1 A bill to be entitled
2 An act relating to Medicaid managed care; amending s.
3 409.908, F.S.; requiring the Agency for Health Care
4 Administration to determine compliance with essential
5 provider contracting requirements; requiring the
6 agency to withhold supplemental payments under certain
7 circumstances; requiring the agency to identify
8 certain essential providers by the end of each fiscal
9 year; requiring certain providers and managed care
10 plans to mediate network contracts and jointly notify
11 the agency of mediation commencement by a specified
12 date; specifying requirements for mediation;
13 specifying the content of a written postmediation
14 report and requiring that such report be submitted to
15 the agency by a specified date; requiring the agency
16 to publish all postmediation reports on its website;
17 amending s. 409.912, F.S.; requiring the reimbursement
18 of certain provider service networks on a prepaid
19 basis; removing obsolete language related to provider
20 service network reimbursement; repealing s. 409.9124,
21 F.S., relating to managed care reimbursement; amending
22 s. 409.964, F.S.; removing obsolete language related
23 to requiring the agency to provide public notice
24 before seeking a Medicaid waiver; amending s. 409.966,
25 F.S.; revising a provision related to a requirement

26 that the agency include certain information in a
27 utilization and spending databook; requiring the
28 agency to conduct a single, statewide procurement and
29 negotiate and select plans on a regional basis;
30 authorizing the agency to select plans on a statewide
31 basis under certain circumstances; specifying the
32 procurement regions; removing obsolete language
33 related to prepaid rates and an additional procurement
34 award; making conforming changes; amending s. 409.967,
35 F.S.; removing obsolete language related to certain
36 hospital contracts; requiring the agency to test
37 provider network databases to confirm that enrollees
38 have timely access to all covered benefits; removing
39 obsolete language related to a request for
40 information; authorizing plans to reduce an achieved
41 savings rebate under certain circumstances;
42 classifying certain expenditures as medical expenses;
43 amending s. 409.968, F.S.; removing obsolete language
44 related to provider service network reimbursement;
45 amending s. 409.973, F.S.; requiring healthy behaviors
46 programs to address tobacco use and opioid abuse;
47 removing obsolete language related to primary care
48 appointments; requiring managed care plans to
49 establish certain programs to improve dental health
50 outcomes; requiring the agency to establish

51 performance and outcome measures; requiring the agency
52 to annually review certain data and expenditures for
53 dental-related emergency department visits and
54 reconcile such expenditures against prepaid dental
55 plan capitation payments; requiring prepaid dental
56 plans and nondental managed care plans to enter into a
57 mutual coordination of benefits agreement for
58 specified purposes by a specified date; requiring
59 prepaid dental plans and nondental managed care plans
60 to meet quarterly for certain purposes beginning on a
61 specified date; specifying the parties' obligations
62 for such meetings; requiring the agency to establish
63 provider network requirements for dental plans,
64 including prepaid dental plan provider network
65 requirements regarding sedation dentistry services;
66 requiring sanctions under certain circumstances;
67 requiring the agency to assess plan compliance at
68 least quarterly and enforce network adequacy
69 requirements in a timely manner; amending s. 409.974,
70 F.S.; establishing numbers of regional contract awards
71 in the Medicaid managed medical assistance program;
72 amending s. 409.975, F.S.; providing that regional
73 perinatal intensive care centers are regional
74 resources and essential providers for managed care
75 plans; requiring managed care plans to contract with

76 such centers; requiring the agency to assess plan
77 compliance with certain requirements at least
78 quarterly; requiring the agency to impose contract
79 enforcement financial sanctions on or assess contract
80 damages against certain plans by a specified date
81 annually; removing regional perinatal intensive care
82 centers from, and including certain cancer hospitals
83 in, the list of statewide essential providers;
84 providing a payment rate for certain cancer hospitals
85 without network contracts; amending s. 409.977, F.S.;
86 prohibiting the agency from automatically enrolling
87 recipients in managed care plans under certain
88 circumstances; removing obsolete language related to
89 automatic enrollment and certain federal approvals;
90 providing that children receiving guardianship
91 assistance payments are eligible for a specialty plan;
92 requiring the agency to amend existing contracts under
93 the Statewide Medicaid Managed Care program to
94 implement specified provisions of the act; requiring
95 the agency to implement specified provisions of the
96 act for the 2025 plan year; amending s. 409.981, F.S.;
97 specifying the number of regional contract awards in
98 the long-term care managed care plan; making a
99 conforming change; amending ss. 409.8132 and 409.906,
100 F.S.; conforming cross-references; providing an

101 effective date.
102
103 Be It Enacted by the Legislature of the State of Florida:
104
105 Section 1. Subsection (26) of section 409.908, Florida
106 Statutes, is amended to read:
107 409.908 Reimbursement of Medicaid providers.—Subject to
108 specific appropriations, the agency shall reimburse Medicaid
109 providers, in accordance with state and federal law, according
110 to methodologies set forth in the rules of the agency and in
111 policy manuals and handbooks incorporated by reference therein.
112 These methodologies may include fee schedules, reimbursement
113 methods based on cost reporting, negotiated fees, competitive
114 bidding pursuant to s. 287.057, and other mechanisms the agency
115 considers efficient and effective for purchasing services or
116 goods on behalf of recipients. If a provider is reimbursed based
117 on cost reporting and submits a cost report late and that cost
118 report would have been used to set a lower reimbursement rate
119 for a rate semester, then the provider's rate for that semester
120 shall be retroactively calculated using the new cost report, and
121 full payment at the recalculated rate shall be effected
122 retroactively. Medicare-granted extensions for filing cost
123 reports, if applicable, shall also apply to Medicaid cost
124 reports. Payment for Medicaid compensable services made on
125 behalf of Medicaid-eligible persons is subject to the

126 availability of moneys and any limitations or directions
127 provided for in the General Appropriations Act or chapter 216.
128 Further, nothing in this section shall be construed to prevent
129 or limit the agency from adjusting fees, reimbursement rates,
130 lengths of stay, number of visits, or number of services, or
131 making any other adjustments necessary to comply with the
132 availability of moneys and any limitations or directions
133 provided for in the General Appropriations Act, provided the
134 adjustment is consistent with legislative intent.
135 (26) The agency may receive funds from state entities,
136 including, but not limited to, the Department of Health, local
137 governments, and other local political subdivisions, for the
138 purpose of making special exception payments and Low Income Pool
139 Program payments, including federal matching funds. Funds
140 received for this purpose shall be separately accounted for and
141 may not be commingled with other state or local funds in any
142 manner. The agency may certify all local governmental funds used
143 as state match under Title XIX of the Social Security Act to the
144 extent and in the manner authorized under the General
145 Appropriations Act and pursuant to an agreement between the
146 agency and the local governmental entity. In order for the
147 agency to certify such local governmental funds, a local
148 governmental entity must submit a final, executed letter of
149 agreement to the agency, which must be received by October 1 of
150 each fiscal year and provide the total amount of local

