provider Medicaid policy and billing compliance records,
126 clinical and medical record audits, and other factors. Providers
127 are not entitled to enrollment in the Medicaid provider network.
128 The agency shall determine instances in which allowing Medicaid
129 beneficiaries to purchase durable medical equipment and other
130 goods is less expensive to the Medicaid program than long-term
131 rental of the equipment or goods. The agency may establish rules
132 to facilitate purchases in lieu of long-term rentals in order to
133 protect against fraud and abuse in the Medicaid program as
134 defined in s. 409.913. The agency may seek federal waivers
135 necessary to administer these policies.
136 (1) The agency may contract with a provider service
137 network, which must ~~may~~ be reimbursed on a ~~fee-for-service or~~
138 prepaid basis. ~~Prepaid~~ Provider service networks shall receive
139 per-member, per-month payments. ~~A provider service network that~~
140 ~~does not choose to be a prepaid plan shall receive fee-for-~~
141 ~~service rates with a shared savings settlement. The fee-for-~~
142 ~~service option shall be available to a provider service network~~
143 ~~only for the first 2 years of the plan’s operation or until the~~

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144 ~~contract year beginning September 1, 2014, whichever is later.~~
145 ~~The agency shall annually conduct cost reconciliations to~~
146 ~~determine the amount of cost savings achieved by fee-for-service~~
147 ~~provider service networks for the dates of service in the period~~
148 ~~being reconciled. Only payments for covered services for dates~~
149 ~~of service within the reconciliation period and paid within 6~~
150 ~~months after the last date of service in the reconciliation~~
151 ~~period shall be included. The agency shall perform the necessary~~
152 ~~adjustments for the inclusion of claims incurred but not~~
153 ~~reported within the reconciliation for claims that could be~~
154 ~~received and paid by the agency after the 6-month claims~~
155 ~~processing time lag. The agency shall provide the results of the~~
156 ~~reconciliations to the fee-for-service provider service networks~~
157 ~~within 45 days after the end of the reconciliation period. The~~
158 ~~fee-for-service provider service networks shall review and~~
159 ~~provide written comments or a letter of concurrence to the~~
160 ~~agency within 45 days after receipt of the reconciliation~~
161 ~~results. This reconciliation shall be considered final.~~
162 ~~(a) A provider service network which is reimbursed by the~~
163 ~~agency on a prepaid basis shall be exempt from parts I and III~~
164 ~~of chapter 641 but must comply with the solvency requirements in~~
165 ~~s. 641.2261(2) and meet appropriate financial reserve, quality~~
166 ~~assurance, and patient rights requirements as established by the~~
167 ~~agency.~~
168 ~~(b)~~ A provider service network is a network established or
169 organized and operated by a health care provider, or group of
170 affiliated health care providers, which provides a substantial
171 proportion of the health care items and services under a
172 contract directly through the provider or affiliated group of

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173 providers and may make arrangements with physicians or other
174 health care professionals, health care institutions, or any
175 combination of such individuals or institutions to assume all or
176 part of the financial risk on a prospective basis for the
177 provision of basic health services by the physicians, by other
178 health professionals, or through the institutions. The health
179 care providers must have a controlling interest in the governing
180 body of the provider service network organization.
181 (a) A provider service network is exempt from parts I and
182 III of chapter 641 but must comply with the solvency
183 requirements in s. 641.2261(2) and meet appropriate financial
184 reserve, quality assurance, and patient rights requirements as
185 established by the agency.
186 (b) This subsection does not authorize the agency to
187 contract with a provider service network outside of the
188 procurement process described in s. 409.966.
189 Section 2. Section 409.9124, Florida Statutes, is repealed.
190 Section 3. Section 409.964, Florida Statutes, is amended to
191 read:
192 409.964 Managed care program; state plan; waivers.—The
193 Medicaid program is established as a statewide, integrated
194 managed care program for all covered services, including long-
195 term care services. The agency shall apply for and implement
196 state plan amendments or waivers of applicable federal laws and
197 regulations necessary to implement the program. ~~Before seeking a~~
198 ~~waiver, the agency shall provide public notice and the~~
199 ~~opportunity for public comment and include public feedback in~~
200 ~~the waiver application. The agency shall hold one public meeting~~
201 ~~in each of the regions described in s. 409.966(2), and the time~~

