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LEGISLATIVE ACTION

Senate	.	House
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05/05/2011 04:51 PM	.	05/06/2011 07:15 PM
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Senator Negron moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Sections 409.961 through 409.985, Florida Statutes, are designated as part IV of chapter 409, Florida Statutes, entitled "Medicaid Managed Care."

Section 2. Section 409.961, Florida Statutes, is created to read:

409.961 Statutory construction; applicability; rules.—It is the intent of the Legislature that if any conflict exists between the provisions contained in this part and in other parts of this chapter, the provisions in this part control. Sections

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409.961-409.985 apply only to the Medicaid managed medical assistance program and long-term care managed care program, as provided in this part. The agency shall adopt any rules necessary to comply with or administer this part and all rules necessary to comply with federal requirements. In addition, the department shall adopt and accept the transfer of any rules necessary to carry out the department's responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility and for ensuring compliance with and administering this part, as those rules relate to the department's responsibilities, and any other provisions related to the department's responsibility for the determination of Medicaid eligibility.

Section 3. Section 409.962, Florida Statutes, is created to read:

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

(1) "Accountable care organization" means an entity qualified as an accountable care organization in accordance with federal regulations, and which meets the requirements of a provider service network as described in s. 409.912(4)(d).

(2) "Agency" means the Agency for Health Care Administration.

(3) "Aging network service provider" means a provider that participated in a home and community-based waiver administered by the Department of Elderly Affairs or the community care service system pursuant to s. 430.205 as of October 1, 2013.

(4) "Comprehensive long-term care plan" means a managed care plan that provides services described in s. 409.973 and


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also provides the services described in s. 409.98.

(5) "Department" means the Department of Children and Family Services.

(6) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(4)(d) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391. For purposes of the long-term care managed care program, the term also includes entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans, and the Program of All-Inclusive Care for the Elderly.

(7) "Long-term care plan" means a managed care plan that provides the services described in s. 409.98 for the long-term care managed care program.

(8) "Long-term care provider service network" means a provider service network a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

(9) "Managed care plan" means an eligible plan under contract with the agency to provide services in the Medicaid program.

(10) "Medicaid" means the medical assistance program

authorized by Title XIX of the Social Security Act, 42 U.S.C. ss. 1396 et seq., and regulations thereunder, as administered in this state by the agency.

(11) "Medicaid recipient" or "recipient" means an individual who the department or, for Supplemental Security Income, the Social Security Administration determines is eligible pursuant to federal and state law to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(12) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(4)(d), in the state and is paid a prospective per-member, per-month payment by the agency.

(13) "Provider service network" means an entity qualified pursuant to s. 409.912(4)(d) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

(15) "Specialty plan" means a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

Section 4. Section 409.963, Florida Statutes, is created to


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read:

409.963 Single state agency.—The agency is designated as the single state agency authorized to manage, operate, and make payments for medical assistance and related services under Title XIX of the Social Security Act. Subject to any limitations or directions provided in the General Appropriations Act, these payments may be made only for services included in the program, only on behalf of eligible individuals, and only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and state law. This program of medical assistance is designated as the "Medicaid program." The department is responsible for Medicaid eligibility determinations, including, but not limited to, policy, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients, as well as the actual determination of eligibility. As a condition of Medicaid eligibility, subject to federal approval, the agency and the department shall ensure that each Medicaid recipient consents to the release of her or his medical records to the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs.

Section 5. Section 409.964, Florida Statutes is created to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Before seeking a

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waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2) and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region. The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.

Section 6. Section 409.965, Florida Statutes, is created to read:

409.965 Mandatory enrollment.—All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver. The following Medicaid recipients are exempt from participation in the statewide managed care program:

(1) Women who are eligible only for family planning services.

(2) Women who are eligible only for breast and cervical cancer services.

(3) Persons who are eligible for emergency Medicaid for aliens.

(4) Children receiving services in a prescribed pediatric extended care center.

Section 7. Section 409.966, Florida Statutes, is created to read:

409.966 Eligible plans; selection.—

(1) ELIGIBLE PLANS.—Services in the Medicaid managed care

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program shall be provided by eligible plans. A provider service network must be capable of providing all covered services to a mandatory Medicaid managed care enrollee or may limit the provision of services to a specific target population based on the age, chronic disease state, or medical condition of the enrollee to whom the network will provide services. A specialty provider service network must be capable of coordinating care and delivering or arranging for the delivery of all covered services to the target population. A provider service network may partner with an insurer licensed under chapter 627 or a health maintenance organization licensed under chapter 641 to meet the requirements of a Medicaid contract.

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

(a) Region 1, which consists of Escambia, Okaloosa, Santa Rosa and Walton Counties.

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(b) Region 2, which consists of Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington Counties.

