A bill to be entitled

An act relating to Medicaid managed care; creating pt. IV of ch. 409, F.S.; creating s. 409.961, F.S.; providing for statutory construction; providing applicability of specified provisions throughout the part; providing rulemaking authority for specified agencies; creating s. 409.962, F.S.; providing definitions; creating s. 409.963, F.S.; designating the Agency for Health Care Administration as the single state agency to administer the Medicaid program; providing for specified agency responsibilities; requiring client consent for release of medical records; creating s. 409.964, F.S.; establishing the Medicaid program as the statewide, integrated managed care program for all covered services; authorizing the agency to apply for and implement waivers; providing for public notice and comment; creating s. 409.965, F.S.; providing for mandatory enrollment; providing for exemptions; creating s. 409.966, F.S.; providing requirements for qualified plans that provide services in the Medicaid managed care program; providing for a medical home network to be designated as a qualified plan; establishing provider service network requirements for qualified plans; providing for qualified plan selection; requiring the agency to use an invitation to negotiate; requiring the agency to compile and publish certain information; establishing regions for separate procurement of plans; providing quality selection criteria for plan selection; establishing quality selection criteria;

providing limitations on serving recipients during the pendency of litigation; providing that a qualified plan that participates in an invitation to negotiate in more than one region may not serve Medicaid recipients until all administrative challenges are finalized; creating s. 409.967, F.S.; providing for managed care plan accountability; establishing contract terms; providing for contract extension under certain circumstances; establishing payments to noncontract providers; establishing requirements for access; requiring plans to establish and maintain an electronic database; establishing requirements for the database; requiring plans to provide encounter data; requiring the agency to establish performance standards for plans; providing program integrity requirements; establishing a grievance resolution process; providing for penalties for early termination of contracts or reduction in enrollment levels; creating s. 409.968, F.S.; establishing managed care plan payments; providing payment requirements for provider service networks; creating s. 409.969, F.S.; requiring enrollment in managed care plans by specified Medicaid recipients; creating requirements for plan selection by recipients; providing for choice counseling; establishing choice counseling requirements; authorizing disenrollment under certain circumstances; defining the term "good cause" for purposes of disenrollment; providing time limits on an internal grievance process; providing requirements for agency determination regarding

disenrollment; requiring recipients to stay in plans for a specified time; creating s. 409.970, F.S.; requiring the agency to maintain an encounter data system; providing requirements for prepaid plans to submit data; creating s. 409.971, F.S.; creating the managed medical assistance program; providing deadlines to begin and finalize implementation of the program; creating s. 409.972, F.S.; providing for mandatory and voluntary enrollment; creating s. 409.973, F.S.; establishing minimum benefits for managed care plans to cover; authorizing plans to customize benefit packages; requiring plans to establish enhanced benefits programs; providing terms for enhanced benefits package; establishing reserve requirements for plans to fund enhanced benefits programs; creating s. 409.974, F.S.; establishing a specified number of qualified plans to be selected in each region; establishing a deadline for issuing invitations to negotiate; establishing quality selection criteria; establishing the Children's Medical Service Network as a qualified plan; creating s. 409.975; establishing managed care plan accountability; creating a medical loss ratio requirement; authorizing plans to limit providers in networks; mandating certain providers be offered contracts in the first year; requiring certain provider types to participate in plans; requiring plans to monitor the quality and performance history of providers; requiring specified programs and procedures be established by plans; establishing provider payments for hospitals; establishing

conflict resolution procedures; establishing the Medicaid Resolution Board for specified purposes; establishing plan requirements for medically needy recipients; creating s. 409.976, F.S.; providing for managed care plan payment; requiring the agency to establish a methodology to ensure certain types of payments to specified providers; establishing eligibility for payments; creating s. 409.977, F.S.; providing for enrollment; establishing choice counseling requirements; providing for automatic enrollment of certain recipients; establishing opt-out opportunities for recipients; creating s. 409.978, F.S.; requiring the Agency for Health Care Administration be responsible for administering the long-term care managed care program; providing implementation dates for the long-term care managed care program; providing duties for the Department of Elderly Affairs relating to assisting the agency in implementing the program; creating s. 409.979, F.S.; providing eligibility requirements for the long-term care managed care program; creating s. 409.980, F.S.; providing the benefits that a managed care plan shall provide when participating in the long-term care managed care program; creating s. 409.981, F.S.; providing criteria for qualified plans; designating regions for plan implementation throughout the state; providing criteria for the selection of plans to participate in the long-term care managed care program; creating s. 409.982, F.S.; providing the agency shall establish a uniform accounting and reporting methods for plans; providing spending

thresholds and consequences relating to spending thresholds; providing for mandatory participation in plans of certain service providers; providing providers can be excluded from plans for failure to meet quality or performance criteria; providing the plans must monitor participating providers using specified criteria; providing certain providers that must be included in plan networks; providing provider payment specifications for nursing homes and hospices; creating s. 409.983, F.S.; providing for negotiation of rates between the agency and the plans participating in the long-term care managed care program; providing specific criteria for calculating and adjusting plan payments; allowing the CARES program to assign plan enrollees to a level of care ; providing incentives for adjustments of payment rates; providing the agency shall establish nursing facility-specific and hospice services payment rates; creating s. 409.984, F.S.; providing that prior to contracting with another vender, the agency shall offer to contract with the aging resource centers to provide choice counseling for the long-term care managed care program; providing criteria for automatic assignments of plan enrollees who fail to chose a plan; creating s. 409.985, F.S.; providing that the agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services program through an interagency agreement with the Department of Elderly Affairs; providing duties of the program; defining the term "nursing facility care"; creating s. 409.986, F.S.;

