By the Committee on Health Policy; and Senator Brodeur

588-02344-22 20221950c1

A bill to be entitled

An act relating to the statewide Medicaid managed care program; amending s. 409.912, F.S.; requiring, rather than authorizing, that the reimbursement method for provider service networks be on a prepaid basis; deleting the authority to reimburse provider service networks on a fee-for-service basis; conforming provisions to changes made by the act; providing that provider service networks are subject to and exempt from certain requirements; providing construction; repealing s. 409.9124, F.S., relating to managed care reimbursement; amending s. 409.964, F.S.; deleting a requirement that the Agency for Health Care Administration provide the opportunity for public feedback on a certain waiver application; amending s. 409.966, F.S.; revising requirements relating to the databook published by the agency consisting of Medicaid utilization and spending data; reallocating regions within the statewide managed care program; deleting a requirement that the agency negotiate plan rates or payments to guarantee a certain savings amount; deleting a requirement for the agency to award additional contracts to plans in specified regions for certain purposes; revising a limitation on when plans may begin serving Medicaid recipients to apply to any eligible plan that participates in an invitation to negotiate, rather than plans participating in certain regions; making technical changes; amending s. 409.967, F.S.; deleting obsolete provisions; revising

provisions relating to agency-defined quality measures under the achieved savings rebate program for Medicaid prepaid plans; amending s. 409.968, F.S.; conforming provisions to changes made by the act; amending s. 409.973, F.S.; revising requirements for healthy behaviors programs established by plans; deleting an obsolete provision; amending s. 409.974, F.S.; requiring the agency to select plans for the managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; deleting a requirement for the agency to exercise a preference for certain plans; amending s. 409.975, F.S.; providing that cancer hospitals meeting certain criteria are statewide essential providers; amending s. 409.977, F.S.; revising the circumstances for maintaining a recipient’s enrollment in a plan; deleting obsolete language; authorizing specialty plans to serve certain children who receive guardianship assistance payments under the Guardianship Assistance Program; amending s. 409.981, F.S.; requiring the agency to select plans for the long-term care managed medical assistance program through a single statewide procurement; authorizing the agency to award contracts to plans on a regional or statewide basis; specifying requirements for

minimum numbers of plans which the agency must procure for each specified region; conforming provisions to changes made by the act; amending s. 409.8132, F.S.; conforming a cross-reference; reenacting ss. 409.962(1), (7), (13), and (14) and 641.19(22) relating to definitions, to incorporate the amendments made by this act to s. 409.912, F.S., in references thereto; reenacting s. 430.2053(3)(h), (i), and (j) and (11), relating to aging resource centers, to incorporate the amendments made by this act to s. 409.981, F.S., in references thereto; providing an effective date.

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

Section 1. Subsection (1) 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.

(1) The agency may contract with a provider service network, which must ~~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 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.

(a) A provider service network is 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) This subsection does not authorize the agency to contract with a provider service network outside of the procurement process described in s. 409.966.

Section 2. Section 409.9124, Florida Statutes, is repealed.

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. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. ~~Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time~~

~~period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.~~

Section 4. Subsections (2), (3), and (4) 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, at a minimum, the 24 most recent months of ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System. The statewide managed care program includes ~~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 ~~1~~, which consists of Bay, Calhoun, Escambia, ~~Okaloosa, Santa Rosa, and Walton Counties.~~

~~(b) Region 2, which consists of Bay, Calhoun,~~ Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and

Washington Counties.

(b) ~~(c)~~ Region B ~~3~~, 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, ~~and~~ Union ~~Counties.~~

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

(c) ~~(e)~~ Region C ~~5~~, which consists of ~~Pasco and Pinellas Counties.~~

~~(f) Region 6, which consists of~~ Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties.

(d) ~~(g)~~ Region D ~~7~~, which consists of Brevard, Orange, Osceola, and Seminole Counties.

(e) ~~(h)~~ Region E ~~8~~, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

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

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

(h) ~~(k)~~ Region H ~~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 determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. 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.

(b) An eligible plan must disclose any business relationship 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 that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification 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, "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, that exists for the purpose of making a profit.

(c) After negotiations are conducted, the agency shall select the eligible plans that are determined to be responsive and provide the best value to the state. Preference shall be given to plans that:

1. Have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to s. 409.967(2)(c).

2. Have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan.

3. Are organizations that are based in and perform

operational functions in this state, in-house or through contractual arrangements, by staff located in this state. Using a tiered approach, the highest number of points shall be awarded to a plan that has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. The agency may establish a third tier; however, preference points may not be awarded to plans that perform only community outreach, medical director functions, and state administrative functions in the state. For purposes of this subparagraph, operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease and quality functions, and finance and administration. For purposes of this subparagraph, the term "corporate headquarters" means the principal office of the organization, which may not be a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings.

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

~~(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.~~

~~(e) To ensure managed care plan participation in Regions 1 and 2, the agency shall award an additional contract to each plan with a contract award in Region 1 or 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 1 or 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.~~

(d) ~~(f)~~ The agency may not execute contracts with managed

care plans at payment rates not supported by the General Appropriations Act.

