By the Committee on Appropriations; and Senators Grimsley and Stargel

576-04402-17 2017916c1

1 A bill to be entitled
2 An act relating to the statewide Medicaid managed care
3 program; amending s. 409.912, F.S.; deleting the fee-
4 for-service option as a basis for the reimbursement of
5 Medicaid provider service networks; amending s.
6 409.964, F.S.; deleting an obsolete provision;
7 amending s. 409.966, F.S.; requiring that a databook
8 consist of data that is consistent with actuarial
9 rate-setting practices and standards; requiring that
10 the source of such data include the 24 most recent
11 months of validated data from the Medicaid Encounter
12 Data System; deleting provisions relating to a report
13 and report requirements; revising the designation and
14 county makeup of regions of the state for purposes of
15 procuring health plans that may participate in the
16 Medicaid program; adding a factor that the Agency for
17 Health Care Administration must consider in the
18 selection of eligible plans; deleting a requirement
19 related to fee-for-service provider service networks;
20 amending s. 409.968, F.S.; requiring, rather than
21 authorizing, provider service networks to be prepaid
22 plans; deleting a fee-for-service option for Medicaid
23 reimbursement for provider service networks; amending
24 s. 409.971, F.S.; deleting an obsolete provision;
25 amending s. 409.974, F.S.; revising the number of
26 eligible Medicaid health care plans the agency must
27 procure for certain regions in the state; deleting an
28 obsolete provision; amending s. 409.978, F.S.;
29 deleting an obsolete provision; amending s. 409.981,

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30 F.S.; revising the number of eligible Medicaid health
31 care plans the agency must procure for certain regions
32 in the state; deleting requirement that the agency
33 consider a specific factor relating to the selection
34 of managed medical assistance plans; providing an
35 effective date.
36
37 Be It Enacted by the Legislature of the State of Florida:
38
39 Section 1. Subsection (2) of section 409.912, Florida
40 Statutes, is amended to read:
41 409.912 Cost-effective purchasing of health care.—The
42 agency shall purchase goods and services for Medicaid recipients
43 in the most cost-effective manner consistent with the delivery
44 of quality medical care. To ensure that medical services are
45 effectively utilized, the agency may, in any case, require a
46 confirmation or second physician's opinion of the correct
47 diagnosis for purposes of authorizing future services under the
48 Medicaid program. This section does not restrict access to
49 emergency services or poststabilization care services as defined
50 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
51 shall be rendered in a manner approved by the agency. The agency
52 shall maximize the use of prepaid per capita and prepaid
53 aggregate fixed-sum basis services when appropriate and other
54 alternative service delivery and reimbursement methodologies,
55 including competitive bidding pursuant to s. 287.057, designed
56 to facilitate the cost-effective purchase of a case-managed
57 continuum of care. The agency shall also require providers to
58 minimize the exposure of recipients to the need for acute

59 inpatient, custodial, and other institutional care and the
60 inappropriate or unnecessary use of high-cost services. The
61 agency shall contract with a vendor to monitor and evaluate the
62 clinical practice patterns of providers in order to identify
63 trends that are outside the normal practice patterns of a
64 provider’s professional peers or the national guidelines of a
65 provider’s professional association. The vendor must be able to
66 provide information and counseling to a provider whose practice
67 patterns are outside the norms, in consultation with the agency,
68 to improve patient care and reduce inappropriate utilization.
69 The agency may mandate prior authorization, drug therapy
70 management, or disease management participation for certain
71 populations of Medicaid beneficiaries, certain drug classes, or
72 particular drugs to prevent fraud, abuse, overuse, and possible
73 dangerous drug interactions. The Pharmaceutical and Therapeutics
74 Committee shall make recommendations to the agency on drugs for
75 which prior authorization is required. The agency shall inform
76 the Pharmaceutical and Therapeutics Committee of its decisions
77 regarding drugs subject to prior authorization. The agency is
78 authorized to limit the entities it contracts with or enrolls as
79 Medicaid providers by developing a provider network through
80 provider credentialing. The agency may competitively bid single-
81 source-provider contracts if procurement of goods or services
82 results in demonstrated cost savings to the state without
83 limiting access to care. The agency may limit its network based
84 on the assessment of beneficiary access to care, provider
85 availability, provider quality standards, time and distance
86 standards for access to care, the cultural competence of the
87 provider network, demographic characteristics of Medicaid