(c) Region 3, which consists of Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.

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

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

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

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

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

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

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

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

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:


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

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

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

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

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

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

7. Evidence that a eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitting a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

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

10. The business relationship an eligible plan has with any


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other eligible plan that responds to the invitation to negotiate.

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

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

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

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


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

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

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

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


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

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

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

(e) To ensure managed care plan participation in Regions 1 and 2, the agency shall award an additional contract to each plan with a contract award in Region 1 or Region 2. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(g) for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan must reimburse the agency for the cost of enrollment changes and other transition activities.

(f) The agency may not execute contracts with managed care

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

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

Section 8. Section 409.967, Florida Statutes, is created to read:

409.967 Managed care plan accountability.—

(1) The agency shall establish a 5-year contract with each managed care plan selected through the procurement process described in s. 409.966. A plan contract may not be renewed;

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however, the agency may extend the term of a plan contract to cover any delays during the transition to a new plan.

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

(a) *Physician compensation.*—Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect available resources and increase compensation for physicians. Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. The agency may impose fines or other sanctions on a plan that fails to meet this performance standard after 2 years of continuous operation.

(b) *Emergency services.*—Managed care plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider. The plans must comply with s. 641.3155. Reimbursement for services under this paragraph is the lesser of:

1. The provider's charges;

2. The usual and customary provider charges for similar services in the community where the services were provided;

3. The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

4. The rate the agency would have paid on the most recent October 1st.

(c) *Access.*—

1. The agency shall establish specific standards for the


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

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after

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making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

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

(d) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans

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and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

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

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

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

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have


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initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under s. 409.977 and 409.984.

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

(f) *Program integrity.*—Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum:

1. A provider credentialing system and ongoing provider monitoring, including maintenance of written provider credentialing policies and procedures which comply with federal and agency guidelines;

2. An effective prepayment and postpayment review process including, but not limited to, data analysis, system editing, and auditing of network providers;

3. Procedures for reporting instances of fraud and abuse pursuant to chapter 641;

4. Administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse; and

5. Designation of a program integrity compliance officer.

(g) *Grievance resolution.*—Consistent with federal law, each managed care plan shall establish and the agency shall approve an internal process for reviewing and responding to grievances


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from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees.

(h) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25 percent of the minimum surplus requirement pursuant to s. 641.225(1). Plans shall provide at least 180 days notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions, pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.


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3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to transition enrollees to other plans, and phase-in the terminations over a time period sufficient to ensure a smooth transition.

(i) *Prompt payment.*—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(j) *Electronic claims.*—Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims in compliance with federal standards.

(k) *Fair payment.*—Provider service networks must ensure that no entity licensed under chapter 395 with a controlling interest in the network charges a Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(l) *Itemized payment.*—Any claims payment to a provider by a managed care plan, or by a fiscal agent or intermediary of the plan, must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is made.

(m) *Provider dispute resolution.*—Disputes between a plan and a provider may be resolved as described in s. 408.7057.

(3) ACHIEVED SAVINGS REBATE.—

(a) The agency is responsible for verifying the achieved

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savings rebate for all Medicaid prepaid plans. To assist the agency, a prepaid plan shall:

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

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

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

(c) Any audit required under this subsection must be conducted by an independent certified public accountant who meets criteria specified by rule. The rules must also provide that:

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

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

3. Each prepaid plan audited shall pay to the agency the


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

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

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

(e) Once the certified public accountant completes the audit, the certified public accountant shall submit an audit


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report to the agency attesting to the achieved savings of the plan. The results of the audit report are dispositive.

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

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

2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state.

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

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

1. Payment of achieved savings rebates.

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

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

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4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of any type paid or awarded to the plan's executive staff, other than base salary.

6. Reserves and reserve accounts.

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

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

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

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

Section 9. Section 409.968, Florida Statutes, is created to read:

409.968 Managed care plan payments.—

(1) Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in s. 409.966. Payments shall be risk-adjusted rates based on

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historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area, and clinical risk profile of the recipients. In negotiating rates with the plans, the agency shall consider any adjustments necessary to encourage plans to use the most cost effective modalities for treatment of chronic disease such as peritoneal dialysis.

(2) Provider service networks may be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the


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agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.

(3) The agency may not approve any plan request for a rate increase unless sufficient funds to support the increase have been authorized in the General Appropriations Act.

Section 10. Section 409.969, Florida Statutes, is created to read:

409.969 Enrollment; disenrollment.—

(1) ENROLLMENT.—All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted under this part. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans.

(2) DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. For purposes of this section, the term "good cause" includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may require a recipient to use the plan's grievance process before the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged.

(a) The managed care plan internal grievance process, when

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used, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the result of the grievance process is approval of an enrollee's request to disenroll, the agency is not required to make a determination in the case.

