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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  
28          regions; making technical changes; amending s.  
29          409.967, F.S.; deleting obsolete provisions; amending

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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  
42 procedures for plan procurements when no provider  
43 service networks submit bids; making technical  
44 changes; deleting a requirement for the agency to  
45 exercise a preference for certain plans; amending s.  
46 409.975, F.S.; providing that cancer hospitals meeting  
47 certain criteria are statewide essential providers;  
48 requiring payments to such hospitals to equal a  
49 certain rate; amending s. 409.977, F.S.; revising the  
50 circumstances for maintaining a recipient's enrollment  
51 in a plan; deleting obsolete language; authorizing  
52 specialty plans to serve certain children who receive  
53 guardianship assistance payments under the  
54 Guardianship Assistance Program; amending s. 409.981,  
55 F.S.; requiring the agency to select plans for the  
56 long-term care managed medical assistance program  
57 through a single statewide procurement; authorizing  
58 the agency to award contracts to plans on a regional

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59 or statewide basis; specifying requirements for  
60 minimum numbers of plans which the agency must procure  
61 for each specified region; conforming provisions to  
62 changes made by the act; deleting procedures for plan  
63 procurements when no provider service networks submit  
64 bids; amending s. 409.8132, F.S.; conforming a cross-  
65 reference; reenacting ss. 409.962(1), (7), (13), and  
66 (14) and 641.19(22) relating to definitions, to  
67 incorporate the amendments made by this act to s.  
68 409.912, F.S., in references thereto; reenacting s.  
69 430.2053(3)(h), (i), and (j) and (11), relating to  
70 aging resource centers, to incorporate the amendments  
71 made by this act to s. 409.981, F.S., in references  
72 thereto; requiring the agency to amend existing  
73 Statewide Medicaid Managed Care contracts to implement  
74 changes made by the act; requiring the agency to  
75 implement changes made by the act for a specified plan  
76 year; providing an effective date.

77  
78 Be It Enacted by the Legislature of the State of Florida:

79  
80 Section 1. Subsection (1) of section 409.912, Florida  
81 Statutes, is amended to read:

82 409.912 Cost-effective purchasing of health care.—The  
83 agency shall purchase goods and services for Medicaid recipients  
84 in the most cost-effective manner consistent with the delivery  
85 of quality medical care. To ensure that medical services are  
86 effectively utilized, the agency may, in any case, require a  
87 confirmation or second physician's opinion of the correct

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88 diagnosis for purposes of authorizing future services under the  
89 Medicaid program. This section does not restrict access to  
90 emergency services or poststabilization care services as defined  
91 in 42 C.F.R. s. 438.114. Such confirmation or second opinion  
92 shall be rendered in a manner approved by the agency. The agency  
93 shall maximize the use of prepaid per capita and prepaid  
94 aggregate fixed-sum basis services when appropriate and other  
95 alternative service delivery and reimbursement methodologies,  
96 including competitive bidding pursuant to s. 287.057, designed  
97 to facilitate the cost-effective purchase of a case-managed  
98 continuum of care. The agency shall also require providers to  
99 minimize the exposure of recipients to the need for acute  
100 inpatient, custodial, and other institutional care and the  
101 inappropriate or unnecessary use of high-cost services. The  
102 agency shall contract with a vendor to monitor and evaluate the  
103 clinical practice patterns of providers in order to identify  
104 trends that are outside the normal practice patterns of a  
105 provider's professional peers or the national guidelines of a  
106 provider's professional association. The vendor must be able to  
107 provide information and counseling to a provider whose practice  
108 patterns are outside the norms, in consultation with the agency,  
109 to improve patient care and reduce inappropriate utilization.  
110 The agency may mandate prior authorization, drug therapy  
111 management, or disease management participation for certain  
112 populations of Medicaid beneficiaries, certain drug classes, or  
113 particular drugs to prevent fraud, abuse, overuse, and possible  
114 dangerous drug interactions. The Pharmaceutical and Therapeutics  
115 Committee shall make recommendations to the agency on drugs for  
116 which prior authorization is required. The agency shall inform