88 beneficiaries, practice and provider-to-beneficiary standards,
89 appointment wait times, beneficiary use of services, provider
90 turnover, provider profiling, provider licensure history,
91 previous program integrity investigations and findings, peer
92 review, provider Medicaid policy and billing compliance records,
93 clinical and medical record audits, and other factors. Providers
94 are not entitled to enrollment in the Medicaid provider network.
95 The agency shall determine instances in which allowing Medicaid
96 beneficiaries to purchase durable medical equipment and other
97 goods is less expensive to the Medicaid program than long-term
98 rental of the equipment or goods. The agency may establish rules
99 to facilitate purchases in lieu of long-term rentals in order to
100 protect against fraud and abuse in the Medicaid program as
101 defined in s. 409.913. The agency may seek federal waivers
102 necessary to administer these policies.
103 (2) The agency may contract with a provider service
104 network~~, which may be reimbursed on a fee-for-service or prepaid~~
105 ~~basis~~. Prepaid provider service networks shall receive per-
106 member, per-month payments. ~~A provider service network that does~~
107 ~~not choose to be a prepaid plan shall receive fee-for-service~~
108 ~~rates with a shared savings settlement. The fee-for-service~~
109 ~~option shall be available to a provider service network only for~~
110 ~~the first 2 years of the plan's operation or until the contract~~
111 ~~year beginning September 1, 2014, whichever is later. The agency~~
112 ~~shall annually conduct cost reconciliations to determine the~~
113 ~~amount of cost savings achieved by fee-for-service provider~~
114 ~~service networks for the dates of service in the period being~~
115 ~~reconciled. Only payments for covered services for dates of~~
116 ~~service within the reconciliation period and paid within 6~~

117 ~~months after the last date of service in the reconciliation~~
118 ~~period shall be included. The agency shall perform the necessary~~
119 ~~adjustments for the inclusion of claims incurred but not~~
120 ~~reported within the reconciliation for claims that could be~~
121 ~~received and paid by the agency after the 6-month claims~~
122 ~~processing time lag. The agency shall provide the results of the~~
123 ~~reconciliations to the fee-for-service provider service networks~~
124 ~~within 45 days after the end of the reconciliation period. The~~
125 ~~fee-for-service provider service networks shall review and~~
126 ~~provide written comments or a letter of concurrence to the~~
127 ~~agency within 45 days after receipt of the reconciliation~~
128 ~~results. This reconciliation shall be considered final.~~
129 (a) A provider service network that ~~which~~ is reimbursed by
130 the agency on a prepaid basis shall be exempt from parts I and
131 III of chapter 641, but must comply with the solvency
132 requirements in s. 641.2261(2) and meet appropriate financial
133 reserve, quality assurance, and patient rights requirements as
134 established by the agency.
135 (b) A provider service network is a network established or
136 organized and operated by a health care provider, or group of
137 affiliated health care providers, which provides a substantial
138 proportion of the health care items and services under a
139 contract directly through the provider or affiliated group of
140 providers and may make arrangements with physicians or other
141 health care professionals, health care institutions, or any
142 combination of such individuals or institutions to assume all or
143 part of the financial risk on a prospective basis for the
144 provision of basic health services by the physicians, by other
145 health professionals, or through the institutions. The health

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146 care providers must have a controlling interest in the governing
147 body of the provider service network organization.
148 Section 2. Section 409.964, Florida Statutes, is amended to
149 read:
150 409.964 Managed care program; state plan; waivers.—The
151 Medicaid program is established as a statewide, integrated
152 managed care program for all covered services, including long-
153 term care services. The agency shall apply for and implement
154 state plan amendments or waivers of applicable federal laws and
155 regulations necessary to implement the program. Before seeking a
156 waiver, the agency shall provide public notice and the
157 opportunity for public comment and include public feedback in
158 the waiver application. The agency shall hold one public meeting
159 in each of the regions described in s. 409.966(2), and the ~~time~~
160 period for public comment for each region shall end no sooner
161 than 30 days after the completion of the public meeting in that
162 region. ~~The agency shall submit any state plan amendments, new~~
163 ~~waiver requests, or requests for extensions or expansions for~~
164 ~~existing waivers, needed to implement the managed care program~~
165 ~~by August 1, 2011.~~
166 Section 3. Subsection (2) and paragraphs (a), (d), and (e)
167 of subsection (3) of section 409.966, Florida Statutes, are
168 amended to read:
169 409.966 Eligible plans; selection.—
170 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a
171 limited number of eligible plans to participate in the Medicaid
172 program using invitations to negotiate in accordance with s.
173 287.057(1)(c). At least 90 days before issuing an invitation to
174 negotiate, the agency shall compile and publish a databook

