

HB 7107

2011

1 A bill to be entitled  
2 An act relating to Medicaid managed care; creating pt. IV  
3 of ch. 409, F.S., entitled "Medicaid Managed Care";  
4 creating s. 409.961, F.S.; providing for statutory  
5 construction; providing applicability of specified  
6 provisions throughout the part; providing rulemaking  
7 authority for specified agencies; creating s. 409.962,  
8 F.S.; providing definitions; creating s. 409.963, F.S.;  
9 designating the Agency for Health Care Administration as  
10 the single state agency to administer the Medicaid  
11 program; providing for specified agency responsibilities;  
12 requiring client consent for release of medical records;  
13 creating s. 409.964, F.S.; establishing the Medicaid  
14 program as the statewide, integrated managed care program  
15 for all covered services; authorizing the agency to apply  
16 for and implement waivers; providing for public notice and  
17 comment; creating s. 409.965, F.S.; providing for  
18 mandatory enrollment; providing for exemptions; creating  
19 s. 409.966, F.S.; providing requirements for eligible  
20 plans that provide services in the Medicaid managed care  
21 program; establishing provider service network  
22 requirements for eligible plans; providing for eligible  
23 plan selection; requiring the agency to use an invitation  
24 to negotiate; requiring the agency to compile and publish  
25 certain information; establishing seven regions for  
26 separate procurement of plans; providing quality criteria  
27 for plan selection; providing limitations on serving  
28 recipients during the pendency of procurement litigation;

Page 1 of 75

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

hb7107-00

29 | creating s. 409.967, F.S.; providing for managed care plan  
30 | accountability; establishing contract terms; providing for  
31 | contract extension under certain circumstances;  
32 | establishing payments to noncontract providers;  
33 | establishing requirements for access; requiring plans to  
34 | establish and maintain an electronic database;  
35 | establishing requirements for the database; requiring  
36 | plans to provide encounter data; requiring the agency to  
37 | maintain an encounter data system; requiring the agency to  
38 | establish performance standards for plans; providing  
39 | program integrity requirements; establishing a grievance  
40 | resolution process; providing penalties for early  
41 | termination of contracts or reduction in enrollment  
42 | levels; establishing prompt payment requirements;  
43 | requiring plans to accept electronic claims; requiring  
44 | fair payment to providers with a controlling interest in a  
45 | provider service network by other plans; requiring the  
46 | agency and prepaid plans to use a uniform method for  
47 | certain financial reports; providing income-sharing  
48 | ratios; providing a timeframe for a plan to pay an  
49 | additional rebate under certain circumstances; requiring  
50 | the agency to return prepaid plan overpayments; creating  
51 | s. 409.968, F.S.; establishing managed care plan payments;  
52 | providing payment requirements for provider service  
53 | networks; requiring the agency to conduct annual cost  
54 | reconciliations to determine certain cost savings and  
55 | report the results of the reconciliations to the fee-for-  
56 | service provider; providing a timeframe for the provider

57 service to respond to the report; creating s. 409.969,  
58 F.S.; requiring enrollment in managed care plans by all  
59 nonexempt Medicaid recipients; creating requirements for  
60 plan selection by recipients; providing for choice  
61 counseling; establishing choice counseling vendor  
62 requirements; authorizing disenrollment under certain  
63 circumstances; defining the term "good cause" for purposes  
64 of disenrollment; providing time limits on an internal  
65 grievance process; providing requirements for agency  
66 determination regarding disenrollment; requiring  
67 recipients to stay in plans for a specified time; creating  
68 s. 409.97, F.S.; authorizing the agency to accept the  
69 transfer of certain revenues from local governments;  
70 requiring the agency to contract with a representative of  
71 certain entities participating in the low-income pool for  
72 the provision of enhanced access to care; providing for  
73 support of these activities by the low-income pool as  
74 authorized in the General Appropriations Act; establishing  
75 the Access to Care Partnership; requiring the agency to  
76 seek necessary waivers and plan amendments; providing  
77 requirements for prepaid plans to submit data; authorizing  
78 the agency to implement a tiered hospital rate system;  
79 creating s. 409.971, F.S.; creating the managed medical  
80 assistance program; providing deadlines to begin and  
81 finalize implementation of the program; creating s.  
82 409.972, F.S.; providing eligibility requirements for  
83 mandatory and voluntary enrollment; creating s. 409.973,  
84 F.S.; establishing minimum benefits for managed care plans

HB 7107

2011

85 | to cover; authorizing plans to customize benefit packages;  
86 | requiring plans to establish a program to encourage  
87 | healthy behaviors; creating s. 409.974, F.S.; establishing  
88 | a deadline for issuing invitations to negotiate;  
89 | establishing a specified number or range of eligible plans  
90 | to be selected in each region; establishing quality  
91 | selection criteria; establishing requirements for  
92 | participation by specialty plans; establishing the  
93 | Children's Medical Service Network as an eligible plan;  
94 | creating s. 409.975, F.S.; providing for managed care plan  
95 | accountability; authorizing plans to limit providers in  
96 | networks; requiring plans to include essential Medicaid  
97 | providers in their networks unless an alternative  
98 | arrangement is approved by the agency; identifying  
99 | statewide essential providers; specifying provider  
100 | payments under certain circumstances; requiring plans to  
101 | include certain statewide essential providers in their  
102 | networks; requiring good faith negotiations; specifying  
103 | provider payments under certain circumstances; allowing  
104 | plans to exclude essential providers under certain  
105 | circumstances; requiring plans to offer a contract to home  
106 | medical equipment and supply providers under certain  
107 | circumstances; establishing the Florida medical school  
108 | quality network; requiring the agency to contract with a  
109 | representative of certain entities to establish a clinical  
110 | outcome improvement program in all plans; providing for  
111 | support of these activities by certain expenditures and  
112 | federal matching funds; requiring the agency to seek

HB 7107

2011

113 necessary waivers and plan amendments; providing for  
114 eligibility for the quality network; requiring plans to  
115 monitor the quality and performance history of providers;  
116 establishing the MomCare network; requiring the agency to  
117 contract with a representative of all Healthy Start  
118 Coalitions to provide certain services to recipients;  
119 providing for support of these activities by certain  
120 expenditures and federal matching funds; requiring plans  
121 to enter into agreements with local Healthy Start  
122 Coalitions for certain purposes; requiring specified  
123 programs and procedures be established by plans;  
124 establishing a screening standard for the Early and  
125 Periodic Screening, Diagnosis, and Treatment Service;  
126 requiring managed care plans and hospitals to negotiate  
127 rates, methods, and terms of payment; providing a limit on  
128 payments to hospitals; establishing plan requirements for  
129 medically needy recipients; creating s. 409.976, F.S.;  
130 providing for managed care plan payment; requiring the  
131 agency to establish payment rates for statewide inpatient  
132 psychiatric programs; requiring payments to managed care  
133 plans to be reconciled to reimburse actual payments to  
134 statewide inpatient psychiatric programs; creating s.  
135 409.977, F.S.; establishing choice counseling  
136 requirements; providing for automatic enrollment in a  
137 managed care plan for certain recipients; establishing  
138 opt-out opportunities for recipients; creating s. 409.978,  
139 F.S.; requiring the agency to be responsible for  
140 administering the long-term care managed care program;

HB 7107

2011

141 providing implementation dates for the long-term care  
142 managed care program; providing duties of the Department  
143 of Elderly Affairs relating to assisting the agency in  
144 implementing the program; creating s. 409.979, F.S.;

145 providing eligibility requirements for the long-term care  
146 managed care program; creating s. 409.98, F.S.;

147 establishing the benefits covered under a managed care  
148 plan participating in the long-term care managed care  
149 program; creating s. 409.981, F.S.; providing criteria for  
150 eligible plans; designating regions for plan  
151 implementation throughout the state; providing criteria  
152 for the selection of plans to participate in the long-term  
153 care managed care program; providing that participation by  
154 the Program of All-Inclusive Care for the Elderly is  
155 pursuant to an agency contract; creating s. 409.982, F.S.;

156 requiring the agency to establish uniform accounting and  
157 reporting methods for plans; providing for mandatory  
158 participation in plans by certain service providers;  
159 authorizing the exclusion of certain providers from plans  
160 for failure to meet quality or performance criteria;  
161 requiring plans to monitor participating providers using  
162 specified criteria; requiring certain providers to be  
163 included in plan networks; providing provider payment  
164 specifications for nursing homes and hospices; creating s.  
165 409.983, F.S.; providing for negotiation of rates between  
166 the agency and the plans participating in the long-term  
167 care managed care program; providing specific criteria for  
168 calculating and adjusting plan payments; allowing the

HB 7107

2011

169 CARES program to assign plan enrollees to a level of care;  
170 providing incentives for adjustments of payment rates;  
171 requiring the agency to establish nursing facility-  
172 specific and hospice services payment rates; creating s.  
173 409.984, F.S.; providing that before contracting with  
174 another vendor, the agency shall offer to contract with  
175 the aging resource centers to provide choice counseling  
176 for the long-term care managed care program; providing  
177 criteria for automatic assignments of plan enrollees who  
178 fail to choose a plan; providing for hospice selection  
179 within a specified timeframe; providing for a choice of  
180 residential setting under certain circumstances; creating  
181 s. 409.9841, F.S.; creating the long-term care managed  
182 care technical advisory workgroup; providing duties;  
183 providing membership; providing for reimbursement for per  
184 diem and travel expenses; providing for repeal by a  
185 specified date; creating s. 409.985, F.S.; providing that  
186 the agency shall operate the Comprehensive Assessment and  
187 Review for Long-Term Care Services program through an  
188 interagency agreement with the Department of Elderly  
189 Affairs; providing duties of the program; defining the  
190 term "nursing facility care"; creating s. 409.986, F.S.;  
191 providing authority and agency duties regarding long-term  
192 care programs for persons with developmental disabilities;  
193 authorizing the agency to delegate specific duties to and  
194 collaborate with the Agency for Persons with Disabilities;  
195 requiring the agency to make payments for long-term care  
196 for persons with developmental disabilities under certain

HB 7107

2011

197 conditions; creating s. 409.987, F.S.; providing  
198 eligibility requirements for long-term care plans;  
199 creating s. 409.988, F.S.; specifying covered benefits for  
200 long-term care plans; creating s. 409.989, F.S.;  
201 establishing criteria for eligible plans; specifying  
202 minimum and maximum number of plans and selection  
203 criteria; authorizing participation by the Children's  
204 Medical Services Network in long-term care plans under  
205 certain conditions; creating s. 409.99, F.S.; providing  
206 requirements for managed care plan accountability;  
207 specifying limitations on providers in plan networks;  
208 providing for evaluation and payment of network providers;  
209 requiring managed care plans to establish family advisory  
210 committees and offer consumer-directed care services;  
211 creating s. 409.991, F.S.; providing for payment of  
212 managed care plans; providing duties for the Agency for  
213 Persons with Disabilities to assign plan enrollees into a  
214 payment-rate level of care; establishing level-of-care  
215 criteria; providing payment requirements for intensive  
216 behavior residential habilitation providers and  
217 intermediate care facilities for the developmentally  
218 disabled; creating s. 409.992, F.S.; providing  
219 requirements for enrollment and choice counseling;  
220 specifying enrollment exceptions for certain Medicaid  
221 recipients; providing an effective date.

222

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

224



HB 7107

2011

225           Section 1. Sections 409.961 through 409.992, Florida  
 226 Statutes, are designated as part IV of chapter 409, Florida  
 227 Statutes, entitled "Medicaid Managed Care."