(b) The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that good cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(c) Medicaid recipients enrolled in a managed care plan after the 90-day period shall remain in the plan for the remainder of the 12-month period. After 12 months, the recipient may select another plan. However, nothing shall prevent a Medicaid recipient from changing providers within the plan during that period.

(d) On the first day of the month after receiving notice from a recipient that the recipient has moved to another region, the agency shall automatically disenroll the recipient from the managed care plan the recipient is currently enrolled in and treat the recipient as if the recipient is a new Medicaid enrollee. At that time, the recipient may choose another plan pursuant to the enrollment process established in this section.

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(e) The agency must monitor plan disenrollment throughout the contract term to identify any discriminatory practices.

Section 11. Section 409.97, Florida Statutes, is created to read:

409.97 State and local Medicaid partnerships.—

(1) INTERGOVERNMENTAL TRANSFERS.—In addition to the contributions required pursuant to s. 409.915, beginning in the 2014-2015 fiscal year, the agency may accept voluntary transfers of local taxes and other qualified revenue from counties, municipalities, and special taxing districts. Such transfers must be contributed to advance the general goals of the Florida Medicaid program without restriction and must be executed pursuant to a contract between the agency and the local funding source. Contracts executed before October 31 shall result in contributions to Medicaid for that same state fiscal year. Contracts executed between November 1 and June 30 shall result in contributions for the following state fiscal year. Based on the date of the signed contracts, the agency shall allocate to the low-income pool the first contributions received up to the limit established by subsection (2). No more than 40 percent of the low-income pool funding shall come from any single funding source. Contributions in excess of the low-income pool shall be allocated to the disproportionate share programs defined in ss. 409.911(3) and 409.9113 and to hospital rates pursuant to subsection (4). The local funding source shall designate in the contract which Medicaid providers ensure access to care for low-income and uninsured people within the applicable jurisdiction and are eligible for low-income pool funding. Eligible providers may include hospitals, primary care providers, and primary care

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access systems.

(2) LOW-INCOME POOL.—The agency shall establish and maintain a low-income pool in a manner authorized by federal waiver. The low-income pool is created to compensate a network of providers designated pursuant to subsection (1). Funding of the low-income pool shall be limited to the maximum amount permitted by federal waiver minus a percentage specified in the General Appropriations Act. The low-income pool must be used to support enhanced access to services by offsetting shortfalls in Medicaid reimbursement, paying for otherwise uncompensated care, and financing coverage for the uninsured. The low-income pool shall be distributed in periodic payments to the Access to Care Partnership throughout the fiscal year. Distribution of low-income pool funds by the Access to Care Partnership to participating providers may be made through capitated payments, fees for services, or contracts for specific deliverables. The agency shall include the distribution amount for each provider in the contract with the Access to Care Partnership pursuant to subsection (3). Regardless of the method of distribution, providers participating in the Access to Care Partnership shall receive payments such that the aggregate benefit in the jurisdiction of each local funding source, as defined in subsection (1), equals the amount of the contribution plus a factor specified in the General Appropriations Act.

(3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract with an administrative services organization that has operating agreements with all health care facilities, programs, and providers supported with local taxes or certified public expenditures and designated pursuant to subsection (1). The

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contract shall provide for enhanced access to care for Medicaid, low-income, and uninsured Floridians. The partnership shall be responsible for an ongoing program of activities that provides needed, but uncovered or undercompensated, health services to Medicaid enrollees and persons receiving charity care, as defined in s. 409.911. Accountability for services rendered under this contract must be based on the number of services provided to unduplicated qualified beneficiaries, the total units of service provided to these persons, and the effectiveness of services provided as measured by specific standards of care. The agency shall seek such plan amendments or waivers as may be necessary to authorize the implementation of the low-income pool as the Access to Care Partnership pursuant to this section.

(4) HOSPITAL RATE DISTRIBUTION.—

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized under the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in s. 408.07(45), and specialty children's hospitals as defined in s. 395.002(28).

2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients, as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).

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3. Tier 3 hospitals include all community hospitals.

(b) When rates are increased pursuant to this section, the Total Tier Allocation (TTA) shall be distributed as follows:

1. Tier 1 (T1A) = 0.35 x TTA.

2. Tier 2 (T2A) = 0.35 x TTA.

3. Tier 3 (T3A) = 0.30 x TTA.

(c) The tier allocation shall be distributed as a percentage increase to the hospital specific base rate (HSBR) established pursuant to s. 409.905(5)(c). The increase in each tier shall be calculated according to the proportion of tier-specific allocation to the total estimated inpatient spending (TEIS) for all hospitals in each tier:

1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total estimated inpatient spending (T1TEIS).