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202 ~~period for public comment for each region shall end no sooner~~
203 ~~than 30 days after the completion of the public meeting in that~~
204 ~~region.~~
205 Section 4. Subsections (2), (3), and (4) of section
206 409.966, Florida Statutes, are amended to read:
207 409.966 Eligible plans; selection.—
208 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a
209 limited number of eligible plans to participate in the Medicaid
210 program using invitations to negotiate in accordance with s.
211 287.057(1)(c). At least 90 days before issuing an invitation to
212 negotiate, the agency shall compile and publish a databook
213 consisting of a comprehensive set of utilization and spending
214 data consistent with actuarial rate-setting practices and
215 standards ~~for the 3 most recent contract years consistent with~~
216 ~~the rate-setting periods for all Medicaid recipients by region~~
217 ~~or county~~. The source of the data in the databook ~~report~~ must
218 include, at a minimum, the 24 most recent months of ~~both~~
219 ~~historic fee-for-service claims and~~ validated data from the
220 Medicaid Encounter Data System. The statewide managed care
221 program includes ~~report must be available in electronic form and~~
222 ~~delineate utilization use by age, gender, eligibility group,~~
223 ~~geographic area, and aggregate clinical risk score. Separate and~~
224 ~~simultaneous procurements shall be conducted in each of~~ the
225 following regions:
226 (a) Region A ~~1~~, which consists of Bay, Calhoun, Escambia,
227 ~~Okaloosa, Santa Rosa, and Walton Counties.~~
228 ~~(b) Region 2, which consists of Bay, Calhoun,~~ Franklin,
229 Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty,
230 Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and

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231 Washington Counties.
232 (b)~~(c)~~ Region B ~~3~~, which consists of Alachua, Baker,
233 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,
234 Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion,
235 Nassau, Putnam, St. Johns, Sumter, Suwannee, ~~and~~ Union ~~Counties.~~
236 ~~(d) Region 4, which consists of Baker, Clay, Duval,~~
237 ~~Flagler, Nassau, St. Johns~~, and Volusia Counties.
238 (c)~~(e)~~ Region C ~~5~~, which consists of ~~Pasco and Pinellas~~
239 ~~Counties.~~
240 ~~(f) Region 6, which consists of~~ Hardee, Highlands,
241 Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties.
242 (d)~~(g)~~ Region D ~~7~~, which consists of Brevard, Orange,
243 Osceola, and Seminole Counties.
244 (e)~~(h)~~ Region E ~~8~~, which consists of Charlotte, Collier,
245 DeSoto, Glades, Hendry, Lee, and Sarasota Counties.
246 (f)~~(i)~~ Region F ~~9~~, which consists of Indian River, Martin,
247 Okeechobee, Palm Beach, and St. Lucie Counties.
248 (g)~~(j)~~ Region G ~~10~~, which consists of Broward County.
249 (h)~~(k)~~ Region H ~~11~~, which consists of Miami-Dade and Monroe
250 Counties.
251 (3) QUALITY SELECTION CRITERIA.—
252 (a) The invitation to negotiate must specify the criteria
253 and the relative weight of the criteria that will be used for
254 determining the acceptability of the reply and guiding the
255 selection of the organizations with which the agency negotiates.
256 In addition to criteria established by the agency, the agency
257 shall consider the following factors in the selection of
258 eligible plans:
259 1. Accreditation by the National Committee for Quality

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260 Assurance, the Joint Commission, or another nationally
261 recognized accrediting body.
262 2. Experience serving similar populations, including the
263 organization’s record in achieving specific quality standards
264 with similar populations.
265 3. Availability and accessibility of primary care and
266 specialty physicians in the provider network.
267 4. Establishment of community partnerships with providers
268 that create opportunities for reinvestment in community-based
269 services.
270 5. Organization commitment to quality improvement and
271 documentation of achievements in specific quality improvement
272 projects, including active involvement by organization
273 leadership.
274 6. Provision of additional benefits, particularly dental
275 care and disease management, and other initiatives that improve
276 health outcomes.
277 7. Evidence that an eligible plan has obtained signed
278 contracts or written agreements or ~~signed contracts or~~ has made
279 substantial progress in establishing relationships with
280 providers before the plan submits ~~submitting~~ a response.
281 8. Comments submitted in writing by any enrolled Medicaid
282 provider relating to a specifically identified plan
283 participating in the procurement in the same region as the
284 submitting provider.
285 9. Documentation of policies and procedures for preventing
286 fraud and abuse.
287 10. The business relationship an eligible plan has with any
288 other eligible plan that responds to the invitation to

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289 negotiate.
290 (b) An eligible plan must disclose any business
291 relationship it has with any other eligible plan that responds
292 to the invitation to negotiate. The agency may not select plans
293 in the same region for the same managed care program that have a
294 business relationship with each other. Failure to disclose any
295 business relationship shall result in disqualification from
296 participation in any region for the first full contract period
297 after the discovery of the business relationship by the agency.
298 For the purpose of this section, "business relationship" means
299 an ownership or controlling interest, an affiliate or subsidiary
300 relationship, a common parent, or any mutual interest in any
301 limited partnership, limited liability partnership, limited
302 liability company, or other entity or business association,
303 including all wholly or partially owned subsidiaries, majority-
304 owned subsidiaries, parent companies, or affiliates of such
305 entities, business associations, or other enterprises, that
306 exists for the purpose of making a profit.
307 (c) After negotiations are conducted, the agency shall
308 select the eligible plans that are determined to be responsive
309 and provide the best value to the state. Preference shall be
310 given to plans that:
311 1. Have signed contracts with primary and specialty
312 physicians in sufficient numbers to meet the specific standards
313 established pursuant to s. 409.967(2)(c).
314 2. Have well-defined programs for recognizing patient-
315 centered medical homes and providing for increased compensation
316 for recognized medical homes, as defined by the plan.
317 3. Are organizations that are based in and perform