providing authority and agency duties related to long-term care plans; creating s. 409.987, F.S.; providing eligibility requirements for long-term care plans; creating s. 409.988, F.S.; providing benefits for long-term care plans; creating s. 409.989, F.S.; establishing criteria for qualified plans; specifying minimum and maximum number of plans and selection criteria; creating s. 409.990, F.S.; providing requirements for managed care plan accountability; specifying limitations on providers in plan networks; providing for evaluation and payment of network providers; creating s. 409.991, F.S.; providing for payment of managed care plans; providing duties for the Agency for Persons with Disabilities to assign plan enrollees into a payment rate level of care; establishing level of care criteria; providing payment requirements for intensive behavior residential habilitation providers and intermediate care facilities for the developmentally disabled; creating s. 409.992, F.S.; providing requirements for enrollment and choice counseling; specifying enrollment exceptions for certain Medicaid recipients; providing an effective date.

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

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

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

409.961 Statutory construction; applicability; rules.—It is the intent of the Legislature that if any conflict exists between the provisions contained in this part and provisions contained in other parts of this chapter, the provisions contained in this part shall control. The provisions of ss. 409.961-409.970 apply only to the Medicaid managed medical assistance program, long-term care managed care program, and managed long-term care for persons with developmental disabilities program, as provided in this part. The agency shall adopt any rules necessary to comply with or administer this part and all rules necessary to comply with federal requirements. In addition, the department shall adopt and accept the transfer of any rules necessary to carry out the department's responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility and for ensuring compliance with and administering this part, as those rules relate to the department's responsibilities, and any other provisions related to the department's responsibility for the determination of Medicaid eligibility.

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

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

(1) "Agency" means the Agency for Health Care Administration. The agency is the Medicaid agency for the state, as provided under federal law.

(2) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, goods, or services.

(3) "Direct care management" means care management activities that involve direct interaction between providers and patients.

(4) "Long-term care comprehensive plan" means a long-term care plan that also provides the services described in s. 409.973.

(5) "Long-term care plan" means a specialty plan that provides institutional and home and community-based services.

(6) "Long term care provider service network" means an entity certified pursuant to s. 409.912(4)(d), of which a controlling interest is owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

(7) "Managed care plan" means a qualified plan under contract with the agency to provide services in the Medicaid program.

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

(9) "Medicaid recipient" or "recipient" means an individual who the department or, for Supplemental Security Income, the Social Security Administration determines is

eligible pursuant to federal and state law to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(10) "Medical home network" means a qualified plan designated by the agency as a medical home network in accordance with the criteria established in s. 409.91207.

(11) "Prepaid plan" means a qualified plan that is licensed or certified as a risk-bearing entity in the state and is paid a prospective per-member, per-month payment by the agency.

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

(13) "Qualified plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(4)(d) that is eligible to participate in the statewide managed care program.

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

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

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

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

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. Prior to seeking a waiver, the agency shall provide public notice and the opportunity for public comment and shall include public feedback in the waiver application. The agency shall include the public feedback in the application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2) and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.

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

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

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

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

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

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

409.966 Qualified plans; selection.—

(1) QUALIFIED PLANS.-Services in the Medicaid managed care program shall be provided by qualified plans.

(a) A qualified plan may request the agency to designate the plan as a medical home network if it meets the criteria established in s. 409.91207.

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

(2) QUALIFIED PLAN SELECTION.-The agency shall select a limited number of qualified plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(3)(a). At least 30 days prior to issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data for the 3 most recent contract years consistent with the rate-setting periods for all Medicaid recipients by region or

county. The source of the data in the report shall include both historic fee-for-service claims and validated data from the Medicaid Encounter Data System. The report shall be made available in electronic form and shall delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. Separate and simultaneous procurements shall be conducted in each of the following regions:

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

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

(c) Region III, which shall consist of Charlotte, DeSoto, Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota Counties.

(d) Region IV, which shall consist of Brevard, Indian River, Lake, Orange, Osceola, Seminole, and Sumter Counties.

(e) Region V, which shall consist of Broward, Glades, Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

(f) Region VI, which shall consist of Collier, Dade, and Monroe Counties.

(3) QUALITY SELECTION CRITERIA.-The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability

of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of qualified plans:

(a) Accreditation by the National Committee for Quality Assurance or another nationally recognized accrediting body.

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

(c) Availability and accessibility of primary care and specialty physicians in the provider network.

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

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

(f) Provision of additional benefits, particularly dental care and disease management, and other enhanced-benefit programs.

(g) History of voluntary or involuntary withdrawal from any state Medicaid program or program area.

(h) Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give

special weight to such evidence, and the evaluation shall be based on the following factors:

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

2. Specific arrangements that provide evidence that the compensation offered is sufficient to retain primary and specialty physicians in sufficient numbers to continue to comply with the standards established pursuant to s. 409.967(2) throughout the 5-year contract term.