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117 the Pharmaceutical and Therapeutics Committee of its decisions  
118 regarding drugs subject to prior authorization. The agency is  
119 authorized to limit the entities it contracts with or enrolls as  
120 Medicaid providers by developing a provider network through  
121 provider credentialing. The agency may competitively bid single-  
122 source-provider contracts if procurement of goods or services  
123 results in demonstrated cost savings to the state without  
124 limiting access to care. The agency may limit its network based  
125 on the assessment of beneficiary access to care, provider  
126 availability, provider quality standards, time and distance  
127 standards for access to care, the cultural competence of the  
128 provider network, demographic characteristics of Medicaid  
129 beneficiaries, practice and provider-to-beneficiary standards,  
130 appointment wait times, beneficiary use of services, provider  
131 turnover, provider profiling, provider licensure history,  
132 previous program integrity investigations and findings, peer  
133 review, provider Medicaid policy and billing compliance records,  
134 clinical and medical record audits, and other factors. Providers  
135 are not entitled to enrollment in the Medicaid provider network.  
136 The agency shall determine instances in which allowing Medicaid  
137 beneficiaries to purchase durable medical equipment and other  
138 goods is less expensive to the Medicaid program than long-term  
139 rental of the equipment or goods. The agency may establish rules  
140 to facilitate purchases in lieu of long-term rentals in order to  
141 protect against fraud and abuse in the Medicaid program as  
142 defined in s. 409.913. The agency may seek federal waivers  
143 necessary to administer these policies.

144 (1) The agency may contract with a provider service  
145 network, which must ~~may~~ be reimbursed on a ~~fee-for-service~~ or

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146 prepaid basis. ~~Prepaid~~ Provider service networks shall receive  
147 per-member, per-month payments. ~~A provider service network that~~  
148 ~~does not choose to be a prepaid plan shall receive fee-for-~~  
149 ~~service rates with a shared savings settlement. The fee-for-~~  
150 ~~service option shall be available to a provider service network~~  
151 ~~only for the first 2 years of the plan's operation or until the~~  
152 ~~contract year beginning September 1, 2014, whichever is later.~~  
153 ~~The agency shall annually conduct cost reconciliations to~~  
154 ~~determine the amount of cost savings achieved by fee-for-service~~  
155 ~~provider service networks for the dates of service in the period~~  
156 ~~being reconciled. Only payments for covered services for dates~~  
157 ~~of service within the reconciliation period and paid within 6~~  
158 ~~months after the last date of service in the reconciliation~~  
159 ~~period shall be included. The agency shall perform the necessary~~  
160 ~~adjustments for the inclusion of claims incurred but not~~  
161 ~~reported within the reconciliation for claims that could be~~  
162 ~~received and paid by the agency after the 6-month claims~~  
163 ~~processing time lag. The agency shall provide the results of the~~  
164 ~~reconciliations to the fee-for-service provider service networks~~  
165 ~~within 45 days after the end of the reconciliation period. The~~  
166 ~~fee-for-service provider service networks shall review and~~  
167 ~~provide written comments or a letter of concurrence to the~~  
168 ~~agency within 45 days after receipt of the reconciliation~~  
169 ~~results. This reconciliation shall be considered final.~~

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

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175 agency.

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

189 (a) A provider service network is exempt from parts I and  
190 III of chapter 641 but must comply with the solvency  
191 requirements in s. 641.2261(2) and meet appropriate financial  
192 reserve, quality assurance, and patient rights requirements as  
193 established by the agency.

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

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

198 Section 3. Section 409.964, Florida Statutes, is amended to  
199 read:

200 409.964 Managed care program; state plan; waivers.—The  
201 Medicaid program is established as a statewide, integrated  
202 managed care program for all covered services, including long-  
203 term care services. The agency shall apply for and implement

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204 state plan amendments or waivers of applicable federal laws and  
205 regulations necessary to implement the program. ~~Before seeking a~~  
206 ~~waiver, the agency shall provide public notice and the~~  
207 ~~opportunity for public comment and include public feedback in~~  
208 ~~the waiver application. The agency shall hold one public meeting~~  
209 ~~in each of the regions described in s. 409.966(2), and the time~~  
210 ~~period for public comment for each region shall end no sooner~~  
211 ~~than 30 days after the completion of the public meeting in that~~  
212 ~~region.~~