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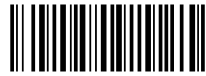
318 operational functions in this state, in-house or through
319 contractual arrangements, by staff located in this state. Using
320 a tiered approach, the highest number of points shall be awarded
321 to a plan that has all or substantially all of its operational
322 functions performed in the state. The second highest number of
323 points shall be awarded to a plan that has a majority of its
324 operational functions performed in the state. The agency may
325 establish a third tier; however, preference points may not be
326 awarded to plans that perform only community outreach, medical
327 director functions, and state administrative functions in the
328 state. For purposes of this subparagraph, operational functions
329 include corporate headquarters, claims processing, member
330 services, provider relations, utilization and prior
331 authorization, case management, disease and quality functions,
332 and finance and administration. For purposes of this
333 subparagraph, the term "corporate headquarters" means the
334 principal office of the organization, which may not be a
335 subsidiary, directly or indirectly through one or more
336 subsidiaries of, or a joint venture with, any other entity whose
337 principal office is not located in the state.
338 4. Have contracts or other arrangements for cancer disease
339 management programs that have a proven record of clinical
340 efficiencies and cost savings.
341 5. Have contracts or other arrangements for diabetes
342 disease management programs that have a proven record of
343 clinical efficiencies and cost savings.
344 6. Have a claims payment process that ensures that claims
345 that are not contested or denied will be promptly paid pursuant
346 to s. 641.3155.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347 ~~(d) For the first year of the first contract term, the~~
348 ~~agency shall negotiate capitation rates or fee for service~~
349 ~~payments with each plan in order to guarantee aggregate savings~~
350 ~~of at least 5 percent.~~
351 ~~1. For prepaid plans, determination of the amount of~~
352 ~~savings shall be calculated by comparison to the Medicaid rates~~
353 ~~that the agency paid managed care plans for similar populations~~
354 ~~in the same areas in the prior year. In regions containing no~~
355 ~~prepaid plans in the prior year, determination of the amount of~~
356 ~~savings shall be calculated by comparison to the Medicaid rates~~
357 ~~established and certified for those regions in the prior year.~~
358 ~~2. For provider service networks operating on a fee-for-~~
359 ~~service basis, determination of the amount of savings shall be~~
360 ~~calculated by comparison to the Medicaid rates that the agency~~
361 ~~paid on a fee-for-service basis for the same services in the~~
362 ~~prior year.~~
363 ~~(e) To ensure managed care plan participation in Regions 1~~
364 ~~and 2, the agency shall award an additional contract to each~~
365 ~~plan with a contract award in Region 1 or Region 2. Such~~
366 ~~contract shall be in any other region in which the plan~~
367 ~~submitted a responsive bid and negotiates a rate acceptable to~~
368 ~~the agency. If a plan that is awarded an additional contract~~
369 ~~pursuant to this paragraph is subject to penalties pursuant to~~
370 ~~s. 409.967(2)(i) for activities in Region 1 or Region 2, the~~
371 ~~additional contract is automatically terminated 180 days after~~
372 ~~the imposition of the penalties. The plan must reimburse the~~
373 ~~agency for the cost of enrollment changes and other transition~~
374 ~~activities.~~
375 (d)~~(f)~~ The agency may not execute contracts with managed

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376 care plans at payment rates not supported by the General
377 Appropriations Act.
378 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that
379 participates in an invitation to negotiate ~~in more than one~~
380 ~~region and is selected in at least one region~~ may not begin
381 serving Medicaid recipients ~~in any region for which it was~~
382 ~~selected~~ until all administrative challenges to procurements
383 required by this section to which the eligible plan is a party
384 have been finalized. If the number of plans selected is less
385 than the maximum amount of plans permitted in the region, the
386 agency may contract with other selected plans in the region not
387 participating in the administrative challenge before resolution
388 of the administrative challenge. For purposes of this
389 subsection, an administrative challenge is finalized if an order
390 granting voluntary dismissal with prejudice has been entered by
391 any court established under Article V of the State Constitution
392 or by the Division of Administrative Hearings, a final order has
393 been entered into by the agency and the deadline for appeal has
394 expired, a final order has been entered by the First District
395 Court of Appeal and the time to seek any available review by the
396 Florida Supreme Court has expired, or a final order has been
397 entered by the Florida Supreme Court and a warrant has been
398 issued.
399 Section 5. Paragraphs (c) and (f) of subsection (2) of
400 section 409.967, Florida Statutes, are amended to read:
401 409.967 Managed care plan accountability.—
402 (2) The agency shall establish such contract requirements
403 as are necessary for the operation of the statewide managed care
404 program. In addition to any other provisions the agency may deem