151 governmental funds authorized by the entity for that fiscal year
152 under the General Appropriations Act. The local governmental
153 entity shall use a certification form prescribed by the agency.
154 At a minimum, the certification form must identify the amount
155 being certified and describe the relationship between the
156 certifying local governmental entity and the local health care
157 provider. Local governmental funds outlined in the letters of
158 agreement must be received by the agency no later than October
159 31 of each fiscal year in which such funds are pledged, unless
160 an alternative plan is specifically approved by the agency. To
161 be eligible for low-income pool funding or other forms of
162 supplemental payments funded by intergovernmental transfers, and
163 in addition to any other applicable requirements, essential
164 providers identified in s. 409.975(1)(a) ~~s. 409.975(1)(a)2.~~ must
165 have a network ~~offer to~~ contract with each managed care plan in
166 their region and essential providers identified in s.
167 409.975(1)(b) ~~s. 409.975(1)(b)1. and 3.~~ must have a network
168 ~~offer to~~ contract with each managed care plan in the state.
169 Before releasing such supplemental payments, ~~in the event the~~
170 ~~parties have not executed network contracts,~~ the agency shall
171 determine whether such contracts are in place and ~~evaluate the~~
172 ~~parties' efforts to complete negotiations. If such efforts~~
173 ~~continue to fail, the agency must~~ withhold such supplemental
174 payments beginning no later than January 1 of each fiscal year
175 for essential providers without such contracts in place. By the

176 end of each fiscal year, the agency shall identify essential
177 providers who have not executed required network contracts with
178 the applicable managed care plans for the next fiscal year. By
179 July 30, such providers and plans must enter into mediation and
180 jointly notify the agency of mediation commencement. Selection
181 of a mediator must be by mutual agreement of the plan and
182 provider, or, if they cannot agree, by the agency from a list of
183 at least four mediators submitted by the parties. The costs of
184 the mediation shall be borne equally by the parties. The
185 mediation must be completed before September 30. On or before
186 October 1, the mediator must submit a written postmediation
187 report to the agency, including the outcome of the mediation
188 and, if mediation resulted in an impasse, conclusions and
189 recommendations as to the cause of the impasse, the party most
190 responsible for the impasse, and whether the mediator believes
191 that either party negotiated in bad faith. If the mediator
192 recommends to the agency that a party or both parties negotiated
193 in bad faith, the postmediation report must state the basis for
194 such recommendation, cite all relevant information forming the
195 basis of the recommendation, and attach any relevant
196 documentation. The agency must promptly publish all
197 postmediation reports on its website ~~in the third quarter of the~~
198 ~~fiscal year if it determines that, based upon the totality of~~
199 ~~the circumstances, the essential provider has negotiated with~~
200 ~~the managed care plan in bad faith. If the agency determines~~

201 ~~that an essential provider has negotiated in bad faith, it must~~
202 ~~notify the essential provider at least 90 days in advance of the~~
203 ~~start of the third quarter of the fiscal year and afford the~~
204 ~~essential provider hearing rights in accordance with chapter~~
205 ~~120~~.
206 Section 2. Subsection (1) of section 409.912, Florida
207 Statutes, is amended to read:
208 409.912 Cost-effective purchasing of health care.—The
209 agency shall purchase goods and services for Medicaid recipients
210 in the most cost-effective manner consistent with the delivery
211 of quality medical care. To ensure that medical services are
212 effectively utilized, the agency may, in any case, require a
213 confirmation or second physician's opinion of the correct
214 diagnosis for purposes of authorizing future services under the
215 Medicaid program. This section does not restrict access to
216 emergency services or poststabilization care services as defined
217 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
218 shall be rendered in a manner approved by the agency. The agency
219 shall maximize the use of prepaid per capita and prepaid
220 aggregate fixed-sum basis services when appropriate and other
221 alternative service delivery and reimbursement methodologies,
222 including competitive bidding pursuant to s. 287.057, designed
223 to facilitate the cost-effective purchase of a case-managed
224 continuum of care. The agency shall also require providers to
225 minimize the exposure of recipients to the need for acute

226 inpatient, custodial, and other institutional care and the
227 inappropriate or unnecessary use of high-cost services. The
228 agency shall contract with a vendor to monitor and evaluate the
229 clinical practice patterns of providers in order to identify
230 trends that are outside the normal practice patterns of a
231 provider's professional peers or the national guidelines of a
232 provider's professional association. The vendor must be able to
233 provide information and counseling to a provider whose practice
234 patterns are outside the norms, in consultation with the agency,
235 to improve patient care and reduce inappropriate utilization.
236 The agency may mandate prior authorization, drug therapy
237 management, or disease management participation for certain
238 populations of Medicaid beneficiaries, certain drug classes, or
239 particular drugs to prevent fraud, abuse, overuse, and possible
240 dangerous drug interactions. The Pharmaceutical and Therapeutics
241 Committee shall make recommendations to the agency on drugs for
242 which prior authorization is required. The agency shall inform
243 the Pharmaceutical and Therapeutics Committee of its decisions
244 regarding drugs subject to prior authorization. The agency is
245 authorized to limit the entities it contracts with or enrolls as
246 Medicaid providers by developing a provider network through
247 provider credentialing. The agency may competitively bid single-
248 source-provider contracts if procurement of goods or services
249 results in demonstrated cost savings to the state without
250 limiting access to care. The agency may limit its network based

251 on the assessment of beneficiary access to care, provider
252 availability, provider quality standards, time and distance
253 standards for access to care, the cultural competence of the
254 provider network, demographic characteristics of Medicaid
255 beneficiaries, practice and provider-to-beneficiary standards,
256 appointment wait times, beneficiary use of services, provider
257 turnover, provider profiling, provider licensure history,
258 previous program integrity investigations and findings, peer
259 review, provider Medicaid policy and billing compliance records,
260 clinical and medical record audits, and other factors. Providers
261 are not entitled to enrollment in the Medicaid provider network.
262 The agency shall determine instances in which allowing Medicaid
263 beneficiaries to purchase durable medical equipment and other
264 goods is less expensive to the Medicaid program than long-term
265 rental of the equipment or goods. The agency may establish rules
266 to facilitate purchases in lieu of long-term rentals in order to
267 protect against fraud and abuse in the Medicaid program as
268 defined in s. 409.913. The agency may seek federal waivers
269 necessary to administer these policies.
270 (1) The agency may contract with a provider service
271 network, which must ~~may~~ be reimbursed on a ~~fee-for-service or~~
272 prepaid basis. Prepaid provider service networks shall receive
273 per-member, per-month payments. ~~A provider service network that~~
274 ~~does not choose to be a prepaid plan shall receive fee-for-~~
275 ~~service rates with a shared savings settlement. The fee-for-~~