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate ~~in more than one region and is selected in at least one region~~ may not begin serving Medicaid recipients ~~in any region for which it was selected~~ until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

Section 5. Paragraphs (c) and (f) of subsection (2) and subsection (3) 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 for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

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.

(f) *Continuous improvement.*—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each plan must collect and report the Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the agency. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the

contract is executed. For any plan not accredited within 18 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.~~

(3) ACHIEVED SAVINGS REBATE.—

(a) The agency is responsible for verifying the achieved savings rebate for all Medicaid prepaid plans. To assist the agency, a prepaid plan shall:

1. Submit an annual financial audit conducted by an independent certified public accountant in accordance with generally accepted auditing standards to the agency on or before June 1 for the preceding year; and

2. Submit an annual statement prepared in accordance with statutory accounting principles on or before March 1 pursuant to s. 624.424 if the plan is regulated by the Office of Insurance Regulation.

(b) The agency shall contract with independent certified public accountants to conduct compliance audits for the purpose of auditing financial information, including but not limited to: annual premium revenue, medical and administrative costs, and income or losses reported by each prepaid plan, in order to determine and validate the achieved savings rebate.

(c) Any audit required under this subsection must be conducted by an independent certified public accountant who

meets criteria specified by rule. The rules must also provide that:

1. The entity selected by the agency to conduct the audit may not have a conflict of interest that might affect its ability to perform its responsibilities with respect to an examination.

2. The rates charged to the prepaid plan being audited are consistent with rates charged by other certified public accountants and are comparable with the rates charged for comparable examinations.

3. Each prepaid plan audited shall pay to the agency the expenses of the audit at the rates established by the agency by rule. Such expenses include actual travel expenses, reasonable living expense allowances, compensation of the certified public accountant, and necessary attendant administrative costs of the agency directly related to the examination. Travel expense and living expense allowances are limited to those expenses incurred on account of the audit and must be paid by the examined prepaid plan together with compensation upon presentation by the agency to the prepaid plan of a detailed account of the charges and expenses after a detailed statement has been filed by the auditor and approved by the agency.

4. All moneys collected from prepaid plans for such audits shall be deposited into the Grants and Donations Trust Fund, and the agency may make deposits into such fund from moneys appropriated for the operation of the agency.

(d) At a location in this state, the prepaid plan shall make available to the agency and the agency's contracted certified public accountant all books, accounts, documents,

files, and information that relate to the prepaid plan's Medicaid transactions. Records not in the prepaid plan's immediate possession must be made available to the agency or the certified public accountant in this state within 3 days after a request is made by the agency or certified public accountant engaged by the agency. A prepaid plan has an obligation to cooperate in good faith with the agency and the certified public accountant. Failure to comply to such record requests shall be deemed a breach of contract.

(e) Once the certified public accountant completes the audit, the certified public accountant shall submit an audit report to the agency attesting to the achieved savings of the plan. The results of the audit report are dispositive.

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 3 ~~5~~ percent of revenue shall be retained by the plan.

2. Fifty percent of income above 3 ~~5~~ percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and transferred to the General Revenue Fund, unallocated.

(g) A plan that exceeds agency-defined quality measures in

the reporting period may retain up to an additional 2 ~~1~~ percent of revenue. For the purpose of this paragraph, the quality measures must include two tiers and must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

1. If the agency-defined quality or performance targets identified in tier one are met, the plan may retain up to 4 percent of revenue. Fifty percent of income above 4 percent and up to 10 percent must be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

2. If the agency-defined quality or performance targets identified in tier two are met, the plan may retain up to 5 percent of revenue. Fifty percent of income above 5 percent and up to 10 percent must be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

(h) The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state or federal government.

4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of

any type paid or awarded to the plan's executive staff, other than base salary.

6. Reserves and reserve accounts.

7. Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

The agency shall consider these and other factors in developing contracts that establish shared savings arrangements.

(i) Prepaid plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.

(j) If, after an audit, the agency determines that a prepaid plan owes an additional rebate, the plan has 30 days after notification to make the payment. Upon failure to timely pay the rebate, the agency shall withhold future payments to the plan until the entire amount is recouped. If the agency determines that a prepaid plan has made an overpayment, the agency shall return the overpayment within 30 days.

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 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 7. Subsections (3) and (4) of section 409.973, Florida Statutes, are amended to read:

409.973 Benefits.—

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved tobacco ~~smoking~~ cessation program, a medically directed weight loss program, and a medically approved alcohol recovery program or substance abuse recovery program that must include, but may not be limited to, opioid abuse recovery. Each plan must identify enrollees who

smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible the appointment should be made within 30 days after enrollment in the plan. ~~For enrollees who become eligible for Medicaid between January 1, 2014, and December 31, 2015, the appointment should be scheduled within 6 months after enrollment in the plan.~~

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Section 8. 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 through a single statewide procurement. The agency may award contracts to plans selected through the procurement process either on a regional or statewide basis. The awards must include at least one provider service network in each of the eight regions outlined in this subsection. The agency shall procure:

(a) At least 3 plans and up to 4 plans for Region A.