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405 necessary, the contract must require:
406 (c) *Access.*—
407 1. The agency shall establish specific standards for the
408 number, type, and regional distribution of providers in managed
409 care plan networks to ensure access to care for both adults and
410 children. Each plan must maintain a regionwide network of
411 providers in sufficient numbers to meet the access standards for
412 specific medical services for all recipients enrolled in the
413 plan. The exclusive use of mail-order pharmacies may not be
414 sufficient to meet network access standards. Consistent with the
415 standards established by the agency, provider networks may
416 include providers located outside the region. ~~A plan may~~
417 ~~contract with a new hospital facility before the date the~~
418 ~~hospital becomes operational if the hospital has commenced~~
419 ~~construction, will be licensed and operational by January 1,~~
420 ~~2013, and a final order has issued in any civil or~~
421 ~~administrative challenge.~~ Each plan shall establish and maintain
422 an accurate and complete electronic database of contracted
423 providers, including information about licensure or
424 registration, locations and hours of operation, specialty
425 credentials and other certifications, specific performance
426 indicators, and such other information as the agency deems
427 necessary. The database must be available online to both the
428 agency and the public and have the capability to compare the
429 availability of providers to network adequacy standards and to
430 accept and display feedback from each provider’s patients. Each
431 plan shall submit quarterly reports to the agency identifying
432 the number of enrollees assigned to each primary care provider.
433 The agency shall conduct, or contract for, systematic and

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434 continuous testing of the provider network databases maintained
435 by each plan to confirm accuracy, confirm that behavioral health
436 providers are accepting enrollees, and confirm that enrollees
437 have access to behavioral health services.
438 2. Each managed care plan must publish any prescribed drug
439 formulary or preferred drug list on the plan's website in a
440 manner that is accessible to and searchable by enrollees and
441 providers. The plan must update the list within 24 hours after
442 making a change. Each plan must ensure that the prior
443 authorization process for prescribed drugs is readily accessible
444 to health care providers, including posting appropriate contact
445 information on its website and providing timely responses to
446 providers. For Medicaid recipients diagnosed with hemophilia who
447 have been prescribed anti-hemophilic-factor replacement
448 products, the agency shall provide for those products and
449 hemophilia overlay services through the agency's hemophilia
450 disease management program.
451 3. Managed care plans, and their fiscal agents or
452 intermediaries, must accept prior authorization requests for any
453 service electronically.
454 4. Managed care plans serving children in the care and
455 custody of the Department of Children and Families must maintain
456 complete medical, dental, and behavioral health encounter
457 information and participate in making such information available
458 to the department or the applicable contracted community-based
459 care lead agency for use in providing comprehensive and
460 coordinated case management. The agency and the department shall
461 establish an interagency agreement to provide guidance for the
462 format, confidentiality, recipient, scope, and method of

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463 information to be made available and the deadlines for
464 submission of the data. The scope of information available to
465 the department shall be the data that managed care plans are
466 required to submit to the agency. The agency shall determine the
467 plan's compliance with standards for access to medical, dental,
468 and behavioral health services; the use of medications; and
469 followup on all medically necessary services recommended as a
470 result of early and periodic screening, diagnosis, and
471 treatment.
472 (f) *Continuous improvement.*—The agency shall establish
473 specific performance standards and expected milestones or
474 timelines for improving performance over the term of the
475 contract.
476 1. Each managed care plan shall establish an internal
477 health care quality improvement system, including enrollee
478 satisfaction and disenrollment surveys. The quality improvement
479 system must include incentives and disincentives for network
480 providers.
481 2. Each plan must collect and report the Health Plan
482 Employer Data and Information Set (HEDIS) measures, as specified
483 by the agency. These measures must be published on the plan's
484 website in a manner that allows recipients to reliably compare
485 the performance of plans. The agency shall use the HEDIS
486 measures as a tool to monitor plan performance.
487 3. Each managed care plan must be accredited by the
488 National Committee for Quality Assurance, the Joint Commission,
489 or another nationally recognized accrediting body, or have
490 initiated the accreditation process, within 1 year after the
491 contract is executed. For any plan not accredited within 18

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months after executing the contract, the agency shall suspend automatic assignment under s. 409.977 and 409.984.