276 ~~service option shall be available to a provider service network~~
277 ~~only for the first 2 years of the plan's operation or until the~~
278 ~~contract year beginning September 1, 2014, whichever is later.~~
279 ~~The agency shall annually conduct cost reconciliations to~~
280 ~~determine the amount of cost savings achieved by fee-for-service~~
281 ~~provider service networks for the dates of service in the period~~
282 ~~being reconciled. Only payments for covered services for dates~~
283 ~~of service within the reconciliation period and paid within 6~~
284 ~~months after the last date of service in the reconciliation~~
285 ~~period shall be included. The agency shall perform the necessary~~
286 ~~adjustments for the inclusion of claims incurred but not~~
287 ~~reported within the reconciliation for claims that could be~~
288 ~~received and paid by the agency after the 6-month claims~~
289 ~~processing time lag. The agency shall provide the results of the~~
290 ~~reconciliations to the fee-for-service provider service networks~~
291 ~~within 45 days after the end of the reconciliation period. The~~
292 ~~fee-for-service provider service networks shall review and~~
293 ~~provide written comments or a letter of concurrence to the~~
294 ~~agency within 45 days after receipt of the reconciliation~~
295 ~~results. This reconciliation shall be considered final.~~
296 (a) A provider service network which is reimbursed by the
297 agency on a prepaid basis shall be exempt from parts I and III
298 of chapter 641 but must comply with the solvency requirements in
299 s. 641.2261(2) and meet appropriate financial reserve, quality
300 assurance, and patient rights requirements as established by the

301 agency.
302 (b) A provider service network is a network established or
303 organized and operated by a health care provider, or group of
304 affiliated health care providers, which provides a substantial
305 proportion of the health care items and services under a
306 contract directly through the provider or affiliated group of
307 providers and may make arrangements with physicians or other
308 health care professionals, health care institutions, or any
309 combination of such individuals or institutions to assume all or
310 part of the financial risk on a prospective basis for the
311 provision of basic health services by the physicians, by other
312 health professionals, or through the institutions. The health
313 care providers must have a controlling interest in the governing
314 body of the provider service network organization.
315 Section 3. <u>Section 409.9124, Florida Statutes, is</u>
316 <u>repealed.</u>
317 Section 4. Section 409.964, Florida Statutes, is amended
318 to read:
319 409.964 Managed care program; state plan; waivers.—The
320 Medicaid program is established as a statewide, integrated
321 managed care program for all covered services, including long-
322 term care services. The agency shall apply for and implement
323 state plan amendments or waivers of applicable federal laws and
324 regulations necessary to implement the program. ~~Before seeking a~~
325 ~~waiver, the agency shall provide public notice and the~~

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

326 ~~opportunity for public comment and include public feedback in~~
327 ~~the waiver application. The agency shall hold one public meeting~~
328 ~~in each of the regions described in s. 409.966(2), and the time~~
329 ~~period for public comment for each region shall end no sooner~~
330 ~~than 30 days after the completion of the public meeting in that~~
331 ~~region.~~
332 Section 5. Paragraph (f) of subsection (3) of section
333 409.966, Florida Statutes, is redesignated as paragraph (d), and
334 subsection (2), present paragraphs (a), (d), and (e) of
335 subsection (3), and subsection (4) of that section are amended
336 to read:
337 409.966 Eligible plans; selection.—
338 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a
339 limited number of eligible plans to participate in the Medicaid
340 program using invitations to negotiate in accordance with s.
341 287.057(1)(c). At least 90 days before issuing an invitation to
342 negotiate, the agency shall compile and publish a databook
343 consisting of a comprehensive set of utilization and spending
344 data consistent with actuarial rate-setting practices and
345 standards for at least the most recent 24 months ~~3 most recent~~
346 ~~contract years consistent with the rate-setting periods~~ for all
347 Medicaid recipients by region ~~or county~~. The source of the data
348 in the report must include ~~both historic fee-for-service claims~~
349 ~~and~~ validated data from the Medicaid Encounter Data System. The
350 report must be available in electronic form and delineate

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351 utilization use by age, gender, eligibility group, geographic
352 area, and aggregate clinical risk score. The agency shall
353 conduct a single, statewide procurement, shall negotiate and
354 select plans on a regional basis, and may select plans on a
355 statewide basis if deemed the best value for the state and
356 Medicaid recipients. Plan selection ~~separate and simultaneous~~
357 ~~procurements~~ shall be conducted in each of the following
358 regions:
359 (a) Region A, which consists of Bay, Calhoun, Escambia,
360 Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon,
361 Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton,
362 and Washington Counties.
363 (b) Region B, which consists of Alachua, Baker, Bradford,
364 Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist,
365 Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau,
366 Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
367 Counties.
368 (c) Region C, which consists of Hardee, Highlands,
369 Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties.
370 (d) Region D, which consists of Brevard, Orange, Osceola,
371 and Seminole Counties.
372 (e) Region E, which consists of Charlotte, Collier,
373 DeSoto, Glades, Hendry, Lee, and Sarasota Counties.
374 (f) Region F, which consists of Indian River, Martin,
375 Okeechobee, Palm Beach, and St. Lucie Counties.

376 (g) Region G, which consists of Broward County.
377 (h) Region H, which consists of Miami-Dade and Monroe
378 Counties.
379 ~~(a) Region 1, which consists of Escambia, Okaloosa, Santa~~
380 ~~Rosa, and Walton Counties.~~
381 ~~(b) Region 2, which consists of Bay, Calhoun, Franklin,~~
382 ~~Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty,~~
383 ~~Madison, Taylor, Wakulla, and Washington Counties.~~
384 ~~(c) Region 3, which consists of Alachua, Bradford, Citrus,~~
385 ~~Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake,~~
386 ~~Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.~~
387 ~~(d) Region 4, which consists of Baker, Clay, Duval,~~
388 ~~Flagler, Nassau, St. Johns, and Volusia Counties.~~
389 ~~(e) Region 5, which consists of Pasco and Pinellas~~
390 ~~Counties.~~
391 ~~(f) Region 6, which consists of Hardee, Highlands,~~
392 ~~Hillsborough, Manatee, and Polk Counties.~~
393 ~~(g) Region 7, which consists of Brevard, Orange, Osceola,~~
394 ~~and Seminole Counties.~~
395 ~~(h) Region 8, which consists of Charlotte, Collier,~~
396 ~~DeSoto, Glades, Hendry, Lee, and Sarasota Counties.~~
397 ~~(i) Region 9, which consists of Indian River, Martin,~~
398 ~~Okeechobee, Palm Beach, and St. Lucie Counties.~~
399 ~~(j) Region 10, which consists of Broward County.~~
400 ~~(k) Region 11, which consists of Miami-Dade and Monroe~~