After negotiations are conducted, the agency shall select the qualified plans that are determined to be responsive and provide the best value to the state. Preference shall be given to organizations designated as medical home networks pursuant to s. 409.91207 or organizations with the greatest number of primary care providers that are recognized as patient-centered medical homes by the National Committee for Quality Assurance or organizations with networks that reflect recruitment of minority physicians and other minority providers.

(4) ADMINISTRATIVE CHALLENGE.—Any qualified plan that participates in an invitation to negotiate in more than one region and is selected in at least one region may not begin serving Medicaid recipients in any region for which it was selected until all administrative challenges to procurements required by this section to which the qualified plan is a party have been finalized. For purposes of this subsection, an administrative challenge is finalized if an order granting

voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been entered by the Florida Supreme Court and a warrant has been issued.

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

409.967 Managed care plan accountability.—

(1) The agency shall establish a 5-year contract with each of the qualified plans selected through the procurement process described in s. 409.966. A plan contract may not be renewed; however, the agency may extend the terms of a plan contract to cover any delays in transition to a new plan.

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

(a) Emergency services.—Plans shall pay for services required by ss. 395.1041 and 401.45 and rendered by a noncontracted provider within 30 days after receipt of a complete and correct claim. Plans must give providers of these services a specific explanation for each claim denied for being incomplete or incorrect. Payment shall be made at the rate the agency would pay for such services from the same provider.

Claims from noncontracted providers shall be accepted by the qualified plan for at least 1 year after the date the services are provided.

(b) Access.—The agency shall establish specific standards for the number, type, and regional distribution of providers in plan networks to ensure access to care. Each plan must maintain a region-wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database shall be available online to both the agency and the public and shall have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

(c) Encounter data.—Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of plans' enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify

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

(d) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract. Each plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system shall include incentives and disincentives for network providers.

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

1. A provider credentialing system and ongoing provider monitoring;

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

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

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

5. Designation of a program integrity compliance officer.

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

(g) Penalties.—Plans that reduce enrollment levels or leave a region prior to the end of the contract term shall reimburse the agency for the cost of enrollment changes and other transition activities, including the cost of additional choice counseling services. If more than one plan leaves a region at the same time, costs shall be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing plans shall pay a per enrollee penalty not to exceed 5 percent of 1 month's payment. Plans shall provide the agency notice no less than 180 days prior to withdrawing from a region.

(h) Prompt payment.—For all electronically submitted claims, a managed care plan shall:

1. Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim;

2. Within 20 days after receipt of the claim, pay the claim or notify the provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the

notice or payment was mailed or electronically transferred; and

3. Within 90 days after receipt of the claim, pay or deny the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an uncontestable obligation to pay the claim.

(i) Electronic claims.-Plans shall accept electronic claims in compliance with federal standards.

(j) Medical home development.-The managed care plan, if not designated as a medical home network pursuant to s. 409.91207, must develop a plan to assist and to provide incentives for its primary care providers to become recognized as patient-centered medical homes by the National Committee for Quality Assurance.

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

409.968 Managed care plan payment.—

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

(2) Beginning September 1, 2010, the agency shall update the rate-setting methodology by initiating a transition to rates based on statewide encounter data submitted by Medicaid managed care plans pursuant to s. 409.970. Prior to this transition, the agency shall conduct appropriate tests and establish specific milestones in order to determine that the Medicaid Encounter

Data system consists of valid, complete, and sound data for a sufficient period of time to provide a reliable basis for establishing actuarially sound payment rates. The transition shall be implemented within 3 years or less, and shall utilize such other data sources as necessary and reliable to make appropriate adjustments during the transition. The agency shall establish a technical advisory panel to obtain input from the prepaid plans regarding the incorporation of encounter data in the rate setting process.

(3) Provider service networks may be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 5 years of the plan's operation in a given region or until the contract year that begins on October 1, 2015, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of incurred but not reported claims within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims

processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.

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

409.969 Enrollment; choice counseling; automatic assignment; disenrollment.—

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

(2) CHOICE COUNSELING.—The agency shall provide choice counseling for Medicaid recipients. The agency may contract for the provision of choice counseling. Any such contract shall be for a period of 5 years. The agency may renew a contract for an additional 5-year period; however, prior to renewal of the contract the agency shall hold at least one public meeting in each of the regions covered by the choice counseling vendor. The agency may extend the term of the contract to cover any delays in transition to a new contractor. Printed choice information

and choice counseling shall be offered in the native or preferred language of the recipient, consistent with federal requirements. The manner and method of choice counseling shall be modified as necessary to assure culturally competent, effective communication with people from diverse cultural backgrounds. The agency shall maintain a record of the recipients who receive such services, identifying the scope and method of the services provided. The agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

(a) An explanation that each recipient has the right to choose a managed care plan at the time of enrollment in Medicaid and again at regular intervals set by the agency, and that if a recipient does not choose a plan, the agency will assign the recipient to a plan according to the criteria specified in this section.

(b) A list and description of the benefits provided in each plan.

(c) An explanation of benefit limits.

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

(e) Plan performance data.

(3) DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. Good cause includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable

delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may require a recipient to use the plan's grievance process prior to the agency's determination of good cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged.

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

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

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

Medicaid recipient from changing primary care providers within the plan during that period.