2. Tier 2 percent increase (T2PI) = T2A /Tier 2 total estimated inpatient spending (T2TEIS).

3. Tier 3 percent increase (T3PI) = T3A/ Tier 3 total estimated inpatient spending (T3TEIS).

(d) The hospital-specific tiered rate (HSTR) shall be calculated as follows:

1. For hospitals in Tier 3: HSTR = (1 + T3PI) x HSBR.

2. For hospitals in Tier 2: HSTR = (1 + T2PI) x HSBR.

3. For hospitals in Tier 1: HSTR = (1 + T1PI) x HSBR.

Section 12. Section 409.971, Florida Statutes, is created to read:

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. By January 1, 2013, the agency shall begin implementation of the statewide managed

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medical assistance program, with full implementation in all regions by October 1, 2014.

Section 13. Section 409.972, Florida Statutes, is created to read:

409.972 Mandatory and voluntary enrollment.—

(1) Persons eligible for the program known as "medically needy" pursuant to s. 409.904(2)(a) shall enroll in managed care plans. Medically needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.

(2) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).

(c) Persons eligible for refugee assistance.

(d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.

(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.

(3) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall


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be served in the Medicaid fee-for-service program as provided in part III of this chapter.

(4) The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

Section 14. Section 409.973, Florida Statutes, is created to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

(e) Dental services.

(f) Early periodic screening diagnosis and treatment services for recipients under age 21.

(g) Emergency services.

(h) Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the agency of that election when submitting a reply to an invitation to negotiate.

(i) Healthy start services, except as provided in s. 409.975(4).

(j) Hearing services.

(k) Home health agency services.

(l) Hospice services.


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(m) Hospital inpatient services.
(n) Hospital outpatient services.
(o) Laboratory and imaging services.
(p) Medical supplies, equipment, prostheses, and orthoses.
(q) Mental health services.
(r) Nursing care.
(s) Optical services and supplies.
(t) Optometrist services.
(u) Physical, occupational, respiratory, and speech therapy services.
(v) Physician services, including physician assistant services.
(w) Podiatric services.
(x) Prescription drugs.
(y) Renal dialysis services.
(z) Respiratory equipment and supplies.
(aa) Rural health clinic services.
(bb) Substance abuse treatment services.
(cc) Transportation to access covered services.
(2) CUSTOMIZED BENEFITS.—Managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plan's enrollees and to verify actuarial equivalence.
(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved smoking cessation program, a

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medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program. Each plan must identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

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

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

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

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

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

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


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Section 15. Section 409.974, Florida Statutes, is created to read:

409.974 Eligible plans.—

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

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

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

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

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

(e) The agency shall procure at least two plans and up to 4 plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

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

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

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

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

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

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

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

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

(3) SPECIALTY PLANS.—Participation by specialty plans shall be subject to the procurement requirements and regional plan number limits of this section. However, a specialty plan whose target population includes no more than 10 percent of the enrollees of that region is not subject to the regional plan number limits of this section.

(4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

Section 16. Section 409.975, Florida Statutes, is created to read:

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

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

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(45).

3. Hospitals that are trauma centers as defined in s.


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395.4001(14).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. If the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed

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care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

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

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

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

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by a regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

(c) After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan

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must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion.

(d) Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency shall contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans. The agency shall support these activities with certified public expenditures and any earned federal matching funds and shall seek any plan amendments or waivers necessary to comply with this subsection. To be eligible to participate in the quality network, a medical school must contract with each managed care plan in its region.

(3) PERFORMANCE MEASUREMENT.—Each managed care plan shall monitor the quality and performance of each participating provider. At the beginning of the contract period, each plan shall notify all its network providers of the metrics used by the plan for evaluating the provider’s performance and determining continued participation in the network.


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(4) MOMCARE NETWORK.—

(a) The agency shall contract with an administrative services organization representing all Healthy Start Coalitions providing risk appropriate care coordination and other services in accordance with a federal waiver and pursuant to s. 409.906. The contract shall require the network of coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver. The agency shall evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. The agency shall support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

(b) Each managed care plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs. Each plan's programs and procedures shall include agreements with each local Healthy Start Coalition in the region to provide risk-appropriate care coordination for pregnant women and infants, consistent with agency policies and the MomCare network. Each managed care plan must notify the agency of the impending birth of a child to an enrollee, or notify the agency as soon as practicable after the child's birth.


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(5) SCREENING RATE.—After the end of the second contract year, each managed care plan shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent of those recipients continuously enrolled for at least 8 months.

(6) PROVIDER PAYMENT.—Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. For rates, methods, and terms of payment negotiated after the contract between the agency and the plan is executed, plans shall pay hospitals, at a minimum, the rate the agency would have paid on the first day of the contract between the provider and the plan. Such payments to hospitals may not exceed 120 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

(7) MEDICALLY NEEDY ENROLLEES.—Each managed care plan must accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the department. The agency shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for medically needy patients for services provided before enrollment in the plan. Medically needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period


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of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.