213 Section 4. Subsections (2), (3), and (4) of section  
214 409.966, Florida Statutes, are amended to read:

215 409.966 Eligible plans; selection.—

216 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a  
217 limited number of eligible plans to participate in the Medicaid  
218 program using invitations to negotiate in accordance with s.  
219 287.057(1)(c). At least 90 days before issuing an invitation to  
220 negotiate, the agency shall compile and publish a databook  
221 consisting of a comprehensive set of utilization and spending  
222 data consistent with actuarial rate-setting practices and  
223 standards for the 3 most recent contract years consistent with  
224 the rate-setting periods for all Medicaid recipients by region  
225 or county. The source of the data in the databook report must  
226 include, at a minimum, the 24 most recent months of both  
227 historic fee-for-service claims and validated data from the  
228 Medicaid Encounter Data System, and the databook must. ~~The~~  
229 ~~report must be available in electronic form and delineate~~  
230 utilization use by age, gender, eligibility group, geographic  
231 area, and aggregate clinical risk score. The statewide managed  
232 care program includes Separate and simultaneous procurements



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233 shall be conducted in each of the following regions:

234 (a) Region A ~~4~~, which consists of Bay, Calhoun, Escambia,  
235 Okaloosa, Santa Rosa, and Walton Counties.

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

240 ~~(b)(e)~~ Region B ~~3~~, which consists of Alachua, Baker,  
241 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,  
242 Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion,  
243 Nassau, Putnam, St. Johns, Sumter, Suwannee, and Union Counties.

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

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

248 ~~(d)(f)~~ Region D ~~6~~, which consists of Hardee, Highlands,  
249 Hillsborough, Manatee, and Polk Counties.

250 ~~(e)(g)~~ Region E ~~7~~, which consists of Brevard, Orange,  
251 Osceola, and Seminole Counties.

252 ~~(f)(h)~~ Region F ~~8~~, which consists of Charlotte, Collier,  
253 DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

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

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

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

259 (3) QUALITY SELECTION CRITERIA.—

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

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262 determining the acceptability of the reply and guiding the  
263 selection of the organizations with which the agency negotiates.  
264 In addition to criteria established by the agency, the agency  
265 shall consider the following factors in the selection of  
266 eligible plans:

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

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

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

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

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

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

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

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

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291 participating in the procurement in the same region as the  
292 submitting provider.

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

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

298 (b) An eligible plan must disclose any business  
299 relationship it has with any other eligible plan that responds  
300 to the invitation to negotiate. The agency may not select plans  
301 in the same region for the same managed care program that have a  
302 business relationship with each other. Failure to disclose any  
303 business relationship shall result in disqualification from  
304 participation in any region for the first full contract period  
305 after the discovery of the business relationship by the agency.  
306 For the purpose of this section, "business relationship" means  
307 an ownership or controlling interest, an affiliate or subsidiary  
308 relationship, a common parent, or any mutual interest in any  
309 limited partnership, limited liability partnership, limited  
310 liability company, or other entity or business association,  
311 including all wholly or partially owned subsidiaries, majority-  
312 owned subsidiaries, parent companies, or affiliates of such  
313 entities, business associations, or other enterprises, that  
314 exists for the purpose of making a profit.

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

319 1. Have signed contracts with primary and specialty

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320 physicians in sufficient numbers to meet the specific standards  
321 established pursuant to s. 409.967(2)(c).

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

325 3. Are organizations that are based in and perform  
326 operational functions in this state, in-house or through  
327 contractual arrangements, by staff located in this state. Using  
328 a tiered approach, the highest number of points shall be awarded  
329 to a plan that has all or substantially all of its operational  
330 functions performed in the state. The second highest number of  
331 points shall be awarded to a plan that has a majority of its  
332 operational functions performed in the state. The agency may  
333 establish a third tier; however, preference points may not be  
334 awarded to plans that perform only community outreach, medical  
335 director functions, and state administrative functions in the  
336 state. For purposes of this subparagraph, operational functions  
337 include corporate headquarters, claims processing, member  
338 services, provider relations, utilization and prior  
339 authorization, case management, disease and quality functions,  
340 and finance and administration. For purposes of this  
341 subparagraph, the term "corporate headquarters" means the  
342 principal office of the organization, which may not be a  
343 subsidiary, directly or indirectly through one or more  
344 subsidiaries of, or a joint venture with, any other entity whose  
345 principal office is not located in the state.