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

Section 11. Section 409.970, Florida Statutes, is created to read:

409.970 Encounter data.—The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans. Prepaid plans shall submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete. The agency is responsible for validating the data submitted by the plans. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

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

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and

related services using a managed care model. By January 1, 2012, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all regions by October 1, 2013.

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

409.972 Mandatory and voluntary enrollment.—

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

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

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

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the Department of Children and Families, and treatment facilities funded through the Substance Abuse and Mental Health program of the Department of Children and Families.

(c) Persons eligible for refugee assistance.

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

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

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

409.973 Benefits.—

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

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

(e) Dental services.

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

(g) Emergency services.

(h) Family planning services and supplies.

(i) Healthy start services.

(j) Hearing services.

(k) Home health agency services.

(l) Hospice services.

(m) Hospital inpatient services.

(n) Hospital outpatient services.

(o) Laboratory and X-ray services.

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

(q) Mental health services.

(r) Nursing care.

(s) Optical services and supplies.

(t) Optometrist services.

(u) Physical, occupational, respiratory, and speech therapy services.

(v) Physician services.

(w) Podiatric services.

(x) Prescription drugs.

(y) Renal dialysis services.

(z) Respiratory equipment and supplies.

(aa) Rural health clinic services.

(bb) Substance abuse treatment services.

(cc) Transportation to access covered services.

(2) CUSTOMIZED BENEFITS.—Managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

(3) ENHANCED BENEFITS.—Each plan operating in the managed medical assistance program shall establish an incentive program that rewards specific healthy behaviors with credits in a flexible spending account.

(a) At the discretion of the recipient, credits shall be used to purchase otherwise uncovered health and related services during the entire period of, and for a maximum of 3 years after, the recipient's Medicaid eligibility, whether or not the recipient remains continuously enrolled in the plan in which the credits were earned.

(b) Enhanced benefits shall be structured to provide greater incentives for those diseases linked with lifestyle and conditions or behaviors associated with avoidable utilization of high-cost services.

(c) To fund these credits, each plan must maintain a reserve account in an amount of up to 2 percent of the plan's Medicaid premium revenue, or benchmark premium revenue in the case of provider service networks, based on an actuarial assessment of the value of the enhanced benefits program.

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

409.974 Qualified plans.—

(1) QUALIFIED PLAN SELECTION.-The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2012.

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

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

(c) The agency shall procure at least five plans and no more than ten plans for Region III. At least two plans shall be provider service networks, if any two provider service networks submit a responsive bid.

(d) The agency shall procure at least four plans and no more than eight plans for Region IV. At least one plan shall be a provider service network if any provider service network submits a responsive bid.

(e) The agency shall procure at least four plans and no more than seven plans for Region V. At least one plan shall be a provider service network, if any provider service network submits a responsive bid.

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

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

(2) QUALITY SELECTION CRITERIA.-In addition to the criteria established in s. 409.966, the agency shall consider evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with providers of critical services pursuant to s. 409.975(3)(a)-(d). The agency shall also consider

whether the organization is a specialty plan. When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

(3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's Medical Services Network authorized under chapter 391 is a qualified plan for purposes of the managed medical assistance program. Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

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

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

(1) MEDICAL LOSS RATIO.—The agency shall establish and implement managed care plans that shall use a uniform method of accounting for and reporting medical, direct care management, and nonmedical costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(b) Plans that spend less than 85 percent of Medicaid premium revenue on medical services and direct care management as determined by the agency shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(c) Plans that spend more than 92 percent of Medicaid premium revenue shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management.

(d) Plans that spend 95 percent or more of Medicaid premium revenue and are determined to be failing to appropriately manage care shall be excluded from automatic enrollments.

(2) PROVIDER NETWORKS.—Plans may limit the providers in their networks based on credentials, quality indicators, and price. However, in the first contract period after a qualified plan is selected in a region by the agency, the plan must offer a network contract to the following providers in the region:

(a) Federally qualified health centers.

(b) Primary care providers certified as medical homes.

(c) Providers listed in paragraphs (3)(a)-(d).

After 12 months of active participation in a plan's network, the plan may exclude any of the above-named providers from the network for failure to meet quality or performance criteria. If the plan excludes a provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days prior to the effective date of the exclusion.

(3) SELECT PROVIDER PARTICIPATION.—Providers may not be required to participate in any qualified plan selected by the agency except as provided in this subsection. The following providers must agree to participate with each qualified plan selected by the agency in the regions where they are located:

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

(b) Hospitals that are trauma centers as defined in s. 395.4001(14).

(c) Hospitals that are regional perinatal intensive care centers as defined in s. 383.16(2).

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

(e) Hospitals with both an active Medicaid provider agreement under s. 409.907 and a certificate of need.

The hospitals described in paragraphs (a)-(d) shall make adequate arrangements for medical staff sufficient to fulfill their contractual obligations with the plans.

(4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the quality and performance of each participating provider. At the

beginning of the contract period, each plan shall notify all its network providers of the metrics used by the plan for evaluating the provider's performance and determining continued participation in the network.

(5) PREGNANCY AND INFANT HEALTH.—Each plan shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants, and Children, and the Children's Medical Services program for children with special health care needs.

(6) SCREENING RATE.—Each plan shall achieve an annual Early and Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent of those recipients continuously enrolled for at least 8 months.