Section 17. Section 409.976, Florida Statutes, is created to read:

409.976 Managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the managed medical assistance program pursuant to this section.

(1) Prepaid payment rates shall be negotiated between the agency and the eligible plans as part of the procurement process described in s. 409.966.

(2) The agency shall establish payment rates for statewide inpatient psychiatric programs. Payments to managed care plans shall be reconciled to reimburse actual payments to statewide inpatient psychiatric programs.

Section 18. Section 409.977, Florida Statutes, is created to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a


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plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

(2) When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria:

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

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

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

(3) A newborn of a mother enrolled in a plan at the time of the child’s birth shall be enrolled in the mother’s plan. Upon birth, such a newborn is deemed enrolled in the managed care plan, regardless of the administrative enrollment procedures, and the managed care plan is responsible for providing Medicaid services to the newborn. The mother may choose another plan for the newborn within 90 days after the child’s birth.

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient’s share of the cost in such employer-sponsored coverage. Contingent upon federal approval, the agency shall also enable recipients with access to other insurance or related products providing access

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

Section 19. Section 409.978, Florida Statutes, is created to read:

409.978 Long-term care managed care program.—

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

(2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model. Unless otherwise specified, ss. 409.961-409.97 apply to the long-term care managed care program.

(3) The Department of Elderly Affairs shall assist the

agency to develop specifications for use in the invitation to negotiate and the model contract, determine clinical eligibility for enrollment in managed long-term care plans, monitor plan performance and measure quality of service delivery, assist clients and families to address complaints with the plans, facilitate working relationships between plans and providers serving elders and disabled adults, and perform other functions specified in a memorandum of agreement.

Section 20. Section 409.979, Florida Statutes, is created to read:

409.979 Eligibility.—

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

(2) Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 12 months without being reevaluated for their need for nursing facility care as defined in s. 409.985(3):

(a) The Assisted Living for the Frail Elderly Waiver.

(b) The Aged and Disabled Adult Waiver.


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(c) The Adult Day Health Care Waiver.

(d) The Consumer-Directed Care Plus Program as described in s. 409.221.

(e) The Program of All-inclusive Care for the Elderly.

(f) The long-term care community-based diversion pilot project as described in s. 430.705.

(g) The Channeling Services Waiver for Frail Elders.

(3) The Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds. Before enrollment offers, the department shall determine that sufficient funds exist to support additional enrollment into plans.

Section 21. Section 409.98, Florida Statutes, is created to read:

409.98 Long-term care plan benefits.—Long-term care plans shall, at a minimum, cover the following:

(1) Nursing facility care.

(2) Services provided in assisted living facilities.

(3) Hospice.

(4) Adult day care.

(5) Medical equipment and supplies, including incontinence supplies.

(6) Personal care.

(7) Home accessibility adaptation.

(8) Behavior management.

(9) Home-delivered meals.

(10) Case management.

(11) Therapies:


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(a) Occupational therapy.
(b) Speech therapy.
(c) Respiratory therapy.
(d) Physical therapy.
(12) Intermittent and skilled nursing.
(13) Medication administration.
(14) Medication management.
(15) Nutritional assessment and risk reduction.
(16) Caregiver training.
(17) Respite care.
(18) Transportation.
(19) Personal emergency response system.

Section 22. Section 409.981, Florida Statutes, is created to read:

409.981 Eligible long-term care plans.—

(1) ELIGIBLE PLANS.—Provider service networks must be long-term care provider service networks. Other eligible plans may be long-term care plans or comprehensive long-term care plans.

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. The agency shall provide notice of invitations to negotiate by July 1, 2012. The agency shall procure:

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

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

(c) At least three plans and up to five plans for Region 3.

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

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

(e) At least two plans and up to 4 plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

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

(g) At least three plans and up to 6 plans for Region 7. At least one plan must be a provider service networks if any provider service networks submit a responsive bid.

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

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

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

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

If no provider service network submits a responsive bid in a region other than Region 1 or Region 2, the agency shall procure

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

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

(a) Evidence of the employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care.

(b) Whether a plan has established a network of service providers dispersed throughout the region and in sufficient numbers to meet specific service standards established by the agency for specialty services for persons receiving home and community-based care.

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

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

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

(4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—Participation by the Program of All-Inclusive Care for the Elderly (PACE) shall be pursuant to a contract with the agency

and not subject to the procurement requirements or regional plan number limits of this section. PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.

(5) MEDICARE PLANS.—Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of recipients who are deemed dually eligible for Medicaid and Medicare services. Otherwise, Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-Sponsored Organizations, and Medicare Advantage Special Needs Plans are subject to all procurement requirements.

