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1	A bill to be entitled
2	An act relating to Medicaid managed care; creating part IV
3	of ch. 409, F.S., entitled "Medicaid Managed Care";
4	creating s. 409.961, F.S.; providing for statutory
5	construction; providing applicability of specified
6	provisions throughout the part; providing rulemaking
7	authority for specified agencies; creating s. 409.962,
8	F.S.; providing definitions; creating s. 409.963, F.S.;
9	designating the Agency for Health Care Administration as
10	the single state agency to administer the Medicaid
11	program; providing for specified agency responsibilities;
12	requiring client consent for release of medical records;
13	creating s. 409.964, F.S.; establishing the Medicaid
14	program as the statewide, integrated managed care program
15	for all covered services; authorizing the agency to apply
16	for and implement waivers; providing for public notice and
17	comment; creating s. 409.965, F.S.; providing for
18	mandatory enrollment; providing exemptions; creating s.
19	409.966, F.S.; providing requirements for eligible plans
20	that provide services in the Medicaid managed care
21	program; establishing provider service network
22	requirements for eligible plans; providing for eligible
23	plan selection; requiring the agency to use an invitation
24	to negotiate; requiring the agency to compile and publish
25	certain information; establishing regions for separate
26	procurement of plans; providing quality criteria for plan
27	selection; providing limitations on serving recipients
28	during the pendency of procurement litigation; creating s.
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29 409.967, F.S.; providing for managed care plan 30 accountability; establishing contract terms; providing for 31 physician compensation; providing for emergency services; 32 establishing requirements for access; requiring a drug formulary or preferred drug list; requiring plans to 33 34 accept requests for service electronically; requiring the 35 agency to maintain an encounter data system; requiring 36 plans to provide encounter data; requiring the agency to 37 establish performance standards for plans; providing 38 program integrity requirements; establishing requirements 39 for the database; establishing a grievance resolution process; providing penalties for early termination of 40 contracts or reduction in enrollment levels; establishing 41 42 prompt payment requirements; requiring fair payment to 43 providers with a controlling interest in a provider 44 service network by other plans; requiring itemized payment; providing for dispute resolutions between plans 45 and providers; providing for achieved savings rebates to 46 47 plans; creating s. 409.968, F.S.; establishing managed care plan payments; providing payment requirements for 48 49 provider service networks; requiring the agency to conduct 50 annual cost reconciliations to determine certain cost 51 savings and report the results of the reconciliations to 52 the fee-for-service provider; prohibiting rate increases 53 that are not authorized in the appropriations act; 54 creating s. 409.969, F.S.; requiring enrollment in managed 55 care plans by all nonexempt Medicaid recipients; creating 56 requirements for plan selection by recipients; authorizing Page 2 of 71

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57 disenrollment under certain circumstances; defining the 58 term "good cause" for purposes of disenrollment; providing 59 time limits on an internal grievance process; providing 60 requirements for agency determination regarding disenrollment; requiring recipients to stay in plans for a 61 62 specified time; creating s. 409.97, F.S.; authorizing the 63 agency to accept the transfer of certain revenues from 64 local governments; requiring the agency to contract with a 65 representative of certain entities participating in the 66 low-income pool for the provision of enhanced access to 67 care; providing for support of these activities by the low-income pool as authorized in the General 68 69 Appropriations Act; establishing the Access to Care 70 Partnership; requiring the agency to seek necessary 71 waivers and plan amendments; providing requirements for 72 prepaid plans to submit data; authorizing the agency to 73 implement a tiered hospital rate system; creating s. 74 409.971, F.S.; creating the managed medical assistance 75 program; providing deadlines to begin and finalize 76 implementation of the program; creating s. 409.972, F.S.; 77 providing eligibility requirements for mandatory and 78 voluntary enrollment; creating s. 409.973, F.S.; 79 establishing minimum benefits for managed care plans to 80 cover; authorizing plans to customize benefit packages; 81 requiring plans to establish programs to encourage healthy 82 behaviors and establish written agreements with certain 83 enrollees to participate in such programs; requiring plans 84 to establish a primary care initiative; providing Page 3 of 71

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85 requirements for primary care initiatives; requiring plans 86 to report certain primary care data to the agency; 87 creating s. 409.974, F.S.; establishing a deadline for 88 issuing invitations to negotiate; establishing a specified 89 number or range of eligible plans to be selected in each region; establishing quality selection criteria; 90 91 establishing requirements for participation by specialty 92 plans; establishing the Children's Medical Service Network 93 as an eligible plan; creating s. 409.975, F.S.; providing 94 for managed care plan accountability; authorizing plans to 95 limit providers in networks; requiring plans to include essential Medicaid providers in their networks unless an 96 alternative arrangement is approved by the agency; 97 98 identifying statewide essential providers; specifying 99 provider payments under certain circumstances; requiring 100 plans to include certain statewide essential providers in 101 their networks; requiring good faith negotiations; 102 specifying provider payments under certain circumstances; 103 allowing plans to exclude essential providers under certain circumstances; requiring plans to offer a contract 104 105 to home medical equipment and supply providers under 106 certain circumstances; establishing the Florida medical school quality network; requiring the agency to contract 107 108 with a representative of certain entities to establish a 109 clinical outcome improvement program in all plans; 110 providing for support of these activities by certain 111 expenditures and federal matching funds; requiring the agency to seek necessary waivers and plan amendments; 112 Page 4 of 71

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113 providing for eligibility for the quality network; 114 requiring plans to monitor the quality and performance 115 history of providers; establishing the MomCare network; 116 requiring the agency to contract with a representative of 117 all Healthy Start Coalitions to provide certain services 118 to recipients; providing for support of these activities 119 by certain expenditures and federal matching funds; 120 requiring plans to enter into agreements with local 121 Healthy Start Coalitions for certain purposes; requiring 122 specified programs and procedures be established by plans; 123 establishing a screening standard for the Early and Periodic Screening, Diagnosis, and Treatment Service; 124 125 requiring managed care plans and hospitals to negotiate 126 rates, methods, and terms of payment; providing a limit on 127 payments to hospitals; establishing plan requirements for 128 medically needy recipients; creating s. 409.976, F.S.; 129 providing for managed care plan payment; requiring the 130 agency to establish payment rates for statewide inpatient 131 psychiatric programs; requiring payments to managed care plans to be reconciled to reimburse actual payments to 132 133 statewide inpatient psychiatric programs; creating s. 134 409.977, F.S.; providing for automatic enrollment in a 135 managed care plan for certain recipients; establishing 136 opt-out opportunities for recipients; creating s. 409.978, 137 F.S.; requiring the agency to be responsible for 138 administering the long-term care managed care program; 139 providing implementation dates for the long-term care managed care program; providing duties of the Department 140 Page 5 of 71

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of Elderly Affairs relating to assisting the agency in 141 implementing the program; creating s. 409.979, F.S.; 142 143 providing eligibility requirements for the long-term care 144 managed care program; creating s. 409.98, F.S.; 145 establishing the benefits covered under a managed care 146 plan participating in the long-term care managed care 147 program; creating s. 409.981, F.S.; providing criteria for 148 eligible plans; designating regions for plan 149 implementation throughout the state; providing criteria 150 for the selection of plans to participate in the long-term 151 care managed care program; providing that participation by 152 the Program of All-Inclusive Care for the Elderly and 153 certain Medicare plans is pursuant to an agency contract 154 and not subject to procurement; creating s. 409.982, F.S.; 155 requiring the agency to establish uniform accounting and 156 reporting methods for plans; providing for mandatory 157 participation in plans by certain service providers; 158 authorizing the exclusion of certain providers from plans 159 for failure to meet quality or performance criteria; requiring plans to monitor participating providers using 160 161 specified criteria; requiring certain providers to be 162 included in plan networks; providing provider payment specifications for nursing homes and hospices; creating s. 163 164 409.983, F.S.; providing for negotiation of rates between the agency and the plans participating in the long-term 165 care managed care program; providing specific criteria for 166 167 calculating and adjusting plan payments; allowing the CARES program to assign plan enrollees to a level of care; 168 Page 6 of 71

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169	providing incentives for adjustments of payment rates;
170	requiring the agency to establish nursing facility-
171	specific and hospice services payment rates; creating s.
172	409.984, F.S.; providing criteria for automatic
173	assignments of plan enrollees who fail to choose a plan;
174	providing for hospice selection within a specified
175	timeframe; providing for a choice of residential setting
176	under certain circumstances; creating s. 409.9841, F.S.;
177	creating the long-term care managed care technical
178	advisory workgroup; providing duties; providing
179	membership; providing for reimbursement for per diem and
180	travel expenses; providing for repeal by a specified date;
181	creating s. 409.985, F.S.; providing that the agency shall
182	operate the Comprehensive Assessment and Review for Long-
183	Term Care Services program through an interagency
184	agreement with the Department of Elderly Affairs;
185	providing duties of the program; defining the term
186	"nursing facility care"; providing for severability;
187	providing an effective date.
188	
189	Be It Enacted by the Legislature of the State of Florida:
190	
191	Section 1. Sections 409.961 through 409.985, Florida
192	Statutes, are designated as part IV of chapter 409, Florida
193	Statutes, entitled "Medicaid Managed Care."
194	Section 2. Section 409.961, Florida Statutes, is created
195	to read:
196	409.961 Statutory construction; applicability; rulesIt
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197	is the intent of the Legislature that if any conflict exists
198	between the provisions contained in this part and in other parts
199	of this chapter, the provisions in this part control. Sections
200	409.961-409.985 apply only to the Medicaid managed medical
201	assistance program and long-term care managed care program, as
202	provided in this part. The agency shall adopt any rules
203	necessary to comply with or administer this part and all rules
204	necessary to comply with federal requirements. In addition, the
205	department shall adopt and accept the transfer of any rules
206	necessary to carry out the department's responsibilities for
207	receiving and processing Medicaid applications and determining
208	Medicaid eligibility and for ensuring compliance with and
209	administering this part, as those rules relate to the
210	department's responsibilities, and any other provisions related
211	to the department's responsibility for the determination of
212	Medicaid eligibility.
213	Section 3. Section 409.962, Florida Statutes, is created
214	to read:
215	409.962 DefinitionsAs used in this part, except as
216	otherwise specifically provided, the term:
217	(1) "Accountable care organization" means an entity
218	qualified as an accountable care organization in accordance with
219	federal regulations, and which meets the requirements of a
220	provider service network as described in s. 409.912(4)(d).
221	(2) "Agency" means the Agency for Health Care
222	Administration.
223	(3) "Aging network service provider" means a provider that
224	participated in a home and community-based waiver administered
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2011 Legislature

225	by the Department of Elderly Affairs or the community care
226	service system pursuant to s. 430.205 as of October 1, 2013.
227	(4) "Comprehensive long-term care plan" means a managed
228	care plan that provides services described in s. 409.973 and
229	also provides the services described in s. 409.98.
230	(5) "Department" means the Department of Children and
231	Family Services.
232	(6) "Eligible plan" means a health insurer authorized
233	under chapter 624, an exclusive provider organization authorized
234	under chapter 627, a health maintenance organization authorized
235	under chapter 641, or a provider service network authorized
236	under s. 409.912(4)(d) or an accountable care organization
237	authorized under federal law. For purposes of the managed
238	medical assistance program, the term also includes the
239	Children's Medical Services Network authorized under chapter
240	391. For purposes of the long-term care managed care program,
241	the term also includes entities qualified under 42 C.F.R. part
242	422 as Medicare Advantage Preferred Provider Organizations,
243	Medicare Advantage Provider-sponsored Organizations, and
244	Medicare Advantage Special Needs Plans, and the Program of All-
245	Inclusive Care for the Elderly.
246	(7) "Long-term care plan" means a managed care plan that
247	provides the services described in s. 409.98 for the long-term
248	care managed care program.
249	(8) "Long-term care provider service network" means a
250	provider service network a controlling interest of which is
251	owned by one or more licensed nursing homes, assisted living
252	facilities with 17 or more beds, home health agencies, community
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253	care for the elderly lead agencies, or hospices.
254	(9) "Managed care plan" means an eligible plan under
255	contract with the agency to provide services in the Medicaid
256	program.
257	(10) "Medicaid" means the medical assistance program
258	authorized by Title XIX of the Social Security Act, 42 U.S.C.
259	ss. 1396 et seq., and regulations thereunder, as administered in
260	this state by the agency.
261	(11) "Medicaid recipient" or "recipient" means an
262	individual who the department or, for Supplemental Security
263	Income, the Social Security Administration determines is
264	eligible pursuant to federal and state law to receive medical
265	assistance and related services for which the agency may make
266	payments under the Medicaid program. For the purposes of
267	determining third-party liability, the term includes an
268	individual formerly determined to be eligible for Medicaid, an
269	individual who has received medical assistance under the
270	Medicaid program, or an individual on whose behalf Medicaid has
271	become obligated.
272	(12) "Prepaid plan" means a managed care plan that is
273	licensed or certified as a risk-bearing entity, or qualified
274	pursuant to s. 409.912(4)(d), in the state and is paid a
275	prospective per-member, per-month payment by the agency.
276	(13) "Provider service network" means an entity qualified
277	pursuant to s. 409.912(4)(d) of which a controlling interest is
278	owned by a health care provider, or group of affiliated
279	providers, or a public agency or entity that delivers health
280	services. Health care providers include Florida-licensed health
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2011 Legislature