(b) At least 3 plans and up to 6 plans for Region B.

(c) At least 5 plans and up to 10 plans for Region C.

(d) At least 3 plans and up to 6 plans for Region D.

(e) At least 3 plans and up to 4 plans for Region E.

(f) At least 3 plans and up to 5 plans for Region F.

(g) At least 3 plans and up to 5 plans for Region G.

(h) At least 5 plans and up to 10 plans for Region H. ~~The agency shall notice invitations to negotiate no later than January 1, 2013.~~

~~(a) The agency shall procure two plans for 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 two plans for 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 three plans and up to five plans for 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 five plans for 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 two plans and up to four plans for 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 four plans and up to seven plans for 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 six plans for 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 two plans and up to four plans for 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 written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan 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 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 9. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to

the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

5. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of

recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 10. Subsections (1), (2), (4), and (5) of section 409.977, Florida Statutes, are amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. ~~In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.~~ Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

(2) When automatically enrolling recipients in managed care plans, if a recipient was enrolled in a plan immediately before the recipient's choice period and that plan is still available in the region, the agency must maintain the recipient's enrollment in that plan unless an applicable specialty plan is available. Otherwise, the agency shall automatically enroll based on the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

(b) Whether the recipient has previously received services from one of the plan's primary care providers.

(c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. ~~Contingent upon federal approval,~~ The agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Florida Health Choices Program, or any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency shall ~~seek federal approval to~~ require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and

use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(5) Specialty plans serving children in the care and custody of the department may serve such children as long as they remain in care, including those remaining in extended foster care pursuant to s. 39.6251, or are in subsidized adoption and continue to be eligible for Medicaid pursuant to s. 409.903, or are receiving guardianship assistance payments and continue to be eligible for Medicaid pursuant to s. 409.903.

Section 11. Subsection (2) of section 409.981, Florida Statutes, is amended 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 through a single statewide procurement. The agency may award contracts to plans selected through the procurement process on a regional or statewide basis. The awards must include at least one provider service network in each of the eight regions outlined in this subsection. The agency shall procure:

(a) At least 3 plans and up to 4 plans for Region A.

(b) At least 3 plans and up to 6 plans for Region B.

(c) At least 5 plans and up to 10 plans for Region C.

(d) At least 3 plans and up to 6 plans for Region D.

(e) At least 3 plans and up to 4 plans for Region E.

(f) At least 3 plans and up to 5 plans for Region F.

(g) At least 3 plans and up to 4 plans for Region G.

(h) At least 5 plans and up to 10 plans for Region H.

~~Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

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

~~(c) At least three plans and up to five plans for 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 five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.~~

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

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

~~(h) At least two plans and up to four plans for 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.

Section 12. Subsection (4) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, ~~409.9124,~~ 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).

Section 13. For the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in references thereto, subsections (1), (7), (13), and (14) of section 409.962, Florida Statutes, are reenacted to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(1) "Accountable care organization" means an entity qualified as an accountable care organization in accordance with federal regulations, and which meets the requirements of a provider service network as described in s. 409.912(1).

(7) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(1) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

(13) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(1), in the state and is paid a prospective per-member, per-month payment by the agency.

(14) "Provider service network" means an entity qualified pursuant to s. 409.912(1) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health

care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

Section 14. For the purpose of incorporating the amendment made by this act to section 409.912, Florida Statutes, in a reference thereto, subsection (22) of section 641.19, Florida Statutes, is reenacted to read:

641.19 Definitions.—As used in this part, the term:

(22) "Provider service network" means a network authorized under s. 409.912(1), reimbursed on a prepaid basis, operated by a health care provider or group of affiliated health care providers, and which directly provides health care services under a Medicare, Medicaid, or Healthy Kids contract.

Section 15. For the purpose of incorporating the amendments made by this act to section 409.981, Florida Statutes, in references thereto, paragraphs (h), (i), and (j) of subsection (3) and subsection (11) of section 430.2053, Florida Statutes, are reenacted to read:

430.2053 Aging resource centers.—

(3) The duties of an aging resource center are to:

(h) Assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program as eligible plans become available in each of the regions pursuant to s. 409.981(2).

(i) Provide enrollment and coverage information to Medicaid managed long-term care enrollees as qualified plans become available in each of the regions pursuant to s. 409.981(2).

(j) Assist Medicaid recipients enrolled in the Medicaid long-term care managed care program with informally resolving grievances with a managed care network and assist Medicaid

recipients in accessing the managed care network's formal grievance process as eligible plans become available in each of the regions defined in s. 409.981(2).

(11) In an area in which the department has designated an area agency on aging as an aging resource center, the department and the agency shall not make payments for the services listed in subsection (9) and the Long-Term Care Community Diversion Project for such persons who were not screened and enrolled through the aging resource center. The department shall cease making payments for recipients in eligible plans as eligible plans become available in each of the regions defined in s. 409.981(2).

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