401 ~~Counties.~~
402 (3) QUALITY SELECTION CRITERIA.—
403 (a) The invitation to negotiate must specify the criteria
404 and the relative weight of the criteria that will be used for
405 determining the acceptability of the reply and guiding the
406 selection of the organizations with which the agency negotiates.
407 In addition to criteria established by the agency, the agency
408 shall consider the following factors in the selection of
409 eligible plans:
410 1. Accreditation by the National Committee for Quality
411 Assurance, the Joint Commission, or another nationally
412 recognized accrediting body.
413 2. Experience serving similar populations, including the
414 organization's record in achieving specific quality standards
415 with similar populations.
416 3. Availability and accessibility of primary care and
417 specialty physicians in the provider network.
418 4. Establishment of community partnerships with providers
419 that create opportunities for reinvestment in community-based
420 services.
421 5. Organization commitment to quality improvement and
422 documentation of achievements in specific quality improvement
423 projects, including active involvement by organization
424 leadership.
425 6. Provision of additional benefits, particularly dental

426 care and disease management, and other initiatives that improve
427 health outcomes.
428 7. Evidence that an eligible plan has obtained signed
429 contracts or written agreements ~~or signed contracts~~ or has made
430 substantial progress in establishing relationships with
431 providers before the plan submits ~~submitting~~ a response.
432 8. Comments submitted in writing by any enrolled Medicaid
433 provider relating to a specifically identified plan
434 participating in the procurement in the same region as the
435 submitting provider.
436 9. Documentation of policies and procedures for preventing
437 fraud and abuse.
438 10. The business relationship an eligible plan has with
439 any other eligible plan that responds to the invitation to
440 negotiate.
441 ~~(d) For the first year of the first contract term, the~~
442 ~~agency shall negotiate capitation rates or fee for service~~
443 ~~payments with each plan in order to guarantee aggregate savings~~
444 ~~of at least 5 percent.~~
445 ~~1. For prepaid plans, determination of the amount of~~
446 ~~savings shall be calculated by comparison to the Medicaid rates~~
447 ~~that the agency paid managed care plans for similar populations~~
448 ~~in the same areas in the prior year. In regions containing no~~
449 ~~prepaid plans in the prior year, determination of the amount of~~
450 ~~savings shall be calculated by comparison to the Medicaid rates~~

451 ~~established and certified for those regions in the prior year.~~
452 ~~2. For provider service networks operating on a fee-for-~~
453 ~~service basis, determination of the amount of savings shall be~~
454 ~~calculated by comparison to the Medicaid rates that the agency~~
455 ~~paid on a fee-for-service basis for the same services in the~~
456 ~~prior year.~~
457 ~~(c) To ensure managed care plan participation in Regions 1~~
458 ~~and 2, the agency shall award an additional contract to each~~
459 ~~plan with a contract award in Region 1 or Region 2. Such~~
460 ~~contract shall be in any other region in which the plan~~
461 ~~submitted a responsive bid and negotiates a rate acceptable to~~
462 ~~the agency. If a plan that is awarded an additional contract~~
463 ~~pursuant to this paragraph is subject to penalties pursuant to~~
464 ~~s. 409.967(2)(i) for activities in Region 1 or Region 2, the~~
465 ~~additional contract is automatically terminated 180 days after~~
466 ~~the imposition of the penalties. the plan must reimburse the~~
467 ~~agency for the cost of enrollment changes and other transition~~
468 ~~activities.~~
469 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that
470 participates in an invitation to negotiate ~~in more than one~~
471 ~~region~~ and is selected ~~in at least one region~~ may not begin
472 serving Medicaid recipients in any region ~~for which it was~~
473 ~~selected~~ until all administrative challenges to procurements
474 required by this section to which the eligible plan is a party
475 have been finalized. If the number of plans selected is less

476 than the maximum amount of plans permitted in the region, the
477 agency may contract with other selected plans in the region not
478 participating in the administrative challenge before resolution
479 of the administrative challenge. For purposes of this
480 subsection, an administrative challenge is finalized if an order
481 granting voluntary dismissal with prejudice has been entered by
482 any court established under Article V of the State Constitution
483 or by the Division of Administrative Hearings, a final order has
484 been entered into by the agency and the deadline for appeal has
485 expired, a final order has been entered by the First District
486 Court of Appeal and the time to seek any available review by the
487 Florida Supreme Court has expired, or a final order has been
488 entered by the Florida Supreme Court and a warrant has been
489 issued.
490 Section 6. Paragraphs (c) and (f) of subsection (2) and
491 paragraph (b) of subsection (4) of section 409.967, Florida
492 Statutes, are amended, and paragraph (k) is added to subsection
493 (3) of that section, to read:
494 409.967 Managed care plan accountability.—
495 (2) The agency shall establish such contract requirements
496 as are necessary for the operation of the statewide managed care
497 program. In addition to any other provisions the agency may deem
498 necessary, the contract must require:
499 (c) Access.—
500 1. The agency shall establish specific standards for the

501 number, type, and regional distribution of providers in managed
502 care plan networks to ensure access to care for both adults and
503 children. Each plan must maintain a regionwide network of
504 providers in sufficient numbers to meet the access standards for
505 specific medical services for all recipients enrolled in the
506 plan. The exclusive use of mail-order pharmacies may not be
507 sufficient to meet network access standards. Consistent with the
508 standards established by the agency, provider networks may
509 include providers located outside the region. ~~A plan may~~
510 ~~contract with a new hospital facility before the date the~~
511 ~~hospital becomes operational if the hospital has commenced~~
512 ~~construction, will be licensed and operational by January 1,~~
513 ~~2013, and a final order has issued in any civil or~~
514 ~~administrative challenge.~~ Each plan shall establish and maintain
515 an accurate and complete electronic database of contracted
516 providers, including information about licensure or
517 registration, locations and hours of operation, specialty
518 credentials and other certifications, specific performance
519 indicators, and such other information as the agency deems
520 necessary. The database must be available online to both the
521 agency and the public and have the capability to compare the
522 availability of providers to network adequacy standards and to
523 accept and display feedback from each provider's patients. Each
524 plan shall submit quarterly reports to the agency identifying
525 the number of enrollees assigned to each primary care provider.