281	care professionals or licensed health care facilities, federally
282	qualified health care centers, and home health care agencies.
283	(15) "Specialty plan" means a managed care plan that
284	serves Medicaid recipients who meet specified criteria based on
285	age, medical condition, or diagnosis.
286	Section 4. Section 409.963, Florida Statutes, is created
287	to read:
288	409.963 Single state agencyThe agency is designated as
289	the single state agency authorized to manage, operate, and make
290	payments for medical assistance and related services under Title
291	XIX of the Social Security Act. Subject to any limitations or
292	directions provided in the General Appropriations Act, these
293	payments may be made only for services included in the program,
294	only on behalf of eligible individuals, and only to qualified
295	providers in accordance with federal requirements for Title XIX
296	of the Social Security Act and state law. This program of
297	medical assistance is designated as the "Medicaid program." The
298	department is responsible for Medicaid eligibility
299	determinations, including, but not limited to, policy, rules,
300	and the agreement with the Social Security Administration for
301	Medicaid eligibility determinations for Supplemental Security
302	Income recipients, as well as the actual determination of
303	eligibility. As a condition of Medicaid eligibility, subject to
304	federal approval, the agency and the department shall ensure
305	that each Medicaid recipient consents to the release of her or
306	his medical records to the agency and the Medicaid Fraud Control
307	Unit of the Department of Legal Affairs.
308	Section 5. Section 409.964, Florida Statutes is created to
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309	read:
310	409.964 Managed care program; state plan; waiversThe
311	Medicaid program is established as a statewide, integrated
312	managed care program for all covered services, including long-
313	term care services. The agency shall apply for and implement
314	state plan amendments or waivers of applicable federal laws and
315	regulations necessary to implement the program. Before seeking a
316	waiver, the agency shall provide public notice and the
317	opportunity for public comment and include public feedback in
318	the waiver application. The agency shall hold one public meeting
319	in each of the regions described in s. 409.966(2) and the time
320	period for public comment for each region shall end no sooner
321	than 30 days after the completion of the public meeting in that
322	region. The agency shall submit any state plan amendments, new
323	waiver requests, or requests for extensions or expansions for
324	existing waivers, needed to implement the managed care program
325	by August 1, 2011.
326	Section 6. Section 409.965, Florida Statutes, is created
327	to read:
328	409.965 Mandatory enrollmentAll Medicaid recipients
329	shall receive covered services through the statewide managed
330	care program, except as provided by this part pursuant to an
331	approved federal waiver. The following Medicaid recipients are
332	exempt from participation in the statewide managed care program:
333	(1) Women who are eligible only for family planning
334	services.
335	(2) Women who are eligible only for breast and cervical
336	cancer services.
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337	(3) Persons who are eligible for emergency Medicaid for
338	aliens.
339	(4) Children receiving services in a prescribed pediatric
340	extended care center.
341	Section 7. Section 409.966, Florida Statutes, is created
342	to read:
343	409.966 Eligible plans; selection
344	(1) ELIGIBLE PLANSServices in the Medicaid managed care
345	program shall be provided by eligible plans. A provider service
346	network must be capable of providing all covered services to a
347	mandatory Medicaid managed care enrollee or may limit the
348	provision of services to a specific target population based on
349	the age, chronic disease state, or medical condition of the
350	enrollee to whom the network will provide services. A specialty
351	provider service network must be capable of coordinating care
352	and delivering or arranging for the delivery of all covered
353	services to the target population. A provider service network
354	may partner with an insurer licensed under chapter 627 or a
355	health maintenance organization licensed under chapter 641 to
356	meet the requirements of a Medicaid contract.
357	(2) ELIGIBLE PLAN SELECTIONThe agency shall select a
358	limited number of eligible plans to participate in the Medicaid
359	program using invitations to negotiate in accordance with s.
360	287.057(3)(a). At least 90 days before issuing an invitation to
361	negotiate, the agency shall compile and publish a databook
362	consisting of a comprehensive set of utilization and spending
363	data for the 3 most recent contract years consistent with the
364	rate-setting periods for all Medicaid recipients by region or
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365	county. The source of the data in the report must include both
366	historic fee-for-service claims and validated data from the
367	Medicaid Encounter Data System. The report must be available in
368	electronic form and delineate utilization use by age, gender,
369	eligibility group, geographic area, and aggregate clinical risk
370	score. Separate and simultaneous procurements shall be conducted
371	in each of the following regions:
372	(a) Region 1, which consists of Escambia, Okaloosa, Santa
373	Rosa and Walton Counties.
374	(b) Region 2, which consists of Bay, Calhoun, Franklin,
375	Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty,
376	Madison, Taylor, Wakulla, and Washington Counties.
377	(c) Region 3, which consists of Alachua, Bradford, Citrus,
378	Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake,
379	Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.
379 380	
380	(d) Region 4, which consists of Baker, Clay, Duval,
380 381	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas
380 381 382	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas
380 381 382 383	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas Counties. (f) Region 6, which consists of Hardee, Highlands,
380 381 382 383 384	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas Counties. (f) Region 6, which consists of Hardee, Highlands,
380 381 382 383 384 385	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas Counties. (f) Region 6, which consists of Hardee, Highlands, Hillsborough, Manatee and Polk Counties.
380 381 382 383 384 385 386	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas Counties. (f) Region 6, which consists of Hardee, Highlands, Hillsborough, Manatee and Polk Counties. (g) Region 7, which consists of Brevard, Orange, Osceola
380 381 382 383 384 385 386 387	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas Counties. (f) Region 6, which consists of Hardee, Highlands, Hillsborough, Manatee and Polk Counties. (g) Region 7, which consists of Brevard, Orange, Osceola and Seminole Counties.
380 381 382 383 384 385 386 387 388	(d) Region 4, which consists of Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia Counties. (e) Region 5, which consists of Pasco and Pinellas Counties. (f) Region 6, which consists of Hardee, Highlands, Hillsborough, Manatee and Polk Counties. (g) Region 7, which consists of Brevard, Orange, Osceola and Seminole Counties. (h) Region 8, which consists of Charlotte, Collier,
380 381 382 383 384 385 386 387 388 389	(d)Region 4, which consists of Baker, Clay, Duval,Flagler, Nassau, St. Johns, and Volusia Counties.(e)Region 5, which consists of Pasco and PinellasCounties.(f)Region 6, which consists of Hardee, Highlands,Hillsborough, Manatee and Polk Counties.(g)Region 7, which consists of Brevard, Orange, Osceolaand Seminole Counties.(h)Region 8, which consists of Charlotte, Collier,DeSoto, Glades, Hendry, Lee, and Sarasota Counties.



FLORIDA HOUSE OF REPRESEN	ΤΑΤΙΥΕS
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CS/HB 7107, Engrossed 3

393 (k) Region 11, which consists of Miami-Dade and Monroe 394 Counties. 395 (3) QUALITY SELECTION CRITERIA.-396 (a) The invitation to negotiate must specify the criteria 397 and the relative weight of the criteria that will be used for 398 determining the acceptability of the reply and guiding the 399 selection of the organizations with which the agency negotiates. 400 In addition to criteria established by the agency, the agency 401 shall consider the following factors in the selection of 402 eligible plans: 403 1. Accreditation by the National Committee for Quality 404 Assurance, the Joint Commission, or another nationally 405 recognized accrediting body. 406 2. Experience serving similar populations, including the 407 organization's record in achieving specific quality standards 408 with similar populations. 409 3. Availability and accessibility of primary care and 410 specialty physicians in the provider network. 411 4. Establishment of community partnerships with providers 412 that create opportunities for reinvestment in community-based 413 services. 414 5. Organization commitment to quality improvement and 415 documentation of achievements in specific quality improvement 416 projects, including active involvement by organization 417 leadership. 6. Provision of additional benefits, particularly dental 418 419 care and disease management, and other initiatives that improve 420 health outcomes.

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421	7. Evidence that a eligible plan has written agreements or
422	signed contracts or has made substantial progress in
423	establishing relationships with providers before the plan
424	submitting a response.
425	8. Comments submitted in writing by any enrolled Medicaid
426	provider relating to a specifically identified plan
427	participating in the procurement in the same region as the
428	submitting provider.
429	9. Documentation of policies and procedures for preventing
430	fraud and abuse.
431	10. The business relationship an eligible plan has with
432	any other eligible plan that responds to the invitation to
433	negotiate.
434	(b) An eligible plan must disclose any business
435	relationship it has with any other elgible plan that responds to
436	the invitation to negotiate. The agency may not select plans in
437	the same region for the same managed care program that have a
438	business relationship with each other. Failure to disclose any
439	business relationship shall result in disqualification from
440	participation in any region for the first full contract period
441	after the discovery of the business relationship by the agency.
442	For the purpose of this section, "business relationship" means
443	an ownership or controlling interest, an affiliate or subsidiary
444	relationship, a common parent, or any mutual interest in any
445	limited partnership, limited liability partnership, limited
446	liability company, or other entity or business association,
447	including all wholly or partially owned subsidiaries, majority-
448	owned subsidiaries, parent companies, or affiliates of such

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449	entities, business associations, or other enterprises, that
450	exists for the purpose of making a profit.
451	(c) After negotiations are conducted, the agency shall
452	select the eligible plans that are determined to be responsive
453	and provide the best value to the state. Preference shall be
454	given to plans that:
455	1. Have signed contracts with primary and specialty
456	physicians in sufficient numbers to meet the specific standards
457	established pursuant to s. 409.967(2)(b).
458	2. Have well-defined programs for recognizing patient-
459	centered medical homes and providing for increased compensation
460	for recognized medical homes, as defined by the plan.
461	3. Are organizations that are based in and perform
462	operational functions in this state, in-house or through
463	contractual arrangements, by staff located in this state. Using
464	a tiered approach, the highest number of points shall be awarded
465	to a plan that has all or substantially all of its operational
466	functions performed in the state. The second highest number of
467	points shall be awarded to a plan that has a majority of its
468	operational functions performed in the state. The agency may
469	establish a third tier; however, preference points may not be
470	awarded to plans that perform only community outreach, medical
471	director functions, and state administrative functions in the
472	state. For purposes of this subparagraph, operational functions
473	include claims processing, member services, provider relations,
474	utilization and prior authorization, case management, disease
475	and quality functions, and finance and administration. For
476	purposes of this subparagraph, the term "based in this state"
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2011 Legislature