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

230           409.961 Statutory construction; applicability; rules.—It  
 231 is the intent of the Legislature that if any conflict exists  
 232 between the provisions contained in this part and provisions  
 233 contained in other parts of this chapter, the provisions  
 234 contained in this part shall control. The provisions of ss.  
 235 409.961-409.97 apply only to the Medicaid managed medical  
 236 assistance program, long-term care managed care program, and  
 237 managed long-term care for persons with developmental  
 238 disabilities program, as provided in this part. The agency shall  
 239 adopt any rules necessary to comply with or administer this part  
 240 and all rules necessary to comply with federal requirements. In  
 241 addition, the department shall adopt and accept the transfer of  
 242 any rules necessary to carry out the department's  
 243 responsibilities for receiving and processing Medicaid  
 244 applications and determining Medicaid eligibility and for  
 245 ensuring compliance with and administering this part, as those  
 246 rules relate to the department's responsibilities, and any other  
 247 provisions related to the department's responsibility for the  
 248 determination of Medicaid eligibility.

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

251           409.962 Definitions.—As used in this part, except as  
 252 otherwise specifically provided, the term:

253       (1) "Agency" means the Agency for Health Care  
 254 Administration.

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

259       (3) "Comprehensive long-term care plan" means a managed  
 260 care plan that provides services described in s. 409.973 and  
 261 also provides the services described in s. 409.98 or s. 409.988.

262       (4) "Department" means the Department of Children and  
 263 Family Services.

264       (5) "Developmental disability provider service network"  
 265 means a provider service network, a controlling interest of  
 266 which includes one or more entities licensed pursuant to s.  
 267 393.067 or s. 400.962 with 18 or more licensed beds and the  
 268 owner or owners of which have at least 10 years' experience  
 269 servicing persons with developmental disabilities.

270       (6) "Direct care management" means care management  
 271 activities that involve direct interaction with Medicaid  
 272 recipients.

273       (7) "Eligible plan" means a health insurer authorized  
 274 under chapter 624, an exclusive provider organization authorized  
 275 under chapter 627, a health maintenance organization authorized  
 276 under chapter 641, or a provider service network authorized  
 277 under s. 409.912(4)(d). For purposes of the managed medical  
 278 assistance program, the term also includes the Children's  
 279 Medical Services Network authorized under chapter 391. For  
 280 purposes of the long-term care managed care program, the term

281 also includes entities qualified under 42 C.F.R. part 422 as  
 282 Medicare Advantage Preferred Provider Organizations, Medicare  
 283 Advantage Provider-sponsored Organizations, and Medicare  
 284 Advantage Special Needs Plans, and the Program of All-Inclusive  
 285 Care for the Elderly.

286 (8) "Long-term care plan" means a managed care plan that  
 287 provides the services described in s. 409.98 for the long-term  
 288 care managed care program or the services described in s.  
 289 409.988 for the long-term care managed care program for persons  
 290 with developmental disabilities.

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

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

299 (11) "Medicaid" means the medical assistance program  
 300 authorized by Title XIX of the Social Security Act, 42 U.S.C.  
 301 ss. 1396 et seq., and regulations thereunder, as administered in  
 302 this state by the agency.

303 (12) "Medicaid recipient" or "recipient" means an  
 304 individual who the department or, for Supplemental Security  
 305 Income, the Social Security Administration determines is  
 306 eligible pursuant to federal and state law to receive medical  
 307 assistance and related services for which the agency may make  
 308 payments under the Medicaid program. For the purposes of

HB 7107

2011

309 determining third-party liability, the term includes an  
310 individual formerly determined to be eligible for Medicaid, an  
311 individual who has received medical assistance under the  
312 Medicaid program, or an individual on whose behalf Medicaid has  
313 become obligated.

314 (13) "Prepaid plan" means a managed care plan that is  
315 licensed or certified as a risk-bearing entity in the state and  
316 is paid a prospective per-member, per-month payment by the  
317 agency.

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

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

328 Section 4. Section 409.963, Florida Statutes, is created  
329 to read:

330 409.963 Single state agency.—The Agency for Health Care  
331 Administration is designated as the single state agency  
332 authorized to manage, operate, and make payments for medical  
333 assistance and related services under Title XIX of the Social  
334 Security Act. Subject to any limitations or directions provided  
335 for in the General Appropriations Act, these payments may be  
336 made only for services included in the program, only on behalf

HB 7107

2011

337 of eligible individuals, and only to qualified providers in  
338 accordance with federal requirements for Title XIX of the Social  
339 Security Act and the provisions of state law. This program of  
340 medical assistance is designated as the "Medicaid program." The  
341 department is responsible for Medicaid eligibility  
342 determinations, including, but not limited to, policy, rules,  
343 and the agreement with the Social Security Administration for  
344 Medicaid eligibility determinations for Supplemental Security  
345 Income recipients, as well as the actual determination of  
346 eligibility. As a condition of Medicaid eligibility, subject to  
347 federal approval, the agency and the department shall ensure  
348 that each Medicaid recipient consents to the release of her or  
349 his medical records to the agency and the Medicaid Fraud Control  
350 Unit of the Department of Legal Affairs.

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

353 409.964 Managed care program; state plan; waivers.—The  
354 Medicaid program is established as a statewide, integrated  
355 managed care program for all covered services, including long-  
356 term care services. The agency shall apply for and implement  
357 state plan amendments or waivers of applicable federal laws and  
358 regulations necessary to implement the program. Before seeking a  
359 waiver, the agency shall provide public notice and the  
360 opportunity for public comment and shall include public feedback  
361 in the waiver application. The agency shall hold one public  
362 meeting in each of the regions described in s. 409.966(2) and  
363 the time period for public comment for each region shall end no

HB 7107

2011

364 sooner than 30 days after the completion of the public meeting  
 365 in that region.

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

368 409.965 Mandatory enrollment.—All Medicaid recipients  
 369 shall receive covered services through the statewide managed  
 370 care program, except as provided by this part pursuant to an  
 371 approved federal waiver. The following Medicaid recipients are  
 372 exempt from participation in the statewide managed care program:

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

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

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

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

381 409.966 Eligible plans; selection.—

382 (1) ELIGIBLE PLANS.—Services in the Medicaid managed care  
 383 program shall be provided by eligible plans. A provider service  
 384 network must be capable of providing all covered services to a  
 385 mandatory Medicaid managed care enrollee or may limit the  
 386 provision of services to a specific target population based on  
 387 the age, chronic disease state, or medical condition of the  
 388 enrollee to whom the network will provide services. A specialty  
 389 provider service network must be capable of coordinating care  
 390 and delivering or arranging for the delivery of all covered  
 391 services to the target population. A provider service network

HB 7107

2011

392 may partner with an insurer licensed under chapter 627 or a  
393 health maintenance organization licensed under chapter 641 to  
394 meet the requirements of a Medicaid contract.

395 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a  
396 limited number of eligible plans to participate in the Medicaid  
397 program using invitations to negotiate in accordance with s.  
398 287.057(3)(a). At least 90 days before issuing an invitation to  
399 negotiate, the agency shall compile and publish a databook  
400 consisting of a comprehensive set of utilization and spending  
401 data for the 3 most recent contract years consistent with the  
402 rate-setting periods for all Medicaid recipients by region or  
403 county. The source of the data in the report shall include both  
404 historic fee-for-service claims and validated data from the  
405 Medicaid Encounter Data System. The report shall be made  
406 available in electronic form and shall delineate utilization use  
407 by age, gender, eligibility group, geographic area, and  
408 aggregate clinical risk score. Separate and simultaneous  
409 procurements shall be conducted in each of the following  
410 regions:

411 (a) Region I, which shall consist of Bay, Calhoun,  
412 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,  
413 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,  
414 Walton, and Washington Counties.

415 (b) Region II, which shall consist of Alachua, Baker,  
416 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,  
417 Gilchrist, Hamilton, Lafayette, Levy, Nassau, Putnam, St. Johns,  
418 Suwannee, Union, and Volusia Counties.

HB 7107

2011

419 (c) Region III, which shall consist of Hernando,  
420 Hillsborough, Pasco, Pinellas, and Polk Counties.

421 (d) Region IV, which shall consist of Brevard, Lake,  
422 Marion, Orange, Osceola, Seminole, and Sumter Counties.

423 (e) Region V, which shall consist of Charlotte, Collier,  
424 DeSoto, Hardee, Highlands, Lee, Manatee, and Sarasota Counties.

425 (f) Region VI, which shall consist of Broward, Glades,  
426 Hendry, Indian River, Martin, Okeechobee, Palm Beach, and St.  
427 Lucie Counties.

428 (g) Region VII, which shall consist of Miami-Dade and  
429 Monroe Counties.

430 (3) QUALITY SELECTION CRITERIA.—

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

438 1. Accreditation by the National Committee for Quality  
439 Assurance or another nationally recognized accrediting body.

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

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



HB 7107

2011

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

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

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

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

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

463 9. The business relationship a qualified plan has with any  
464 other qualified plan that responds to the invitation to  
465 negotiate.

466  
467 A qualified plan must disclose any business relationship it has  
468 with any other qualified plan that responds to the invitation to  
469 negotiate. For the purpose of this section, "business  
470 relationship" means an ownership or controlling interest, an  
471 affiliate or subsidiary relationship, a common parent, or any  
472 mutual interest in any limited partnership, limited liability

HB 7107

2011

473 partnership, limited liability company, or other entity or  
474 business association, including all wholly or partially owned  
475 subsidiaries, majority-owned subsidiaries, parent companies, or  
476 affiliates of such entities, business associations, or other  
477 enterprises, that exists for the purpose of making a profit.  
478 Failure to disclose any business relationship shall result in  
479 disqualification.

480 (b) After negotiations are conducted, the agency shall  
481 select the eligible plans that are determined to be responsive  
482 and provide the best value to the state. Preference shall be  
483 given to plans that demonstrate the following:

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

487 2. Well-defined programs for recognizing patient-centered  
488 medical homes or accountable care organizations, and providing  
489 for increased compensation for recognized medical homes or  
490 accountable care organizations, as defined by the plan.

491 3. Greater net economic benefit to Florida compared to  
492 other bidders through employment of, or subcontracting with  
493 firms that employ, Floridians in order to accomplish the  
494 contract requirements. Contracts with such bidders shall specify  
495 performance measures to evaluate the plan's employment-based  
496 economic impact. Valuation of the net economic benefit may not  
497 include employment of or subcontracts with providers.

498 (c) To ensure managed care plan participation in Region I,  
499 the agency shall award contracts in Region VII to each managed

HB 7107

2011

500 care plan selected in Region I for such plans which submitted  
501 responsive bids in Region VII.

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

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

525 409.967 Managed care plan accountability.—

526 (1) The agency shall establish a 5-year contract with each  
527 managed care plan selected through the procurement process

HB 7107

2011

528 described in s. 409.966. A plan contract may not be renewed;  
529 however, the agency may extend the terms of a plan contract to  
530 cover any delays in transition to a new plan.

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

535 (a) Emergency services.—Managed care plans shall pay for  
536 services required by ss. 395.1041 and 401.45 and rendered by a  
537 noncontracted provider within 30 days after receipt of a  
538 complete and correct claim. Plans must give providers of these  
539 services a specific explanation for each claim denied for being  
540 incomplete or incorrect. Providers may resubmit corrected claims  
541 for reconsideration within 30 days after receiving notice from  
542 the managed care plans that the claims are incomplete or  
543 incorrect. Claims from noncontracted providers shall be accepted  
544 by the managed care plan for at least 1 year after the date the  
545 services are provided. Reimbursement for services under this  
546 paragraph shall be the lesser of:

- 547 1. The provider's charges;  
548 2. The usual and customary provider charges for similar  
549 services in the community where the services were provided;  
550 3. The charge mutually agreed to by the entity and the  
551 provider within 60 days after submittal of the claim; or  
552 4. The rate the agency would have paid on the first day of  
553 the contract between the provider and the plan.