(7) PROVIDER PAYMENT.—Plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. At a minimum, plans shall pay hospitals the Medicaid rate. Payments to hospitals shall not exceed 150 percent of the rate the agency would have paid on the first day of the contract between the provider and the plan, unless specifically approved by the agency. Payment rates may be updated periodically.

(8) CONFLICT RESOLUTION.—In order to protect the continued statewide operation of the Medicaid managed care program, the Medicaid Resolution Board is established to resolve disputes between managed care plans and hospitals and between managed care plans and the medical staff of the providers listed in s. 409.975(3)(a)-(d). The board shall consist of two members

appointed by the Speaker of the House of Representatives, two members appointed by the President of the Senate, and three members appointed by the Governor. The costs of the board's activities to review and resolve disputes shall be shared equally by the parties to the dispute. Any managed care plan or above-named provider may initiate a review by the board for any conflict related to payment rates, contract terms, or other conditions. The board shall make recommendations to the agency regarding payment rates, procedures, or other contract terms to resolve such conflicts. The agency may amend the terms of the contracts with the parties to ensure compliance with these recommendations. This process shall not be used to review and reverse any managed care plan decision to exclude any provider that fails to meet quality standards.

(9) MEDICALLY NEEDY ENROLLEES.—Each selected plan shall accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the department. The agency shall pay the remainder of the monthly premium. Plans must provide a grace period of at least 120 days before disenrolling recipients who fail to pay their shares of the premium.

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

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

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

(2) The agency shall develop a methodology to ensure the availability of intergovernmental transfers in the statewide integrated managed care program to support providers that have historically served Medicaid recipients. Such providers include, but are not limited to, safety net providers, trauma hospitals, children's hospitals, statutory teaching hospitals, and medical and osteopathic physicians employed by or under contract with a medical school in this state. The agency may develop a supplemental capitation rate, risk pool, or incentive payment to plans that contract with these providers. A plan is eligible for a supplemental payment only if there are sufficient intergovernmental transfers available from allowable sources and the plan can demonstrate that it pays a reimbursement rate not less than the equivalent fee-for-service rate. The agency may develop the supplemental capitation rate to consider rates higher than the fee-for-service Medicaid rate when needed to ensure access and supported by funds provided by a locality. The agency shall evaluate the development of the rate cell to accurately reflect the underlying utilization to the maximum extent possible. This methodology may include interim rate adjustments as permitted under federal regulations. Any such

methodology shall preserve federal funding to these entities and must be actuarially sound. In the absence of federal approval for the above methodology, the agency is authorized to set an enhanced rate and require that plans pay the enhanced rate, if the agency determines the enhanced rate is necessary to ensure access to care by the providers described in this subsection. The amount paid to the plans to make supplemental payments or to enhance provider rates pursuant to this subsection shall be reconciled to the exact amounts the plans are required to pay to providers. The plans shall make the designated payments to providers within 15 business days of notification by the agency regarding provider-specific distributions.

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

409.977 Choice counseling and enrollment.—

(1) CHOICE COUNSELING.-In addition to the choice counseling information required by s. 409.969, the agency shall make available clear and easily understandable choice information to Medicaid recipients that includes:

(a) Information about earning credits in the plan's enhanced benefit program.

(b) Information about cost sharing requirements of each plan.

(2) AUTOMATIC ENROLLMENT.-The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant

to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. The agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall automatically enroll based on the following criteria:

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

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

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

(3) OPT-OUT OPTION.-The agency shall develop a process to enable any recipient with access to employer-sponsored insurance to opt out of all qualified plans in the Medicaid program and to use Medicaid financial assistance to pay for the recipient's share of the cost in any such plan. Contingent upon federal approval, the agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Cover Florida Health Access Program, the Florida Health Choices Program, or any health exchange, to opt out. The amount of financial assistance provided for each

recipient may not exceed the amount of the Medicaid premium that would have been paid to a plan for that recipient.

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

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. By July 1, 2011, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2012.

(2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model. Unless otherwise specified, the provisions of ss. 409.961-409.970 apply to the long-term care managed care program.

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

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

409.979 Eligibility.—

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

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

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

(2) Medicaid recipients who on the date long-term care managed care plans becomes available in the recipient's region, are residing in a nursing home facility or enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program:

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

(b) The Aged and Disabled Adult Waiver.

(c) The Adult Day Health Care Waiver.

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

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

(f) The Long-Term Care Community-Based Diversion Pilot Project as described in s. 430.705.

(g) The Channeling Services Waiver for Frail Elders.

Section 21. Section 409.980, Florida Statutes, is created to read:

409.980 Benefits.—Managed care plans shall cover, at a minimum, the following services:

(1) Nursing facility.

(2) Assisted living facility.

(3) Hospice.

(4) Adult day care.

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

(5) Personal care.

(7) Home accessibility adaptation.

(9) Behavior management.

(9) Home delivered meals.

(10) Case management.

(11) Therapies:

(a) Occupational therapy

(b) Speech therapy

(c) Respiratory therapy

(d) Physical therapy.

(12) Intermittent and skilled nursing.

(13) Medication administration.

(14) Medication management.

(15) Nutritional assessment and risk reduction.

(16) Caregiver training.

(17) Respite care.

(18) Transportation.

(19) Personal emergency response system.