477	means that the entity's principal office is in this state and
478	the plan is not a subsidiary, directly or indirectly through one
479	or more subsidiaries of, or a joint venture with, any other
480	entity whose principal office is not located in the state.
481	4. Have contracts or other arrangements for cancer disease
482	management programs that have a proven record of clinical
483	efficiencies and cost savings.
484	5. Have contracts or other arrangements for diabetes
485	disease management programs that have a proven record of
486	clinical efficiencies and cost savings.
487	6. Have a claims payment process that ensures that claims
488	that are not contested or denied will be promptly paid pursuant
489	to s. 641.3155.
490	(d) For the first year of the first contract term, the
491	agency shall negotiate capitation rates or fee for service
492	payments with each plan in order to guarantee aggregate savings
493	of at least 5 percent.
494	1. For prepaid plans, determination of the amount of
495	savings shall be calculated by comparison to the Medicaid rates
496	that the agency paid managed care plans for similar populations
497	in the same areas in the prior year. In regions containing no
498	prepaid plans in the prior year, determination of the amount of
499	savings shall be calculated by comparison to the Medicaid rates
500	established and certified for those regions in the prior year.
501	2. For provider service networks operating on a fee-for-
502	service basis, determination of the amount of savings shall be
503	calculated by comparison to the Medicaid rates that the agency
504	paid on a fee-for-service basis for the same services in the
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505	prior year.
506	(e) To ensure managed care plan participation in Regions 1
507	and 2, the agency shall award an additional contract to each
508	plan with a contract award in Region 1 or Region 2. Such
509	contract shall be in any other region in which the plan
510	submitted a responsive bid and negotiates a rate acceptable to
511	the agency. If a plan that is awarded an additional contract
512	pursuant to this paragraph is subject to penalties pursuant to
513	s. 409.967(2)(g) for activities in Region 1 or Region 2, the
514	additional contract is automatically terminated 180 days after
515	the imposition of the penalties. The plan must reimburse the
516	agency for the cost of enrollment changes and other transition
517	activities.
518	(f) The agency may not execute contracts with managed care
519	plans at payment rates not supported by the General
520	Appropriations Act.
521	(4) ADMINISTRATIVE CHALLENGE Any eligible plan that
522	participates in an invitation to negotiate in more than one
523	region and is selected in at least one region may not begin
524	serving Medicaid recipients in any region for which it was
525	selected until all administrative challenges to procurements
526	required by this section to which the eligible plan is a party
527	have been finalized. If the number of plans selected is less
528	than the maximum amount of plans permitted in the region, the
529	agency may contract with other selected plans in the region not
530	participating in the administrative challenge before resolution
531	of the administrative challenge. For purposes of this
532	subsection, an administrative challenge is finalized if an order
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533	granting voluntary dismissal with prejudice has been entered by
534	any court established under Article V of the State Constitution
535	or by the Division of Administrative Hearings, a final order has
536	been entered into by the agency and the deadline for appeal has
537	expired, a final order has been entered by the First District
538	Court of Appeal and the time to seek any available review by the
539	Florida Supreme Court has expired, or a final order has been
540	entered by the Florida Supreme Court and a warrant has been
541	issued.
542	Section 8. Section 409.967, Florida Statutes, is created
543	to read:
544	409.967 Managed care plan accountability
545	(1) The agency shall establish a 5-year contract with each
546	managed care plan selected through the procurement process
547	described in s. 409.966. A plan contract may not be renewed;
548	however, the agency may extend the term of a plan contract to
549	cover any delays during the transition to a new plan.
550	(2) The agency shall establish such contract requirements
551	as are necessary for the operation of the statewide managed care
552	program. In addition to any other provisions the agency may deem
553	necessary, the contract must require:
554	(a) Physician compensationManaged care plans are
555	expected to coordinate care, manage chronic disease, and prevent
556	the need for more costly services. Effective care management
557	should enable plans to redirect available resources and increase
558	compensation for physicians. Plans achieve this performance
559	standard when physician payment rates equal or exceed Medicare
560	rates for similar services. The agency may impose fines or

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561	other sanctions on a plan that fails to meet this performance
562	standard after 2 years of continuous operation.
563	(b) Emergency servicesManaged care plans shall pay for
564	services required by ss. 395.1041 and 401.45 and rendered by a
565	noncontracted provider. The plans must comply with s. 641.3155.
566	Reimbursement for services under this paragraph is the lesser
567	<u>of:</u>
568	1. The provider's charges;
569	2. The usual and customary provider charges for similar
570	services in the community where the services were provided;
571	3. The charge mutually agreed to by the entity and the
572	provider within 60 days after submittal of the claim; or
573	4. The rate the agency would have paid on the most recent
574	October 1st.
575	(c) Access.—
576	1. The agency shall establish specific standards for the
577	number, type, and regional distribution of providers in managed
578	care plan networks to ensure access to care for both adults and
579	children. Each plan must maintain a region-wide network of
580	providers in sufficient numbers to meet the access standards for
581	specific medical services for all recipients enrolled in the
582	plan. The exclusive use of mail-order pharmacies may not be
583	sufficient to meet network access standards. Consistent with the
584	standards established by the agency, provider networks may
585	include providers located outside the region. A plan may
586	contract with a new hospital facility before the date the
587	hospital becomes operational if the hospital has commenced
588	construction, will be licensed and operational by January 1,



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589	2013, and a final order has issued in any civil or
590	administrative challenge. Each plan shall establish and maintain
591	an accurate and complete electronic database of contracted
592	providers, including information about licensure or
593	registration, locations and hours of operation, specialty
594	credentials and other certifications, specific performance
595	indicators, and such other information as the agency deems
596	necessary. The database must be available online to both the
597	agency and the public and have the capability to compare the
598	availability of providers to network adequacy standards and to
599	accept and display feedback from each provider's patients. Each
600	plan shall submit quarterly reports to the agency identifying
601	the number of enrollees assigned to each primary care provider.
602	2. Each managed care plan must publish any prescribed drug
603	formulary or preferred drug list on the plan's website in a
604	manner that is accessible to and searchable by enrollees and
605	providers. The plan must update the list within 24 hours after
606	making a change. Each plan must ensure that the prior
607	authorization process for prescribed drugs is readily accessible
608	to health care providers, including posting appropriate contact
609	information on its website and providing timely responses to
610	providers. For Medicaid recipients diagnosed with hemophilia who
611	have been prescribed anti-hemophilic-factor replacement
612	products, the agency shall provide for those products and
613	hemophilia overlay services through the agency's hemophilia
614	disease management program.
615	3. Managed care plans, and their fiscal agents or
616	intermediaries, must accept prior authorization requests for any
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617	service electronically.
618	(d) Encounter data.—The agency shall maintain and operate
619	a Medicaid Encounter Data System to collect, process, store, and
620	report on covered services provided to all Medicaid recipients
621	enrolled in prepaid plans.
622	1. Each prepaid plan must comply with the agency's
623	reporting requirements for the Medicaid Encounter Data System.
624	Prepaid plans must submit encounter data electronically in a
625	format that complies with the Health Insurance Portability and
626	Accountability Act provisions for electronic claims and in
627	accordance with deadlines established by the agency. Prepaid
628	plans must certify that the data reported is accurate and
629	complete.
630	2. The agency is responsible for validating the data
631	submitted by the plans. The agency shall develop methods and
632	protocols for ongoing analysis of the encounter data that
633	adjusts for differences in characteristics of prepaid plan
634	enrollees to allow comparison of service utilization among plans
635	and against expected levels of use. The analysis shall be used
636	to identify possible cases of systemic underutilization or
637	denials of claims and inappropriate service utilization such as
638	higher-than-expected emergency department encounters. The
639	analysis shall provide periodic feedback to the plans and enable
640	the agency to establish corrective action plans when necessary.
641	One of the focus areas for the analysis shall be the use of
642	prescription drugs.
643	3. The agency shall make encounter data available to those
644	plans accepting enrollees who are assigned to them from other
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645	plans leaving a region.
646	(e) Continuous improvementThe agency shall establish
647	specific performance standards and expected milestones or
648	timelines for improving performance over the term of the
649	contract.
650	1. Each managed care plan shall establish an internal
651	health care quality improvement system, including enrollee
652	satisfaction and disenrollment surveys. The quality improvement
653	system must include incentives and disincentives for network
654	providers.
655	2. Each plan must collect and report the Health Plan
656	Employer Data and Information Set (HEDIS) measures, as specified
657	by the agency. These measures must be published on the plan's
658	website in a manner that allows recipients to reliably compare
659	the performance of plans. The agency shall use the HEDIS
660	measures as a tool to monitor plan performance.
661	3. Each managed care plan must be accredited by the
662	National Committee for Quality Assurance, the Joint Commission,
663	or another nationally recognized accrediting body, or have
664	initiated the accreditation process, within 1 year after the
665	contract is executed. For any plan not accredited within 18
666	months after executing the contract, the agency shall suspend
667	automatic assignment under s. 409.977 and 409.984.
668	4. By the end of the fourth year of the first contract
669	term, the agency shall issue a request for information to
670	determine whether cost savings could be achieved by contracting
671	for plan oversight and monitoring, including analysis of
672	encounter data, assessment of performance measures, and
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673	compliance with other contractual requirements.
674	(f) Program integrityEach managed care plan shall
675	establish program integrity functions and activities to reduce
676	the incidence of fraud and abuse, including, at a minimum:
677	1. A provider credentialing system and ongoing provider
678	monitoring, including maintenance of written provider
679	credentialing policies and procedures which comply with federal
680	and agency guidelines;
681	2. An effective prepayment and postpayment review process
682	including, but not limited to, data analysis, system editing,
683	and auditing of network providers;
684	3. Procedures for reporting instances of fraud and abuse
685	pursuant to chapter 641;
686	4. Administrative and management arrangements or
687	procedures, including a mandatory compliance plan, designed to
688	prevent fraud and abuse; and
689	5. Designation of a program integrity compliance officer.
690	(g) Grievance resolutionConsistent with federal law,
691	each managed care plan shall establish and the agency shall
692	approve an internal process for reviewing and responding to
693	grievances from enrollees. Each plan shall submit quarterly
694	reports on the number, description, and outcome of grievances
695	filed by enrollees.
696	(h) Penalties
697	1. Withdrawal and enrollment reductionManaged care plans
698	that reduce enrollment levels or leave a region before the end
699	of the contract term must reimburse the agency for the cost of
700	enrollment changes and other transition activities. If more than
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701	one plan leaves a region at the same time, costs must be shared
702	by the departing plans proportionate to their enrollments. In
703	addition to the payment of costs, departing provider services
704	networks must pay a per enrollee penalty of up to 3 month's
705	payment and continue to provide services to the enrollee for 90
706	days or until the enrollee is enrolled in another plan,
707	whichever occurs first. In addition to payment of costs, all
708	other plans must pay a penalty of 25 percent of the minimum
709	surplus requirement pursuant to s. 641.225(1). Plans shall
710	provide at least 180 days notice to the agency before
711	withdrawing from a region. If a managed care plan leaves a
712	region before the end of the contract term, the agency shall
713	terminate all contracts with that plan in other regions,
714	pursuant to the termination procedures in subparagraph 3.
715	2. Encounter dataIf a plan fails to comply with the
716	encounter data reporting requirements of this section for 30
717	days, the agency must assess a fine of \$5,000 per day for each
718	day of noncompliance beginning on the 31st day. On the 31st day,
719	the agency must notify the plan that the agency will initiate
720	contract termination procedures on the 90th day unless the plan
721	comes into compliance before that date.
722	3. TerminationIf the agency terminates more than one
723	regional contract with the same managed care plan due to
724	noncompliance with the requirements of this section, the agency
725	shall terminate all the regional contracts held by that plan.
726	When terminating multiple contracts, the agency must develop a
727	plan to transition enrollees to other plans, and phase-in the
728	terminations over a time period sufficient to ensure a smooth
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729	transition.
730	(i) Prompt paymentManaged care plans shall comply with
731	ss. 641.315, 641.3155, and 641.513.
732	(j) Electronic claimsManaged care plans, and their
733	fiscal agents or intermediaries, shall accept electronic claims
734	in compliance with federal standards.
735	(k) Fair paymentProvider service networks must ensure
736	that no entity licensed under chapter 395 with a controlling
737	interest in the network charges a Medicaid managed care plan
738	more than the amount paid to that provider by the provider
739	service network for the same service.
740	(1) Itemized payment.—Any claims payment to a provider by
741	a managed care plan, or by a fiscal agent or intermediary of the
742	plan, must be accompanied by an itemized accounting of the
743	individual claims included in the payment including, but not
744	limited to, the enrollee's name, the date of service, the
745	procedure code, the amount of reimbursement, and the
746	identification of the plan on whose behalf the payment is made.
747	(m) Provider dispute resolutionDisputes between a plan
748	and a provider may be resolved as described in s. 408.7057.
749	(3) ACHIEVED SAVINGS REBATE.—
750	(a) The agency is responsible for verifying the achieved
751	savings rebate for all Medicaid prepaid plans. To assist the
752	agency, a prepaid plan shall:
753	1. Submit an annual financial audit conducted by an
754	independent certified public accountant in accordance with
755	generally accepted auditing standards to the agency on or before
756	June 1 for the preceding year; and