Section 23. Section 409.982, Florida Statutes, is created to read:

409.982 Long-term care managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the long-term care managed care program must comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price. For the period between October 1, 2013, and September 30, 2014, each selected plan must offer a network contract to all the following providers in the region:

(a) Nursing homes.

(b) Hospices.

(c) Aging network service providers that have previously participated in home and community-based waivers serving elders

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or community-service programs administered by the Department of Elderly Affairs.

After 12 months of active participation in a managed care plan's network, the plan may exclude any of the providers named in this subsection from the network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice must be provided at least 30 days before the effective date of the exclusion. The agency shall establish contract provisions governing the transfer of recipients from excluded residential providers.

(2) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the managed care plans they join. Nursing homes and hospices that are enrolled Medicaid providers must participate in all eligible plans selected by the agency in the region in which the provider is located.

(3) PERFORMANCE MEASUREMENT.—Each managed care plan shall monitor the quality and performance of each participating provider using measures adopted by and collected by the agency and any additional measures mutually agreed upon by the provider and the plan

(4) PROVIDER NETWORK STANDARDS.—The agency shall establish and each managed care plan must comply with specific standards for the number, type, and regional distribution of providers in the plan's network, which must include:

(a) Adult day care centers.

(b) Adult family-care homes.

(c) Assisted living facilities.


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(d) Health care services pools.

(e) Home health agencies.

(f) Homemaker and companion services.

(g) Hospices.

(h) Community care for the elderly lead agencies.

(i) Nurse registries.

(j) Nursing homes.

(5) PROVIDER PAYMENT.—Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay nursing homes an amount equal to the nursing facility-specific payment rates set by the agency; however, mutually acceptable higher rates may be negotiated for medically complex care. Plans shall pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by the agency. For recipients residing in a nursing facility and receiving hospice services, the plan shall pay the hospice provider the per diem rate set by the agency minus the nursing facility component and shall pay the nursing facility the applicable state rate. Plans must ensure that electronic nursing home and hospice claims that contain sufficient information for processing are paid within 10 business days after receipt.

Section 24. Section 409.983, Florida Statutes, is created to read:

409.983 Long-term care managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the long-term care managed care program pursuant to this section.

(1) Prepaid payment rates for long-term care managed care


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plans shall be negotiated between the agency and the eligible plans as part of the procurement process described in s. 409.966.

(2) Payment rates for comprehensive long-term care plans covering services described in s. 409.973 shall be blended with rates for long-term care plans for services specified in s. 409.98.

(3) Payment rates for plans must reflect historic utilization and spending for covered services projected forward and adjusted to reflect the level of care profile for enrollees in each plan. The payment shall be adjusted to provide an incentive for reducing institutional placements and increasing the utilization of home and community-based services.

(4) The initial assessment of an enrollee's level of care shall be made by the Comprehensive Assessment and Review for Long-Term-Care Services (CARES) program, which shall assign the recipient into one of the following levels of care:

(a) Level of care 1 consists of recipients residing in or who must be placed in a nursing home.

(b) Level of care 2 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, and require extensive health-related care and services because of mental or physical incapacitation.

(c) Level of care 3 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and services and are mildly medically or physically incapacitated.


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The agency shall periodically adjust payment rates to account for changes in the level of care profile for each managed care plan based on encounter data.

(5) The agency shall make an incentive adjustment in payment rates to encourage the increased utilization of home and community-based services and a commensurate reduction of institutional placement. The incentive adjustment shall be modified in each successive rate period during the first contract period, as follows:

(a) A 2 percentage point shift in the first rate-setting period;

(b) A 2 percentage point shift in the second rate-setting period, as compared to the utilization mix at the end of the first rate-setting period; or

(c) A 3 percentage point shift in the third rate-setting period, and in each subsequent rate-setting period during the first contract period, as compared to the utilization mix at the end of the immediately preceding rate-setting period.

The incentive adjustment shall continue in subsequent contract periods, at a rate of 3 percentage points per year as compared to the utilization mix at the end of the immediately preceding rate-setting period, until no more than 35 percent of the plan's enrollees are placed in institutional settings. The agency shall annually report to the Legislature the actual change in the utilization mix of home and community-based services compared to institutional placements and provide a recommendation for utilization mix requirements for future contracts.


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(6) The agency shall establish nursing-facility-specific payment rates for each licensed nursing home based on facility costs adjusted for inflation and other factors as authorized in the General Appropriations Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to nursing facilities.

(7) The agency shall establish hospice payment rates pursuant to Title XVIII of the Social Security Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to hospices.

Section 25. Section 409.984, Florida Statutes, is created to read:

409.984 Enrollment in a long-term care managed care plan.—

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as otherwise provided in this part, the agency

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may not engage in practices that are designed to favor one managed care plan over another.