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

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

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

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

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

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

371 ~~(e) To ensure managed care plan participation in Regions 1~~  
372 ~~and 2, the agency shall award an additional contract to each~~  
373 ~~plan with a contract award in Region 1 or Region 2. Such~~  
374 ~~contract shall be in any other region in which the plan~~  
375 ~~submitted a responsive bid and negotiates a rate acceptable to~~  
376 ~~the agency. If a plan that is awarded an additional contract~~  
377 ~~pursuant to this paragraph is subject to penalties pursuant to~~

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378 ~~s. 409.967(2)(i) for activities in Region 1 or Region 2, the~~  
379 ~~additional contract is automatically terminated 180 days after~~  
380 ~~the imposition of the penalties. The plan must reimburse the~~  
381 ~~agency for the cost of enrollment changes and other transition~~  
382 ~~activities.~~

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

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

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407 Section 5. Paragraphs (c) and (f) of subsection (2) of  
408 section 409.967, Florida Statutes, are amended to read:

409 409.967 Managed care plan accountability.—

410 (2) The agency shall establish such contract requirements  
411 as are necessary for the operation of the statewide managed care  
412 program. In addition to any other provisions the agency may deem  
413 necessary, the contract must require:

414 (c) Access.—

415 1. The agency shall establish specific standards for the  
416 number, type, and regional distribution of providers in managed  
417 care plan networks to ensure access to care for both adults and  
418 children. Each plan must maintain a regionwide network of  
419 providers in sufficient numbers to meet the access standards for  
420 specific medical services for all recipients enrolled in the  
421 plan. The exclusive use of mail-order pharmacies may not be  
422 sufficient to meet network access standards. Consistent with the  
423 standards established by the agency, provider networks may  
424 include providers located outside the region. ~~A plan may~~  
425 ~~contract with a new hospital facility before the date the~~  
426 ~~hospital becomes operational if the hospital has commenced~~  
427 ~~construction, will be licensed and operational by January 1,~~  
428 ~~2013, and a final order has issued in any civil or~~  
429 ~~administrative challenge.~~ Each plan shall establish and maintain  
430 an accurate and complete electronic database of contracted  
431 providers, including information about licensure or  
432 registration, locations and hours of operation, specialty  
433 credentials and other certifications, specific performance  
434 indicators, and such other information as the agency deems  
435 necessary. The database must be available online to both the

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436 agency and the public and have the capability to compare the  
437 availability of providers to network adequacy standards and to  
438 accept and display feedback from each provider's patients. Each  
439 plan shall submit quarterly reports to the agency identifying  
440 the number of enrollees assigned to each primary care provider.  
441 The agency shall conduct, or contract for, systematic and  
442 continuous testing of the provider network databases maintained  
443 by each plan to confirm accuracy, confirm that behavioral health  
444 providers are accepting enrollees, and confirm that enrollees  
445 have access to behavioral health services.

446       2. Each managed care plan must publish any prescribed drug  
447 formulary or preferred drug list on the plan's website in a  
448 manner that is accessible to and searchable by enrollees and  
449 providers. The plan must update the list within 24 hours after  
450 making a change. Each plan must ensure that the prior  
451 authorization process for prescribed drugs is readily accessible  
452 to health care providers, including posting appropriate contact  
453 information on its website and providing timely responses to  
454 providers. For Medicaid recipients diagnosed with hemophilia who  
455 have been prescribed anti-hemophilic-factor replacement  
456 products, the agency shall provide for those products and  
457 hemophilia overlay services through the agency's hemophilia  
458 disease management program.

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

462       4. Managed care plans serving children in the care and  
463 custody of the Department of Children and Families must maintain  
464 complete medical, dental, and behavioral health encounter



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465 information and participate in making such information available  
466 to the department or the applicable contracted community-based  
467 care lead agency for use in providing comprehensive and  
468 coordinated case management. The agency and the department shall  
469 establish an interagency agreement to provide guidance for the  
470 format, confidentiality, recipient, scope, and method of  
471 information to be made available and the deadlines for  
472 submission of the data. The scope of information available to  
473 the department shall be the data that managed care plans are  
474 required to submit to the agency. The agency shall determine the  
475 plan's compliance with standards for access to medical, dental,  
476 and behavioral health services; the use of medications; and  
477 followup on all medically necessary services recommended as a  
478 result of early and periodic screening, diagnosis, and  
479 treatment.