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757	2. Submit an annual statement prepared in accordance with
758	statutory accounting principles on or before March 1 pursuant to
759	s. 624.424 if the plan is regulated by the Office of Insurance
760	Regulation.
761	(b) The agency shall contract with independent certified
762	public accountants to conduct compliance audits for the purpose
763	of auditing financial information, including but not limited to:
764	annual premium revenue, medical and administrative costs, and
765	income or losses reported by each prepaid plan, in order to
766	determine and validate the achieved savings rebate.
767	(c) Any audit required under this subsection must be
768	conducted by an independent certified public accountant who
769	meets criteria specified by rule. The rules must also provide
770	that:
771	1. The entity selected by the agency to conduct the audit
772	may not have a conflict of interest that might affect its
773	ability to perform its responsibilities with respect to an
774	examination.
775	2. The rates charged to the prepaid plan being audited are
776	consistent with rates charged by other certified public
777	accountants and are comparable with the rates charged for
778	comparable examinations.
779	3. Each prepaid plan audited shall pay to the agency the
780	expenses of the audit at the rates established by the agency by
781	rule. Such expenses include actual travel expenses, reasonable
782	living expense allowances, compensation of the certified public
783	accountant, and necessary attendant administrative costs of the
784	agency directly related to the examination. Travel expense and
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785	living expense allowances are limited to those expenses incurred
786	on account of the audit and must be paid by the examined prepaid
787	plan together with compensation upon presentation by the agency
788	to the prepaid plan of a detailed account of the charges and
789	expenses after a detailed statement has been filed by the
790	auditor and approved by the agency.
791	4. All moneys collected from prepaid plans for such audits
792	shall be deposited into the Grants and Donations Trust Fund and
793	the agency may make deposits into such fund from moneys
794	appropriated for the operation of the agency.
795	(d) At a location in this state, the prepaid plan shall
796	make available to the agency and the agency's contracted
797	certified public accountant all books, accounts, documents,
798	files, information, that relate to the prepaid plan's Medicaid
799	transactions. Records not in the prepaid plan's immediate
800	possession must be made available to the agency or the certified
801	public accountant in this state within 3 days after a request is
802	made by the agency or certified public accountant engaged by the
803	agency. A prepaid plan has an obligation to cooperate in good
804	faith with the agency and the certified public accountant.
805	Failure to comply to such record requests shall be deemed a
806	breach of contract.
807	(e) Once the certified public accountant completes the
808	audit, the certified public accountant shall submit an audit
809	report to the agency attesting to the achieved savings of the
810	plan. The results of the audit report are dispositive.
811	(f) Achieved savings rebates validated by the certified
812	public accountant are due within 30 days after the report is
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813	submitted. Except as provided in paragraph (h), the achieved
814	savings rebate is established by determining pretax income as a
815	percentage of revenues and applying the following income sharing
816	ratios:
817	1. One hundred percent of income up to and including 5
818	percent of revenue shall be retained by the plan.
819	2. Fifty percent of income above 5 percent and up to 10
820	percent shall be retained by the plan, and the other 50 percent
821	refunded to the state.
822	3. One hundred percent of income above 10 percent of
823	revenue shall be refunded to the state.
824	(g) A plan that exceeds agency-defined quality measures in
825	the reporting period may retain an additional 1 percent of
826	revenue. For the purpose of this paragraph, the quality measures
827	must include plan performance for preventing or managing
828	complex, chronic conditions that are associated with an elevated
829	likelihood of requiring high-cost medical treatments.
830	(h) The following may not be included as allowable
831	expenses in calculating income for determining the achieved
832	savings rebate:
833	1. Payment of achieved savings rebates.
834	2. Any financial incentive payments made to the plan
835	outside of the capitation rate.
836	3. Any financial disincentive payments levied by the state
837	or federal governments.
838	4. Expenses associated with any lobbying or political
839	activities.
840	5. The cash value or equivalent cash value of bonuses of
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841	any type paid or awarded to the plan's executive staff, other
842	than base salary.
843	6. Reserves and reserve accounts.
844	7. Administrative costs, including, but not limited to,
845	reinsurance expenses, interest payments, depreciation expenses,
846	bad debt expenses, and outstanding claims expenses in excess of
847	actuarially sound maximum amounts set by the agency.
848	
849	The agency shall consider these and other factors in developing
850	contracts that establish shared savings arrangements.
851	(i) Prepaid plans that incur a loss in the first contract
852	year may apply the full amount of the loss as an offset to
853	income in the second contract year.
854	(j) If, after an audit, the agency determines that a
855	prepaid plan owes an additional rebate, the plan has 30 days
856	after notification to make the payment. Upon failure to timely
857	pay the rebate, the agency shall withhold future payments to the
858	plan until the entire amount is recouped. If the agency
859	determines that a prepaid plan has made an overpayment, the
860	agency shall return the overpayment within 30 days.
861	Section 9. Section 409.968, Florida Statutes, is created
862	to read:
863	409.968 Managed care plan payments
864	(1) Prepaid plans shall receive per-member, per-month
865	payments negotiated pursuant to the procurements described in s.
866	409.966. Payments shall be risk-adjusted rates based on
867	historical utilization and spending data, projected forward, and
868	adjusted to reflect the eligibility category, geographic area,