526 The agency shall conduct, or contract for, systematic and
527 continuous testing of the provider network databases maintained
528 by each plan to confirm accuracy, confirm that behavioral health
529 providers are accepting enrollees, and confirm that enrollees
530 have <u>timely</u> access to <u>all covered benefits</u> ~~behavioral health~~
531 ~~services~~.
532 2. Each managed care plan must publish any prescribed drug
533 formulary or preferred drug list on the plan's website in a
534 manner that is accessible to and searchable by enrollees and
535 providers. The plan must update the list within 24 hours after
536 making a change. Each plan must ensure that the prior
537 authorization process for prescribed drugs is readily accessible
538 to health care providers, including posting appropriate contact
539 information on its website and providing timely responses to
540 providers. For Medicaid recipients diagnosed with hemophilia who
541 have been prescribed anti-hemophilic-factor replacement
542 products, the agency shall provide for those products and
543 hemophilia overlay services through the agency's hemophilia
544 disease management program.
545 3. Managed care plans, and their fiscal agents or
546 intermediaries, must accept prior authorization requests for any
547 service electronically.
548 4. Managed care plans serving children in the care and
549 custody of the Department of Children and Families must maintain
550 complete medical, dental, and behavioral health encounter

551 information and participate in making such information available
552 to the department or the applicable contracted community-based
553 care lead agency for use in providing comprehensive and
554 coordinated case management. The agency and the department shall
555 establish an interagency agreement to provide guidance for the
556 format, confidentiality, recipient, scope, and method of
557 information to be made available and the deadlines for
558 submission of the data. The scope of information available to
559 the department shall be the data that managed care plans are
560 required to submit to the agency. The agency shall determine the
561 plan's compliance with standards for access to medical, dental,
562 and behavioral health services; the use of medications; and
563 followup on all medically necessary services recommended as a
564 result of early and periodic screening, diagnosis, and
565 treatment.
566 (f) Continuous improvement.—The agency shall establish
567 specific performance standards and expected milestones or
568 timelines for improving performance over the term of the
569 contract.
570 1. Each managed care plan shall establish an internal
571 health care quality improvement system, including enrollee
572 satisfaction and disenrollment surveys. The quality improvement
573 system must include incentives and disincentives for network
574 providers.
575 2. Each plan must collect and report the Health Plan

576 Employer Data and Information Set (HEDIS) measures, as specified
577 by the agency. These measures must be published on the plan's
578 website in a manner that allows recipients to reliably compare
579 the performance of plans. The agency shall use the HEDIS
580 measures as a tool to monitor plan performance.
581 3. Each managed care plan must be accredited by the
582 National Committee for Quality Assurance, the Joint Commission,
583 or another nationally recognized accrediting body, or have
584 initiated the accreditation process, within 1 year after the
585 contract is executed. For any plan not accredited within 18
586 months after executing the contract, the agency shall suspend
587 automatic assignment under s. 409.977 and 409.984.
588 ~~4. By the end of the fourth year of the first contract~~
589 ~~term, the agency shall issue a request for information to~~
590 ~~determine whether cost savings could be achieved by contracting~~
591 ~~for plan oversight and monitoring, including analysis of~~
592 ~~encounter data, assessment of performance measures, and~~
593 ~~compliance with other contractual requirements.~~
594 (3) ACHIEVED SAVINGS REBATE.—
595 <u>(k) Plans that contribute funds pursuant to paragraph</u>
596 <u>(4)(b) or paragraph (4)(c) may reduce the rebate owed by an</u>
597 <u>amount equal to the amount of the contribution.</u>
598 (4) MEDICAL LOSS RATIO.—If required as a condition of a
599 waiver, the agency may calculate a medical loss ratio for
600 managed care plans. The calculation shall use uniform financial

601 data collected from all plans and shall be computed for each
602 plan on a statewide basis. The method for calculating the
603 medical loss ratio shall meet the following criteria:
604 (b) Funds provided by plans to ~~graduate medical~~ education
605 institutions to underwrite the costs of residency positions in
606 graduate medical education programs, undergraduate and graduate
607 student positions in nursing education programs, or student
608 positions in any degree or technical program deemed a critical
609 shortage area by the agency shall be classified as medical
610 expenditures, provided that the funding is sufficient to sustain
611 the positions for the number of years necessary to complete the
612 program ~~residency~~ requirements and the residency or student
613 positions funded by the plans are actively involved in the
614 institution's provision ~~active providers~~ of care to Medicaid and
615 uninsured patients.
616 Section 7. Subsection (2) of section 409.968, Florida
617 Statutes, is amended to read:
618 409.968 Managed care plan payments.—
619 ~~(2) Provider service networks may be prepaid plans and~~
620 ~~receive per-member, per-month payments negotiated pursuant to~~
621 ~~the procurement process described in s. 409.966. Provider~~
622 ~~service networks that choose not to be prepaid plans shall~~
623 ~~receive fee-for-service rates with a shared savings settlement.~~
624 ~~The fee-for-service option shall be available to a provider~~
625 ~~service network only for the first 2 years of its operation. The~~

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626 ~~agency shall annually conduct cost reconciliations to determine~~
627 ~~the amount of cost savings achieved by fee-for-service provider~~
628 ~~service networks for the dates of service within the period~~
629 ~~being reconciled. Only payments for covered services for dates~~
630 ~~of service within the reconciliation period and paid within 6~~
631 ~~months after the last date of service in the reconciliation~~
632 ~~period must be included. The agency shall perform the necessary~~
633 ~~adjustments for the inclusion of claims incurred but not~~
634 ~~reported within the reconciliation period for claims that could~~
635 ~~be received and paid by the agency after the 6-month claims~~
636 ~~processing time lag. The agency shall provide the results of the~~
637 ~~reconciliations to the fee-for-service provider service networks~~
638 ~~within 45 days after the end of the reconciliation period. The~~
639 ~~fee-for-service provider service networks shall review and~~
640 ~~provide written comments or a letter of concurrence to the~~
641 ~~agency within 45 days after receipt of the reconciliation~~
642 ~~results. This reconciliation is considered final.~~
643 Section 8. Subsection (3) and paragraph (b) of subsection
644 (4) of section 409.973, Florida Statutes, are amended, and
645 paragraphs (c) through (g) are added to subsection (5) of that
646 section, to read:
647 409.973 Benefits.—
648 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed
649 medical assistance program shall establish a program to
650 encourage and reward healthy behaviors. At a minimum, each plan

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651 must establish a medically approved tobacco use ~~smoking~~
652 cessation program, a medically directed weight loss program, and
653 a medically approved alcohol or substance abuse recovery
654 program, which shall include, at a minimum, a focus on opioid
655 abuse recovery. Each plan must identify enrollees who use
656 tobacco ~~smoke~~, are morbidly obese, or are diagnosed with alcohol
657 or substance abuse in order to establish written agreements to
658 secure the enrollees' commitment to participation in these
659 programs.
660 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the
661 managed medical assistance program shall establish a program to
662 encourage enrollees to establish a relationship with their
663 primary care provider. Each plan shall:
664 (b) If the enrollee was not a Medicaid recipient before
665 enrollment in the plan, assist the enrollee in scheduling an
666 appointment with the primary care provider. If possible the
667 appointment should be made within 30 days after enrollment in
668 the plan. ~~For enrollees who become eligible for Medicaid between~~
669 ~~January 1, 2014, and December 31, 2015, the appointment should~~
670 ~~be scheduled within 6 months after enrollment in the plan.~~
671 (5) PROVISION OF DENTAL SERVICES.—
672 (c) Given the effect of oral health on overall health,
673 each prepaid dental plan shall establish a program to improve
674 dental health outcomes and increase utilization of preventive
675 dental services. The agency shall establish performance and