554 (b) Access.—The agency shall establish specific standards  
555 for the number, type, and regional distribution of providers in

HB 7107

2011

556 managed care plan networks to ensure access to care. Each plan  
557 must maintain a region-wide network of providers in sufficient  
558 numbers to meet the access standards for specific medical  
559 services for all recipients enrolled in the plan. Consistent  
560 with the standards established by the agency, provider networks  
561 may include providers located outside the region. Each plan  
562 shall establish and maintain an accurate and complete electronic  
563 database of contracted providers, including information about  
564 licensure or registration, locations and hours of operation,  
565 specialty credentials and other certifications, specific  
566 performance indicators, and such other information as the agency  
567 deems necessary. The database shall be available online to both  
568 the agency and the public and shall have the capability to  
569 compare the availability of providers to network adequacy  
570 standards and to accept and display feedback from each  
571 provider's patients. Each plan shall submit quarterly reports to  
572 the agency identifying the number of enrollees assigned to each  
573 primary care provider.

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

578 1. Each prepaid plan must comply with the agency's  
579 reporting requirements for the Medicaid Encounter Data System.  
580 Prepaid plans must submit encounter data electronically in a  
581 format that complies with the Health Insurance Portability and  
582 Accountability Act provisions for electronic claims and in  
583 accordance with deadlines established by the agency. Prepaid

HB 7107

2011

584 plans must certify that the data reported is accurate and  
585 complete.

586 2. The agency is responsible for validating the data  
587 submitted by the plans. The agency shall develop methods and  
588 protocols for ongoing analysis of the encounter data that  
589 adjusts for differences in characteristics of prepaid plan  
590 enrollees to allow comparison of service utilization among plans  
591 and against expected levels of use. The analysis shall be used  
592 to identify possible cases of systemic underutilization or  
593 denials of claims and inappropriate service utilization such as  
594 higher-than-expected emergency department encounters. The  
595 analysis shall provide periodic feedback to the plans and enable  
596 the agency to establish corrective action plans when necessary.  
597 One of the focus areas for the analysis shall be the use of  
598 prescription drugs.

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

602 (d) Continuous improvement.—The agency shall establish  
603 specific performance standards and expected milestones or  
604 timelines for improving performance over the term of the  
605 contract. By the end of the fourth year of the first contract  
606 term, the agency shall issue a request for information to  
607 determine whether cost savings could be achieved by contracting  
608 for plan oversight and monitoring, including analysis of  
609 encounter data, assessment of performance measures, and  
610 compliance with other contractual requirements. Each managed  
611 care plan shall establish an internal health care quality

HB 7107

2011

612 improvement system, including enrollee satisfaction and  
613 disenrollment surveys. The quality improvement system shall  
614 include incentives and disincentives for network providers.

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

618 1. A provider credentialing system and ongoing provider  
619 monitoring;

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

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

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

628 5. Designation of a program integrity compliance officer.

629 (f) Grievance resolution.—Each managed care plan shall  
630 establish and the agency shall approve an internal process for  
631 reviewing and responding to grievances from enrollees consistent  
632 with the requirements of s. 641.511. Each plan shall submit  
633 quarterly reports on the number, description, and outcome of  
634 grievances filed by enrollees. The agency shall maintain a  
635 process for provider service networks consistent with s.  
636 408.7056.

637 (g) Penalties.—Managed care plans that reduce enrollment  
638 levels or leave a region before the end of the contract term  
639 shall reimburse the agency for the cost of enrollment changes

HB 7107

2011

640 and other transition activities, including the cost of  
641 additional choice counseling services. If more than one plan  
642 leaves a region at the same time, costs shall be shared by the  
643 departing plans proportionate to their enrollments. In addition  
644 to the payment of costs, departing plans shall pay a per  
645 enrollee penalty not to exceed 1 month's payment. Plans shall  
646 provide the agency notice no less than 180 days before  
647 withdrawing from a region.

648 (h) Prompt payment.—Managed care plans shall comply with  
649 ss. 641.315, 641.3155, and 641.513.

650 (i) Electronic claims.—Managed care plans shall accept  
651 electronic claims in compliance with federal standards.

652 (j) Fair payment.—Provider service networks must ensure  
653 that no network provider with a controlling interest in the  
654 network charges any Medicaid managed care plan more than the  
655 amount paid to that provider by the provider service network for  
656 the same service.

657 (3) ACHIEVED SAVINGS REBATE.—

658 (a) The agency shall establish and the prepaid plans shall  
659 use a uniform method for annually reporting premium revenue,  
660 medical and administrative costs, and income or losses, across  
661 all Florida Medicaid prepaid plan lines of business in all  
662 regions. The reports shall be due to the agency within 270 days  
663 after the conclusion of the reporting period and the agency may  
664 audit the reports. Achieved savings rebates shall be due within  
665 30 days after the report is submitted. Except as provided in  
666 paragraph (b), the achieved savings rebate will be established



HB 7107

2011

667 by determining pretax income as a percentage of revenues and  
668 applying the following income sharing ratios:

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

671 2. Fifty percent of income above 5 percent and up to 9  
672 percent shall be retained by the plan, with the other 50 percent  
673 refunded to the state.

674 3. One hundred percent of income above 9 percent of  
675 revenue shall be refunded to the state.

676 (b) For any plan that meets or exceeds agency-defined  
677 quality measures in the reporting period, the achieved savings  
678 rebate shall be established by determining pretax income as a  
679 percentage of revenues and applying the following income-sharing  
680 ratios:

681 1. One hundred percent of income up to and including 6  
682 percent of revenue shall be retained by the plan.

683 2. Fifty percent of income above 6 percent and up to 10  
684 percent shall be retained by the plan, with the other 50 percent  
685 refunded to the state.

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

688 (c) The following expenses may not be included in  
689 calculating income to the plan:

690 1. Payment of achieved savings rebates.

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

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

695 4. Expenses associated with lobbying activities.

696 5. Administrative, reinsurance, and outstanding claims  
 697 expenses in excess of actuarially sound maximum amounts set by  
 698 the agency.

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

702 (e) If, after an audit or other reconciliation, the agency  
 703 determines that a prepaid plan owes an additional rebate, the  
 704 plan shall have 30 days after notification to make the payment.  
 705 Upon failure to timely pay the rebate, the agency shall withhold  
 706 future payments to the plan until the entire amount is recouped.  
 707 If the agency determines that a prepaid plan has made an  
 708 overpayment, the agency shall return the overpayment within 30  
 709 days.

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

712 409.968 Managed care plan payments.-

713 (1) Prepaid plans shall receive per-member, per-month  
 714 payments negotiated pursuant to the procurements described in s.  
 715 409.966. Payments shall be risk-adjusted rates based on  
 716 historical utilization and spending data, projected forward, and  
 717 adjusted to reflect the eligibility category, geographic area,  
 718 and clinical risk profile of the recipients.

719 (2) Provider service networks may be prepaid plans and  
 720 receive per-member, per-month payments negotiated pursuant to  
 721 the procurement process described in s. 409.966. Provider  
 722 service networks that choose not to be prepaid plans shall

HB 7107

2011

723 receive fee-for-service rates with a shared savings settlement.  
724 The fee-for-service option shall be available to a provider  
725 service network only for the first 5 years of its operation in a  
726 given region. The agency shall annually conduct cost  
727 reconciliations to determine the amount of cost savings achieved  
728 by fee-for-service provider service networks for the dates of  
729 service within the period being reconciled. Only payments for  
730 covered services for dates of service within the reconciliation  
731 period and paid within 6 months after the last date of service  
732 in the reconciliation period shall be included. The agency shall  
733 perform the necessary adjustments for the inclusion of claims  
734 incurred but not reported within the reconciliation period for  
735 claims that could be received and paid by the agency after the  
736 6-month claims processing time lag. The agency shall provide the  
737 results of the reconciliations to the fee-for-service provider  
738 service networks within 45 days after the end of the  
739 reconciliation period. The fee-for-service provider service  
740 networks shall review and provide written comments or a letter  
741 of concurrence to the agency within 45 days after receipt of the  
742 reconciliation results. This reconciliation shall be considered  
743 final.

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

746 409.969 Enrollment; choice counseling; automatic  
747 assignment; disenrollment.-

748 (1) ENROLLMENT.-All Medicaid recipients shall be enrolled  
749 in a managed care plan unless specifically exempted under this  
750 part. Each recipient shall have a choice of plans and may select

HB 7107

2011

751 any available plan unless that plan is restricted by contract to  
752 a specific population that does not include the recipient.  
753 Medicaid recipients shall have 30 days in which to make a choice  
754 of plans. All recipients shall be offered choice counseling  
755 services in accordance with this section.

756 (2) CHOICE COUNSELING.—The agency shall provide choice  
757 counseling for Medicaid recipients. The agency may contract for  
758 the provision of choice counseling. Any such contract shall be  
759 with a vendor that employs Floridians to accomplish the contract  
760 requirements and shall be for a period of 5 years. The agency  
761 may renew a contract for an additional 5-year period; however,  
762 before renewal of the contract the agency shall hold at least  
763 one public meeting in each of the regions covered by the choice  
764 counseling vendor. The agency may extend the term of the  
765 contract to cover any delays in transition to a new contractor.  
766 Printed choice information and choice counseling shall be  
767 offered in the native or preferred language of the recipient,  
768 consistent with federal requirements. The manner and method of  
769 choice counseling shall be modified as necessary to ensure  
770 culturally competent, effective communication with people from  
771 diverse cultural backgrounds. The agency shall maintain a record  
772 of the recipients who receive such services, identifying the  
773 scope and method of the services provided. The agency shall make  
774 available clear and easily understandable choice information to  
775 Medicaid recipients that includes:

776 (a) An explanation that each recipient has the right to  
777 choose a managed care plan at the time of enrollment in Medicaid  
778 and again at regular intervals set by the agency, and that if a

HB 7107

2011

779 recipient does not choose a plan, the agency will assign the  
780 recipient to a plan according to the criteria specified in this  
781 section.

782 (b) A list and description of the benefits provided in  
783 each managed care plan.

784 (c) An explanation of benefit limits.

785 (d) A current list of providers participating in the  
786 network, including location and contact information.

787 (e) Managed care plan performance data.

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

801 (a) The managed care plan internal grievance process, when  
802 used, must be completed in time to permit the recipient to  
803 disenroll by the first day of the second month after the month  
804 the disenrollment request was made. If the result of the  
805 grievance process is approval of an enrollee's request to

HB 7107

2011

806 disenroll, the agency is not required to make a determination in  
807 the case.

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

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

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

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

HB 7107

2011

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

835 409.97 State and local Medicaid partnerships.-

836 (1) INTERGOVERNMENTAL TRANSFERS.-In addition to the  
837 contributions required pursuant to s. 409.915, beginning in the  
838 2014-2015 fiscal year, the agency may accept voluntary transfers  
839 of local taxes and other qualified revenue from counties,  
840 municipalities, and special taxing districts. Such transfers  
841 must be contributed to advance the general goals of the Florida  
842 Medicaid program without restriction and must be executed  
843 pursuant to a contract between the agency and the local funding  
844 source. Contracts executed before October 31 shall result in  
845 contributions to Medicaid for that same state fiscal year.  
846 Contracts executed between November 1 and June 30 shall result  
847 in contributions for the following state fiscal year. Based on  
848 the date of the signed contracts, the agency shall allocate to  
849 the low-income pool the first contributions received up to the  
850 limit established by subsection (2). No more than 40 percent of  
851 the low-income pool funding shall come from any single funding  
852 source. Contributions in excess of the low-income pool shall be  
853 allocated to the disproportionate share programs defined in ss.  
854 409.911(3) and 409.9113 and to hospital rates pursuant to  
855 subsection (4). The local funding source shall designate in the  
856 contract which Medicaid providers ensure access to care for low-  
857 income and uninsured people within the applicable jurisdiction  
858 and are eligible for low-income pool funding. Eligible providers  
859 may include both hospitals and primary care providers.