~~4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.~~

Section 6. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

(2) Provider service networks must ~~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~~

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521 ~~reconciliations to the fee-for-service provider service networks~~
522 ~~within 45 days after the end of the reconciliation period. The~~
523 ~~fee-for-service provider service networks shall review and~~
524 ~~provide written comments or a letter of concurrence to the~~
525 ~~agency within 45 days after receipt of the reconciliation~~
526 ~~results. This reconciliation is considered final.~~
527 Section 7. Subsections (3) and (4) of section 409.973,
528 Florida Statutes, are amended to read:
529 409.973 Benefits.—
530 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed
531 medical assistance program shall establish a program to
532 encourage and reward healthy behaviors. At a minimum, each plan
533 must establish a medically approved tobacco ~~smoking~~ cessation
534 program, a medically directed weight loss program, and a
535 medically approved alcohol recovery program or substance abuse
536 recovery program that must include, but may not be limited to,
537 opioid abuse recovery. Each plan must identify enrollees who
538 smoke, are morbidly obese, or are diagnosed with alcohol or
539 substance abuse in order to establish written agreements to
540 secure the enrollees' commitment to participation in these
541 programs.
542 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the
543 managed medical assistance program shall establish a program to
544 encourage enrollees to establish a relationship with their
545 primary care provider. Each plan shall:
546 (a) Provide information to each enrollee on the importance
547 of and procedure for selecting a primary care provider, and
548 thereafter automatically assign to a primary care provider any
549 enrollee who fails to choose a primary care provider.

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550 (b) If the enrollee was not a Medicaid recipient before
551 enrollment in the plan, assist the enrollee in scheduling an
552 appointment with the primary care provider. If possible the
553 appointment should be made within 30 days after enrollment in
554 the plan. ~~For enrollees who become eligible for Medicaid between~~
555 ~~January 1, 2014, and December 31, 2015, the appointment should~~
556 ~~be scheduled within 6 months after enrollment in the plan.~~
557 (c) Report to the agency the number of enrollees assigned
558 to each primary care provider within the plan's network.
559 (d) Report to the agency the number of enrollees who have
560 not had an appointment with their primary care provider within
561 their first year of enrollment.
562 (e) Report to the agency the number of emergency room
563 visits by enrollees who have not had at least one appointment
564 with their primary care provider.
565 Section 8. Subsections (1) and (2) of section 409.974,
566 Florida Statutes, are amended to read:
567 409.974 Eligible plans.—
568 (1) ELIGIBLE PLAN SELECTION.—The agency shall select
569 eligible plans <u>for the managed medical assistance program</u>
570 through the procurement process described in s. 409.966 <u>through</u>
571 <u>a single statewide procurement. The agency may award contracts</u>
572 <u>to plans selected through the procurement process either on a</u>
573 <u>regional or statewide basis. The awards must include at least</u>
574 <u>one provider service network in each of the eight regions</u>
575 <u>outlined in this subsection. The agency shall procure:</u>
576 <u>(a) At least 3 plans and up to 4 plans for Region A.</u>
577 <u>(b) At least 3 plans and up to 6 plans for Region B.</u>
578 <u>(c) At least 5 plans and up to 10 plans for Region C.</u>

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579 (d) At least 3 plans and up to 6 plans for Region D.
580 (e) At least 3 plans and up to 4 plans for Region E.
581 (f) At least 3 plans and up to 5 plans for Region F.
582 (g) At least 3 plans and up to 5 plans for Region G.
583 (h) At least 5 plans and up to 10 plans for Region H. ~~The~~
584 ~~agency shall notice invitations to negotiate no later than~~
585 ~~January 1, 2013.~~
586 ~~(a) The agency shall procure two plans for Region 1. At~~
587 ~~least one plan shall be a provider service network if any~~
588 ~~provider service networks submit a responsive bid.~~
589 ~~(b) The agency shall procure two plans for Region 2. At~~
590 ~~least one plan shall be a provider service network if any~~
591 ~~provider service networks submit a responsive bid.~~
592 ~~(c) The agency shall procure at least three plans and up to~~
593 ~~five plans for Region 3. At least one plan must be a provider~~
594 ~~service network if any provider service networks submit a~~
595 ~~responsive bid.~~
596 ~~(d) The agency shall procure at least three plans and up to~~
597 ~~five plans for Region 4. At least one plan must be a provider~~
598 ~~service network if any provider service networks submit a~~
599 ~~responsive bid.~~
600 ~~(e) The agency shall procure at least two plans and up to~~
601 ~~four plans for Region 5. At least one plan must be a provider~~
602 ~~service network if any provider service networks submit a~~
603 ~~responsive bid.~~
604 ~~(f) The agency shall procure at least four plans and up to~~
605 ~~seven plans for Region 6. At least one plan must be a provider~~
606 ~~service network if any provider service networks submit a~~
607 ~~responsive bid.~~