175 consisting of a comprehensive set of utilization and spending
176 data consistent with actuarial rate-setting practices and
177 standards ~~for the 3 most recent contract years consistent with~~
178 ~~the rate-setting periods for all Medicaid recipients by region~~
179 ~~or county~~. The source of the data in the databook ~~report~~ must
180 include the 24 most recent months of ~~both historic fee-for-~~
181 ~~service claims and~~ validated data from the Medicaid Encounter
182 Data System. ~~The report must be available in electronic form and~~
183 ~~delineate utilization use by age, gender, eligibility group,~~
184 ~~geographic area, and aggregate clinical risk score.~~ Separate and
185 simultaneous procurements shall be conducted in each of the
186 following regions:
187 (a) Region A ~~Region 1~~, which consists of Bay, Calhoun,
188 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,
189 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,
190 ~~and~~ Walton, and Washington Counties.
191 (b) Region B ~~Region 2~~, which consists of Alachua, Baker,
192 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,
193 Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion,
194 Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
195 ~~Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson,~~
196 ~~Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and~~
197 ~~Washington~~ Counties.
198 (c) Region C ~~Region 3~~, which consists of Hardee, Highlands,
199 Hillsborough, Manatee, Pasco, Pinellas, and Polk ~~Alachua,~~
200 ~~Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton,~~
201 ~~Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter,~~
202 ~~Suwannee, and Union~~ Counties.
203 (d) Region D ~~Region 4~~, which consists of Brevard, Orange,

204 Osceola, and Seminole ~~Baker, Clay, Duval, Flagler, Nassau, St.~~
205 ~~Johns, and Volusia~~ Counties.
206 (e) Region E ~~Region 5~~, which consists of Charlotte,
207 Collier, DeSoto, Glades, Hendry, Lee, and Sarasota ~~Pasco and~~
208 ~~Pinellas~~ Counties.
209 (f) Region F ~~Region 6~~, which consists of Indian River,
210 Martin, Okeechobee, Palm Beach, and St. Lucie ~~Hardee, Highlands,~~
211 ~~Hillsborough, Manatee, and Polk~~ Counties.
212 (g) Region G ~~Region 7~~, which consists of Broward County
213 ~~Brevard, Orange, Osceola, and Seminole Counties~~.
214 (h) Region H ~~Region 8~~, which consists of Miami-Dade and
215 Monroe ~~Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and~~
216 ~~Sarasota~~ Counties.
217 ~~(i) Region 9, which consists of Indian River, Martin,~~
218 ~~Okeechobee, Palm Beach, and St. Lucie Counties.~~
219 ~~(j) Region 10, which consists of Broward County.~~
220 ~~(k) Region 11, which consists of Miami-Dade and Monroe~~
221 ~~Counties.~~
222 (3) QUALITY SELECTION CRITERIA.—
223 (a) The invitation to negotiate must specify the criteria
224 and the relative weight of the criteria that will be used for
225 determining the acceptability of the reply and guiding the
226 selection of the organizations with which the agency negotiates.
227 In addition to criteria established by the agency, the agency
228 shall consider the following factors in the selection of
229 eligible plans:
230 1. Accreditation by the National Committee for Quality
231 Assurance, the Joint Commission, or another nationally
232 recognized accrediting body.