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

409.981 Qualified plans.—

(1) QUALIFIED PLANS.—For purposes of the long-term care managed care program, qualified plans also include entities who are qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans. Such plans are eligible to participate in the statewide long-term care managed care program. Qualified plans that are provider service networks must be long-term care provider service networks. Qualified plans may either be long-term care plans that cover benefits pursuant to s. 409.980, or comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.980.

(2) QUALIFIED PLAN SELECTION.—The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than July 1, 2011.

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

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

(c) The agency shall procure at least five plans and no more than ten plans for Region III. At least two plans shall be provider service networks, if any two submit a responsive bid.

(d) The agency shall procure at least four plans and no more than eight plans for Region IV. At least one plan shall be a provider service network if any submit a responsive bid.

(e) The agency shall procure at least four plans and no more than seven plans for Region V. At least one plan shall be a provider service network, if any submit a responsive bid.

(f) The agency shall procure at least five plans and no more than ten plans for Region VI. At least two plans shall be provider service networks, if any two submit a responsive bid. If no provider service network submits a responsive bid, the agency shall procure one less qualified plan in each of the regions. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a qualified plan that is a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in such region where no provider service network has been selected.

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

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

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

(c) Whether a plan is proposing to establish a comprehensive long-term care plan and whether the qualified plan has a contract to provide managed medical assistance services in the same region. The agency shall exercise a preference for such plans.

(d) Whether a plan is designated as a medical home network pursuant to s. 409.91207 or offers consumer-directed care services to enrollees pursuant to s. 409.221. Consumer-directed care services provide a flexible budget which is managed by enrolled individuals and their families or representatives and allows them to choose providers of services, determine provider rates of payment and direct the delivery of services to best meet their special long-term care needs. When all other factors are equal among competing qualified plans, the agency shall exercise a preference for such plans.

(e) Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with providers of critical services pursuant to s. 409.982(2)(a)-(c).

(4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—The Program for All-Inclusive Care for the Elderly (PACE) is a qualified plan for purposes of the long-term care managed care program. Participation by PACE shall be pursuant to a contract with the agency and not subject to the procurement requirements or regional plan number limits of this section. PACE plans may

continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.

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

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

(1) MEDICAL LOSS RATIO.—The agency shall establish and plans shall use a uniform method of accounting and reporting long-term care service costs, direct care management costs, and administrative costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 85 percent of the Medicaid premium revenue.

(b) Plans that spend less than 85 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be required to pay back the amount of the difference between actual spending and 85 percent of Medicaid premium revenue.

(c) Plans that spend more than 92 percent of Medicaid

premium revenue on long-term care services, including direct care management as determined by the agency, shall be evaluated by the agency to determine whether higher expenditures are the result of failures in care management.

(d) Plans that spend 95 percent or more of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency, and are determined to be failing to appropriately manage care shall be excluded from automatic enrollments.

(2) PROVIDER NETWORKS.—Plans may limit the providers in their networks based on credentials, quality indicators, and price. However, in the first contract period after a qualified plan is selected in a region by the agency, the plan must offer a network contract to the following providers in the region:

(a) Nursing homes.

(b) Hospices.

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

After 12 months of active participation in a plan's network, the plan may exclude any of the providers named in this subsection from the network for failure to meet quality or performance criteria.

(3) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the plans they join. Nursing homes and hospices must participate in all qualified

plans selected by the agency in the region in which the provider is located.

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

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

(a) Adult day centers.

(b) Adult family care homes.

(c) Assisted living facilities.

(d) Health care services pools.

(e) Home health agencies.

(f) Homemaker and companion services.

(g) Hospices.

(h) Community Care for the Elderly Lead Agencies.

(i) Nurse registries.

(j) Nursing homes.

(6) PROVIDER PAYMENT.—Plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay nursing homes an amount equal to the nursing facility-specific payment rates set by the agency. Plans shall pay hospice providers an amount equal to the per diem rate set by the agency. For recipients residing in a nursing facility and

receiving hospice services, the plan shall pay the hospice provider the per diem rate set by the agency minus the nursing facility component and shall pay the nursing facility the appropriate state rate.

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

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

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

(2) Payment rates for comprehensive long-term care plans covering services described in s. 409.973 shall be combined with rates for long-term care plans for services specified in s. 409.980.

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

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

(a) Level of care 1 consists of recipients residing in

nursing homes or needing immediate placement in a nursing home.

(b) Level of care 2 consists of recipients who require the constant availability of routine medical and nursing treatment and care, and require extensive health-related care and services because of mental or physical incapacitation.

(c) Level of care 3 consists of recipients who require the constant availability of routine medical and nursing treatment and care, have a limited need for health-related care and services, are mildly medically or physically incapacitated, and have a priority score of 5 or above.

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

(5) The incentive adjustment for reducing institutional placements shall be modified in each successive rate period during the contract in order to encourage a progressive rebalancing of the spending distribution for institutional and community services. The expected change toward more home and community-based services shall be at least a 3 percent, up to a 5 percent, annual increase in the ratio of home and community-based service expenditures compared to nursing facility expenditures.

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

(7) The agency shall establish hospice payment rates. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to hospices.