HB 7107

2011

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

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



HB 7107

2011

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

902 (4) HOSPITAL RATE DISTRIBUTION.—

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

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

912 2. Tier 2 hospitals are community hospitals not included  
913 in Tier 1 that provided more than 9 percent of the hospital's  
914 total inpatient days to Medicaid patients and charity patients,

HB 7107

2011

915 as defined in s. 409.911, and are located in the jurisdiction of  
 916 a local funding source pursuant to subsection (1).

917 3. Tier 3 hospitals include all community hospitals.

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

920 1. Tier 1 (T1A) = 0.15 x TTA.

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

922 3. Tier 3 (T3A) = 0.50 x TTA.

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

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

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

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

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

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

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

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

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

HB 7107

2011

942        409.971 Managed medical assistance program.—The agency  
943 shall make payments for primary and acute medical assistance and  
944 related services using a managed care model. By January 1, 2013,  
945 the agency shall begin implementation of the statewide managed  
946 medical assistance program, with full implementation in all  
947 regions by October 1, 2014.

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

950        409.972 Mandatory and voluntary enrollment.—

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

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

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

962        (b) Medicaid recipients residing in residential commitment  
963 facilities operated through the Department of Juvenile Justice  
964 or mental health treatment facilities as defined by s.  
965 394.455(32).

966        (c) Persons eligible for refugee assistance.

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

970           (3) Persons eligible for Medicaid but exempt from  
 971 mandatory participation who do not choose to enroll in managed  
 972 care shall be served in the Medicaid fee-for-service program as  
 973 provided in part III of this chapter.

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

976           409.973 Benefits.—

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

979           (a) Advanced registered nurse practitioner services.

980           (b) Ambulatory surgical treatment center services.

981           (c) Birthing center services.

982           (d) Chiropractic services.

983           (e) Dental services.

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

986           (g) Emergency services.

987           (h) Family planning services and supplies.

988           (i) Healthy start services.

989           (j) Hearing services.

990           (k) Home health agency services.

991           (l) Hospice services.

992           (m) Hospital inpatient services.

993           (n) Hospital outpatient services.

994           (o) Laboratory and imaging services.

995           (p) Medical supplies, equipment, prostheses, and orthoses.

996           (q) Mental health services.

997           (r) Nursing care.

HB 7107

2011

998        (s) Optical services and supplies.  
 999        (t) Optometrist services.  
 1000       (u) Physical, occupational, respiratory, and speech  
 1001 therapy services.  
 1002       (v) Physician services.  
 1003       (w) Podiatric services.  
 1004       (x) Prescription drugs.  
 1005       (y) Renal dialysis services.  
 1006       (z) Respiratory equipment and supplies.  
 1007       (aa) Rural health clinic services.  
 1008       (bb) Substance abuse treatment services.  
 1009       (cc) Transportation to access covered services.  
 1010       (2) CUSTOMIZED BENEFITS.—Managed care plans may customize  
 1011 benefit packages for nonpregnant adults, vary cost-sharing  
 1012 provisions, and provide coverage for additional services. The  
 1013 agency shall evaluate the proposed benefit packages to ensure  
 1014 services are sufficient to meet the needs of the plan's  
 1015 enrollees and to verify actuarial equivalence.  
 1016       (3) HEALTHY BEHAVIORS.—Each plan operating in the managed  
 1017 medical assistance program shall establish a program to  
 1018 encourage and reward healthy behaviors.  
 1019       Section 15. Section 409.974, Florida Statutes, is created  
 1020 to read:  
 1021       409.974 Eligible plans.—  
 1022       (1) ELIGIBLE PLAN SELECTION.—The agency shall select  
 1023 eligible plans through the procurement process described in s.  
 1024 409.966. The agency shall notice invitations to negotiate no  
 1025 later than January 1, 2013.

1026        (a) The agency shall procure three plans for Region I. At  
 1027 least one plan shall be a provider service network, if any  
 1028 provider service network submits a responsive bid.

1029        (b) The agency shall procure at least three and no more  
 1030 than six plans for Region II. At least one plan shall be a  
 1031 provider service network, if any provider service network  
 1032 submits a responsive bid.

1033        (c) The agency shall procure at least four plans and no  
 1034 more than eight plans for Region III. At least two plans shall  
 1035 be provider service networks, if any two provider service  
 1036 networks submit responsive bids.

1037        (d) The agency shall procure at least four plans and no  
 1038 more than seven plans for Region IV. At least two plans shall be  
 1039 provider service networks if any two provider service networks  
 1040 submit responsive bids.

1041        (e) The agency shall procure three plans for Region V. At  
 1042 least one plan shall be a provider service network, if any  
 1043 provider service network submits a responsive bid.

1044        (f) The agency shall procure at least four plans and no  
 1045 more than seven plans for Region VI. At least two plans shall be  
 1046 provider service networks, if any two provider service networks  
 1047 submit a responsive bid.

1048        (g) The agency shall procure at least five plans and no  
 1049 more than nine plans for Region VII. At least two plans shall be  
 1050 provider service networks, if any two provider service network  
 1051 submit responsive bids.

1052

HB 7107

2011

1053 If no provider service network submits a responsive bid, the  
1054 agency shall procure no more than one less than the maximum  
1055 number of eligible plans permitted in that region. Within 12  
1056 months after the initial invitation to negotiate, the agency  
1057 shall attempt to procure a provider service network. The agency  
1058 shall notice another invitation to negotiate only with provider  
1059 service networks in such region where no provider service  
1060 network has been selected.

1061 (2) QUALITY SELECTION CRITERIA.—In addition to the  
1062 criteria established in s. 409.966, the agency shall consider  
1063 evidence that an eligible plan has written agreements or signed  
1064 contracts or has made substantial progress in establishing  
1065 relationships with providers before the plan submitting a  
1066 response. The agency shall evaluate and give special weight to  
1067 evidence of signed contracts with essential providers as defined  
1068 by the agency pursuant to s. 409.975(2). The agency shall  
1069 exercise a preference for plans with a provider network in which  
1070 over 10 percent of the providers use electronic health records,  
1071 as defined in s. 408.051. When all other factors are equal, the  
1072 agency shall consider whether the organization has a contract to  
1073 provide managed long-term care services in the same region and  
1074 shall exercise a preference for such plans.

1075 (3) SPECIALTY PLANS.—Participation by specialty plans  
1076 shall be subject to the procurement requirements and regional  
1077 plan number limits of this section. However, a specialty plan  
1078 whose target population includes no more than 10 percent of the  
1079 enrollees of that region is not subject to the regional plan  
1080 number limits of this section.

HB 7107

2011

1081 (4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by  
 1082 the Children's Medical Services Network shall be pursuant to a  
 1083 single, statewide contract with the agency that is not subject  
 1084 to the procurement requirements or regional plan number limits  
 1085 of this section. The Children's Medical Services Network must  
 1086 meet all other plan requirements for the managed medical  
 1087 assistance program.

1088 Section 16. Section 409.975, Florida Statutes, is created  
 1089 to read:

1090 409.975 Managed care plan accountability.—In addition to  
 1091 the requirements of s. 409.967, plans and providers  
 1092 participating in the managed medical assistance program shall  
 1093 comply with the requirements of this section.

1094 (1) PROVIDER NETWORKS.—Managed care plans must develop and  
 1095 maintain provider networks that meet the medical needs of their  
 1096 enrollees in accordance with standards established pursuant to  
 1097 409.967(2)(b). Except as provided in this section, managed care  
 1098 plans may limit the providers in their networks based on  
 1099 credentials, quality indicators, and price.

1100 (a) Plans must include all providers in the region that  
 1101 are classified by the agency as essential Medicaid providers,  
 1102 unless the agency approves, in writing, an alternative  
 1103 arrangement for securing the types of services offered by the  
 1104 essential providers. Providers are essential for serving  
 1105 Medicaid enrollees if they offer services that are not available  
 1106 from any other provider within a reasonable access standard, or  
 1107 if they provided a substantial share of the total units of a  
 1108 particular service used by Medicaid patients within the region



HB 7107

2011

1109 during the last 3 years and the combined capacity of other  
1110 service providers in the region is insufficient to meet the  
1111 total needs of the Medicaid patients. The agency may not  
1112 classify physicians and other practitioners as essential  
1113 providers. The agency, at a minimum, shall determine which  
1114 providers in the following categories are essential Medicaid  
1115 providers:

1116 1. Federally qualified health centers.

1117 2. Statutory teaching hospitals as defined in s.  
1118 408.07(45).

1119 3. Hospitals that are trauma centers as defined in s.  
1120 395.4001(14).

1121 4. Hospitals located at least 25 miles from any other  
1122 hospital with similar services.

1123  
1124 Managed care plans that have not contracted with all essential  
1125 providers in the region as of the first date of recipient  
1126 enrollment, or with whom an essential provider has terminated  
1127 its contract, must negotiate in good faith with such essential  
1128 providers for 1 year or until an agreement is reached, whichever  
1129 is first. Payments for services rendered by a nonparticipating  
1130 essential provider shall be made at the applicable Medicaid rate  
1131 as of the first day of the contract between the agency and the  
1132 plan. A rate schedule for all essential providers shall be  
1133 attached to the contract between the agency and the plan. After  
1134 1 year, managed care plans that are unable to contract with  
1135 essential providers shall notify the agency and propose an  
1136 alternative arrangement for securing the essential services for

HB 7107

2011

1137 Medicaid enrollees. The arrangement must rely on contracts with  
1138 other participating providers, regardless of whether those  
1139 providers are located within the same region as the  
1140 nonparticipating essential service provider. If the alternative  
1141 arrangement is approved by the agency, payments to  
1142 nonparticipating essential providers after the date of the  
1143 agency's approval shall equal 90 percent of the applicable  
1144 Medicaid rate. If the alternative arrangement is not approved by  
1145 the agency, payment to nonparticipating essential providers  
1146 shall equal 110 percent of the applicable Medicaid rate.

1147 (b) Certain providers are statewide resources and  
1148 essential providers for all managed care plans in all regions.  
1149 All managed care plans must include these essential providers in  
1150 their networks. Statewide essential providers include:

- 1151 1. Faculty plans of Florida medical schools.
- 1152 2. Regional perinatal intensive care centers as defined in  
1153 s. 383.16(2).
- 1154 3. Hospitals licensed as specialty children's hospitals as  
1155 defined in s. 395.002(28).

1156  
1157 Managed care plans that have not contracted with all statewide  
1158 essential providers in all regions as of the first date of  
1159 recipient enrollment must continue to negotiate in good faith.  
1160 Payments to physicians on the faculty of nonparticipating  
1161 Florida medical schools shall be made at the applicable Medicaid  
1162 rate. Payments for services rendered by a regional perinatal  
1163 intensive care centers shall be made at the applicable Medicaid  
1164 rate as of the first day of the contract between the agency and

HB 7107

2011

1165 the plan. Payments to nonparticipating specialty children's  
1166 hospitals shall equal the highest rate established by contract  
1167 between that provider and any other Medicaid managed care plan.

1168 (c) After 12 months of active participation in a plan's  
1169 network, the plan may exclude any essential provider from the  
1170 network for failure to meet quality or performance criteria. If  
1171 the plan excludes an essential provider from the plan, the plan  
1172 must provide written notice to all recipients who have chosen  
1173 that provider for care. The notice shall be provided at least 30  
1174 days before the effective date of the exclusion.