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608 ~~(g) The agency shall procure at least three plans and up to~~
609 ~~six plans for Region 7. At least one plan must be a provider~~
610 ~~service network if any provider service networks submit a~~
611 ~~responsive bid.~~
612 ~~(h) The agency shall procure at least two plans and up to~~
613 ~~four plans for Region 8. At least one plan must be a provider~~
614 ~~service network if any provider service networks submit a~~
615 ~~responsive bid.~~
616 ~~(i) The agency shall procure at least two plans and up to~~
617 ~~four plans for Region 9. At least one plan must be a provider~~
618 ~~service network if any provider service networks submit a~~
619 ~~responsive bid.~~
620 ~~(j) The agency shall procure at least two plans and up to~~
621 ~~four plans for Region 10. At least one plan must be a provider~~
622 ~~service network if any provider service networks submit a~~
623 ~~responsive bid.~~
624 ~~(k) The agency shall procure at least five plans and up to~~
625 ~~10 plans for Region 11. At least one plan must be a provider~~
626 ~~service network if any provider service networks submit a~~
627 ~~responsive bid.~~
628
629 If no provider service network submits a responsive bid, the
630 agency shall procure no more than one less than the maximum
631 number of eligible plans permitted in that region. Within 12
632 months after the initial invitation to negotiate, the agency
633 shall attempt to procure a provider service network. The agency
634 shall notice another invitation to negotiate only with provider
635 service networks in those regions where no provider service
636 network has been selected.

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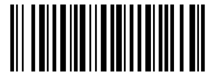
637 (2) QUALITY SELECTION CRITERIA.—In addition to the criteria
638 established in s. 409.966, the agency shall consider evidence
639 that an eligible plan has written agreements or signed contracts
640 or has made substantial progress in establishing relationships
641 with providers before the plan submitting a response. The agency
642 shall evaluate and give special weight to evidence of signed
643 contracts with essential providers as defined by the agency
644 pursuant to s. 409.975(1). ~~The agency shall exercise a~~
645 ~~preference for plans with a provider network in which over 10~~
646 ~~percent of the providers use electronic health records, as~~
647 ~~defined in s. 408.051.~~ When all other factors are equal, the
648 agency shall consider whether the organization has a contract to
649 provide managed long-term care services in the same region and
650 shall exercise a preference for such plans.
651 Section 9. Paragraph (b) of subsection (1) of section
652 409.975, Florida Statutes, is amended to read:
653 409.975 Managed care plan accountability.—In addition to
654 the requirements of s. 409.967, plans and providers
655 participating in the managed medical assistance program shall
656 comply with the requirements of this section.
657 (1) PROVIDER NETWORKS.—Managed care plans must develop and
658 maintain provider networks that meet the medical needs of their
659 enrollees in accordance with standards established pursuant to
660 s. 409.967(2)(c). Except as provided in this section, managed
661 care plans may limit the providers in their networks based on
662 credentials, quality indicators, and price.
663 (b) Certain providers are statewide resources and essential
664 providers for all managed care plans in all regions. All managed
665 care plans must include these essential providers in their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666 networks. Statewide essential providers include:
667 1. Faculty plans of Florida medical schools.
668 2. Regional perinatal intensive care centers as defined in
669 s. 383.16(2).
670 3. Hospitals licensed as specialty children’s hospitals as
671 defined in s. 395.002(28).
672 4. Accredited and integrated systems serving medically
673 complex children which comprise separately licensed, but
674 commonly owned, health care providers delivering at least the
675 following services: medical group home, in-home and outpatient
676 nursing care and therapies, pharmacy services, durable medical
677 equipment, and Prescribed Pediatric Extended Care.
678 5. Florida cancer hospitals that meet the criteria in 42
679 U.S.C. s. 1395ww(d)(1)(B)(v).
680
681 Managed care plans that have not contracted with all statewide
682 essential providers in all regions as of the first date of
683 recipient enrollment must continue to negotiate in good faith.
684 Payments to physicians on the faculty of nonparticipating
685 Florida medical schools shall be made at the applicable Medicaid
686 rate. Payments for services rendered by regional perinatal
687 intensive care centers shall be made at the applicable Medicaid
688 rate as of the first day of the contract between the agency and
689 the plan. Except for payments for emergency services, payments
690 to nonparticipating specialty children’s hospitals shall equal
691 the highest rate established by contract between that provider
692 and any other Medicaid managed care plan.
693 Section 10. Subsections (1), (2), (4), and (5) of section
694 409.977, Florida Statutes, are amended to read:

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695 409.977 Enrollment.—
696 (1) The agency shall automatically enroll into a managed
697 care plan those Medicaid recipients who do not voluntarily
698 choose a plan pursuant to s. 409.969. The agency shall
699 automatically enroll recipients in plans that meet or exceed the
700 performance or quality standards established pursuant to s.
701 409.967 and may not automatically enroll recipients in a plan
702 that is deficient in those performance or quality standards.
703 When a specialty plan is available to accommodate a specific
704 condition or diagnosis of a recipient, the agency shall assign
705 the recipient to that plan. ~~In the first year of the first~~
706 ~~contract term only, if a recipient was previously enrolled in a~~
707 ~~plan that is still available in the region, the agency shall~~
708 ~~automatically enroll the recipient in that plan unless an~~
709 ~~applicable specialty plan is available.~~ Except as otherwise
710 provided in this part, the agency may not engage in practices
711 that are designed to favor one managed care plan over another.
712 (2) When automatically enrolling recipients in managed care
713 plans, if a recipient was enrolled in a plan immediately before
714 the recipient's choice period and that plan is still available
715 in the region, the agency must maintain the recipient's
716 enrollment in that plan unless an applicable specialty plan is
717 available. Otherwise, the agency shall automatically enroll
718 based on the following criteria:
719 (a) Whether the plan has sufficient network capacity to
720 meet the needs of the recipients.
721 (b) Whether the recipient has previously received services
722 from one of the plan's primary care providers.
723 (c) Whether primary care providers in one plan are more