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869	and clinical risk profile of the recipients. In negotiating
870	rates with the plans, the agency shall consider any adjustments
871	necessary to encourage plans to use the most cost effective
872	modalities for treatment of chronic disease such as peritoneal
873	dialysis.
874	(2) Provider service networks may be prepaid plans and
875	receive per-member, per-month payments negotiated pursuant to
876	the procurement process described in s. 409.966. Provider
877	service networks that choose not to be prepaid plans shall
878	receive fee-for-service rates with a shared savings settlement.
879	The fee-for-service option shall be available to a provider
880	service network only for the first 2 years of its operation. The
881	agency shall annually conduct cost reconciliations to determine
882	the amount of cost savings achieved by fee-for-service provider
883	service networks for the dates of service within the period
884	being reconciled. Only payments for covered services for dates
885	of service within the reconciliation period and paid within 6
886	months after the last date of service in the reconciliation
887	period must be included. The agency shall perform the necessary
888	adjustments for the inclusion of claims incurred but not
889	reported within the reconciliation period for claims that could
890	be received and paid by the agency after the 6-month claims
891	processing time lag. The agency shall provide the results of the
892	reconciliations to the fee-for-service provider service networks
893	within 45 days after the end of the reconciliation period. The
894	fee-for-service provider service networks shall review and
895	provide written comments or a letter of concurrence to the
896	agency within 45 days after receipt of the reconciliation
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897	results. This reconciliation is considered final.
898	(3) The agency may not approve any plan request for a rate
899	increase unless sufficient funds to support the increase have
900	been authorized in the General Appropriations Act.
901	Section 10. Section 409.969, Florida Statutes, is created
902	to read:
903	409.969 Enrollment; disenrollment
904	(1) ENROLLMENTAll Medicaid recipients shall be enrolled
905	in a managed care plan unless specifically exempted under this
906	part. Each recipient shall have a choice of plans and may select
907	any available plan unless that plan is restricted by contract to
908	a specific population that does not include the recipient.
909	Medicaid recipients shall have 30 days in which to make a choice
910	of plans.
911	(2) DISENROLLMENT; GRIEVANCESAfter a recipient has
912	enrolled in a managed care plan, the recipient shall have 90
913	days to voluntarily disenroll and select another plan. After 90
914	days, no further changes may be made except for good cause. For
915	purposes of this section, the term "good cause" includes, but is
916	not limited to, poor quality of care, lack of access to
917	necessary specialty services, an unreasonable delay or denial of
918	service, or fraudulent enrollment. The agency must make a
919	determination as to whether good cause exists. The agency may
920	require a recipient to use the plan's grievance process before
921	the agency's determination of good cause, except in cases in
922	which immediate risk of permanent damage to the recipient's
923	health is alleged.
924	(a) The managed care plan internal grievance process, when
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925	used, must be completed in time to permit the recipient to
926	disenroll by the first day of the second month after the month
927	the disenrollment request was made. If the result of the
928	grievance process is approval of an enrollee's request to
929	disenroll, the agency is not required to make a determination in
930	the case.
931	(b) The agency must make a determination and take final
932	action on a recipient's request so that disenrollment occurs no
933	later than the first day of the second month after the month the
934	request was made. If the agency fails to act within the
935	specified timeframe, the recipient's request to disenroll is
936	deemed to be approved as of the date agency action was required.
937	Recipients who disagree with the agency's finding that good
938	cause does not exist for disenrollment shall be advised of their
939	right to pursue a Medicaid fair hearing to dispute the agency's
940	finding.
941	(c) Medicaid recipients enrolled in a managed care plan
942	after the 90-day period shall remain in the plan for the
943	remainder of the 12-month period. After 12 months, the recipient
944	may select another plan. However, nothing shall prevent a
945	Medicaid recipient from changing providers within the plan
946	during that period.
947	(d) On the first day of the month after receiving notice
948	from a recipient that the recipient has moved to another region,
949	the agency shall automatically disenroll the recipient from the
950	managed care plan the recipient is currently enrolled in and
951	treat the recipient as if the recipient is a new Medicaid
952	enrollee. At that time, the recipient may choose another plan
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953	pursuant to the enrollment process established in this section.
954	(e) The agency must monitor plan disenrollment throughout
955	the contract term to identify any discriminatory practices.
956	Section 11. Section 409.97, Florida Statutes, is created
957	to read:
958	409.97 State and local Medicaid partnerships
959	(1) INTERGOVERNMENTAL TRANSFERSIn addition to the
960	contributions required pursuant to s. 409.915, beginning in the
961	2014-2015 fiscal year, the agency may accept voluntary transfers
962	of local taxes and other qualified revenue from counties,
963	municipalities, and special taxing districts. Such transfers
964	must be contributed to advance the general goals of the Florida
965	Medicaid program without restriction and must be executed
966	pursuant to a contract between the agency and the local funding
967	source. Contracts executed before October 31 shall result in
968	contributions to Medicaid for that same state fiscal year.
969	Contracts executed between November 1 and June 30 shall result
970	in contributions for the following state fiscal year. Based on
971	the date of the signed contracts, the agency shall allocate to
972	the low-income pool the first contributions received up to the
973	limit established by subsection (2). No more than 40 percent of
974	the low-income pool funding shall come from any single funding
975	source. Contributions in excess of the low-income pool shall be
976	allocated to the disproportionate share programs defined in ss.
977	409.911(3) and 409.9113 and to hospital rates pursuant to
978	subsection (4). The local funding source shall designate in the
979	contract which Medicaid providers ensure access to care for low-
980	income and uninsured people within the applicable jurisdiction
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981	and are eligible for low-income pool funding. Eligible providers
982	may include hospitals, primary care providers, and primary care
983	access systems.
984	(2) LOW-INCOME POOLThe agency shall establish and
985	maintain a low-income pool in a manner authorized by federal
986	waiver. The low-income pool is created to compensate a network
987	of providers designated pursuant to subsection (1). Funding of
988	the low-income pool shall be limited to the maximum amount
989	permitted by federal waiver minus a percentage specified in the
990	General Appropriations Act. The low-income pool must be used to
991	support enhanced access to services by offsetting shortfalls in
992	Medicaid reimbursement, paying for otherwise uncompensated care,
993	and financing coverage for the uninsured. The low-income pool
994	shall be distributed in periodic payments to the Access to Care
995	Partnership throughout the fiscal year. Distribution of low-
996	income pool funds by the Access to Care Partnership to
997	participating providers may be made through capitated payments,
998	fees for services, or contracts for specific deliverables. The
999	agency shall include the distribution amount for each provider
1000	in the contract with the Access to Care Partnership pursuant to
1001	subsection (3). Regardless of the method of distribution,
1002	providers participating in the Access to Care Partnership shall
1003	receive payments such that the aggregate benefit in the
1004	jurisdiction of each local funding source, as defined in
1005	subsection (1), equals the amount of the contribution plus a
1006	factor specified in the General Appropriations Act.
1007	(3) ACCESS TO CARE PARTNERSHIPThe agency shall contract
1008	with an administrative services organization that has operating
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1009	agreements with all health care facilities, programs, and
1010	providers supported with local taxes or certified public
1011	expenditures and designated pursuant to subsection (1). The
1012	contract shall provide for enhanced access to care for Medicaid,
1013	low-income, and uninsured Floridians. The partnership shall be
1014	responsible for an ongoing program of activities that provides
1015	needed, but uncovered or undercompensated, health services to
1016	Medicaid enrollees and persons receiving charity care, as
1017	defined in s. 409.911. Accountability for services rendered
1018	under this contract must be based on the number of services
1019	provided to unduplicated qualified beneficiaries, the total
1020	units of service provided to these persons, and the
1021	effectiveness of services provided as measured by specific
1022	standards of care. The agency shall seek such plan amendments or
1023	waivers as may be necessary to authorize the implementation of
1024	the low-income pool as the Access to Care Partnership pursuant
1025	to this section.
1026	(4) HOSPITAL RATE DISTRIBUTION
1027	(a) The agency is authorized to implement a tiered
1028	hospital rate system to enhance Medicaid payments to all
1029	hospitals when resources for the tiered rates are available from
1030	general revenue and such contributions pursuant to subsection
1031	(1) as are authorized under the General Appropriations Act.
1032	1. Tier 1 hospitals are statutory rural hospitals as
1033	defined in s. 395.602, statutory teaching hospitals as defined
1034	in s. 408.07(45), and specialty children's hospitals as defined
1035	<u>in s. 395.002(28).</u>
1036	2. Tier 2 hospitals are community hospitals not included
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1037	in Tier 1 that provided more than 9 percent of the hospital's
1038	total inpatient days to Medicaid patients and charity patients,
1039	as defined in s. 409.911, and are located in the jurisdiction of
1040	a local funding source pursuant to subsection (1).
1041	3. Tier 3 hospitals include all community hospitals.
1042	(b) When rates are increased pursuant to this section, the
1043	Total Tier Allocation (TTA) shall be distributed as follows:
1044	1. Tier 1 (T1A) = 0.35 x TTA.
1045	2. Tier 2 (T2A) = 0.35 x TTA.
1046	3. Tier 3 (T3A) = 0.30 x TTA.
1047	(c) The tier allocation shall be distributed as a
1048	percentage increase to the hospital specific base rate (HSBR)
1049	established pursuant to s. 409.905(5)(c). The increase in each
1050	tier shall be calculated according to the proportion of tier-
1051	specific allocation to the total estimated inpatient spending
1052	(TEIS) for all hospitals in each tier:
1053	1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total
1054	estimated inpatient spending (T1TEIS).
1055	2. Tier 2 percent increase (T2PI) = T2A /Tier 2 total
1056	estimated inpatient spending (T2TEIS).
1057	3. Tier 3 percent increase (T3PI) = T3A/ Tier 3 total
1058	estimated inpatient spending (T3TEIS).
1059	(d) The hospital-specific tiered rate (HSTR) shall be
1060	calculated as follows:
1061	1. For hospitals in Tier 3: HSTR = $(1 + T3PI) \times HSBR$.
1062	2. For hospitals in Tier 2: HSTR = $(1 + T2PI) \times HSBR$.
1063	3. For hospitals in Tier 1: HSTR = $(1 + T1PI) \times HSBR$.
1064	Section 12. Section 409.971, Florida Statutes, is created
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1065	to read:
1066	409.971 Managed medical assistance programThe agency
1067	shall make payments for primary and acute medical assistance and
1068	related services using a managed care model. By January 1, 2013,
1069	the agency shall begin implementation of the statewide managed
1070	medical assistance program, with full implementation in all
1071	regions by October 1, 2014.
1072	Section 13. Section 409.972, Florida Statutes, is created
1073	to read:
1074	409.972 Mandatory and voluntary enrollment
1075	(1) Persons eligible for the program known as "medically
1076	needy" pursuant to s. 409.904(2)(a) shall enroll in managed care
1077	plans. Medically needy recipients shall meet the share of the
1078	cost by paying the plan premium, up to the share of the cost
1079	amount, contingent upon federal approval.
1080	(2) The following Medicaid-eligible persons are exempt
1081	from mandatory managed care enrollment required by s. 409.965,
1082	and may voluntarily choose to participate in the managed medical
1083	assistance program:
1084	(a) Medicaid recipients who have other creditable health
1085	care coverage, excluding Medicare.
1086	(b) Medicaid recipients residing in residential commitment
1087	facilities operated through the Department of Juvenile Justice
1088	or mental health treatment facilities as defined by s.
1089	394.455(32).
1090	(c) Persons eligible for refugee assistance.
1091	(d) Medicaid recipients who are residents of a
1092	developmental disability center, including Sunland Center in
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1093	Marianna and Tacachale in Gainesville.
1094	(e) Medicaid recipients enrolled in the home and community
1095	based services waiver pursuant to chapter 393, and Medicaid
1096	recipients waiting for waiver services.
1097	(3) Persons eligible for Medicaid but exempt from
1098	mandatory participation who do not choose to enroll in managed
1099	care shall be served in the Medicaid fee-for-service program as
1100	provided in part III of this chapter.
1101	(4) The agency shall seek federal approval to require
1102	Medicaid recipients enrolled in managed care plans, as a
1103	condition of Medicaid eligibility, to pay the Medicaid program a
1104	share of the premium of \$10 per month.
1105	Section 14. Section 409.973, Florida Statutes, is created
1106	to read:
1107	409.973 Benefits
1108	(1) MINIMUM BENEFITSManaged care plans shall cover, at a
1109	minimum, the following services:
1110	(a) Advanced registered nurse practitioner services.
1111	(b) Ambulatory surgical treatment center services.
1112	(c) Birthing center services.
1113	(d) Chiropractic services.
1114	(e) Dental services.
1115	(f) Early periodic screening diagnosis and treatment
1116	services for recipients under age 21.
1117	(g) Emergency services.
1118	(h) Family planning services and supplies. Pursuant to 42
1119	C.F.R. s. 438.102, plans may elect to not provide these services
1120	due to an objection on moral or religious grounds, and must
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1121	notify the agency of that election when submitting a reply to an
1122	invitation to negotiate.
1123	(i) Healthy start services, except as provided in s.
1124	409.975(4).
1125	(j) Hearing services.
1126	(k) Home health agency services.
1127	(1) Hospice services.
1128	(m) Hospital inpatient services.
1129	(n) Hospital outpatient services.
1130	(o) Laboratory and imaging services.
1131	(p) Medical supplies, equipment, prostheses, and orthoses.
1132	(q) Mental health services.
1133	(r) Nursing care.
1134	(s) Optical services and supplies.
1135	(t) Optometrist services.
1136	(u) Physical, occupational, respiratory, and speech
1137	therapy services.
1138	(v) Physician services, including physician assistant
1139	services.
1140	(w) Podiatric services.
1141	(x) Prescription drugs.
1142	(y) Renal dialysis services.
1143	(z) Respiratory equipment and supplies.
1144	(aa) Rural health clinic services.
1145	(bb) Substance abuse treatment services.
1146	(cc) Transportation to access covered services.
1147	(2) CUSTOMIZED BENEFITSManaged care plans may customize
1148	benefit packages for nonpregnant adults, vary cost-sharing
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1149	provisions, and provide coverage for additional services. The
1150	agency shall evaluate the proposed benefit packages to ensure
1151	services are sufficient to meet the needs of the plan's
1152	enrollees and to verify actuarial equivalence.
1153	(3) HEALTHY BEHAVIORSEach plan operating in the managed
1154	medical assistance program shall establish a program to
1155	encourage and reward healthy behaviors. At a minimum, each plan
1156	must establish a medically approved smoking cessation program, a
1157	medically directed weight loss program, and a medically approved
1158	alcohol or substance abuse recovery program. Each plan must
1159	identify enrollees who smoke, are morbidly obese, or are
1160	diagnosed with alcohol or substance abuse in order to establish
1161	written agreements to secure the enrollees' commitment to
1162	participation in these programs.
1163	(4) PRIMARY CARE INITIATIVEEach plan operating in the
1164	managed medical assistance program shall establish a program to
1165	encourage enrollees to establish a relationship with their
1166	primary care provider. Each plan shall:
1167	(a) Provide information to each enrollee on the importance
1168	of and procedure for selecting a primary care physician, and
1169	thereafter automatically assign to a primary care provider any
1170	enrollee who fails to choose a primary care provider.
1171	(b) If the enrollee was not a Medicaid recipient before
1172	enrollment in the plan, assist the enrollee in scheduling an
1173	appointment with the primary care provider. If possible the
1174	appointment should be made within 30 days after enrollment in
1175	the plan. For enrollees who become eligible for Medicaid between
1176	January 1, 2014, and December 31, 2015, the appointment should
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1177	be be scheduled within 6 months after enrollment in the plan.
1178	(c) Report to the agency the number of enrollees assigned
1179	to each primary care provider within the plan's network.
1180	(d) Report to the agency the number of enrollees who have
1181	not had an appointment with their primary care provider within
1182	their first year of enrollment.
1183	(e) Report to the agency the number of emergency room
1184	visits by enrollees who have not had a least one appointment
1185	with their primary care provider.
1186	Section 15. Section 409.974, Florida Statutes, is created
1187	to read:
1188	409.974 Eligible plans
1189	(1) ELIGIBLE PLAN SELECTIONThe agency shall select
1190	eligible plans through the procurement process described in s.
1191	409.966. The agency shall notice invitations to negotiate no
1192	later than January 1, 2013.
1193	(a) The agency shall procure two plans for Region 1. At
1194	least one plan shall be a provider service network if any
1195	provider service networks submit a responsive bid.
1196	(b) The agency shall procure two plans for Region 2. At
1197	least one plan shall be a provider service network if any
1198	provider service networks submit a responsive bid.
1199	(c) The agency shall procure at least three plans and up
1200	to five plans for Region 3. At least one plan must be a provider
1201	service network if any provider service networks submit a
1202	responsive bids.
1203	(d) The agency shall procure at least three plans and up
1204	to five plans for Region 4. At least one plan must be a provider
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1205	service network if any provider service networks submit a
1206	responsive bid.
1207	(e) The agency shall procure at least two plans and up to
1208	4 plans for Region 5. At least one plan must be a provider
1209	service network if any provider service networks submit a
1210	responsive bid.
1211	(f) The agency shall procure at least four plans and up to
1212	seven plans for Region 6. At least one plan must be a provider
1213	service network if any provider service networks submit a
1214	responsive bid.
1215	(g) The agency shall procure at least three plans and up
1216	to six plans for Region 7. At least one plan must be a provider
1217	service network if any provider service networks submit a
1218	responsive bid.
1219	(h) The agency shall procure at least two plans and up to
1220	four plans for Region 8. At least one plan must be a provider
1221	service network if any provider service networks submit a
1222	responsive bid.
1223	(i) The agency shall procure at least two plans and up to
1224	four plans for Region 9. At least one plan must be a provider
1225	service network if any provider service networks submit a
1226	responsive bid.
1227	(j) The agency shall procure at least two plans and up to
1228	four plans for Region 10. At least one plan must be a provider
1229	service network if any provider service networks submit a
1230	responsive bid.
1231	(k) The agency shall procure at least five plans and up to
1232	ten plans for Region 11. At least one plan must be a provider
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1233	service network if any provider service networks submit a
1234	responsive bid.
1235	
1236	If no provider service network submits a responsive bid, the
1237	agency shall procure no more than one less than the maximum
1238	number of eligible plans permitted in that region. Within 12
1239	months after the initial invitation to negotiate, the agency
1240	shall attempt to procure a provider service network. The agency
1241	shall notice another invitation to negotiate only with provider
1242	service networks in those regions where no provider service
1243	network has been selected.
1244	(2) QUALITY SELECTION CRITERIAIn addition to the
1245	criteria established in s. 409.966, the agency shall consider
1246	evidence that an eligible plan has written agreements or signed
1247	contracts or has made substantial progress in establishing
1248	relationships with providers before the plan submitting a
1249	response. The agency shall evaluate and give special weight to
1250	evidence of signed contracts with essential providers as defined
1251	by the agency pursuant to s. 409.975(2). The agency shall
1252	exercise a preference for plans with a provider network in which
1253	over 10 percent of the providers use electronic health records,
1254	as defined in s. 408.051. When all other factors are equal, the
1255	agency shall consider whether the organization has a contract to
1256	provide managed long-term care services in the same region and
1257	shall exercise a preference for such plans.
1258	(3) SPECIALTY PLANSParticipation by specialty plans
1259	shall be subject to the procurement requirements and regional
1260	plan number limits of this section. However, a specialty plan
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1261	whose target population includes no more than 10 percent of the
1262	enrollees of that region is not subject to the regional plan
1263	number limits of this section.
1264	(4) CHILDREN'S MEDICAL SERVICES NETWORKParticipation by
1265	the Children's Medical Services Network shall be pursuant to a
1266	single, statewide contract with the agency that is not subject
1267	to the procurement requirements or regional plan number limits
1268	of this section. The Children's Medical Services Network must
1269	meet all other plan requirements for the managed medical
1270	assistance program.
1271	Section 16. Section 409.975, Florida Statutes, is created
1272	to read:
1273	409.975 Managed care plan accountabilityIn addition to
1274	the requirements of s. 409.967, plans and providers
1275	participating in the managed medical assistance program shall
1276	comply with the requirements of this section.
1277	(1) PROVIDER NETWORKSManaged care plans must develop and
1278	maintain provider networks that meet the medical needs of their
1279	enrollees in accordance with standards established pursuant to
1280	409.967(2)(b). Except as provided in this section, managed care
1281	plans may limit the providers in their networks based on
1282	credentials, quality indicators, and price.
1283	(a) Plans must include all providers in the region that
1284	are classified by the agency as essential Medicaid providers,
1285	unless the agency approves, in writing, an alternative
1286	arrangement for securing the types of services offered by the
1287	essential providers. Providers are essential for serving
1288	Medicaid enrollees if they offer services that are not available
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1289	from any other provider within a reasonable access standard, or
1290	if they provided a substantial share of the total units of a
1291	particular service used by Medicaid patients within the region
1292	during the last 3 years and the combined capacity of other
1293	service providers in the region is insufficient to meet the
1294	total needs of the Medicaid patients. The agency may not
1295	classify physicians and other practitioners as essential
1296	providers. The agency, at a minimum, shall determine which
1297	providers in the following categories are essential Medicaid
1298	providers:
1299	1. Federally qualified health centers.
1300	2. Statutory teaching hospitals as defined in s.
1301	408.07(45).
1302	3. Hospitals that are trauma centers as defined in s.
1303	395.4001(14).
1304	4. Hospitals located at least 25 miles from any other
1305	hospital with similar services.
1306	
1307	Managed care plans that have not contracted with all essential
1308	providers in the region as of the first date of recipient
1309	enrollment, or with whom an essential provider has terminated
1310	its contract, must negotiate in good faith with such essential
1311	providers for 1 year or until an agreement is reached, whichever
1312	is first. Payments for services rendered by a nonparticipating
1313	essential provider shall be made at the applicable Medicaid rate
1314	as of the first day of the contract between the agency and the
1315	plan. A rate schedule for all essential providers shall be
1316	attached to the contract between the agency and the plan. After