1175 (d) Each managed care plan must offer a network contract  
1176 to each home medical equipment and supplies provider in the  
1177 region which meets quality and fraud prevention and detection  
1178 standards established by the plan and which agrees to accept the  
1179 lowest price previously negotiated between the plan and another  
1180 such provider.

1181 (2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency  
1182 shall contract with a single organization representing medical  
1183 schools and graduate medical education programs in the state for  
1184 the purpose of establishing an active and ongoing program to  
1185 improve clinical outcomes in all managed care plans. Contracted  
1186 activities must support greater clinical integration for  
1187 Medicaid enrollees through interdependent and cooperative  
1188 efforts of all providers participating in managed care plans.  
1189 The agency shall support these activities with certified public  
1190 expenditures of general revenue appropriated to the  
1191 participating medical schools and any earned federal matching  
1192 funds and shall seek any plan amendments or waivers necessary to

1193 comply with this subsection. To be eligible to participate in  
 1194 the quality network, a medical school must contract with each  
 1195 managed care plan in its region.

1196 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall  
 1197 monitor the quality and performance of each participating  
 1198 provider. At the beginning of the contract period, each plan  
 1199 shall notify all its network providers of the metrics used by  
 1200 the plan for evaluating the provider's performance and  
 1201 determining continued participation in the network.

1202 (4) MOMCARE NETWORK.—

1203 (a) The agency shall contract with an administrative  
 1204 services organization representing all Healthy Start Coalitions  
 1205 providing risk appropriate care coordination and other services  
 1206 in accordance with a federal waiver and pursuant to s. 409.906.  
 1207 The contract shall require the network of coalitions to provide  
 1208 choice counseling, education, risk-reduction and case management  
 1209 services, and quality assurance for all enrollees of the waiver.  
 1210 The agency shall evaluate the impact of the MomCare network by  
 1211 monitoring each plan's performance on specific measures to  
 1212 determine the adequacy, timeliness, and quality of services for  
 1213 pregnant women and infants. The agency shall support this  
 1214 contract with certified public expenditures of general revenue  
 1215 appropriated for Healthy Start services and any earned federal  
 1216 matching funds.

1217 (b) Each managed care plan shall establish specific  
 1218 programs and procedures to improve pregnancy outcomes and infant  
 1219 health, including, but not limited to, coordination with the  
 1220 Healthy Start program, immunization programs, and referral to

HB 7107

2011

1221 the Special Supplemental Nutrition Program for Women, Infants,  
 1222 and Children, and the Children's Medical Services program for  
 1223 children with special health care needs. Each plan's programs  
 1224 and procedures shall include agreements with each local Healthy  
 1225 Start Coalition in the region to provide risk-appropriate care  
 1226 coordination for pregnant women and infants, consistent with  
 1227 agency policies and the MomCare network.

1228 (5) TRANSPORTATION.—Nonemergency transportation services  
 1229 shall be provided pursuant to a single, statewide contract  
 1230 between the agency and the Commission for the Transportation  
 1231 Disadvantaged. The agency shall establish performance standards  
 1232 in the contract and shall evaluate the performance of the  
 1233 Commission for the Transportation Disadvantaged.

1234 (6) SCREENING RATE.—After the end of the second contract  
 1235 year, each managed care plan shall achieve an annual Early and  
 1236 Periodic Screening, Diagnosis, and Treatment Service screening  
 1237 rate of at least 80 percent of those recipients continuously  
 1238 enrolled for at least 8 months.

1239 (7) PROVIDER PAYMENT.—Managed care plan and hospitals  
 1240 shall negotiate mutually acceptable rates, methods, and terms of  
 1241 payment. For rates, methods, and terms of payment negotiated  
 1242 after the contract between the agency and the plan is executed,  
 1243 plans shall pay hospitals, at a minimum, the rate the agency  
 1244 would have paid on the first day of the contract between the  
 1245 provider and the plan. Such payments to hospitals may not exceed  
 1246 120 percent of the rate the agency would have paid on the first  
 1247 day of the contract between the provider and the plan, unless

HB 7107

2011

1248 specifically approved by the agency. Payment rates may be  
1249 updated periodically.

1250 (8) MEDICALLY NEEDED ENROLLEES.—Each managed care plan  
1251 shall accept any medically needy recipient who selects or is  
1252 assigned to the plan and provide that recipient with continuous  
1253 enrollment for 12 months. After the first month of qualifying as  
1254 a medically needy recipient and enrolling in a plan, and  
1255 contingent upon federal approval, the enrollee shall pay the  
1256 plan a portion of the monthly premium equal to the enrollee's  
1257 share of the cost as determined by the department. The agency  
1258 shall pay any remaining portion of the monthly premium. Plans  
1259 are not obligated to pay claims for medically needy patients for  
1260 services provided before enrollment in the plan. Medically needy  
1261 patients are responsible for payment of incurred claims that are  
1262 used to determine eligibility. Plans must provide a grace period  
1263 of at least 90 days before disenrolling recipients who fail to  
1264 pay their shares of the premium.

1265 Section 17. Section 409.976, Florida Statutes, is created  
1266 to read:

1267 409.976 Managed care plan payment.—In addition to the  
1268 payment provisions of s. 409.968, the agency shall provide  
1269 payment to plans in the managed medical assistance program  
1270 pursuant to this section.

1271 (1) Prepaid payment rates shall be negotiated between the  
1272 agency and the eligible plans as part of the procurement process  
1273 described in s. 409.966.

1274 (2) The agency shall establish payment rates for statewide  
1275 inpatient psychiatric programs. Payments to managed care plans

HB 7107

2011

1276 shall be reconciled to reimburse actual payments to statewide  
 1277 inpatient psychiatric programs.

1278 Section 18. Section 409.977, Florida Statutes, is created  
 1279 to read:

1280 409.977 Choice counseling and enrollment.-

1281 (1) CHOICE COUNSELING.-In addition to the choice  
 1282 counseling information required by s. 409.969, the agency shall  
 1283 make available clear and easily understandable choice  
 1284 information to Medicaid recipients that includes information  
 1285 about the cost-sharing requirements of each managed care plan.

1286 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically  
 1287 enroll into a managed care plan those Medicaid recipients who do  
 1288 not voluntarily choose a plan pursuant to s. 409.969. The agency  
 1289 shall automatically enroll recipients in plans that meet or  
 1290 exceed the performance or quality standards established pursuant  
 1291 to s. 409.967 and may not automatically enroll recipients in a  
 1292 plan that is deficient in those performance or quality  
 1293 standards. When a specialty plan is available to accommodate a  
 1294 specific condition or diagnosis of a recipient, the agency shall  
 1295 assign the recipient to that plan. In the first year of the  
 1296 first contract term only, if a recipient was previously enrolled  
 1297 in a plan that is still available in the region, the agency  
 1298 shall automatically enroll the recipient in that plan unless an  
 1299 applicable specialty plan is available. Except as otherwise  
 1300 provided in this part, the agency may not engage in practices  
 1301 that are designed to favor one managed care plan over another.  
 1302 When automatically enrolling recipients in managed care plans,

HB 7107

2011

1303 the agency shall automatically enroll based on the following  
 1304 criteria:

1305 (a) Whether the plan has sufficient network capacity to  
 1306 meet the needs of the recipients.

1307 (b) Whether the recipient has previously received services  
 1308 from one of the plan's primary care providers.

1309 (c) Whether primary care providers in one plan are more  
 1310 geographically accessible to the recipient's residence than  
 1311 those in other plans.

1312 (3) OPT-OUT OPTION.—The agency shall develop a process to  
 1313 enable any recipient with access to employer-sponsored health  
 1314 care coverage to opt out of all managed care plans and to use  
 1315 Medicaid financial assistance to pay for the recipient's share  
 1316 of the cost in such employer-sponsored coverage. Contingent upon  
 1317 federal approval, the agency shall also enable recipients with  
 1318 access to other insurance or related products providing access  
 1319 to health care services created pursuant to state law, including  
 1320 any product available under the Florida Health Choices Program,  
 1321 or any health exchange, to opt out. The amount of financial  
 1322 assistance provided for each recipient may not exceed the amount  
 1323 of the Medicaid premium that would have been paid to a managed  
 1324 care plan for that recipient.

1325 Section 19. Section 409.978, Florida Statutes, is created  
 1326 to read:

1327 409.978 Long-term care managed care program.—

1328 (1) Pursuant to s. 409.963, the agency shall administer  
 1329 the long-term care managed care program described in ss.  
 1330 409.978-409.985, but may delegate specific duties and



HB 7107

2011

1331 responsibilities for the program to the Department of Elderly  
 1332 Affairs and other state agencies. By July 1, 2012, the agency  
 1333 shall begin implementation of the statewide long-term care  
 1334 managed care program, with full implementation in all regions by  
 1335 October 1, 2013.

1336 (2) The agency shall make payments for long-term care,  
 1337 including home and community-based services, using a managed  
 1338 care model. Unless otherwise specified, the provisions of ss.  
 1339 409.961-409.97 apply to the long-term care managed care program.

1340 (3) The Department of Elderly Affairs shall assist the  
 1341 agency to develop specifications for use in the invitation to  
 1342 negotiate and the model contract, determine clinical eligibility  
 1343 for enrollment in managed long-term care plans, monitor plan  
 1344 performance and measure quality of service delivery, assist  
 1345 clients and families to address complaints with the plans,  
 1346 facilitate working relationships between plans and providers  
 1347 serving elders and disabled adults, and perform other functions  
 1348 specified in a memorandum of agreement.

1349 Section 20. Section 409.979, Florida Statutes, is created  
 1350 to read:

1351 409.979 Eligibility.-

1352 (1) Medicaid recipients who meet all of the following  
 1353 criteria are eligible to receive long-term care services and  
 1354 must receive long-term care services by participating in the  
 1355 long-term care managed care program. The recipient must be:

1356 (a) Sixty-five years of age or older or eligible for  
 1357 Medicaid by reason of a disability.

1358 (b) Determined by the Comprehensive Assessment Review and

HB 7107

2011

1359 Evaluation for Long-Term Care Services (CARES) Program to  
 1360 require nursing facility care as defined in s. 409.985(3).

1361 (2) Medicaid recipients who, on the date long-term care  
 1362 managed care plans become available in their region, reside in a  
 1363 nursing home facility or are enrolled in one of the following  
 1364 long-term care Medicaid waiver programs are eligible to  
 1365 participate in the long-term care managed care program for up to  
 1366 24 months without being reevaluated for their need of nursing  
 1367 facility care as defined in s. 409.985(3):

1368 (a) The Assisted Living for the Frail Elderly Waiver.

1369 (b) The Aged and Disabled Adult Waiver.

1370 (c) The Adult Day Health Care Waiver.

1371 (d) The Consumer-Directed Care Plus Program as described  
 1372 in s. 409.221.

1373 (e) The Program of All-inclusive Care for the Elderly.

1374 (f) The long-term care community-based diversion pilot  
 1375 project as described in s. 430.705.

1376 (g) The Channeling Services Waiver for Frail Elders.

1377 Section 21. Section 409.98, Florida Statutes, is created  
 1378 to read:

1379 409.98 Benefits.—Long-term care plans shall cover, at a  
 1380 minimum, the following:

1381 (1) Nursing facility care.

1382 (2) Services provided in assisted living facilities.

1383 (3) Hospice.

1384 (4) Adult day care.

1385 (5) Medical equipment and supplies, including incontinence  
 1386 supplies.