676 outcome measures, regularly assess plan performance, and publish
677 data on such measures. Program components shall, at a minimum,
678 include:
679 1. An education program to inform enrollees of the
680 connection between oral health and overall health and preventive
681 steps to improve dental health.
682 2. An enrollee incentive program designed to increase
683 utilization of preventive dental services.
684 (d) The agency shall annually review encounter data and
685 claims expenditures in the Statewide Medicaid Managed Care
686 program for emergency department visits relating to nontraumatic
687 and ambulatory sensitive dental conditions and reconcile service
688 expenditures for these visits against capitation payments made
689 to the prepaid dental plans.
690 (e) By October 1, 2022, each prepaid dental plan and each
691 nondental managed care plan shall enter into a mutual
692 coordination of benefits agreement that includes data sharing
693 requirements and coordination protocols to support the provision
694 of dental services and reduction of potentially preventable
695 events.
696 (f) Beginning July 2022, each prepaid dental plan and each
697 nondental managed care plan must meet quarterly to collaborate
698 on specific goals to improve quality of care and enrollee
699 health. Plans shall mutually establish, in writing, shared
700 goals, specific and measurable objectives, and complementary

701 strategies pertinent to state Medicaid priorities. The goals,
702 objectives, and strategies must address improving access and
703 appropriate utilization, maximizing efficiency by integrating
704 health and dental care, improving patient experiences, attending
705 to unmet social needs that affect preventive care utilization
706 and early disease detection, and identifying and reducing
707 disparities.
708 (g) The agency shall establish provider network
709 requirements for dental plans. In addition, the agency must
710 establish provider network requirements sufficient to ensure
711 access to medically necessary sedation services, including, but
712 not limited to, network participation by dentists credentialed
713 to provide services in inpatient and outpatient settings and by
714 inpatient and outpatient facilities and anesthesia service
715 providers. The agency shall assess plan compliance with network
716 adequacy requirements at least quarterly and shall enforce such
717 requirements in a timely manner.
718 Section 9. Subsections (1) and (2) of section 409.974,
719 Florida Statutes, are amended to read:
720 409.974 Eligible plans.—
721 (1) ELIGIBLE PLAN SELECTION.—The agency shall select
722 eligible plans for the managed medical assistance program
723 through the procurement process described in s. 409.966. The
724 agency shall select at least one provider service network for
725 each region, if any submit a responsive bid. The agency shall

726 procure the number of plans, inclusive of statewide plans, if
727 any, for each region as follows:
728 (a) At least three plans and up to four plans for Region
729 A.
730 (b) At least five plans and up to six plans for Region B.
731 (c) At least six plans and up to ten plans for Region C.
732 (d) At least five plans and up to six plans for Region D.
733 (e) At least three plans and up to four plans for Region
734 E.
735 (f) At least three plans and up to five plans for Region
736 F.
737 (g) At least three plans and up to five plans for Region
738 G.
739 (h) At least five plans and up to ten plans for Region H
740 ~~The agency shall notice invitations to negotiate no later than~~
741 ~~January 1, 2013~~.
742 ~~(a) The agency shall procure two plans for Region 1. At~~
743 ~~least one plan shall be a provider service network if any~~
744 ~~provider service networks submit a responsive bid.~~
745 ~~(b) The agency shall procure two plans for Region 2. At~~
746 ~~least one plan shall be a provider service network if any~~
747 ~~provider service networks submit a responsive bid.~~
748 ~~(c) The agency shall procure at least three plans and up~~
749 ~~to five plans for Region 3. At least one plan must be a provider~~
750 ~~service network if any provider service networks submit a~~

751 ~~responsive bid.~~
752 ~~(d) The agency shall procure at least three plans and up~~
753 ~~to five plans for Region 4. At least one plan must be a provider~~
754 ~~service network if any provider service networks submit a~~
755 ~~responsive bid.~~
756 ~~(e) The agency shall procure at least two plans and up to~~
757 ~~four plans for Region 5. At least one plan must be a provider~~
758 ~~service network if any provider service networks submit a~~
759 ~~responsive bid.~~
760 ~~(f) The agency shall procure at least four plans and up to~~
761 ~~seven plans for Region 6. At least one plan must be a provider~~
762 ~~service network if any provider service networks submit a~~
763 ~~responsive bid.~~
764 ~~(g) The agency shall procure at least three plans and up~~
765 ~~to six plans for Region 7. At least one plan must be a provider~~
766 ~~service network if any provider service networks submit a~~
767 ~~responsive bid.~~
768 ~~(h) The agency shall procure at least two plans and up to~~
769 ~~four plans for Region 8. At least one plan must be a provider~~
770 ~~service network if any provider service networks submit a~~
771 ~~responsive bid.~~
772 ~~(i) The agency shall procure at least two plans and up to~~
773 ~~four plans for Region 9. At least one plan must be a provider~~
774 ~~service network if any provider service networks submit a~~
775 ~~responsive bid.~~

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776 ~~(j) The agency shall procure at least two plans and up to~~
777 ~~four plans for Region 10. At least one plan must be a provider~~
778 ~~service network if any provider service networks submit a~~
779 ~~responsive bid.~~
780 ~~(k) The agency shall procure at least five plans and up to~~
781 ~~10 plans for Region 11. At least one plan must be a provider~~
782 ~~service network if any provider service networks submit a~~
783 ~~responsive bid.~~
784
785 If no provider service network submits a responsive bid, the
786 agency shall procure no more than one less than the maximum
787 number of eligible plans permitted in that region. Within 12
788 months after the initial invitation to negotiate, the agency
789 shall attempt to procure a provider service network. The agency
790 shall notice another invitation to negotiate only with provider
791 service networks in those regions where no provider service
792 network has been selected.
793 (2) QUALITY SELECTION CRITERIA.—In addition to the
794 criteria established in s. 409.966, the agency shall consider
795 evidence that an eligible plan has <u>obtained signed contracts or</u>
796 written agreements ~~or signed contracts~~ or has made substantial
797 progress in establishing relationships with providers before the
798 plan <u>submits</u> ~~submitting~~ a response. The agency shall evaluate
799 and give special weight to evidence of signed contracts with
800 essential providers as defined by the agency pursuant to s.