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

409.984 Choice counseling; enrollment.—

(1) CHOICE COUNSELING.—Before contracting with a vendor to provide choice counseling as authorized under s. 409.969, the agency shall offer to contract with aging resource centers established under s. 430.2053 for choice counseling services. If the aging resource center is determined not to be the vendor that provides choice counseling, the agency shall establish a memorandum of understanding with the aging resource center to coordinate staffing and collaborate with the choice counseling vendor.

(2) AUTOMATIC ENROLLMENT.—The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. The agency shall assign individuals who are deemed dually eligible for Medicaid and Medicare to a plan that provides both Medicaid and Medicare services. The agency may not engage in practices that are designed to favor one managed care plan over another. When

automatically enrolling recipients in plans, the agency shall take into account the following criteria:

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

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

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

(3) Notwithstanding the provisions of s. 409.969(3)(c), when a recipient is referred for hospice services, the recipient shall have a 30-day period during which the recipient may select to enroll in another plan to access the hospice provider of the recipient's choice.

Section 26. Section 409.985, Florida Statutes, is created to read:

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

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

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

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

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). For the purposes of the long-term care managed care program, "nursing facility care" means the individual:

(a) Requires the constant availability of routine medical and nursing treatment and care, and requires extensive health-related care and services because of mental or physical incapacitation; or

(b) Requires the constant availability of routine medical and nursing treatment and care, has a limited need for health-related care and services, is mildly medically or physically incapacitated, and has a priority score of 5 or above.

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

reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

Section 27. Section 409.986, Florida Statutes, is created to read:

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

(1) Pursuant to s. 409.963, the agency is responsible for administering the long-term care managed care program for persons with developmental disabilities described in ss. 409.986-409.992, but may delegate specific duties and responsibilities for the program to the Agency for Persons with Disabilities and other state agencies. By January 1, 2014, the agency shall begin implementation of statewide long-term care managed care for persons with developmental disabilities, with full implementation in all regions by October 1, 2015.

(2) The agency shall make payments for long-term care for persons with developmental disabilities, including home and community-based services, using a managed care model. Unless otherwise specified, the provisions of ss. 409.961-409.970 apply to the long-term care managed care program for persons with developmental disabilities.

(3) The Agency for Persons with Disabilities shall assist the agency to develop the specifications for use in the invitations to negotiate and the model contract; determine clinical eligibility for enrollment in long-term care plans for persons with developmental disabilities; assist the agency to monitor plan performance and measure quality; assist clients and

families to address complaints with the plans; facilitate working relationships between plans and providers serving persons with developmental disabilities; and perform other functions specified in a memorandum of agreement.

Section 28. Section 409.987, Florida Statutes, is created to read:

409.987 Eligibility.—

(1) Medicaid recipients who meet all of the following criteria are eligible to be enrolled in a developmental disabilities comprehensive long-term care plan or developmental disabilities long-term care plan:

(a) Medicaid eligible pursuant to income and asset tests in state and federal law.

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

(c) Meets the level of care need including:

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

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

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

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

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

(e) Is enrolled or has been offered enrollment in one of the four tier waivers established in s. 393.0661(3) or the recipient is a Medicaid-funded resident of a private intermediate care facility for the developmentally disabled on the date the managed long-term care plans for persons with disabilities become available in the recipient's region or the recipient has been offered enrollment in a developmental disabilities comprehensive long-term care plan or developmental disabilities long-term care plan.

(2) Unless specifically exempted, all eligible persons must be enrolled in a developmental disabilities comprehensive long-term care plan or a developmental disabilities long-term care plan. Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale Center in Gainesville, are exempt from mandatory enrollment but may voluntarily enroll in a long-term care plan.

Section 29. Section 409.988, Florida Statutes, is created to read:

409.988 Benefits.-Managed care plans shall cover, at a

minimum, the services in this section. Plans may customize benefit packages or offer additional benefits to meet the needs of enrollees in the plan.

(1) Intermediate care for the developmentally disabled.

(2) Alternative residential services, including, but not limited to:

(a) Group homes and foster care homes licensed pursuant to chapters 393 and 409.

(b) Comprehensive transitional education programs licensed pursuant to chapter 393.

(c) Residential habilitation centers licensed pursuant to chapter 393.

(d) Assisted living facilities, and transitional living facilities licensed pursuant to chapters 400 and 429.

(3) Adult day training.

(4) Behavior analysis services.

(5) Companion services.

(6) Consumable medical supplies.

(7) Durable medical equipment and supplies.

(8) Environmental accessibility adaptations.

(9) In-home support services.

(10) Therapies, including occupational, speech, respiratory, and physical therapy.

(11) Personal care assistance.

(12) Residential habilitation services.

(13) Intensive behavioral residential habilitation services.

(14) Behavior focus residential habilitation services.

(15) Residential nursing services.

(16) Respite care.

(17) Case management.

(18) Supported employment.

(19) Supported living coaching.

(20) Transportation.

Section 30. Section 409.989, Florida Statutes, is created to read:

409.989 Qualified plans.—

(1) QUALIFIED PLANS.—Qualified plans that are a provider service network or the Children's Medical Services Network authorized under chapter 391 may be either developmental disabilities long-term care plans that cover benefits pursuant to s. 409.988, or developmental disabilities comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.988. Other qualified plans may only be developmental disabilities comprehensive long-term care plans that cover benefits pursuant to ss. 409.973 and 409.988.