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

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

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

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494 measures as a tool to monitor plan performance.

495 3. Each managed care plan must be accredited by the  
496 National Committee for Quality Assurance, the Joint Commission,  
497 or another nationally recognized accrediting body, or have  
498 initiated the accreditation process, within 1 year after the  
499 contract is executed. For any plan not accredited within 18  
500 months after executing the contract, the agency shall suspend  
501 automatic assignment under s. 409.977 and 409.984.

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

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

510 409.968 Managed care plan payments.—

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

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

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

537 409.973 Benefits.—

538 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed  
539 medical assistance program shall establish a program to  
540 encourage and reward healthy behaviors. At a minimum, each plan  
541 must establish a medically approved tobacco ~~smoking~~ cessation  
542 program, a medically directed weight loss program, and a  
543 medically approved alcohol recovery program or substance abuse  
544 recovery program that must include, but may not be limited to,  
545 opioid abuse recovery. Each plan must identify enrollees who  
546 smoke, are morbidly obese, or are diagnosed with alcohol or  
547 substance abuse in order to establish written agreements to  
548 secure the enrollees' commitment to participation in these  
549 programs.

550 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the  
551 managed medical assistance program shall establish a program to

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552 encourage enrollees to establish a relationship with their  
553 primary care provider. Each plan shall:

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

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

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

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

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

573 Section 8. Subsections (1) and (2) of section 409.974,  
574 Florida Statutes, are amended to read:

575 409.974 Eligible plans.—

576 (1) ELIGIBLE PLAN SELECTION.—The agency shall select  
577 eligible plans for the managed medical assistance program  
578 through the procurement process described in s. 409.966 through  
579 a single statewide procurement. The agency may award contracts  
580 to plans selected through the procurement process either on a

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581 regional or statewide basis. The awards must include at least  
582 one provider service network in each of the nine regions  
583 outlined in this subsection. The agency shall procure:

- 584 (a) At least 3 plans and up to 4 plans for Region A.  
585 (b) At least 3 plans and up to 6 plans for Region B.  
586 (c) At least 3 plans and up to 5 plans for Region C.  
587 (d) At least 4 plans and up to 7 plans for Region D.  
588 (e) At least 3 plans and up to 6 plans for Region E.  
589 (f) At least 3 plans and up to 4 plans for Region F.  
590 (g) At least 3 plans and up to 5 plans for Region G.  
591 (h) At least 3 plans and up to 5 plans for Region H.  
592 (i) At least 5 plans and up to 10 plans for Region I. The  
593 agency shall notice invitations to negotiate no later than  
594 January 1, 2013.

595 ~~(a) The agency shall procure two plans for Region 1. At~~  
596 ~~least one plan shall be a provider service network if any~~  
597 ~~provider service networks submit a responsive bid.~~

598 ~~(b) The agency shall procure two plans for Region 2. At~~  
599 ~~least one plan shall be a provider service network if any~~  
600 ~~provider service networks submit a responsive bid.~~

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

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

609 ~~(e) The agency shall procure at least two plans and up to~~

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610 ~~four plans for Region 5. At least one plan must be a provider~~  
611 ~~service network if any provider service networks submit a~~  
612 ~~responsive bid.~~

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

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

621 ~~(h) The agency shall procure at least two plans and up to~~  
622 ~~four plans for Region 8. At least one plan must be a provider~~  
623 ~~service network if any provider service networks submit a~~  
624 ~~responsive bid.~~

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

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

633 ~~(k) The agency shall procure at least five plans and up to~~  
634 ~~10 plans for Region 11. At least one plan must be a provider~~  
635 ~~service network if any provider service networks submit a~~  
636 ~~responsive bid.~~

637  
638 ~~If no provider service network submits a responsive bid, the~~

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

646 (2) QUALITY SELECTION CRITERIA.—In addition to the criteria  
647 established in s. 409.966, the agency shall consider evidence  
648 that an eligible plan has obtained signed contracts or written  
649 ~~agreements or signed contracts or~~ has made substantial progress  
650 in establishing relationships with providers before the plan  
651 submits ~~submitting~~ a response. The agency shall evaluate and  
652 give special weight to evidence of signed contracts with  
653 essential providers as defined by the agency pursuant to s.  
654 409.975(1). ~~The agency shall exercise a preference for plans~~  
655 ~~with a provider network in which over 10 percent of the~~  
656 ~~providers use electronic health records, as defined in s.~~  
657 ~~408.051.~~ When all other factors are equal, the agency shall  
658 consider whether the organization has a contract to provide  
659 managed long-term care services in the same region and shall  
660 exercise a preference for such plans.