(1) When automatically enrolling recipients in plans, the agency shall take into account the following criteria:

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

(b) Whether the recipient has previously received services from one of the plan's home and community-based service providers.

(c) Whether the home and community-based providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(3) Notwithstanding s. 409.969(3)(c), if a recipient is referred for hospice services, the recipient has 30 days during which the recipient may select to enroll in another managed care plan to access the hospice provider of the recipient's choice.

(4) If a recipient is referred for placement in a nursing home or assisted living facility, the plan must inform the recipient of any facilities within the plan that have specific cultural or religious affiliations and, if requested by the recipient, make a reasonable effort to place the recipient in the facility of the recipient's choice.

Section 26. Section 409.9841, Florida Statutes, is created to read:

409.9841 Long-term care managed care technical advisory workgroup.—

(1) Before August 1, 2011, the agency shall establish a technical advisory workgroup to assist in developing:

(a) The method of determining Medicaid eligibility pursuant


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to s. 409.985(3).

(b) The requirements for provider payments to nursing homes under s. 409.983(6).

(c) The method for managing Medicare coinsurance crossover claims.

(d) Uniform requirements for claims submissions and payments, including electronic funds transfers and claims processing.

(e) The process for enrollment of and payment for individuals pending determination of Medicaid eligibility.

(2) The advisory workgroup must include, but is not limited to, representatives of providers and plans who could potentially participate in long-term care managed care. Members of the workgroup shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(3) This section is repealed on June 30, 2013.

Section 27. Section 409.985, Florida Statutes, is created to read:

409.985 Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program.—

(1) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) preadmission screening program to ensure that only individuals whose conditions require long-term care services are enrolled in the long-term care managed care program.

(2) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES


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program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and review.

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:

(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;

(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual who is incapacitated mentally or


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physically; or

(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

(4) For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage and is being terminated for lack of progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believe that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

Section 28. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

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Section 29. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid managed care; creating part IV of ch. 409, F.S., entitled "Medicaid Managed Care"; creating s. 409.961, F.S.; providing for statutory construction; providing applicability of specified provisions throughout the part; providing rulemaking authority for specified agencies; creating s. 409.962, F.S.; providing definitions; creating s. 409.963, F.S.; designating the Agency for Health Care Administration as the single state agency to administer the Medicaid program; providing for specified agency responsibilities; requiring client consent for release of medical records; creating s. 409.964, F.S.; establishing the Medicaid program as the statewide, integrated managed care program for all covered services; authorizing the agency to apply for and implement waivers; providing for public notice and comment; creating s. 409.965, F.S.; providing for mandatory enrollment; providing exemptions; creating s. 409.966, F.S.; providing requirements for eligible plans that provide services in the Medicaid managed care program; establishing provider service network requirements for eligible plans; providing for


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eligible plan selection; requiring the agency to use an invitation to negotiate; requiring the agency to compile and publish certain information; establishing regions for separate procurement of plans; providing quality criteria for plan selection; providing limitations on serving recipients during the pendency of procurement litigation; creating s. 409.967, F.S.; providing for managed care plan accountability; establishing contract terms; providing for physician compensation; providing for emergency services; establishing requirements for access; requiring a drug formulary or preferred drug list; requiring plans to accept requests for service electronically; requiring the agency to maintain an encounter data system; requiring plans to provide encounter data; requiring the agency to establish performance standards for plans; providing program integrity requirements; establishing requirements for the database; establishing a grievance resolution process; providing penalties for early termination of contracts or reduction in enrollment levels; establishing prompt payment requirements; requiring fair payment to providers with a controlling interest in a provider service network by other plans; requiring itemized payment; providing for dispute resolutions between plans and providers; providing for achieved savings rebates to plans; creating s. 409.968, F.S.; establishing managed care plan payments; providing payment requirements for provider service networks;


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requiring the agency to conduct annual cost reconciliations to determine certain cost savings and report the results of the reconciliations to the fee-for-service provider; prohibiting rate increases that are not authorized in the appropriations act; creating s. 409.969, F.S.; requiring enrollment in managed care plans by all nonexempt Medicaid recipients; creating requirements for plan selection by recipients; authorizing disenrollment under certain circumstances; defining the term "good cause" for purposes of disenrollment; providing time limits on an internal grievance process; providing requirements for agency determination regarding disenrollment; requiring recipients to stay in plans for a specified time; creating s. 409.97, F.S.; authorizing the agency to accept the transfer of certain revenues from local governments; requiring the agency to contract with a representative of certain entities participating in the low-income pool for the provision of enhanced access to care; providing for support of these activities by the low-income pool as authorized in the General Appropriations Act; establishing the Access to Care Partnership; requiring the agency to seek necessary waivers and plan amendments; providing requirements for prepaid plans to submit data; authorizing the agency to implement a tiered hospital rate system; creating s. 409.971, F.S.; creating the managed medical assistance program; providing deadlines to begin and finalize implementation of the