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801 409.975(1). ~~The agency shall exercise a preference for plans~~
802 ~~with a provider network in which over 10 percent of the~~
803 ~~providers use electronic health records, as defined in s.~~
804 ~~408.051.~~ When all other factors are equal, the agency shall
805 consider whether the organization has a contract to provide
806 managed long-term care services in the same region and shall
807 exercise a preference for such plans.
808 Section 10. Paragraphs (a) and (b) of subsection (1) of
809 section 409.975, Florida Statutes, are amended to read:
810 409.975 Managed care plan accountability.—In addition to
811 the requirements of s. 409.967, plans and providers
812 participating in the managed medical assistance program shall
813 comply with the requirements of this section.
814 (1) PROVIDER NETWORKS.—Managed care plans must develop and
815 maintain provider networks that meet the medical needs of their
816 enrollees in accordance with standards established pursuant to
817 s. 409.967(2)(c). Except as provided in this section, managed
818 care plans may limit the providers in their networks based on
819 credentials, quality indicators, and price.
820 (a) Plans must include all providers in the region that
821 are classified by the agency as essential Medicaid providers,
822 unless the agency approves, in writing, an alternative
823 arrangement for securing the types of services offered by the
824 essential providers. Providers are essential for serving
825 Medicaid enrollees if they offer services that are not available

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826 from any other provider within a reasonable access standard, or
827 if they provided a substantial share of the total units of a
828 particular service used by Medicaid patients within the region
829 during the last 3 years and the combined capacity of other
830 service providers in the region is insufficient to meet the
831 total needs of the Medicaid patients. The agency may not
832 classify physicians and other practitioners as essential
833 providers.
834 1. The agency, at a minimum, shall determine which
835 providers in the following categories are essential Medicaid
836 providers:
837 a.~~1.~~ Federally qualified health centers.
838 b.~~2.~~ Statutory teaching hospitals as defined in s.
839 408.07(46).
840 c.~~3.~~ Hospitals that are trauma centers as defined in s.
841 395.4001(15).
842 d.~~4.~~ Hospitals located at least 25 miles from any other
843 hospital with similar services.
844 2. Regional perinatal intensive care centers as defined in
845 s. 383.16(2) are regional resources and essential providers for
846 all managed care plans in the applicable region. All managed
847 care plans in a region must have a network contract with each
848 regional perinatal intensive care center in the region.
849 3. Managed care plans that have not contracted with all
850 essential providers in the region as of the first date of

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851 recipient enrollment, or with whom an essential provider has
852 terminated its contract, must negotiate in good faith with such
853 essential providers for 1 year or until an agreement is reached,
854 whichever is first. Payments for services rendered by a
855 nonparticipating essential provider shall be made at the
856 applicable Medicaid rate as of the first day of the contract
857 between the agency and the plan. A rate schedule for all
858 essential providers shall be attached to the contract between
859 the agency and the plan. After 1 year, managed care plans that
860 are unable to contract with essential providers shall notify the
861 agency and propose an alternative arrangement for securing the
862 essential services for Medicaid enrollees. The arrangement must
863 rely on contracts with other participating providers, regardless
864 of whether those providers are located within the same region as
865 the nonparticipating essential service provider. If the
866 alternative arrangement is approved by the agency, payments to
867 nonparticipating essential providers after the date of the
868 agency's approval shall equal 90 percent of the applicable
869 Medicaid rate. Except for payment for emergency services, if the
870 alternative arrangement is not approved by the agency, payment
871 to nonparticipating essential providers shall equal 110 percent
872 of the applicable Medicaid rate.
873
874 The agency shall assess plan compliance with this paragraph at
875 least quarterly. No later than January 1 of each year, the

876 agency must impose contract enforcement financial sanctions on,
877 or assess contract damages against, a plan without a network
878 contract as required by this subsection with an essential
879 provider subject to the requirements of s. 409.908(26).
880 (b) Certain providers are statewide resources and
881 essential providers for all managed care plans in all regions.
882 All managed care plans must include these essential providers in
883 their networks.
884 1. Statewide essential providers include:
885 a.~~1.~~ Faculty plans of Florida medical schools.
886 ~~2. Regional perinatal intensive care centers as defined in~~
887 ~~s. 383.16(2).~~
888 b.~~3.~~ Hospitals licensed as specialty children's hospitals
889 as defined in s. 395.002(28).
890 c. Florida cancer hospitals that meet the criteria in 42
891 U.S.C. s. 1395ww(d)(1)(B)(v).
892 ~~4. Accredited and integrated systems serving medically~~
893 ~~complex children which comprise separately licensed, but~~
894 ~~commonly owned, health care providers delivering at least the~~
895 ~~following services: medical group home, in-home and outpatient~~
896 ~~nursing care and therapies, pharmacy services, durable medical~~
897 ~~equipment, and Prescribed Pediatric Extended Care.~~
898 2. Managed care plans that have not contracted with all
899 statewide essential providers in all regions as of the first
900 date of recipient enrollment must continue to negotiate in good

901 faith. Payments to physicians on the faculty of nonparticipating
902 Florida medical schools shall be made at the applicable Medicaid
903 rate. Payments for services rendered by regional perinatal
904 intensive care centers shall be made at the applicable Medicaid
905 rate as of the first day of the contract between the agency and
906 the plan. Except for payments for emergency services, payments
907 to nonparticipating specialty children's hospitals and payments
908 to nonparticipating Florida cancer hospitals that meet the
909 criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v) shall equal the
910 highest rate established by contract between that provider and
911 any other Medicaid managed care plan.
912
913 The agency shall assess plan compliance with this paragraph at
914 least quarterly. No later than January 1 of each year, the
915 agency must impose contract enforcement financial sanctions on,
916 or assess contract damages against, a plan without a network
917 contract as required by this subsection with an essential
918 provider subject to the requirements of s. 409.908(26).
919 Section 11. Subsections (1), (4), and (5) of section
920 409.977, Florida Statutes, are amended to read:
921 409.977 Enrollment.—
922 (1) The agency shall automatically enroll into a managed
923 care plan those Medicaid recipients who do not voluntarily
924 choose a plan pursuant to s. 409.969. The agency shall
925 automatically enroll recipients in plans that meet or exceed the

926 performance or quality standards established pursuant to s.
927 409.967 and may not automatically enroll recipients in a plan
928 that is deficient in those performance or quality standards.
929 When a specialty plan is available to accommodate a specific
930 condition or diagnosis of a recipient, the agency shall assign
931 the recipient to that plan. The agency may not automatically
932 enroll recipients in a managed medical assistance plan that has
933 more than 50 percent of the enrollees in the region. ~~In the~~
934 ~~first year of the first contract term only, if a recipient was~~
935 ~~previously enrolled in a plan that is still available in the~~
936 ~~region, the agency shall automatically enroll the recipient in~~
937 ~~that plan unless an applicable specialty plan is available.~~
938 Except as otherwise provided in this part, the agency may not
939 engage in practices that are designed to favor one managed care
940 plan over another.
941 (4) The agency shall develop a process to enable a
942 recipient with access to employer-sponsored health care coverage
943 to opt out of all managed care plans and to use Medicaid
944 financial assistance to pay for the recipient's share of the
945 cost in such employer-sponsored coverage. ~~Contingent upon~~
946 ~~federal approval,~~ The agency shall also enable recipients with
947 access to other insurance or related products providing access
948 to health care services created pursuant to state law, including
949 any product available under ~~the Florida Health Choices Program,~~
950 ~~or~~ any health exchange, to opt out. The amount of financial