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

(3) QUALIFIED PLAN SELECTION.—The agency shall select qualified plans through the procurement described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2014.

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

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

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

(d) The agency shall procure at least three plans and no more than six plans for Region IV. At least one plan shall be a provider service network if any submit a responsive bid.

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

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

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

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

(a) Specialized staffing. Plan employment of executive managers with expertise and experience in serving persons with developmental disabilities.

(b) Network qualifications. Plan establishment of a network of service providers dispersed throughout the region and in sufficient numbers to meet specific accessibility standards established by the agency for specialty services for persons with developmental disabilities.

(c) Whether the plan has proposed to be a developmental disabilities comprehensive long-term care plan and has a contract to provide managed medical assistance services in the same region. The agency shall exercise a preference for such plans.

(d) Whether the plan offers consumer-directed care services to enrollees pursuant to s. 409.221. Consumer-directed care services provide a flexible budget which is managed by enrolled individuals and their families or representatives and allows them to choose providers of services, determine provider rates of payment and direct the delivery of services to best meet their special long-term care needs. When all other factors are equal among competing qualified plans, the agency shall exercise a preference for such plans.

(e) Evidence that a qualified plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers prior to the plan

submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with providers of critical services pursuant to s. 409.990(2)a)-(b).

(5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's Medical Services Network authorized under chapter 391 is a qualified plan for purposes of the developmental disabilities long-term care plans and developmental disabilities comprehensive long-term care plans. Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency not subject to the procurement requirements or regional plan number limits of this section. The Children's Medical Services Network must meet all other plan requirements.

Section 31. Section 409.990, Florida Statutes, is created to read:

409.990 Managed care plan accountability.—In addition to the requirements of s. 409.967, qualified plans and providers shall comply with the requirements of this section.

(1) MEDICAL LOSS RATIO.—The agency shall establish and plans shall use a uniform method of accounting and reporting long-term care service costs, direct care management costs, and administrative costs. The agency shall evaluate plan spending patterns beginning after the plan completes 2 full years of operation and at least annually thereafter. The agency shall implement the following thresholds and consequences of various spending patterns:

(a) Plans that spend less than 75 percent of Medicaid premium revenue on long-term care services, including direct

care management as determined by the agency shall be excluded from automatic enrollments and shall be required to pay back the amount between actual spending and 92 percent of the Medicaid premium revenue.

(b) Plans that spend less than 92 percent of Medicaid premium revenue on long-term care services, including direct care management as determined by the agency shall be required to pay back the amount between actual spending and 92 percent of the Medicaid premium revenue.

(2) PROVIDER NETWORKS.—Plans may limit the providers in their networks based on credentials, quality indicators, and price. However, in the first contract period after a qualified plan is selected in a region by the agency, the plan must offer a network contract to the following providers in the region:

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

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

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

(3) SELECT PROVIDER PARTICIPATION.—Except as provided in this subsection, providers may limit the plans they join.

Licensed institutional care facilities for the developmentally disabled with an active Medicaid provider agreement must agree to participate in any qualified plan selected by the agency in the region in which the provider is located.

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

(5) PROVIDER PAYMENT.—Plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay intermediate care facilities for the developmentally disabled an amount equal to the facility-specific payment rate set by the agency.

(6) CONSUMER AND FAMILY INVOLVEMENT.—Plans must establish a family advisory committee to participate in program design and oversight.

Section 32. Section 409.991, Florida Statutes, is created to read:

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

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

(2) Payment for developmental disabilities comprehensive long-term care plans covering services pursuant to s. 409.973 shall be combined with payments for developmental disabilities long-term care plans for services specified in s. 409.988.

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

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

(5) Payment rates for developmental disabilities long-term care plans shall be classified into five levels of care to account for variations in risk status and service needs among enrollees.

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

(b) Level of care 2 consists of individuals with intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others.

(c) Level of care 3 consists of individuals with service needs, including a licensed residential facility and a moderate

level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or individuals in supported living who require more than 6 hours a day of in-home support services.

(d) Level of care 4 consists of individuals requiring less than moderate level of residential habilitation support in a residential placement, or individuals in independent or supported living situations, or who live in their family home.

(e) Level of care 5 consists of individuals requiring minimal support services while living in independent or supported living situations and individuals who live in their family home.

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

(6) The agency shall establish intensive behavior residential habilitation rates for providers approved by the agency to provide this service. The agency shall also establish intermediate care facility for the developmentally disabled-specific payment rates for each licensed intermediate care facility based on facility costs adjusted for inflation and other factors. Payments to intermediate care facilities for the developmentally disabled and providers of intensive behavior residential habilitation service shall be reconciled to reimburse the plan's actual payments to the facilities.

Section 33. Section 409.992, Florida Statutes, is created to read:

409.992 Automatic enrollment.—

(1) The agency shall automatically enroll into a developmental disabilities comprehensive long-term care plan or a developmental disabilities long-term care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967, and shall not automatically enroll recipients in a plan that is deficient in those performance or quality standards. The agency shall assign individuals who are deemed dually eligible for Medicaid and Medicare, to a plan that provides both Medicaid and Medicare services. The agency may not engage in practices that are designed to favor one managed care plan over another. When automatically enrolling recipients in plans, the agency shall take into account the following criteria:

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

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

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

Section 34. This act shall take effect July 1, 2010.