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1317	1 year, managed care plans that are unable to contract with
1318	essential providers shall notify the agency and propose an
1319	alternative arrangement for securing the essential services for
1320	Medicaid enrollees. The arrangement must rely on contracts with
1321	other participating providers, regardless of whether those
1322	providers are located within the same region as the
1323	nonparticipating essential service provider. If the alternative
1324	arrangement is approved by the agency, payments to
1325	nonparticipating essential providers after the date of the
1326	agency's approval shall equal 90 percent of the applicable
1327	Medicaid rate. If the alternative arrangement is not approved by
1328	the agency, payment to nonparticipating essential providers
1329	shall equal 110 percent of the applicable Medicaid rate.
1330	(b) Certain providers are statewide resources and
1331	essential providers for all managed care plans in all regions.
1332	All managed care plans must include these essential providers in
1333	their networks. Statewide essential providers include:
1334	1. Faculty plans of Florida medical schools.
1335	2. Regional perinatal intensive care centers as defined in
1336	<u>s. 383.16(2).</u>
1337	3. Hospitals licensed as specialty children's hospitals as
1338	defined in s. 395.002(28).
1339	4. Accredited and integrated systems serving medically
1340	complex children that are comprised of separately licensed, but
1341	commonly owned, health care providers delivering at least the
1342	following services: medical group home, in-home and outpatient
1343	nursing care and therapies, pharmacy services, durable medical
1344	equipment, and Prescribed Pediatric Extended Care.
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1345	
1346	Managed care plans that have not contracted with all statewide
1347	essential providers in all regions as of the first date of
1348	recipient enrollment must continue to negotiate in good faith.
1349	Payments to physicians on the faculty of nonparticipating
1350	Florida medical schools shall be made at the applicable Medicaid
1351	rate. Payments for services rendered by a regional perinatal
1352	intensive care centers shall be made at the applicable Medicaid
1353	rate as of the first day of the contract between the agency and
1354	the plan. Payments to nonparticipating specialty children's
1355	hospitals shall equal the highest rate established by contract
1356	between that provider and any other Medicaid managed care plan.
1357	(c) After 12 months of active participation in a plan's
1358	network, the plan may exclude any essential provider from the
1359	network for failure to meet quality or performance criteria. If
1360	the plan excludes an essential provider from the plan, the plan
1361	must provide written notice to all recipients who have chosen
1362	that provider for care. The notice shall be provided at least 30
1363	days before the effective date of the exclusion.
1364	(d) Each managed care plan must offer a network contract
1365	to each home medical equipment and supplies provider in the
1366	region which meets quality and fraud prevention and detection
1367	standards established by the plan and which agrees to accept the
1368	lowest price previously negotiated between the plan and another
1369	such provider.
1370	(2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORKThe agency
1371	shall contract with a single organization representing medical
1372	schools and graduate medical education programs in the state for
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1373	the purpose of establishing an active and ongoing program to
1374	improve clinical outcomes in all managed care plans. Contracted
1375	activities must support greater clinical integration for
1376	Medicaid enrollees through interdependent and cooperative
1377	efforts of all providers participating in managed care plans.
1378	The agency shall support these activities with certified public
1379	expenditures and any earned federal matching funds and shall
1380	seek any plan amendments or waivers necessary to comply with
1381	this subsection. To be eligible to participate in the quality
1382	network, a medical school must contract with each managed care
1383	plan in its region.
1384	(3) PERFORMANCE MEASUREMENTEach managed care plan shall
1385	monitor the quality and performance of each participating
1386	provider. At the beginning of the contract period, each plan
1387	shall notify all its network providers of the metrics used by
1388	the plan for evaluating the provider's performance and
1389	determining continued participation in the network.
1390	(4) MOMCARE NETWORK
1391	(a) The agency shall contract with an administrative
1392	services organization representing all Healthy Start Coalitions
1393	providing risk appropriate care coordination and other services
1394	in accordance with a federal waiver and pursuant to s. 409.906.
1395	The contract shall require the network of coalitions to provide
1396	counseling, education, risk-reduction and case management
1397	services, and quality assurance for all enrollees of the waiver.
1398	The agency shall evaluate the impact of the MomCare network by
1399	monitoring each plan's performance on specific measures to
1400	determine the adequacy, timeliness, and quality of services for
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1401	pregnant women and infants. The agency shall support this
1402	contract with certified public expenditures of general revenue
1403	appropriated for Healthy Start services and any earned federal
1404	matching funds.
1405	(b) Each managed care plan shall establish specific
1406	programs and procedures to improve pregnancy outcomes and infant
1407	health, including, but not limited to, coordination with the
1408	Healthy Start program, immunization programs, and referral to
1409	the Special Supplemental Nutrition Program for Women, Infants,
1410	and Children, and the Children's Medical Services program for
1411	children with special health care needs. Each plan's programs
1412	and procedures shall include agreements with each local Healthy
1413	Start Coalition in the region to provide risk-appropriate care
1414	coordination for pregnant women and infants, consistent with
1415	agency policies and the MomCare network. Each managed care plan
1416	must notify the agency of the impending birth of a child to an
1417	enrollee, or notify the agency as soon as practicable after the
1418	child's birth.
1419	(5) SCREENING RATEAfter the end of the second contract
1420	year, each managed care plan shall achieve an annual Early and
1421	Periodic Screening, Diagnosis, and Treatment Service screening
1422	rate of at least 80 percent of those recipients continuously
1423	enrolled for at least 8 months.
1424	(6) PROVIDER PAYMENTManaged care plans and hospitals
1425	shall negotiate mutually acceptable rates, methods, and terms of
1426	payment. For rates, methods, and terms of payment negotiated
1427	after the contract between the agency and the plan is executed,
1428	plans shall pay hospitals, at a minimum, the rate the agency
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1429	would have paid on the first day of the contract between the
1430	provider and the plan. Such payments to hospitals may not exceed
1431	120 percent of the rate the agency would have paid on the first
1432	day of the contract between the provider and the plan, unless
1433	specifically approved by the agency. Payment rates may be
1434	updated periodically.
1435	(7) MEDICALLY NEEDY ENROLLEESEach managed care plan must
1436	accept any medically needy recipient who selects or is assigned
1437	to the plan and provide that recipient with continuous
1438	enrollment for 12 months. After the first month of qualifying as
1439	a medically needy recipient and enrolling in a plan, and
1440	contingent upon federal approval, the enrollee shall pay the
1441	plan a portion of the monthly premium equal to the enrollee's
1442	share of the cost as determined by the department. The agency
1443	shall pay any remaining portion of the monthly premium. Plans
1444	are not obligated to pay claims for medically needy patients for
1445	services provided before enrollment in the plan. Medically needy
1446	patients are responsible for payment of incurred claims that are
1447	used to determine eligibility. Plans must provide a grace period
1448	of at least 90 days before disenrolling recipients who fail to
1449	pay their shares of the premium.
1450	Section 17. Section 409.976, Florida Statutes, is created
1451	to read:
1452	409.976 Managed care plan paymentIn addition to the
1453	payment provisions of s. 409.968, the agency shall provide
1454	payment to plans in the managed medical assistance program
1455	pursuant to this section.
1456	(1) Prepaid payment rates shall be negotiated between the
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1457	agency and the eligible plans as part of the procurement process
1458	described in s. 409.966.
1459	(2) The agency shall establish payment rates for statewide
1460	inpatient psychiatric programs. Payments to managed care plans
1461	shall be reconciled to reimburse actual payments to statewide
1462	inpatient psychiatric programs.
1463	Section 18. Section 409.977, Florida Statutes, is created
1464	to read:
1465	409.977 Enrollment
1466	(1) The agency shall automatically enroll into a managed
1467	care plan those Medicaid recipients who do not voluntarily
1468	choose a plan pursuant to s. 409.969. The agency shall
1469	automatically enroll recipients in plans that meet or exceed the
1470	performance or quality standards established pursuant to s.
1471	409.967 and may not automatically enroll recipients in a plan
1472	that is deficient in those performance or quality standards.
1473	When a specialty plan is available to accommodate a specific
1474	condition or diagnosis of a recipient, the agency shall assign
1475	the recipient to that plan. In the first year of the first
1476	contract term only, if a recipient was previously enrolled in a
1477	plan that is still available in the region, the agency shall
1478	automatically enroll the recipient in that plan unless an
1479	applicable specialty plan is available. Except as otherwise
1480	provided in this part, the agency may not engage in practices
1481	that are designed to favor one managed care plan over another.
1482	(2) When automatically enrolling recipients in managed
1483	care plans, the agency shall automatically enroll based on the
1484	following criteria:
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1485	(a) Whether the plan has sufficient network capacity to
1486	meet the needs of the recipients.
1487	(b) Whether the recipient has previously received services
1488	from one of the plan's primary care providers.
1489	(c) Whether primary care providers in one plan are more
1490	geographically accessible to the recipient's residence than
1491	those in other plans.
1492	(3) A newborn of a mother enrolled in a plan at the time
1493	of the child's birth shall be enrolled in the mother's plan.
1494	Upon birth, such a newborn is deemed enrolled in the managed
1495	care plan, regardless of the administrative enrollment
1496	procedures, and the managed care plan is responsible for
1497	providing Medicaid services to the newborn. The mother may
1498	choose another plan for the newborn within 90 days after the
1499	child's birth.
1500	(4) The agency shall develop a process to enable a
1501	recipient with access to employer-sponsored health care coverage
1502	to opt out of all managed care plans and to use Medicaid
1503	financial assistance to pay for the recipient's share of the
1504	cost in such employer-sponsored coverage. Contingent upon
1505	federal approval, the agency shall also enable recipients with
1506	access to other insurance or related products providing access
1507	to health care services created pursuant to state law, including
1508	any product available under the Florida Health Choices Program,
1509	or any health exchange, to opt out. The amount of financial
1510	assistance provided for each recipient may not exceed the amount
1511	of the Medicaid premium that would have been paid to a managed
1512	care plan for that recipient. The agency shall seek federal
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1513	approval to require Medicaid recipients with access to employer-
1514	sponsored health care coverage to enroll in that coverage and
1515	use Medicaid financial assistance to pay for the recipient's
1516	share of the cost for such coverage. The amount of financial
1517	assistance provided for each recipient may not exceed the amount
1518	of the Medicaid premium that would have been paid to a managed
1519	care plan for that recipient.
1520	Section 19. Section 409.978, Florida Statutes, is created
1521	to read:
1522	409.978 Long-term care managed care program
1523	(1) Pursuant to s. 409.963, the agency shall administer
1524	the long-term care managed care program described in ss.
1525	409.978-409.985, but may delegate specific duties and
1526	responsibilities for the program to the Department of Elderly
1527	Affairs and other state agencies. By July 1, 2012, the agency
1528	shall begin implementation of the statewide long-term care
1529	managed care program, with full implementation in all regions by
1530	<u>October 1, 2013.</u>
1531	(2) The agency shall make payments for long-term care,
1532	including home and community-based services, using a managed
1533	care model. Unless otherwise specified, ss. 409.961-409.97 apply
1534	to the long-term care managed care program.
1535	(3) The Department of Elderly Affairs shall assist the
1536	agency to develop specifications for use in the invitation to
1537	negotiate and the model contract, determine clinical eligibility
1538	for enrollment in managed long-term care plans, monitor plan
1539	performance and measure quality of service delivery, assist