951 assistance provided for each recipient may not exceed the amount
952 of the Medicaid premium that would have been paid to a managed
953 care plan for that recipient. The agency shall ~~seek federal~~
954 ~~approval to~~ require Medicaid recipients with access to employer-
955 sponsored health care coverage to enroll in that coverage and
956 use Medicaid financial assistance to pay for the recipient's
957 share of the cost for such coverage. The amount of financial
958 assistance provided for each recipient may not exceed the amount
959 of the Medicaid premium that would have been paid to a managed
960 care plan for that recipient.
961 (5) Specialty plans serving children in the care and
962 custody of the department may serve such children as long as
963 they remain in care, including those remaining in extended
964 foster care pursuant to s. 39.6251, or are in subsidized
965 adoption and continue to be eligible for Medicaid pursuant to s.
966 409.903, or are receiving guardianship assistance payments and
967 continue to be eligible for Medicaid pursuant to s. 409.903.
968 Section 12. The Agency for Health Care Administration must
969 amend existing contracts under the Statewide Medicaid Managed
970 Care program to implement the amendments made by this act to ss.
971 409.908, 409.967, 409.973, 409.975, and 409.977, Florida
972 Statutes. The agency must implement the amendments made by this
973 act to ss. 409.966, 409.974, and 409.981, Florida Statutes, for
974 the 2025 plan year.
975 Section 13. Subsection (2) of section 409.981, Florida

976 Statutes, is amended to read:
977 409.981 Eligible long-term care plans.—
978 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
979 eligible plans for the long-term care managed care program
980 through the procurement process described in s. 409.966. The
981 agency shall select at least one provider service network for
982 each region, if any provider service network submits a
983 responsive bid. The agency shall procure the number of plans,
984 inclusive of statewide plans, if any, for each region as
985 follows:
986 (a) At least three plans and up to four plans for Region
987 A.
988 (b) At least three plans and up to six plans for Region B.
989 (c) At least five plans and up to ten plans for Region C.
990 (d) At least three plans and up to six plans for Region D.
991 (e) At least three plans and up to four plans for Region
992 E.
993 (f) At least three plans and up to five plans for Region
994 F.
995 (g) At least three plans and up to four plans for Region
996 G.
997 (h) At least five plans and up to ten plans for Region H.
998 (a) Two plans for Region 1. At least one plan must be a
999 provider service network if any provider service networks submit
1000 a responsive bid.

1001 ~~(b) Two plans for Region 2. At least one plan must be a~~
1002 ~~provider service network if any provider service networks submit~~
1003 ~~a responsive bid.~~
1004 ~~(c) At least three plans and up to five plans for Region~~
1005 ~~3. At least one plan must be a provider service network if any~~
1006 ~~provider service networks submit a responsive bid.~~
1007 ~~(d) At least three plans and up to five plans for Region~~
1008 ~~4. At least one plan must be a provider service network if any~~
1009 ~~provider service network submits a responsive bid.~~
1010 ~~(e) At least two plans and up to four plans for Region 5.~~
1011 ~~At least one plan must be a provider service network if any~~
1012 ~~provider service networks submit a responsive bid.~~
1013 ~~(f) At least four plans and up to seven plans for Region~~
1014 ~~6. At least one plan must be a provider service network if any~~
1015 ~~provider service networks submit a responsive bid.~~
1016 ~~(g) At least three plans and up to six plans for Region 7.~~
1017 ~~At least one plan must be a provider service network if any~~
1018 ~~provider service networks submit a responsive bid.~~
1019 ~~(h) At least two plans and up to four plans for Region 8.~~
1020 ~~At least one plan must be a provider service network if any~~
1021 ~~provider service networks submit a responsive bid.~~
1022 ~~(i) At least two plans and up to four plans for Region 9.~~
1023 ~~At least one plan must be a provider service network if any~~
1024 ~~provider service networks submit a responsive bid.~~
1025 ~~(j) At least two plans and up to four plans for Region 10.~~

1026 ~~At least one plan must be a provider service network if any~~
1027 ~~provider service networks submit a responsive bid.~~
1028 ~~(k) At least five plans and up to 10 plans for Region 11.~~
1029 ~~At least one plan must be a provider service network if any~~
1030 ~~provider service networks submit a responsive bid.~~
1031
1032 If no provider service network submits a responsive bid in a
1033 region other than Region A ~~1 or Region 2~~, the agency shall
1034 procure no more than one fewer ~~less~~ than the maximum number of
1035 eligible plans permitted in that region. Within 12 months after
1036 the initial invitation to negotiate, the agency shall attempt to
1037 procure a provider service network. The agency shall notice
1038 another invitation to negotiate only with provider service
1039 networks in regions where no provider service network has been
1040 selected.
1041 Section 14. Subsection (4) of section 409.8132, Florida
1042 Statutes, is amended to read:
1043 409.8132 Medikids program component.—
1044 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
1045 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
1046 409.912, 409.9121, 409.9122, 409.9123, ~~409.9124,~~ 409.9127,
1047 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply
1048 to the administration of the Medikids program component of the
1049 Florida Kidcare program, except that s. 409.9122 applies to
1050 Medikids as modified by ~~the provisions of~~ subsection (7).

1051 Section 15. Paragraph (d) of subsection (13) of section
1052 409.906, Florida Statutes, is amended to read:
1053 409.906 Optional Medicaid services.—Subject to specific
1054 appropriations, the agency may make payments for services which
1055 are optional to the state under Title XIX of the Social Security
1056 Act and are furnished by Medicaid providers to recipients who
1057 are determined to be eligible on the dates on which the services
1058 were provided. Any optional service that is provided shall be
1059 provided only when medically necessary and in accordance with
1060 state and federal law. Optional services rendered by providers
1061 in mobile units to Medicaid recipients may be restricted or
1062 prohibited by the agency. Nothing in this section shall be
1063 construed to prevent or limit the agency from adjusting fees,
1064 reimbursement rates, lengths of stay, number of visits, or
1065 number of services, or making any other adjustments necessary to
1066 comply with the availability of moneys and any limitations or
1067 directions provided for in the General Appropriations Act or
1068 chapter 216. If necessary to safeguard the state's systems of
1069 providing services to elderly and disabled persons and subject
1070 to the notice and review provisions of s. 216.177, the Governor
1071 may direct the Agency for Health Care Administration to amend
1072 the Medicaid state plan to delete the optional Medicaid service
1073 known as "Intermediate Care Facilities for the Developmentally
1074 Disabled." Optional services may include:
1075 (13) HOME AND COMMUNITY-BASED SERVICES.—

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1076 (d) The agency shall seek federal approval to pay for
1077 flexible services for persons with severe mental illness or
1078 substance use disorders, including, but not limited to,
1079 temporary housing assistance. Payments may be made as enhanced
1080 capitation rates or incentive payments to managed care plans
1081 that meet the requirements of s. 409.968(3) ~~s. 409.968(4)~~.
1082 Section 16. This act shall take effect July 1, 2022.

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