661 Section 9. Paragraph (b) of subsection (1) of section  
662 409.975, Florida Statutes, is amended to read:

663 409.975 Managed care plan accountability.—In addition to  
664 the requirements of s. 409.967, plans and providers  
665 participating in the managed medical assistance program shall  
666 comply with the requirements of this section.

667 (1) PROVIDER NETWORKS.—Managed care plans must develop and

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668 maintain provider networks that meet the medical needs of their  
669 enrollees in accordance with standards established pursuant to  
670 s. 409.967(2)(c). Except as provided in this section, managed  
671 care plans may limit the providers in their networks based on  
672 credentials, quality indicators, and price.

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

677 1. Faculty plans of Florida medical schools.  
678 2. Regional perinatal intensive care centers as defined in  
679 s. 383.16(2).

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

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

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

690  
691 Managed care plans that have not contracted with all statewide  
692 essential providers in all regions as of the first date of  
693 recipient enrollment must continue to negotiate in good faith.  
694 Payments to physicians on the faculty of nonparticipating  
695 Florida medical schools shall be made at the applicable Medicaid  
696 rate. Payments for services rendered by regional perinatal



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697 intensive care centers shall be made at the applicable Medicaid  
698 rate as of the first day of the contract between the agency and  
699 the plan. Except for payments for emergency services, payments  
700 to nonparticipating specialty children's hospitals, and payments  
701 to nonparticipating Florida cancer hospitals that meet the  
702 criteria in 42 U.S.C. s. 1395ww(d) (1) (B) (v), shall equal the  
703 highest rate established by contract between that provider and  
704 any other Medicaid managed care plan.

705 Section 10. Subsections (1), (2), (4), and (5) of section  
706 409.977, Florida Statutes, are amended to read:

707 409.977 Enrollment.—

708 (1) The agency shall automatically enroll into a managed  
709 care plan those Medicaid recipients who do not voluntarily  
710 choose a plan pursuant to s. 409.969. The agency shall  
711 automatically enroll recipients in plans that meet or exceed the  
712 performance or quality standards established pursuant to s.  
713 409.967 and may not automatically enroll recipients in a plan  
714 that is deficient in those performance or quality standards.  
715 When a specialty plan is available to accommodate a specific  
716 condition or diagnosis of a recipient, the agency shall assign  
717 the recipient to that plan. ~~In the first year of the first~~  
718 ~~contract term only, if a recipient was previously enrolled in a~~  
719 ~~plan that is still available in the region, the agency shall~~  
720 ~~automatically enroll the recipient in that plan unless an~~  
721 ~~applicable specialty plan is available.~~ Except as otherwise  
722 provided in this part, the agency may not engage in practices  
723 that are designed to favor one managed care plan over another.

724 (2) When automatically enrolling recipients in managed care  
725 plans, if a recipient was enrolled in a plan immediately before

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726 the recipient's choice period and that plan is still available  
727 in the region, the agency must maintain the recipient's  
728 enrollment in that plan unless an applicable specialty plan is  
729 available. Otherwise, the agency shall automatically enroll  
730 based on the following criteria:

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

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

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

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

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755 assistance provided for each recipient may not exceed the amount  
756 of the Medicaid premium that would have been paid to a managed  
757 care plan for that recipient.

758 (5) Specialty plans serving children in the care and  
759 custody of the department may serve such children as long as  
760 they remain in care, including those remaining in extended  
761 foster care pursuant to s. 39.6251, or are in subsidized  
762 adoption and continue to be eligible for Medicaid pursuant to s.  
763 409.903, or are receiving guardianship assistance payments and  
764 continue to be eligible for Medicaid pursuant to s. 409.903.