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program; creating s. 409.972, F.S.; providing eligibility requirements for mandatory and voluntary enrollment; creating s. 409.973, F.S.; establishing minimum benefits for managed care plans to cover; authorizing plans to customize benefit packages; requiring plans to establish programs to encourage healthy behaviors and establish written agreements with certain enrollees to participate in such programs; requiring plans to establish a primary care initiative; providing requirements for primary care initiatives; requiring plans to report certain primary care data to the agency; creating s. 409.974, F.S.; establishing a deadline for issuing invitations to negotiate; establishing a specified number or range of eligible plans to be selected in each region; establishing quality selection criteria; establishing requirements for participation by specialty plans; establishing the Children's Medical Service Network as an eligible plan; creating s. 409.975, F.S.; providing for managed care plan accountability; authorizing plans to limit providers in networks; requiring plans to include essential Medicaid providers in their networks unless an alternative arrangement is approved by the agency; identifying statewide essential providers; specifying provider payments under certain circumstances; requiring plans to include certain statewide essential providers in their networks; requiring good faith negotiations; specifying provider payments under certain circumstances; allowing plans


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to exclude essential providers under certain circumstances; requiring plans to offer a contract to home medical equipment and supply providers under certain circumstances; establishing the Florida medical school quality network; requiring the agency to contract with a representative of certain entities to establish a clinical outcome improvement program in all plans; providing for support of these activities by certain expenditures and federal matching funds; requiring the agency to seek necessary waivers and plan amendments; providing for eligibility for the quality network; requiring plans to monitor the quality and performance history of providers; establishing the MomCare network; requiring the agency to contract with a representative of all Healthy Start Coalitions to provide certain services to recipients; providing for support of these activities by certain expenditures and federal matching funds; requiring plans to enter into agreements with local Healthy Start Coalitions for certain purposes; requiring specified programs and procedures be established by plans; establishing a screening standard for the Early and Periodic Screening, Diagnosis, and Treatment Service; requiring managed care plans and hospitals to negotiate rates, methods, and terms of payment; providing a limit on payments to hospitals; establishing plan requirements for medically needy recipients; creating s. 409.976, F.S.; providing for managed care plan payment; requiring the agency to


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establish payment rates for statewide inpatient psychiatric programs; requiring payments to managed care plans to be reconciled to reimburse actual payments to statewide inpatient psychiatric programs; creating s. 409.977, F.S.; providing for automatic enrollment in a managed care plan for certain recipients; establishing opt-out opportunities for recipients; creating s. 409.978, F.S.; requiring the agency to be responsible for administering the long-term care managed care program; providing implementation dates for the long-term care managed care program; providing duties of the Department of Elderly Affairs relating to assisting the agency in implementing the program; creating s. 409.979, F.S.; providing eligibility requirements for the long-term care managed care program; creating s. 409.98, F.S.; establishing the benefits covered under a managed care plan participating in the long-term care managed care program; creating s. 409.981, F.S.; providing criteria for eligible plans; designating regions for plan implementation throughout the state; providing criteria for the selection of plans to participate in the long-term care managed care program; providing that participation by the Program of All-Inclusive Care for the Elderly and certain Medicare plans is pursuant to an agency contract and not subject to procurement; creating s. 409.982, F.S.; requiring the agency to establish uniform accounting and reporting methods for plans; providing for mandatory


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participation in plans by certain service providers; authorizing the exclusion of certain providers from plans for failure to meet quality or performance criteria; requiring plans to monitor participating providers using specified criteria; requiring certain providers to be included in plan networks; providing provider payment specifications for nursing homes and hospices; creating s. 409.983, F.S.; providing for negotiation of rates between the agency and the plans participating in the long-term care managed care program; providing specific criteria for calculating and adjusting plan payments; allowing the CARES program to assign plan enrollees to a level of care; providing incentives for adjustments of payment rates; requiring the agency to establish nursing facility-specific and hospice services payment rates; creating s. 409.984, F.S.; providing criteria for automatic assignments of plan enrollees who fail to choose a plan; providing for hospice selection within a specified timeframe; providing for a choice of residential setting under certain circumstances; creating s. 409.9841, F.S.; creating the long-term care managed care technical advisory workgroup; providing duties; providing membership; providing for reimbursement for per diem and travel expenses; providing for repeal by a specified date; creating s. 409.985, F.S.; providing that the agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services program through an interagency agreement


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with the Department of Elderly Affairs; providing duties of the program; defining the term "nursing facility care"; providing for severability; providing an effective date.