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724 geographically accessible to the recipient’s residence than
725 those in other plans.
726 (4) The agency shall develop a process to enable a
727 recipient with access to employer-sponsored health care coverage
728 to opt out of all managed care plans and to use Medicaid
729 financial assistance to pay for the recipient’s share of the
730 cost in such employer-sponsored coverage. ~~Contingent upon~~
731 ~~federal approval,~~ The agency shall also enable recipients with
732 access to other insurance or related products providing access
733 to health care services created pursuant to state law, including
734 any product available under the Florida Health Choices Program,
735 or any health exchange, to opt out. The amount of financial
736 assistance provided for each recipient may not exceed the amount
737 of the Medicaid premium that would have been paid to a managed
738 care plan for that recipient. The agency shall ~~seek federal~~
739 ~~approval to~~ require Medicaid recipients with access to employer-
740 sponsored health care coverage to enroll in that coverage and
741 use Medicaid financial assistance to pay for the recipient’s
742 share of the cost for such coverage. The amount of financial
743 assistance provided for each recipient may not exceed the amount
744 of the Medicaid premium that would have been paid to a managed
745 care plan for that recipient.
746 (5) Specialty plans serving children in the care and
747 custody of the department may serve such children as long as
748 they remain in care, including those remaining in extended
749 foster care pursuant to s. 39.6251, or are in subsidized
750 adoption and continue to be eligible for Medicaid pursuant to s.
751 409.903, or are receiving guardianship assistance payments and
752 continue to be eligible for Medicaid pursuant to s. 409.903.

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753 Section 11. Subsection (2) of section 409.981, Florida
754 Statutes, is amended to read:
755 409.981 Eligible long-term care plans.—
756 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
757 eligible plans for the long-term care managed care program
758 through the procurement process described in s. 409.966 through
759 a single statewide procurement. The agency may award contracts
760 to plans selected through the procurement process on a regional
761 or statewide basis. The awards must include at least one
762 provider service network in each of the eight regions outlined
763 in this subsection. The agency shall procure:
764 (a) At least 3 plans and up to 4 plans for Region A.
765 (b) At least 3 plans and up to 6 plans for Region B.
766 (c) At least 5 plans and up to 10 plans for Region C.
767 (d) At least 3 plans and up to 6 plans for Region D.
768 (e) At least 3 plans and up to 4 plans for Region E.
769 (f) At least 3 plans and up to 5 plans for Region F.
770 (g) At least 3 plans and up to 4 plans for Region G.
771 (h) At least 5 plans and up to 10 plans for Region H.
772 ~~Two plans for Region 1. At least one plan must be a~~
773 ~~provider service network if any provider service networks submit~~
774 ~~a responsive bid.~~
775 ~~(b) Two plans for Region 2. At least one plan must be a~~
776 ~~provider service network if any provider service networks submit~~
777 ~~a responsive bid.~~
778 ~~(c) At least three plans and up to five plans for Region 3.~~
779 ~~At least one plan must be a provider service network if any~~
780 ~~provider service networks submit a responsive bid.~~
781 ~~(d) At least three plans and up to five plans for Region 4.~~

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782 ~~At least one plan must be a provider service network if any~~
783 ~~provider service network submits a responsive bid.~~
784 ~~(e) At least two plans and up to four plans for Region 5.~~
785 ~~At least one plan must be a provider service network if any~~
786 ~~provider service networks submit a responsive bid.~~
787 ~~(f) At least four plans and up to seven plans for Region 6.~~
788 ~~At least one plan must be a provider service network if any~~
789 ~~provider service networks submit a responsive bid.~~
790 ~~(g) At least three plans and up to six plans for Region 7.~~
791 ~~At least one plan must be a provider service network if any~~
792 ~~provider service networks submit a responsive bid.~~
793 ~~(h) At least two plans and up to four plans for Region 8.~~
794 ~~At least one plan must be a provider service network if any~~
795 ~~provider service networks submit a responsive bid.~~
796 ~~(i) At least two plans and up to four plans for Region 9.~~
797 ~~At least one plan must be a provider service network if any~~
798 ~~provider service networks submit a responsive bid.~~
799 ~~(j) At least two plans and up to four plans for Region 10.~~
800 ~~At least one plan must be a provider service network if any~~
801 ~~provider service networks submit a responsive bid.~~
802 ~~(k) At least five plans and up to 10 plans for Region 11.~~
803 ~~At least one plan must be a provider service network if any~~
804 ~~provider service networks submit a responsive bid.~~
805
806 If no provider service network submits a responsive bid ~~in a~~
807 ~~region other than Region 1 or Region 2~~, the agency shall procure
808 no more than one less than the maximum number of eligible plans
809 permitted in that region. Within 12 months after the initial
810 invitation to negotiate, the agency shall attempt to procure a