- 1387        (6) Personal care.
- 1388        (7) Home accessibility adaptation.
- 1389        (8) Behavior management.
- 1390        (9) Home-delivered meals.
- 1391        (10) Case management.
- 1392        (11) Therapies:
- 1393        (a) Occupational therapy.
- 1394        (b) Speech therapy.
- 1395        (c) Respiratory therapy.
- 1396        (d) Physical therapy.
- 1397        (12) Intermittent and skilled nursing.
- 1398        (13) Medication administration.
- 1399        (14) Medication management.
- 1400        (15) Nutritional assessment and risk reduction.
- 1401        (16) Caregiver training.
- 1402        (17) Respite care.
- 1403        (18) Transportation.
- 1404        (19) Personal emergency response system.
- 1405        Section 22. Section 409.981, Florida Statutes, is created
- 1406        to read:
- 1407        409.981 Eligible plans.—
- 1408        (1) ELIGIBLE PLANS.—Provider service networks must be
- 1409        long-term care provider service networks. Other eligible plans
- 1410        may either be long-term care plans or comprehensive long-term
- 1411        care plans.
- 1412        (2) ELIGIBLE PLAN SELECTION.—The agency shall select
- 1413        eligible plans through the procurement process described in s.

HB 7107

2011

1414 409.966. The agency shall provide notice of invitations to  
1415 negotiate no later than July 1, 2012.

1416 (a) The agency shall procure three plans for Region I. At  
1417 least one plan shall be a provider service network, if any  
1418 submit a responsive bid.

1419 (b) The agency shall procure at least three and no more  
1420 than six plans for Region II. At least one plan shall be a  
1421 provider service network, if any submit a responsive bid.

1422 (c) The agency shall procure at least four plans and no  
1423 more than eight plans for Region III. At least two plans shall  
1424 be provider service networks, if any two submit responsive bids.

1425 (d) The agency shall procure at least four plans and no  
1426 more than seven plans for Region IV. At least two plans shall be  
1427 provider service networks, if any two submit responsive bids.

1428 (e) The agency shall procure three plans for Region V. At  
1429 least one plan shall be a provider service network, if any  
1430 submit a responsive bid.

1431 (f) The agency shall procure at least four plans and no  
1432 more than seven plans for Region VI. At least two plans shall be  
1433 provider service networks, if any two submit a responsive bid.

1434 (g) The agency shall procure at least five plans and no  
1435 more than 10 plans for Region VII. At least two plans shall be  
1436 provider service networks, if any two submit responsive bids.

1437  
1438 If no provider service network submits a responsive bid, the  
1439 agency shall procure one fewer eligible plan in each of the  
1440 regions. Within 12 months after the initial invitation to  
1441 negotiate, the agency shall attempt to procure an eligible plan

HB 7107

2011

1442 that is a provider service network. The agency shall notice  
1443 another invitation to negotiate only with provider service  
1444 networks in a region where no provider service network has been  
1445 selected.

1446 (3) QUALITY SELECTION CRITERIA.—In addition to the  
1447 criteria established in s. 409.966, the agency shall consider  
1448 the following factors in the selection of eligible plans:

1449 (a) Evidence of the employment of executive managers with  
1450 expertise and experience in serving aged and disabled persons  
1451 who require long-term care.

1452 (b) Whether a plan has established a network of service  
1453 providers dispersed throughout the region and in sufficient  
1454 numbers to meet specific service standards established by the  
1455 agency for specialty services for persons receiving home and  
1456 community-based care.

1457 (c) Whether a plan is proposing to establish a  
1458 comprehensive long-term care plan and whether the eligible plan  
1459 has a contract to provide managed medical assistance services in  
1460 the same region.

1461 (d) Whether a plan offers consumer-directed care services  
1462 to enrollees pursuant to s. 409.221.

1463 (e) Whether a plan is proposing to provide home and  
1464 community-based services in addition to the minimum benefits  
1465 required by s. 409.98.

1466 (4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—  
1467 Participation by the Program of All-Inclusive Care for the  
1468 Elderly (PACE) shall be pursuant to a contract with the agency  
1469 and not subject to the procurement requirements or regional plan

HB 7107

2011

1470 number limits of this section. PACE plans may continue to  
1471 provide services to individuals at such levels and enrollment  
1472 caps as authorized by the General Appropriations Act.

1473 Section 23. Section 409.982, Florida Statutes, is created  
1474 to read:

1475 409.982 Managed care plan accountability.—In addition to  
1476 the requirements of s. 409.967, plans and providers  
1477 participating in the long-term care managed care program shall  
1478 comply with the requirements of this section.

1479 (1) PROVIDER NETWORKS.—Managed care plans may limit the  
1480 providers in their networks based on credentials, quality  
1481 indicators, and price. For the period between October 1, 2013,  
1482 and September 30, 2014, each selected plan must offer a network  
1483 contract to all the following providers in the region:

1484 (a) Nursing homes.

1485 (b) Hospices.

1486 (c) Aging network service providers that have previously  
1487 participated in home and community-based waivers serving elders  
1488 or community-service programs administered by the Department of  
1489 Elderly Affairs.

1490  
1491 After 12 months of active participation in a managed care plan's  
1492 network, the plan may exclude any of the providers named in this  
1493 subsection from the network for failure to meet quality or  
1494 performance criteria. If the plan excludes a provider from the  
1495 plan, the plan must provide written notice to all recipients who  
1496 have chosen that provider for care. The notice shall be provided  
1497 at least 30 days before the effective date of the exclusion. The

HB 7107

2011

1498 agency shall establish contract provisions governing the  
 1499 transfer of recipients from excluded residential providers.

1500 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in  
 1501 this subsection, providers may limit the managed care plans they  
 1502 join. Nursing homes and hospices that are enrolled Medicaid  
 1503 providers must participate in all eligible plans selected by the  
 1504 agency in the region in which the provider is located.

1505 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall  
 1506 monitor the quality and performance of each participating  
 1507 provider using measures adopted by and collected by the agency  
 1508 and any additional measures mutually agreed upon by the provider  
 1509 and the plan

1510 (4) PROVIDER NETWORK STANDARDS.—The agency shall establish  
 1511 and each managed care plan must comply with specific standards  
 1512 for the number, type, and regional distribution of providers in  
 1513 the plan's network, which must include:

- 1514 (a) Adult day care centers.
- 1515 (b) Adult family-care homes.
- 1516 (c) Assisted living facilities.
- 1517 (d) Health care services pools.
- 1518 (e) Home health agencies.
- 1519 (f) Homemaker and companion services.
- 1520 (g) Hospices.
- 1521 (h) Community care for the elderly lead agencies.
- 1522 (i) Nurse registries.
- 1523 (j) Nursing homes.

1524 (5) PROVIDER PAYMENT.—Managed care plans and providers  
 1525 shall negotiate mutually acceptable rates, methods, and terms of

HB 7107

2011

1526 payment. Plans shall pay nursing homes an amount equal to the  
1527 nursing facility-specific payment rates set by the agency;  
1528 however, mutually acceptable higher rates may be negotiated for  
1529 medically complex care. Plans shall pay hospice providers an  
1530 amount equal to the per diem rate set by the agency. For  
1531 recipients residing in a nursing facility and receiving hospice  
1532 services, the plan shall pay the hospice provider the per diem  
1533 rate set by the agency minus the nursing facility component and  
1534 shall pay the nursing facility the applicable state rate. Plans  
1535 shall ensure that electronic nursing home and hospice claims  
1536 that contain sufficient information for processing are paid  
1537 within 10 business days after receipt.

1538 Section 24. Section 409.983, Florida Statutes, is created  
1539 to read:

1540 409.983 Managed care plan payment.—In addition to the  
1541 payment provisions of s. 409.968, the agency shall provide  
1542 payment to plans in the long-term care managed care program  
1543 pursuant to this section.

1544 (1) Prepaid payment rates for long-term care managed care  
1545 plans shall be negotiated between the agency and the eligible  
1546 plans as part of the procurement process described in s.  
1547 409.966.

1548 (2) Payment rates for comprehensive long-term care plans  
1549 covering services described in s. 409.973 shall be blended with  
1550 rates for long-term care plans for services specified in s.  
1551 409.98.

1552 (3) Payment rates for plans shall reflect historic  
1553 utilization and spending for covered services projected forward



HB 7107

2011

1554 and adjusted to reflect the level of care profile for enrollees  
1555 in each plan. The payment shall be adjusted to provide an  
1556 incentive for reducing institutional placements and increasing  
1557 the utilization of home and community-based services.

1558 (4) The initial assessment of an enrollee's level of care  
1559 shall be made by the Comprehensive Assessment and Review for  
1560 Long-Term-Care Services (CARES) program, which shall assign the  
1561 recipient into one of the following levels of care:

1562 (a) Level of care 1 consists of recipients residing in or  
1563 who must be placed in a nursing home.

1564 (b) Level of care 2 consists of recipients at imminent  
1565 risk of nursing home placement, as evidenced by the need for the  
1566 constant availability of routine medical and nursing treatment  
1567 and care, and require extensive health-related care and services  
1568 because of mental or physical incapacitation.

1569 (c) Level of care 3 consists of recipients at imminent  
1570 risk of nursing home placement, as evidenced by the need for the  
1571 constant availability of routine medical and nursing treatment  
1572 and care, who have a limited need for health-related care and  
1573 services and are mildly medically or physically incapacitated.

1574  
1575 The agency shall periodically adjust payment rates to account  
1576 for changes in the level of care profile for each managed care  
1577 plan based on encounter data.

1578 (5) The agency shall make an incentive adjustment in  
1579 payment rates to encourage the increased utilization of home and  
1580 community-based services and a commensurate reduction of  
1581 institutional placement. The incentive adjustment shall be

HB 7107

2011

1582 modified in each successive rate period during the first  
1583 contract period, as follows:

1584 (a) A 2 percentage point shift in the first rate-setting  
1585 period;

1586 (b) A 2 percentage point shift in the second rate-setting  
1587 period, as compared to the utilization mix at the end of the  
1588 first rate-setting period;

1589 (c) A 3 percentage point shift in the third rate-setting  
1590 period, and in each subsequent rate-setting period during the  
1591 first contract period, as compared to the utilization mix at the  
1592 end of the immediately preceding rate-setting period.

1593  
1594 The incentive adjustment shall continue in subsequent contract  
1595 periods, at a rate of 3 percentage points per year as compared  
1596 to the utilization mix at the end of the immediately preceding  
1597 rate-setting period, until no more than 35 percent of the plan's  
1598 enrollees are placed in institutional settings. The agency shall  
1599 annually report to the Legislature the actual change in the  
1600 utilization mix of home and community-based services compared to  
1601 institutional placements and provide a recommendation for  
1602 utilization mix requirements for future contracts.

1603 (6) The agency shall establish nursing-facility-specific  
1604 payment rates for each licensed nursing home based on facility  
1605 costs adjusted for inflation and other factors as authorized in  
1606 the General Appropriations Act. Payments to long-term care  
1607 managed care plans shall be reconciled to reimburse actual  
1608 payments to nursing facilities.

1609 (7) The agency shall establish hospice payment rates.

HB 7107

2011

1610 Payments to long-term care managed care plans shall be  
 1611 reconciled to reimburse actual payments to hospices.

1612 Section 25. Section 409.984, Florida Statutes, is created  
 1613 to read:

1614 409.984 Choice counseling; enrollment.—

1615 (1) CHOICE COUNSELING.—Before contracting with a vendor to  
 1616 provide choice counseling as authorized under s. 409.969, the  
 1617 agency shall offer to contract with aging resource centers  
 1618 established under s. 430.2053 for choice counseling services. If  
 1619 the aging resource center is determined not to be the vendor  
 1620 that provides choice counseling, the agency shall establish a  
 1621 memorandum of understanding with the aging resource center to  
 1622 coordinate staffing and collaborate with the choice counseling  
 1623 vendor. In addition to the requirements of s. 409.969, any  
 1624 contract to provide choice counseling for the long-term care  
 1625 managed care program shall provide that each recipient be given  
 1626 the option of having in-person choice counseling.