233 2. Experience serving similar populations, including the
234 organization’s record in achieving specific quality standards
235 with similar populations.
236 3. Availability and accessibility of primary care and
237 specialty physicians in the provider network.
238 4. Establishment of community partnerships with providers
239 that create opportunities for reinvestment in community-based
240 services.
241 5. Organization commitment to quality improvement and
242 documentation of achievements in specific quality improvement
243 projects, including active involvement by organization
244 leadership.
245 6. Provision of additional benefits, particularly dental
246 care and disease management, and other initiatives that improve
247 health outcomes.
248 7. Evidence that an eligible plan has written agreements or
249 signed contracts or has made substantial progress in
250 establishing relationships with providers before the plan
251 submitting a response.
252 8. Comments submitted in writing by any enrolled Medicaid
253 provider relating to a specifically identified plan
254 participating in the procurement in the same region as the
255 submitting provider.
256 9. Documentation of policies and procedures for preventing
257 fraud and abuse.
258 10. The business relationship an eligible plan has with any
259 other eligible plan that responds to the invitation to
260 negotiate.
261 11. Whether a plan is proposing to establish a

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262 <u>comprehensive long-term care plan.</u>
263 (d) For the first year of the first contract term, the
264 agency shall negotiate capitation rates or fee for service
265 payments with each plan in order to guarantee aggregate savings
266 of at least 5 percent.
267 ~~1.~~ For prepaid plans, determination of the amount of
268 savings shall be calculated by comparison to the Medicaid rates
269 that the agency paid managed care plans for similar populations
270 in the same areas in the prior year. In regions containing no
271 prepaid plans in the prior year, determination of the amount of
272 savings shall be calculated by comparison to the Medicaid rates
273 established and certified for those regions in the prior year.
274 ~~2. For provider service networks operating on a fee-for-~~
275 ~~service basis, determination of the amount of savings shall be~~
276 ~~calculated by comparison to the Medicaid rates that the agency~~
277 ~~paid on a fee-for-service basis for the same services in the~~
278 ~~prior year.~~
279 (e) To ensure managed care plan participation in <u>Regions A</u>
280 <u>and E</u> ~~Regions 1 and 2~~, the agency shall award an additional
281 contract to each plan with a contract award in <u>Region A</u> ~~Region 1~~
282 or <u>Region E</u> ~~Region 2~~. Such contract shall be in any other region
283 in which the plan submitted a responsive bid and negotiates a
284 rate acceptable to the agency. If a plan that is awarded an
285 additional contract pursuant to this paragraph is subject to
286 penalties pursuant to s. 409.967(2)(i) for activities in <u>Region</u>
287 <u>A</u> ~~Region 1~~ or <u>Region E</u> ~~Region 2~~, the additional contract is
288 automatically terminated 180 days after the imposition of the
289 penalties. The plan must reimburse the agency for the cost of
290 enrollment changes and other transition activities.

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291 Section 4. Subsection (2) of section 409.968, Florida
292 Statutes, is amended to read:
293 409.968 Managed care plan payments.—
294 (2) Provider service networks shall ~~may~~ be prepaid plans
295 and receive per-member, per-month payments negotiated pursuant
296 to the procurement process described in s. 409.966. ~~Provider~~
297 ~~service networks that choose not to be prepaid plans shall~~
298 ~~receive fee-for-service rates with a shared savings settlement.~~
299 ~~The fee-for-service option shall be available to a provider~~
300 ~~service network only for the first 2 years of its operation. The~~
301 ~~agency shall annually conduct cost reconciliations to determine~~
302 ~~the amount of cost savings achieved by fee-for-service provider~~
303 ~~service networks for the dates of service within the period~~
304 ~~being reconciled. Only payments for covered services for dates~~
305 ~~of service within the reconciliation period and paid within 6~~
306 ~~months after the last date of service in the reconciliation~~
307 ~~period must be included. The agency shall perform the necessary~~
308 ~~adjustments for the inclusion of claims incurred but not~~
309 ~~reported within the reconciliation period for claims that could~~
310 ~~be received and paid by the agency after the 6-month claims~~
311 ~~processing time lag. The agency shall provide the results of the~~
312 ~~reconciliations to the fee-for-service provider service networks~~
313 ~~within 45 days after the end of the reconciliation period. The~~
314 ~~fee-for-service provider service networks shall review and~~
315 ~~provide written comments or a letter of concurrence to the~~
316 ~~agency within 45 days after receipt of the reconciliation~~
317 ~~results. This reconciliation is considered final.~~
318 Section 5. Section 409.971, Florida Statutes, is amended to
319 read:

