256010

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| | . | |
| | . | |
| Floor: 1J/AD/2R | . | Floor: RC |
| 05/06/2011 07:05 PM | . | 05/06/2011 10:48 PM |
| | . | |

Senator Garcia moved the following:

**Senate Amendment to Amendment (258560) (with title amendment)**

Between lines 2937 and 2938
insert:

Section 74. Section 409.981, Florida Statutes, is created to read:

409.981 Eligible long-term care plans.—

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

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

409.966. The agency shall provide notice of invitations to negotiate by July 1, 2012. The agency shall procure:

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

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

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

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

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

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

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

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

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

256010

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

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

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

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

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

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

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



the same region.

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

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

(4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—Participation by the Program of All-Inclusive Care for the Elderly (PACE) shall be pursuant to a contract with the agency and not subject to the procurement requirements or regional plan number limits of this section. PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the General Appropriations Act.

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

Section 75. Section 409.984, Florida Statutes, is created to read:

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

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

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

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

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

(c) Whether the home and community-based providers in one plan are more geographically accessible to the recipient’s

256010

residence than those in other plans.

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

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

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

And the title is amended as follows:

Delete line 4902

and insert:

psychiatric facility; creating s. 409.981, F.S.; providing criteria for eligible plans; designating regions for plan implementation throughout the state; providing criteria for the selection of plans to participate in the long-term care managed care program; providing that participation by the Program of All-Inclusive Care for the Elderly and certain Medicare plans is pursuant to an agency contract and not subject to procurement; creating s. 409.984, F.S.; providing criteria for automatic assignments of plan enrollees who fail to choose a plan; providing for hospice selection within a specified timeframe; providing for a choice of residential setting under


256010

certain circumstances; amending s. 429.07, F.S.;