1627 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically  
 1628 enroll into a long-term care managed care plan those Medicaid  
 1629 recipients who do not voluntarily choose a plan pursuant to s.  
 1630 409.969. The agency shall automatically enroll recipients in  
 1631 plans that meet or exceed the performance or quality standards  
 1632 established pursuant to s. 409.967 and may not automatically  
 1633 enroll recipients in a plan that is deficient in those  
 1634 performance or quality standards. If a recipient is deemed  
 1635 dually eligible for Medicaid and Medicare services and is  
 1636 currently receiving Medicare services from an entity qualified  
 1637 under 42 C.F.R. part 422 as a Medicare Advantage Preferred

HB 7107

2011

1638 Provider Organization, Medicare Advantage Provider-sponsored  
1639 Organization, or Medicare Advantage Special Needs Plan, the  
1640 agency shall automatically enroll the recipient in such plan for  
1641 Medicaid services if the plan is currently participating in the  
1642 long-term care managed care program. Except as otherwise  
1643 provided in this part, the agency may not engage in practices  
1644 that are designed to favor one managed care plan over another.  
1645 When automatically enrolling recipients in plans, the agency  
1646 shall take into account the following criteria:

1647 (a) Whether the plan has sufficient network capacity to  
1648 meet the needs of the recipients.

1649 (b) Whether the recipient has previously received services  
1650 from one of the plan's home and community-based service  
1651 providers.

1652 (c) Whether the home and community-based providers in one  
1653 plan are more geographically accessible to the recipient's  
1654 residence than those in other plans.

1655 (3) HOSPICE SELECTION.—Notwithstanding the provisions of  
1656 s. 409.969(3)(c), when a recipient is referred for hospice  
1657 services, the recipient shall have a 30-day period during which  
1658 the recipient may select to enroll in another managed care plan  
1659 to access the hospice provider of the recipient's choice.

1660 (4) CHOICE OF RESIDENTIAL SETTING.—When a recipient is  
1661 referred for placement in a nursing home or assisted living  
1662 facility, the plan shall inform the recipient of any facilities  
1663 within the plan that have specific cultural or religious  
1664 affiliations and, if requested by the recipient, make a  
1665 reasonable effort to place the recipient in the facility of the

HB 7107

2011

1666 recipient's choice.

1667 Section 26. Section 409.9841, Florida Statutes, is created  
1668 to read:

1669 409.9841 Long-term care managed care technical advisory  
1670 workgroup.—

1671 (1) Before August 1, 2011, the agency shall establish a  
1672 technical advisory workgroup to assist in developing:

1673 (a) The method of determining Medicaid eligibility  
1674 pursuant to s. 409.985(3).

1675 (b) The requirements for provider payments to nursing  
1676 homes under s. 409.982(6).

1677 (c) The method for managing nonpayment of Medicare  
1678 coinsurance crossover claims.

1679 (d) Uniform requirements for claims submissions and  
1680 payments, including electronic funds transfers and claims  
1681 processing.

1682 (e) The process for enrollment of and payment for  
1683 individuals pending determination of Medicaid eligibility.

1684 (2) The advisory workgroup shall include, but is not  
1685 limited to, representatives of providers and plans who could  
1686 potentially participate in long-term care managed care. Members  
1687 of the workgroup shall serve without compensation but may be  
1688 reimbursed for per diem and travel expenses as provided in s.  
1689 112.061.

1690 (3) This section is repealed on June 30, 2013.

1691 Section 27. Section 409.985, Florida Statutes, is created  
1692 to read:

1693 409.985 Comprehensive Assessment and Review for Long-Term

HB 7107

2011

1694 Care Services (CARES) Program.—

1695 (1) The agency shall operate the Comprehensive Assessment  
 1696 and Review for Long-Term Care Services (CARES) preadmission  
 1697 screening program to ensure that only individuals whose  
 1698 conditions require long-term care services are enrolled in the  
 1699 long-term care managed care program.

1700 (2) The agency shall operate the CARES program through an  
 1701 interagency agreement with the Department of Elderly Affairs.  
 1702 The agency, in consultation with the Department of Elderly  
 1703 Affairs, may contract for any function or activity of the CARES  
 1704 program, including any function or activity required by 42  
 1705 C.F.R. part 483.20, relating to preadmission screening and  
 1706 review.

1707 (3) The CARES program shall determine if an individual  
 1708 requires nursing facility care and, if the individual requires  
 1709 such care, assign the individual to a level of care as described  
 1710 in s. 409.983(4). When determining the need for nursing facility  
 1711 care, consideration shall be given to the nature of the services  
 1712 prescribed and which level of nursing or other health care  
 1713 personnel meets the qualifications necessary to provide such  
 1714 services and the availability to and access by the individual of  
 1715 community or alternative resources. For the purposes of the  
 1716 long-term care managed care program, the term "nursing facility  
 1717 care" means the individual:

1718 (a) Requires nursing home placement as evidenced by the  
 1719 need for medical observation throughout a 24-hour period and  
 1720 care required to be performed on a daily basis by, or under the  
 1721 direct supervision of, a registered nurse or other health care

HB 7107

2011

1722 professional and requires services that are sufficiently  
 1723 medically complex to require supervision, assessment, planning,  
 1724 or intervention by a registered nurse because of a mental or  
 1725 physical incapacitation by the individual;

1726 (b) Requires or is at imminent risk of nursing home  
 1727 placement as evidenced by the need for observation throughout a  
 1728 24-hour period and care and the constant availability of medical  
 1729 and nursing treatment and requires services on a daily or  
 1730 intermittent basis that are to be performed under the  
 1731 supervision of licensed nursing or other health professionals  
 1732 because the individual who is incapacitated mentally or  
 1733 physically; or

1734 (c) Requires or is at imminent risk of nursing home  
 1735 placement as evidenced by the need for observation throughout a  
 1736 24-hour period and care and the constant availability of medical  
 1737 and nursing treatment and requires limited services that are to  
 1738 be performed under the supervision of licensed nursing or other  
 1739 health professionals because the individual is mildly  
 1740 incapacitated mentally or physically.

1741 (4) For individuals whose nursing home stay is initially  
 1742 funded by Medicare and Medicare coverage and is being terminated  
 1743 for lack of progress towards rehabilitation, CARES staff shall  
 1744 consult with the person making the determination of progress  
 1745 toward rehabilitation to ensure that the recipient is not being  
 1746 inappropriately disqualified from Medicare coverage. If, in  
 1747 their professional judgment, CARES staff believe that a Medicare  
 1748 beneficiary is still making progress toward rehabilitation, they  
 1749 may assist the Medicare beneficiary with an appeal of the

HB 7107

2011

1750 disqualification from Medicare coverage. The use of CARES teams  
1751 to review Medicare denials for coverage under this section is  
1752 authorized only if it is determined that such reviews qualify  
1753 for federal matching funds through Medicaid. The agency shall  
1754 seek or amend federal waivers as necessary to implement this  
1755 section.

1756 Section 28. Section 409.986, Florida Statutes, is created  
1757 to read:

1758 409.986 Managed long-term care for persons with  
1759 developmental disabilities.-

1760 (1) Pursuant to s. 409.963, the agency is responsible for  
1761 administering the long-term care managed care program for  
1762 persons with developmental disabilities described in ss.  
1763 409.986-409.992, but may delegate specific duties and  
1764 responsibilities for the program to the Agency for Persons with  
1765 Disabilities and other state agencies. By January 1, 2015, the  
1766 agency shall begin implementation of statewide long-term care  
1767 managed care for persons with developmental disabilities, with  
1768 full implementation in all regions by October 1, 2016.

1769 (2) The agency shall make payments for long-term care for  
1770 persons with developmental disabilities, including home and  
1771 community-based services, using a managed care model. Unless  
1772 otherwise specified, the provisions of ss. 409.961-409.97 apply  
1773 to the long-term care managed care program for persons with  
1774 developmental disabilities.

1775 (3) The Agency for Persons with Disabilities shall assist  
1776 the agency to develop the specifications for use in the  
1777 invitations to negotiate and the model contract, determine



HB 7107

2011

1778 clinical eligibility for enrollment in long-term care plans for  
1779 persons with developmental disabilities, assist the agency to  
1780 monitor plan performance and measure quality, assist clients and  
1781 families to address complaints with the plans, facilitate  
1782 working relationships between plans and providers serving  
1783 persons with developmental disabilities, and perform other  
1784 functions specified in a memorandum of agreement.

1785 Section 29. Section 409.987, Florida Statutes, is created  
1786 to read:

1787 409.987 Eligibility.—

1788 (1) Medicaid recipients who meet all of the following  
1789 criteria are eligible and shall be enrolled in a comprehensive  
1790 long-term care plan or long-term care plan:

1791 (a) Is Medicaid eligible pursuant to s. 409.904.

1792 (b) Is a Florida resident who has a developmental  
1793 disability as defined in s. 393.063.

1794 (c) Meets the level of care need, including:

1795 1. The recipient's intelligence quotient is 59 or less;

1796 2. The recipient's intelligence quotient is 60-69,  
1797 inclusive, and the recipient has a secondary condition that  
1798 includes cerebral palsy, spina bifida, Prader-Willi syndrome,  
1799 epilepsy, or autistic disorder or has ambulation, sensory,  
1800 chronic health, and behavioral problems;

1801 3. The recipient's intelligence quotient is 60-69,  
1802 inclusive, and the recipient has severe functional limitations  
1803 in at least three major life activities, including self-care,  
1804 learning, mobility, self-direction, understanding and use of  
1805 language, and capacity for independent living; or

HB 7107

2011

1806        4. The recipient is eligible under a primary disability of  
1807 autistic disorder, cerebral palsy, spina bifida, or Prader-Willi  
1808 syndrome. In addition, the condition must result in substantial  
1809 functional limitations in three or more major life activities,  
1810 including self-care, learning, mobility, self-direction,  
1811 understanding and use of language, and capacity for independent  
1812 living.

1813        (d) Meets the level of care need to receive services in an  
1814 intermediate care facility for the developmentally disabled.

1815        (e) Is enrolled in a home and community-based Medicaid  
1816 waiver established in chapter 393 or the Consumer Directed Care  
1817 Plus program for persons with developmental disabilities under  
1818 the Medicaid state plan, is a Medicaid-funded resident of a  
1819 private intermediate care facility for the developmentally  
1820 disabled on the date the managed long-term care plans for  
1821 persons with disabilities becomes available in the recipient's  
1822 region, or has been offered enrollment in a comprehensive long-  
1823 term care plan or a long-term care plan.

1824        (2) The Agency for Persons with Disabilities shall make  
1825 offers for enrollment to eligible individuals based on the wait-  
1826 list prioritization in s. 393.065(5) and subject to availability  
1827 of funds. Before enrollment offers, the agency shall determine  
1828 that sufficient funds exist to support additional enrollment  
1829 into plans.

1830        (3) Unless specifically exempted, all eligible persons  
1831 must be enrolled in a comprehensive long-term care plan or a  
1832 long-term care plan. Medicaid recipients who are residents of a  
1833 developmental disability center, including Sunland Center in

1834 Marianna and Tacachale Center in Gainesville, are exempt from  
 1835 mandatory enrollment but may voluntarily enroll in a long-term  
 1836 care plan.

1837 Section 30. Section 409.988, Florida Statutes, is created  
 1838 to read:

1839 409.988 Benefits.—Managed care plans shall cover, at a  
 1840 minimum, the services in this section. Plans may customize  
 1841 benefit packages or offer additional benefits to meet the needs  
 1842 of enrollees in the plan.

1843 (1) Intermediate care for the developmentally disabled.

1844 (2) Services in alternative residential settings,  
 1845 including, but not limited to:

1846 (a) Group homes licensed under chapter 393 and foster care  
 1847 homes licensed under chapter 409.