320 409.971 Managed medical assistance program.—The agency
321 shall make payments for primary and acute medical assistance and
322 related services using a managed care model. ~~By January 1, 2013,~~
323 ~~the agency shall begin implementation of the statewide managed~~
324 ~~medical assistance program, with full implementation in all~~
325 ~~regions by October 1, 2014.~~
326 Section 6. Subsections (1) and (2) of section 409.974,
327 Florida Statutes, are amended to read:
328 409.974 Eligible plans.—
329 (1) ELIGIBLE PLAN SELECTION.—The agency shall select
330 eligible plans for the managed medical assistance program
331 through the procurement process described in s. 409.966. ~~The~~
332 ~~agency shall notice invitations to negotiate no later than~~
333 ~~January 1, 2013.~~
334 (a) The agency shall procure at least three ~~two~~ plans and
335 up to four plans for Region A ~~Region 1~~. At least one plan shall
336 be a provider service network if any provider service networks
337 submit a responsive bid.
338 (b) The agency shall procure at least three plans and up to
339 six ~~two~~ plans for Region B ~~Region 2~~. At least one plan shall be
340 a provider service network if any provider service networks
341 submit a responsive bid.
342 (c) The agency shall procure at least 5 ~~three~~ plans and up
343 to 10 ~~five~~ plans for Region C ~~Region 3~~. At least one plan must
344 be a provider service network if any provider service networks
345 submit a responsive bid.
346 (d) The agency shall procure at least three plans and up to
347 six ~~five~~ plans for Region D ~~Region 4~~. At least one plan must be
348 a provider service network if any provider service networks

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349 submit a responsive bid.
350 (e) The agency shall procure at least three ~~two~~ plans and
351 up to four plans for Region E ~~Region 5~~. At least one plan must
352 be a provider service network if any provider service networks
353 submit a responsive bid.
354 (f) The agency shall procure at least three ~~four~~ plans and
355 up to five ~~seven~~ plans for Region F ~~Region 6~~. At least one plan
356 must be a provider service network if any provider service
357 networks submit a responsive bid.
358 (g) The agency shall procure at least three plans and up to
359 five ~~six~~ plans for Region G ~~Region 7~~. At least one plan must be
360 a provider service network if any provider service networks
361 submit a responsive bid.
362 (h) The agency shall procure at least 5 ~~two~~ plans and up to
363 10 ~~four~~ plans for Region H ~~Region 8~~. At least one plan must be a
364 provider service network if any provider service networks submit
365 a responsive bid.
366 ~~(i) The agency shall procure at least two plans and up to~~
367 ~~four plans for Region 9. At least one plan must be a provider~~
368 ~~service network if any provider service networks submit a~~
369 ~~responsive bid.~~
370 ~~(j) The agency shall procure at least two plans and up to~~
371 ~~four plans for Region 10. At least one plan must be a provider~~
372 ~~service network if any provider service networks submit a~~
373 ~~responsive bid.~~
374 ~~(k) The agency shall procure at least five plans and up to~~
375 ~~10 plans for Region 11. At least one plan must be a provider~~
376 ~~service network if any provider service networks submit a~~
377 ~~responsive bid.~~

378

379 ~~If no provider service network submits a responsive bid, the~~
380 ~~agency shall procure no more than one less than the maximum~~
381 ~~number of eligible plans permitted in that region. Within 12~~
382 ~~months after the initial invitation to negotiate, the agency~~
383 ~~shall attempt to procure a provider service network. The agency~~
384 ~~shall notice another invitation to negotiate only with provider~~
385 ~~service networks in those regions where no provider service~~
386 ~~network has been selected.~~
387 (2) QUALITY SELECTION CRITERIA.—In addition to the criteria
388 established in s. 409.966, the agency shall consider evidence
389 that an eligible plan has written agreements or signed contracts
390 or has made substantial progress in establishing relationships
391 with providers before the plan <u>submits</u> ~~submitting~~ a response.
392 The agency shall evaluate and give special weight to evidence of
393 signed contracts with essential providers as defined by the
394 agency pursuant to s. 409.975(1). The agency shall exercise a
395 preference for plans with a provider network in which <u>more than</u>
396 ~~over~~ 10 percent of the providers use electronic health records,
397 as defined in s. 408.051. ~~When all other factors are equal, the~~
398 ~~agency shall consider whether the organization has a contract to~~
399 ~~provide managed long-term care services in the same region and~~
400 ~~shall exercise a preference for such plans.~~
401 Section 7. Subsection (1) of section 409.978, Florida
402 Statutes, is amended to read:
403 409.978 Long-term care managed care program.—
404 (1) Pursuant to s. 409.963, the agency shall administer the
405 long-term care managed care program described in ss. 409.978-
406 409.985, but may delegate specific duties and responsibilities