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811 provider service network. The agency shall notice another
812 invitation to negotiate only with provider service networks in
813 regions where no provider service network has been selected.
814 Section 12. Subsection (4) of section 409.8132, Florida
815 Statutes, is amended to read:
816 409.8132 Medikids program component.—
817 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
818 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
819 409.912, 409.9121, 409.9122, 409.9123, ~~409.9124,~~ 409.9127,
820 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply
821 to the administration of the Medikids program component of the
822 Florida Kidcare program, except that s. 409.9122 applies to
823 Medikids as modified by the provisions of subsection (7).
824 Section 13. For the purpose of incorporating the amendment
825 made by this act to section 409.912, Florida Statutes, in
826 references thereto, subsections (1), (7), (13), and (14) of
827 section 409.962, Florida Statutes, are reenacted to read:
828 409.962 Definitions.—As used in this part, except as
829 otherwise specifically provided, the term:
830 (1) "Accountable care organization" means an entity
831 qualified as an accountable care organization in accordance with
832 federal regulations, and which meets the requirements of a
833 provider service network as described in s. 409.912(1).
834 (7) "Eligible plan" means a health insurer authorized under
835 chapter 624, an exclusive provider organization authorized under
836 chapter 627, a health maintenance organization authorized under
837 chapter 641, or a provider service network authorized under s.
838 409.912(1) or an accountable care organization authorized under
839 federal law. For purposes of the managed medical assistance

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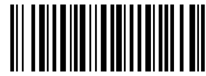
840 program, the term also includes the Children's Medical Services
841 Network authorized under chapter 391 and entities qualified
842 under 42 C.F.R. part 422 as Medicare Advantage Preferred
843 Provider Organizations, Medicare Advantage Provider-sponsored
844 Organizations, Medicare Advantage Health Maintenance
845 Organizations, Medicare Advantage Coordinated Care Plans, and
846 Medicare Advantage Special Needs Plans, and the Program of All-
847 inclusive Care for the Elderly.
848 (13) "Prepaid plan" means a managed care plan that is
849 licensed or certified as a risk-bearing entity, or qualified
850 pursuant to s. 409.912(1), in the state and is paid a
851 prospective per-member, per-month payment by the agency.
852 (14) "Provider service network" means an entity qualified
853 pursuant to s. 409.912(1) of which a controlling interest is
854 owned by a health care provider, or group of affiliated
855 providers, or a public agency or entity that delivers health
856 services. Health care providers include Florida-licensed health
857 care professionals or licensed health care facilities, federally
858 qualified health care centers, and home health care agencies.
859 Section 14. For the purpose of incorporating the amendment
860 made by this act to section 409.912, Florida Statutes, in a
861 reference thereto, subsection (22) of section 641.19, Florida
862 Statutes, is reenacted to read:
863 641.19 Definitions.—As used in this part, the term:
864 (22) "Provider service network" means a network authorized
865 under s. 409.912(1), reimbursed on a prepaid basis, operated by
866 a health care provider or group of affiliated health care
867 providers, and which directly provides health care services
868 under a Medicare, Medicaid, or Healthy Kids contract.

 625186

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869 Section 15. For the purpose of incorporating the amendments
870 made by this act to section 409.981, Florida Statutes, in
871 references thereto, paragraphs (h), (i), and (j) of subsection
872 (3) and subsection (11) of section 430.2053, Florida Statutes,
873 are reenacted to read:
874 430.2053 Aging resource centers.—
875 (3) The duties of an aging resource center are to:
876 (h) Assist clients who request long-term care services in
877 being evaluated for eligibility for enrollment in the Medicaid
878 long-term care managed care program as eligible plans become
879 available in each of the regions pursuant to s. 409.981(2).
880 (i) Provide enrollment and coverage information to Medicaid
881 managed long-term care enrollees as qualified plans become
882 available in each of the regions pursuant to s. 409.981(2).
883 (j) Assist Medicaid recipients enrolled in the Medicaid
884 long-term care managed care program with informally resolving
885 grievances with a managed care network and assist Medicaid
886 recipients in accessing the managed care network's formal
887 grievance process as eligible plans become available in each of
888 the regions defined in s. 409.981(2).
889 (11) In an area in which the department has designated an
890 area agency on aging as an aging resource center, the department
891 and the agency shall not make payments for the services listed
892 in subsection (9) and the Long-Term Care Community Diversion
893 Project for such persons who were not screened and enrolled
894 through the aging resource center. The department shall cease
895 making payments for recipients in eligible plans as eligible
896 plans become available in each of the regions defined in s.
897 409.981(2).

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898 Section 16. This act shall take effect July 1, 2022.