1848 (b) Comprehensive transitional education programs licensed  
 1849 under chapter 393.

1850 (c) Residential habilitation centers licensed under  
 1851 chapter 393.

1852 (d) Assisted living facilities licensed under chapter 429  
 1853 and transitional living facilities licensed under part V of  
 1854 chapter 400.

1855 (3) Adult day training.

1856 (4) Behavior analysis services.

1857 (5) Companion services.

1858 (6) Consumable medical supplies.

1859 (7) Durable medical equipment and supplies.

1860 (8) Environmental accessibility adaptations.

1861 (9) In-home support services.

HB 7107

2011

- 1862           (10) Therapies, including occupational, speech,
- 1863 respiratory, and physical therapy.
- 1864           (11) Personal care assistance.
- 1865           (12) Residential habilitation services.
- 1866           (13) Intensive behavioral residential habilitation
- 1867 services.
- 1868           (14) Behavior focus residential habilitation services.
- 1869           (15) Residential nursing services.
- 1870           (16) Respite care.
- 1871           (17) Support coordination.
- 1872           (18) Supported employment.
- 1873           (19) Supported living coaching.
- 1874           (20) Transportation.

1875           Section 31. Section 409.989, Florida Statutes, is created  
 1876 to read:

1877           409.989 Eligible plans.—

1878           (1) ELIGIBLE PLANS.—Provider service networks may be  
 1879 either long-term care plans or comprehensive long-term care  
 1880 plans. Other plans must be comprehensive long-term care plans  
 1881 and under contract to provide services pursuant to s. 409.973 or  
 1882 s. 409.98 in any of the regions that form the combined region as  
 1883 defined in this section.

1884           (2) PROVIDER SERVICE NETWORKS.—Provider service networks  
 1885 targeted to serve persons with disabilities must include one or  
 1886 more owners licensed pursuant to s. 393.067 or s. 400.962 and  
 1887 with at least 10 years' experience in serving this population.

1888           (3) ELIGIBLE PLAN SELECTION.—The agency shall select  
 1889 eligible plans through the procurement process described in s.

HB 7107

2011

1890 409.966. The agency shall notice invitations to negotiate no  
 1891 later than January 1, 2015.

1892 (a) The agency shall procure at least two plans and no  
 1893 more than three plans for services in combined Regions I and II.  
 1894 At least one plan shall be a provider service network, if any  
 1895 submit a responsive bid.

1896 (b) The agency shall procure at least two plans and no  
 1897 more than three plans for services in combined Regions III and  
 1898 IV. At least one plan shall be a provider service network, if  
 1899 any submit a responsive bid.

1900 (c) The agency shall procure at least two plans and no  
 1901 more than four plans for services in combined Regions V, VI, and  
 1902 VII. At least one plan shall be a provider service network, if  
 1903 any submit a responsive bid.

1904  
 1905 If no provider service network submits a responsive bid, the  
 1906 agency shall procure no more than one less than the maximum  
 1907 number of eligible plans permitted in the combined region.  
 1908 Within 12 months after the initial invitation to negotiate, the  
 1909 agency shall attempt to procure an eligible plan that is a  
 1910 provider service network. The agency shall notice another  
 1911 invitation to negotiate only with provider service networks in  
 1912 such combined region where no provider service network has been  
 1913 selected.

1914 (4) QUALITY SELECTION CRITERIA.—In addition to the  
 1915 criteria established in s. 409.966, the agency shall consider  
 1916 the following factors in the selection of eligible plans:

1917 (a) Whether the plan has sufficient specialized staffing,  
 1918 including employment of executive managers with expertise and  
 1919 experience in serving persons with developmental disabilities.

1920 (b) Whether the plan has sufficient network  
 1921 qualifications, including establishment of a network of service  
 1922 providers dispersed throughout the combined region and in  
 1923 sufficient numbers to meet specific accessibility standards  
 1924 established by the agency for specialty services for persons  
 1925 with developmental disabilities.

1926 (c) Whether the plan has written agreements or signed  
 1927 contracts or has made substantial progress in establishing  
 1928 relationships with providers before the plan submitting a  
 1929 response. The agency shall give preference to plans with  
 1930 evidence of signed contracts with providers listed in s.  
 1931 409.99(1).

1932 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's  
 1933 Medical Services Network may provide either long-term care plans  
 1934 or comprehensive long-term care plans. Participation by the  
 1935 Children's Medical Services Network shall be pursuant to a  
 1936 single, statewide contract with the agency not subject to the  
 1937 procurement requirements or regional plan number limits of this  
 1938 section. The Children's Medical Services Network must meet all  
 1939 other plan requirements.

1940 Section 32. Section 409.99, Florida Statutes, is created  
 1941 to read:

1942 409.99 Managed care plan accountability.—In addition to  
 1943 the requirements of s. 409.967, managed care plans and providers  
 1944 shall comply with the requirements of this section.

1945           (1) PROVIDER NETWORKS.—Managed care plans may limit the  
 1946 providers in their networks based on credentials, quality  
 1947 indicators, and price. However, in the first contract period  
 1948 after an eligible plan is selected in a region by the agency,  
 1949 the plan must offer a network contract to the following  
 1950 providers in the region:

1951           (a) Providers with licensed institutional care facilities  
 1952 for the developmentally disabled.

1953           (b) Providers of alternative residential facilities  
 1954 specified in s. 409.988.

1955  
 1956 After 12 months of active participation in a managed care plan  
 1957 network, the plan may exclude any of the above-named providers  
 1958 from the network for failure to meet quality or performance  
 1959 criteria. If the plan excludes a provider from the plan, the  
 1960 plan must provide written notice to all recipients who have  
 1961 chosen that provider for care. The notice shall be issued at  
 1962 least 90 days before the effective date of the exclusion.

1963           (2) SELECT PROVIDER PARTICIPATION.—Except as provided in  
 1964 this subsection, providers may limit the managed care plans they  
 1965 join. Licensed institutional care facilities for the  
 1966 developmentally disabled and licensed residential settings  
 1967 providing Intensive Behavioral Residential Habilitation services  
 1968 with an active Medicaid provider agreement must agree to  
 1969 participate in any eligible plan selected by the agency.

1970           (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall  
 1971 monitor the quality and performance of each participating  
 1972 provider. At the beginning of the contract period, each plan

HB 7107

2011

1973 shall notify all its network providers of the metrics used by  
 1974 the plan for evaluating the provider's performance and  
 1975 determining continued participation in the network.

1976 (4) PROVIDER PAYMENT.—Managed care plans and providers  
 1977 shall negotiate mutually acceptable rates, methods, and terms of  
 1978 payment. Plans shall pay intermediate care facilities for the  
 1979 developmentally disabled and intensive behavior residential  
 1980 habilitation providers an amount equal to the facility-specific  
 1981 payment rate set by the agency.

1982 (5) CONSUMER AND FAMILY INVOLVEMENT.—Each managed care  
 1983 plan must establish a family advisory committee to participate  
 1984 in program design and oversight.

1985 (6) CONSUMER-DIRECTED CARE.—Each managed care plan must  
 1986 offer consumer-directed care services to enrollees pursuant to  
 1987 s. 409.221.

1988 Section 33. Section 409.991, Florida Statutes, is created  
 1989 to read:

1990 409.991 Managed care plan payment.—In addition to the  
 1991 payment provisions of s. 409.968, the agency shall provide  
 1992 payment to comprehensive long-term care plans and long-term care  
 1993 plans pursuant to this section.

1994 (1) Prepaid payment rates shall be negotiated between the  
 1995 agency and the eligible plans as part of the procurement process  
 1996 described in s. 409.966.

1997 (2) Payment for comprehensive long-term care plans  
 1998 covering services pursuant to s. 409.973 shall be blended with  
 1999 payments for long-term care plans for services specified in s.  
 2000 409.988.



2001           (3) Payment rates for plans covering services specified in  
 2002 s. 409.988 shall be based on historical utilization and spending  
 2003 for covered services projected forward and adjusted to reflect  
 2004 the level-of-care profile of each plan's enrollees.

2005           (4) The Agency for Persons with Disabilities shall conduct  
 2006 the initial assessment of an enrollee's level of care. The  
 2007 evaluation of level of care shall be based on assessment and  
 2008 service utilization information from the most recent version of  
 2009 the Questionnaire for Situational Information and encounter  
 2010 data.

2011           (5) The agency shall assign enrollees of developmental  
 2012 disabilities long-term care plans into one of five levels of  
 2013 care to account for variations in risk status and service needs  
 2014 among enrollees.

2015           (a) Level of care 1 consists of individuals receiving  
 2016 services in an intermediate care facility for the  
 2017 developmentally disabled.

2018           (b) Level of care 2 consists of individuals with intensive  
 2019 medical or adaptive needs and who require essential services to  
 2020 avoid institutionalization or who possess behavioral problems  
 2021 that are exceptional in intensity, duration, or frequency and  
 2022 present a substantial risk of harm to themselves or others.

2023           (c) Level of care 3 consists of individuals with service  
 2024 needs, including a licensed residential facility and a moderate  
 2025 level of support for standard residential habilitation services  
 2026 or a minimal level of support for behavior focus residential  
 2027 habilitation services, or individuals in supported living who  
 2028 require more than 6 hours a day of in-home support services.

HB 7107

2011

2029 (d) Level of care 4 consists of individuals requiring less  
 2030 than a moderate level of residential habilitation support in a  
 2031 residential placement or individuals in supported living who  
 2032 require 6 hours a day or less of in-home support services.

2033 (e) Level of care 5 consists of individuals who do not  
 2034 receive in-home support services and need minimal support  
 2035 services while living in independent or supported living  
 2036 situations or in their family home.

2037  
 2038 The agency shall periodically adjust aggregate payments to plans  
 2039 based on encounter data to account for variations in risk levels  
 2040 among plans' enrollees.

2041 (6) The agency shall establish intensive behavior  
 2042 residential habilitation rates for providers approved by the  
 2043 agency to provide this service. The agency shall also establish  
 2044 intermediate care facility for the developmentally disabled-  
 2045 specific payment rates for each licensed intermediate care  
 2046 facility. Payments to intermediate care facilities for the  
 2047 developmentally disabled and providers of intensive behavior  
 2048 residential habilitation services shall be reconciled to  
 2049 reimburse the plan's actual payments to the facilities.

2050 Section 34. Section 409.992, Florida Statutes, is created  
 2051 to read:

2052 409.992 Automatic enrollment.—The agency shall  
 2053 automatically enroll into a comprehensive long-term care plan or  
 2054 a long-term care plan those Medicaid recipients who do not  
 2055 voluntarily choose a plan pursuant to s. 409.969. The agency  
 2056 shall automatically enroll recipients in plans that meet or

HB 7107

2011

2057 exceed the performance or quality standards established pursuant  
2058 to s. 409.967 and shall not automatically enroll recipients in a  
2059 plan that is deficient in those performance or quality  
2060 standards. Except as otherwise provided in this part, the agency  
2061 shall assign individuals who are deemed dually eligible for  
2062 Medicaid and Medicare to a plan that provides both Medicaid and  
2063 Medicare services. The agency may not engage in practices that  
2064 are designed to favor one managed care plan over another. When  
2065 automatically enrolling recipients in plans, the agency shall  
2066 take into account the following criteria:

2067 (1) Whether the plan has sufficient network capacity to  
2068 meet the needs of the recipients.

2069 (2) Whether the recipient has previously received services  
2070 from one of the plan's home and community-based service  
2071 providers.

2072 (3) Whether home and community-based providers in one plan  
2073 are more geographically accessible to the recipient's residence  
2074 than those in other plans.

2075 Section 35. This act shall take effect July 1, 2011.