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407 for the program to the Department of Elderly Affairs and other
408 state agencies. ~~By July 1, 2012, the agency shall begin~~
409 ~~implementation of the statewide long-term care managed care~~
410 ~~program, with full implementation in all regions by October 1,~~
411 ~~2013.~~
412 Section 8. Subsection (2) and paragraphs (c), (d), and (e)
413 of subsection (3) of section 409.981, Florida Statutes, are
414 amended to read:
415 409.981 Eligible long-term care plans.—
416 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
417 eligible plans for the long-term care managed care program
418 through the procurement process described in s. 409.966. The
419 agency shall procure:
420 (a) At least three ~~two~~ plans and up to four plans for
421 Region A ~~Region 1~~. At least one plan must be a provider service
422 network if any provider service networks submit a responsive
423 bid.
424 (b) At least three ~~Two~~ plans and up to six plans for Region
425 B ~~Region 2~~. At least one plan must be a provider service network
426 if any provider service networks submit a responsive bid.
427 (c) At least five ~~three~~ plans and up to eight ~~five~~ plans
428 for Region C ~~Region 3~~. At least one plan must be a provider
429 service network if any provider service networks submit a
430 responsive bid.
431 (d) At least three plans and up to six ~~five~~ plans for
432 Region D ~~Region 4~~. At least one plan must be a provider service
433 network if any provider service network submits a responsive
434 bid.
435 (e) At least three ~~two~~ plans and up to four plans for

436 Region E ~~Region 5~~. At least one plan must be a provider service
437 network if any provider service networks submit a responsive
438 bid.
439 (f) At least three ~~four~~ plans and up to five ~~seven~~ plans
440 for Region F ~~Region 6~~. At least one plan must be a provider
441 service network if any provider service networks submit a
442 responsive bid.
443 (g) At least three plans and up to four ~~six~~ plans for
444 Region G ~~Region 7~~. At least one plan must be a provider service
445 network if any provider service networks submit a responsive
446 bid.
447 (h) At least 5 ~~two~~ plans and up to 10 ~~four~~ plans for Region
448 H ~~Region 8~~. At least one plan must be a provider service network
449 if any provider service networks submit a responsive bid.
450 ~~(i) At least two plans and up to four plans for Region 9.~~
451 ~~At least one plan must be a provider service network if any~~
452 ~~provider service networks submit a responsive bid.~~
453 ~~(j) At least two plans and up to four plans for Region 10.~~
454 ~~At least one plan must be a provider service network if any~~
455 ~~provider service networks submit a responsive bid.~~
456 ~~(k) At least five plans and up to 10 plans for Region 11.~~
457 ~~At least one plan must be a provider service network if any~~
458 ~~provider service networks submit a responsive bid.~~
459
460 ~~If no provider service network submits a responsive bid in a~~
461 ~~region other than Region 1 or Region 2, the agency shall procure~~
462 ~~no more than one less than the maximum number of eligible plans~~
463 ~~permitted in that region. Within 12 months after the initial~~
464 ~~invitation to negotiate, the agency shall attempt to procure a~~

465 ~~provider service network. The agency shall notice another~~
466 ~~invitation to negotiate only with provider service networks in~~
467 ~~regions where no provider service network has been selected.~~
468 (3) QUALITY SELECTION CRITERIA.—In addition to the criteria
469 established in s. 409.966, the agency shall consider the
470 following factors in the selection of eligible plans:
471 ~~(c) Whether a plan is proposing to establish a~~
472 ~~comprehensive long-term care plan and whether the eligible plan~~
473 ~~has a contract to provide managed medical assistance services in~~
474 ~~the same region.~~
475 (c)~~(d)~~ Whether a plan offers consumer-directed care
476 services to enrollees pursuant to s. 409.221.
477 (d)~~(e)~~ Whether a plan is proposing to provide home and
478 community-based services in addition to the minimum benefits
479 required by s. 409.98.
480 Section 9. This act shall take effect July 1, 2017.

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