765 Section 11. Subsection (2) of section 409.981, Florida  
766 Statutes, is amended to read:

767 409.981 Eligible long-term care plans.—

768 (2) ELIGIBLE PLAN SELECTION.—The agency shall select  
769 eligible plans for the long-term care managed care program  
770 through the procurement process described in s. 409.966 through  
771 a single statewide procurement. The agency may award contracts  
772 to plans selected through the procurement process on a regional  
773 or statewide basis. The awards must include at least one  
774 provider service network in each of the nine regions outlined in  
775 this subsection. The agency shall procure:

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

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

778 (c) At least 3 plans and up to 5 plans for Region C.

779 (d) At least 4 plans and up to 7 plans for Region D.

780 (e) At least 3 plans and up to 6 plans for Region E.

781 (f) At least 3 plans and up to 4 plans for Region F.

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

783 (h) At least 3 plans and up to 4 plans for Region H.

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784 (i) At least 5 plans and up to 10 plans for Region I ~~Two~~  
785 ~~plans for Region 1. At least one plan must be a provider service~~  
786 ~~network if any provider service networks submit a responsive~~  
787 ~~bid.~~

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

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

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

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

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

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

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

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

812 ~~(j) At least two plans and up to four plans for Region 10.~~

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813 ~~At least one plan must be a provider service network if any~~  
814 ~~provider service networks submit a responsive bid.~~

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

818  
819 ~~If no provider service network submits a responsive bid in a~~  
820 ~~region other than Region 1 or Region 2, the agency shall procure~~  
821 ~~no more than one less than the maximum number of eligible plans~~  
822 ~~permitted in that region. Within 12 months after the initial~~  
823 ~~invitation to negotiate, the agency shall attempt to procure a~~  
824 ~~provider service network. The agency shall notice another~~  
825 ~~invitation to negotiate only with provider service networks in~~  
826 ~~regions where no provider service network has been selected.~~

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

829 409.8132 Medikids program component.—

830 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The  
831 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,  
832 409.912, 409.9121, 409.9122, 409.9123, ~~409.9124~~, 409.9127,  
833 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply  
834 to the administration of the Medikids program component of the  
835 Florida Kidcare program, except that s. 409.9122 applies to  
836 Medikids as modified by the provisions of subsection (7).

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

841 409.962 Definitions.—As used in this part, except as

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842 otherwise specifically provided, the term:

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

847 (7) "Eligible plan" means a health insurer authorized under  
848 chapter 624, an exclusive provider organization authorized under  
849 chapter 627, a health maintenance organization authorized under  
850 chapter 641, or a provider service network authorized under s.  
851 409.912(1) or an accountable care organization authorized under  
852 federal law. For purposes of the managed medical assistance  
853 program, the term also includes the Children's Medical Services  
854 Network authorized under chapter 391 and entities qualified  
855 under 42 C.F.R. part 422 as Medicare Advantage Preferred  
856 Provider Organizations, Medicare Advantage Provider-sponsored  
857 Organizations, Medicare Advantage Health Maintenance  
858 Organizations, Medicare Advantage Coordinated Care Plans, and  
859 Medicare Advantage Special Needs Plans, and the Program of All-  
860 inclusive Care for the Elderly.

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

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

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871 qualified health care centers, and home health care agencies.

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

876 641.19 Definitions.—As used in this part, the term:

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

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

887 430.2053 Aging resource centers.—

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

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

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

896 (j) Assist Medicaid recipients enrolled in the Medicaid  
897 long-term care managed care program with informally resolving  
898 grievances with a managed care network and assist Medicaid  
899 recipients in accessing the managed care network's formal

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900 grievance process as eligible plans become available in each of  
901 the regions defined in s. 409.981(2).

902 (11) In an area in which the department has designated an  
903 area agency on aging as an aging resource center, the department  
904 and the agency shall not make payments for the services listed  
905 in subsection (9) and the Long-Term Care Community Diversion  
906 Project for such persons who were not screened and enrolled  
907 through the aging resource center. The department shall cease  
908 making payments for recipients in eligible plans as eligible  
909 plans become available in each of the regions defined in s.  
910 409.981(2).

911 Section 16. The Agency for Health Care Administration shall  
912 amend existing Statewide Medicaid Managed Care contracts to  
913 implement the changes made by this act to sections 409.973,  
914 409.975, and 409.977, Florida Statutes. The agency shall  
915 implement the changes made by this act to sections 409.966,  
916 409.974, and 409.981, Florida Statutes, for the 2025 plan year.

917 Section 17. This act shall take effect July 1, 2022.