1540	clients and families to address complaints with the plans,
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1541	facilitate working relationships between plans and providers
1542	serving elders and disabled adults, and perform other functions
1543	specified in a memorandum of agreement.
1544	Section 20. Section 409.979, Florida Statutes, is created
1545	to read:
1546	409.979 Eligibility
1547	(1) Medicaid recipients who meet all of the following
1548	criteria are eligible to receive long-term care services and
1549	must receive long-term care services by participating in the
1550	long-term care managed care program. The recipient must be:
1551	(a) Sixty-five years of age or older, or age 18 or older
1552	and eligible for Medicaid by reason of a disability.
1553	(b) Determined by the Comprehensive Assessment Review and
1554	Evaluation for Long-Term Care Services (CARES) Program to
1555	require nursing facility care as defined in s. 409.985(3).
1556	(2) Medicaid recipients who, on the date long-term care
1557	managed care plans become available in their region, reside in a
1558	nursing home facility or are enrolled in one of the following
1559	long-term care Medicaid waiver programs are eligible to
1560	participate in the long-term care managed care program for up to
1561	12 months without being reevaluated for their need for nursing
1562	facility care as defined in s. 409.985(3):
1563	(a) The Assisted Living for the Frail Elderly Waiver.
1564	(b) The Aged and Disabled Adult Waiver.
1565	(c) The Adult Day Health Care Waiver.
1566	(d) The Consumer-Directed Care Plus Program as described
1567	<u>in s. 409.221.</u>
1568	(e) The Program of All-inclusive Care for the Elderly.
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1569	(f) The long-term care community-based diversion pilot
1570	project as described in s. 430.705.
1571	(g) The Channeling Services Waiver for Frail Elders.
1572	(3) The Department of Elderly Affairs shall make offers
1573	for enrollment to eligible individuals based on a wait-list
1574	prioritization and subject to availability of funds. Before
1575	enrollment offers, the department shall determine that
1576	sufficient funds exist to support additional enrollment into
1577	plans.
1578	Section 21. Section 409.98, Florida Statutes, is created
1579	to read:
1580	409.98 Long-term care plan benefitsLong-term care plans
1581	shall, at a minimum, cover the following:
1582	(1) Nursing facility care.
1583	(2) Services provided in assisted living facilities.
1584	(3) Hospice.
1585	(4) Adult day care.
1586	(5) Medical equipment and supplies, including incontinence
1587	supplies.
1588	(6) Personal care.
1589	(7) Home accessibility adaptation.
1590	(8) Behavior management.
1591	(9) Home-delivered meals.
1592	(10) Case management.
1593	(11) Therapies:
1594	(a) Occupational therapy.
1595	(b) Speech therapy.
1596	(c) Respiratory therapy.
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1597	(d) Physical therapy.
1598	(12) Intermittent and skilled nursing.
1599	(13) Medication administration.
1600	(14) Medication management.
1601	(15) Nutritional assessment and risk reduction.
1602	(16) Caregiver training.
1603	(17) Respite care.
1604	(18) Transportation.
1605	(19) Personal emergency response system.
1606	Section 22. Section 409.981, Florida Statutes, is created
1607	to read:
1608	409.981 Eligible long-term care plans
1609	(1) ELIGIBLE PLANSProvider service networks must be
1610	long-term care provider service networks. Other eligible plans
1611	may be long-term care plans or comprehensive long-term care
1612	plans.
1613	(2) ELIGIBLE PLAN SELECTIONThe agency shall select
1614	eligible plans through the procurement process described in s.
1615	409.966. The agency shall provide notice of invitations to
1616	negotiate by July 1, 2012. The agency shall procure:
1617	(a) Two plans for Region 1. At least one plan must be a
1618	provider service network if any provider service networks submit
1619	a responsive bid.
1620	(b) Two plans for Region 2. At least one plan must be a
1621	provider service network if any provider service networks submit
1622	a responsive bid.
1623	(c) At least three plans and up to five plans for Region
1624	3. At least one plan must be a provider service network if any
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1625	provider service networks submit a responsive bid.
1626	(d) At least three plans and up to five plans for Region
1627	4. At least one plan must be a provider service network if any
1628	provider service network submits a responsive bid.
1629	(e) At least two plans and up to 4 plans for Region 5. At
1630	least one plan must be a provider service network if any
1631	provider service networks submit a responsive bid.
1632	(f) At least four plans and up to seven plans for Region
1633	6. At least one plan must be a provider service network if any
1634	provider service networks submit a responsive bid.
1635	(g) At least three plans and up to 6 plans for Region 7.
1636	At least one plan must be a provider service networks if any
1637	provider service networks submit a responsive bid.
1638	(h) At least two plans and up to four plans for Region 8.
1639	At least one plan must be a provider service network if any
1640	provider service networks submit a responsive bid.
1641	(i) At least two plans and up to four plans for Region 9.
1642	At least one plan must be a provider service network if any
1643	provider service networks submit a responsive bid.
1644	(j) At least two plans and up to four plans for Region 10.
1645	At least one plan must be a provider service network if any
1646	provider service networks submit a responsive bid.
1647	(k) At least five plans and up to ten plans for Region 11.
1648	At least one plan must be a provider service network if any
1649	provider service networks submit a responsive bid.
1650	
1651	If no provider service network submits a responsive bid in a
1652	region other than Region 1 or Region 2, the agency shall procure
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1653	no more than one less than the maximum number of eligible plans
1654	permitted in that region. Within 12 months after the initial
1655	invitation to negotiate, the agency shall attempt to procure a
1656	provider service network. The agency shall notice another
1657	invitation to negotiate only with provider service networks in
1658	regions where no provider service network has been selected.
1659	(3) QUALITY SELECTION CRITERIA In addition to the
1660	criteria established in s. 409.966, the agency shall consider
1661	the following factors in the selection of eligible plans:
1662	(a) Evidence of the employment of executive managers with
1663	expertise and experience in serving aged and disabled persons
1664	who require long-term care.
1665	(b) Whether a plan has established a network of service
1666	providers dispersed throughout the region and in sufficient
1667	numbers to meet specific service standards established by the
1668	agency for specialty services for persons receiving home and
1669	community-based care.
1670	(c) Whether a plan is proposing to establish a
1671	comprehensive long-term care plan and whether the eligible plan
1672	has a contract to provide managed medical assistance services in
1673	the same region.
1674	(d) Whether a plan offers consumer-directed care services
1675	to enrollees pursuant to s. 409.221.
1676	(e) Whether a plan is proposing to provide home and
1677	community-based services in addition to the minimum benefits
1678	required by s. 409.98.
1679	(4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
1680	Participation by the Program of All-Inclusive Care for the
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1681	Elderly (PACE) shall be pursuant to a contract with the agency
1682	and not subject to the procurement requirements or regional plan
1683	number limits of this section. PACE plans may continue to
1684	provide services to individuals at such levels and enrollment
1685	caps as authorized by the General Appropriations Act.
1686	(5) MEDICARE PLANSParticipation by a Medicare Advantage
1687	Preferred Provider Organization, Medicare Advantage Provider-
1688	sponsored Organization, or Medicare Advantage Special Needs Plan
1689	shall be pursuant to a contract with the agency and not subject
1690	to the procurement requirements if the plan's Medicaid enrollees
1691	consist exclusively of recipients who are deemed dually eligible
1692	for Medicaid and Medicare services. Otherwise, Medicare
1693	Advantage Preferred Provider Organizations, Medicare Advantage
1694	Provider-Sponsored Organizations, and Medicare Advantage Special
1695	Needs Plans are subject to all procurement requirements.
1696	Section 23. Section 409.982, Florida Statutes, is created
1697	to read:
1698	409.982 Long-term care managed care plan accountability
1699	In addition to the requirements of s. 409.967, plans and
1700	providers participating in the long-term care managed care
1701	program must comply with the requirements of this section.
1702	(1) PROVIDER NETWORKSManaged care plans may limit the
1703	providers in their networks based on credentials, quality
1704	indicators, and price. For the period between October 1, 2013,
1705	and September 30, 2014, each selected plan must offer a network
1706	contract to all the following providers in the region:
1707	(a) Nursing homes.
1708	(b) Hospices.
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1709	(c) Aging network service providers that have previously
1710	participated in home and community-based waivers serving elders
1711	or community-service programs administered by the Department of
1712	Elderly Affairs.
1713	
1714	After 12 months of active participation in a managed care plan's
1715	network, the plan may exclude any of the providers named in this
1716	subsection from the network for failure to meet quality or
1717	performance criteria. If the plan excludes a provider from the
1718	plan, the plan must provide written notice to all recipients who
1719	have chosen that provider for care. The notice must be provided
1720	at least 30 days before the effective date of the exclusion. The
1721	agency shall establish contract provisions governing the
1722	transfer of recipients from excluded residential providers.
1723	(2) SELECT PROVIDER PARTICIPATIONExcept as provided in
1724	this subsection, providers may limit the managed care plans they
1725	join. Nursing homes and hospices that are enrolled Medicaid
1726	providers must participate in all eligible plans selected by the
1727	agency in the region in which the provider is located.
1728	(3) PERFORMANCE MEASUREMENTEach managed care plan shall
1729	monitor the quality and performance of each participating
1730	provider using measures adopted by and collected by the agency
1731	and any additional measures mutually agreed upon by the provider
1732	and the plan
1733	(4) PROVIDER NETWORK STANDARDS The agency shall establish
1734	and each managed care plan must comply with specific standards
1735	for the number, type, and regional distribution of providers in
1736	the plan's network, which must include:
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1737	(a) Adult day care centers.
1738	(b) Adult family-care homes.
1739	(c) Assisted living facilities.
1740	(d) Health care services pools.
1741	(e) Home health agencies.
1742	(f) Homemaker and companion services.
1743	(g) Hospices.
1744	(h) Community care for the elderly lead agencies.
1745	(i) Nurse registries.
1746	(j) Nursing homes.
1747	(5) PROVIDER PAYMENTManaged care plans and providers
1748	shall negotiate mutually acceptable rates, methods, and terms of
1749	payment. Plans shall pay nursing homes an amount equal to the
1750	nursing facility-specific payment rates set by the agency;
1751	however, mutually acceptable higher rates may be negotiated for
1752	medically complex care. Plans shall pay hospice providers
1753	through a prospective system for each enrollee an amount equal
1754	to the per diem rate set by the agency. For recipients residing
1755	in a nursing facility and receiving hospice services, the plan
1756	shall pay the hospice provider the per diem rate set by the
1757	agency minus the nursing facility component and shall pay the
1758	nursing facility the applicable state rate. Plans must ensure
1759	that electronic nursing home and hospice claims that contain
1760	sufficient information for processing are paid within 10
1761	business days after receipt.
1762	Section 24. Section 409.983, Florida Statutes, is created
1763	to read:
1764	409.983 Long-term care managed care plan paymentIn
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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 eligible
plans as part of the procurement process described in s.
409.966.
(2) Payment rates for comprehensive long-term care plans
covering services described in s. 409.973 shall be blended with
rates for long-term care plans for services specified in s.
409.98.
(3) Payment rates for plans must reflect historic
utilization and spending for covered services projected forward
and adjusted to reflect the level of care profile for enrollees
in each plan. The payment shall be adjusted to provide an
incentive for reducing institutional placements and increasing
the utilization of home and community-based services.
(4) The initial assessment of an enrollee's level of care
shall be made by the Comprehensive Assessment and Review for
Long-Term-Care Services (CARES) program, which shall assign the
recipient into one of the following levels of care:
(a) Level of care 1 consists of recipients residing in or
who must be placed in a nursing home.
(b) Level of care 2 consists of recipients at imminent
risk of nursing home placement, as evidenced by the need for the
constant availability of routine medical and nursing treatment
and care, and require extensive health-related care and services
because of mental or physical incapacitation.

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1793 (c) Level of care 3 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the 1794 1795 constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and 1796 1797 services and are mildly medically or physically incapacitated. 1798 1799 The agency shall periodically adjust payment rates to account 1800 for changes in the level of care profile for each managed care 1801 plan based on encounter data. 1802 The agency shall make an incentive adjustment in (5) 1803 payment rates to encourage the increased utilization of home and 1804 community-based services and a commensurate reduction of 1805 institutional placement. The incentive adjustment shall be 1806 modified in each successive rate period during the first 1807 contract period, as follows: 1808 (a) A 2 percentage point shift in the first rate-setting 1809 period; 1810 (b) A 2 percentage point shift in the second rate-setting 1811 period, as compared to the utilization mix at the end of the 1812 first rate-setting period; or 1813 A 3 percentage point shift in the third rate-setting (C) period, and in each subsequent rate-setting period during the 1814 1815 first contract period, as compared to the utilization mix at the 1816 end of the immediately preceding rate-setting period. 1817 The incentive adjustment shall continue in subsequent contract 1818 periods, at a rate of 3 percentage points per year as compared 1819 1820 to the utilization mix at the end of the immediately preceding

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

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1821	rate-setting period, until no more than 35 percent of the plan's
1822	enrollees are placed in institutional settings. The agency shall
1823	annually report to the Legislature the actual change in the
1824	utilization mix of home and community-based services compared to
1825	institutional placements and provide a recommendation for
1826	utilization mix requirements for future contracts.
1827	(6) The agency shall establish nursing-facility-specific
1828	payment rates for each licensed nursing home based on facility
1829	costs adjusted for inflation and other factors as authorized in
1830	the General Appropriations Act. Payments to long-term care
1831	managed care plans shall be reconciled to reimburse actual
1832	payments to nursing facilities.
1833	(7) The agency shall establish hospice payment rates
1834	pursuant to Title XVIII of the Social Security Act. Payments to
1835	long-term care managed care plans shall be reconciled to
1836	reimburse actual payments to hospices.
1837	Section 25. Section 409.984, Florida Statutes, is created
1838	to read:
1839	409.984 Enrollment in a long-term care managed care plan
1840	(1) The agency shall automatically enroll into a long-term
1841	care managed care plan those Medicaid recipients who do not
1842	voluntarily choose a plan pursuant to s. 409.969. The agency
1843	shall automatically enroll recipients in plans that meet or
1844	exceed the performance or quality standards established pursuant
1845	to s. 409.967 and may not automatically enroll recipients in a
1846	plan that is deficient in those performance or quality
1847	standards. If a recipient is deemed dually eligible for Medicaid
1848	and Medicare services and is currently receiving Medicare
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1849	services from an entity qualified under 42 C.F.R. part 422 as a
1850	Medicare Advantage Preferred Provider Organization, Medicare
1851	Advantage Provider-sponsored Organization, or Medicare Advantage
1852	Special Needs Plan, the agency shall automatically enroll the
1853	recipient in such plan for Medicaid services if the plan is
1854	currently participating in the long-term care managed care
1855	program. Except as otherwise provided in this part, the agency
1856	may not engage in practices that are designed to favor one
1857	managed care plan over another.
1858	(1) When automatically enrolling recipients in plans, the
1859	agency shall take into account the following criteria:
1860	(a) Whether the plan has sufficient network capacity to
1861	meet the needs of the recipients.
1862	(b) Whether the recipient has previously received services
1863	from one of the plan's home and community-based service
1864	providers.
1865	(c) Whether the home and community-based providers in one
1866	plan are more geographically accessible to the recipient's
1867	residence than those in other plans.
1868	(3) Notwithstanding s. 409.969(3)(c), if a recipient is
1869	referred for hospice services, the recipient has 30 days during
1870	which the recipient may select to enroll in another managed care
1871	plan to access the hospice provider of the recipient's choice.
1872	(4) If a recipient is referred for placement in a nursing
1873	home or assisted living facility, the plan must inform the
1874	recipient of any facilities within the plan that have specific
1875	cultural or religious affiliations and, if requested by the
1876	recipient, make a reasonable effort to place the recipient in
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CS/HB 7107, Engrossed 3 2011 Legislature 1877 the facility of the recipient's choice. 1878 Section 26. Section 409.9841, Florida Statutes, is created 1879 to read: 1880 409.9841 Long-term care managed care technical advisory 1881 workgroup.-1882 (1) Before August 1, 2011, the agency shall establish a 1883 technical advisory workgroup to assist in developing: 1884 The method of determining Medicaid eligibility (a) 1885 pursuant to s. 409.985(3). 1886 The requirements for provider payments to nursing (b) homes under s. 409.983(6). 1887 1888 (C) The method for managing Medicare coinsurance crossover 1889 claims. 1890 (d) Uniform requirements for claims submissions and payments, including electronic funds transfers and claims 1891 1892 processing. 1893 The process for enrollment of and payment for (e) 1894 individuals pending determination of Medicaid eligibility. 1895 (2) The advisory workgroup must include, but is not 1896 limited to, representatives of providers and plans who could 1897 potentially participate in long-term care managed care. Members of the workgroup shall serve without compensation but may be 1898 1899 reimbursed for per diem and travel expenses as provided in s. 1900 112.061. 1901 This section is repealed on June 30, 2013. (3) Section 27. Section 409.985, Florida Statutes, is created 1902 to read: 1903 1904 409.985 Comprehensive Assessment and Review for Long-Term Page 68 of 71

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1905	Care Services (CARES) Program
1906	(1) The agency shall operate the Comprehensive Assessment
1907	and Review for Long-Term Care Services (CARES) preadmission
1908	screening program to ensure that only individuals whose
1909	conditions require long-term care services are enrolled in the
1910	long-term care managed care program.
1911	(2) The agency shall operate the CARES program through an
1912	interagency agreement with the Department of Elderly Affairs.
1913	The agency, in consultation with the Department of Elderly
1914	Affairs, may contract for any function or activity of the CARES
1915	program, including any function or activity required by 42
1916	C.F.R. part 483.20, relating to preadmission screening and
1917	review.
1918	(3) The CARES program shall determine if an individual
1919	requires nursing facility care and, if the individual requires
1920	such care, assign the individual to a level of care as described
1921	in s. 409.983(4). When determining the need for nursing facility
1922	care, consideration shall be given to the nature of the services
1923	prescribed and which level of nursing or other health care
1924	personnel meets the qualifications necessary to provide such
1925	services and the availability to and access by the individual of
1926	community or alternative resources. For the purposes of the
1927	long-term care managed care program, the term "nursing facility
1928	care" means the individual:
1929	(a) Requires nursing home placement as evidenced by the
1930	need for medical observation throughout a 24-hour period and
1931	care required to be performed on a daily basis by, or under the
1932	direct supervision of, a registered nurse or other health care
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1933	professional and requires services that are sufficiently
1934	medically complex to require supervision, assessment, planning,
1935	or intervention by a registered nurse because of a mental or
1936	physical incapacitation by the individual;
1937	(b) Requires or is at imminent risk of nursing home
1938	placement as evidenced by the need for observation throughout a
1939	24-hour period and care and the constant availability of medical
1940	and nursing treatment and requires services on a daily or
1941	intermittent basis that are to be performed under the
1942	supervision of licensed nursing or other health professionals
1943	because the individual who is incapacitated mentally or
1944	physically; or
1945	(c) Requires or is at imminent risk of nursing home
1946	placement as evidenced by the need for observation throughout a
1947	24-hour period and care and the constant availability of medical
1948	and nursing treatment and requires limited services that are to
1949	be performed under the supervision of licensed nursing or other
1950	health professionals because the individual is mildly
1951	incapacitated mentally or physically.
1952	(4) For individuals whose nursing home stay is initially
1953	funded by Medicare and Medicare coverage and is being terminated
1954	for lack of progress towards rehabilitation, CARES staff shall
1955	consult with the person making the determination of progress
1956	toward rehabilitation to ensure that the recipient is not being
1957	inappropriately disqualified from Medicare coverage. If, in
1958	their professional judgment, CARES staff believe that a Medicare
1959	beneficiary is still making progress toward rehabilitation, they
1960	may assist the Medicare beneficiary with an appeal of the
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1961	disqualification from Medicare coverage. The use of CARES teams	
1962	to review Medicare denials for coverage under this section is	
1963	authorized only if it is determined that such reviews qualify	
1964	for federal matching funds through Medicaid. The agency shall	
1965	seek or amend federal waivers as necessary to implement this	
1966	section.	
1967	Section 28. If any provision of this act or its	
1968	application to any person or circumstance is held invalid, the	
1969	invalidity does not affect other provisions or applications of	
1970	the act which can be given effect without the invalid provision	
1971	or application, and to this end the provisions of this act are	
1972	severable.	
1973	Section 29. This act shall take effect July 1, 2011.	

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