Health & Human Services Access Subcommittee

Wednesday, February 9, 2011
9:00-11:00 AM
12 HOB

Dean Cannon
Speaker

Gayle Harrell
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Access Subcommittee

Start Date and Time:	Wednesday, February 09, 2011 09:00 am
End Date and Time:	Wednesday, February 09, 2011 11:00 am
Location:	12 HOB
Duration:	2.00 hrs

Workshop on Medicaid Reform

The purpose of the workshop is to hear public testimony. Participants are invited to provide feedback and to recommend changes to HB 7223 from the 2010 Legislative Session. Discussion will be limited to sections pertaining to managed long-term care for persons with developmental disabilities in sections 27, 28, 29, 30, 31, 32, and 33 of HB 7223.

Update on implementation of Four-Tier Medicaid waiver legislation and ibudget legislation.

Anyone wishing to speak at the workshop must complete the appearance request form and return to the Health & Human Services Access Subcommittee.

The form can be found on the MyFloridaHouse.gov website or can be completed at the committee suite in 214 House Office Building. Online forms may be submitted via email to: bobbye.iseminger@myfloridahouse.gov, faxed to our office at (850) 488-9933 or submitted at the beginning of the meeting.

NOTICE FINALIZED on 02/02/2011 16:12 by Iseminger.Bobbye

Medicaid Waiver and ibudget

Overview of Medicaid Waiver and ibudget Legislation

Health and Human Services Access Subcommittee

February 9, 2011

Agency for Persons with Disabilities (APD)

- Chapter 393, F.S.
- APD was established in 2004 as a separate agency. Formerly the program was part of the Department of Children and Families
- APD provides services to persons with disorders associated with retardation, cerebral palsy, autism, spina bifida and Prader-Willi syndrome.

What is a Medicaid waiver?

- Waivers must be approved by federal Center for Medicaid and Medicare Services (CMS).
- Waives institutional services for an individual to receive home and community based services instead.
- An array of services are available under a waiver.
- Medicaid waiver enrollment is capped.

Four Tier Medicaid Waiver

- In 2007, APD was projecting a $150 million deficit in the Medicaid waiver program for FY 2007-08.
- Four Tier waiver was created by the 2007 Legislature (s. 393.0661, F.S.) to address program deficits, curb overutilization of services and create a predictable spending model.
- APD serves approximately 30,000 people in this program.
- Over 19,000 people are on a waitlist to get in the program.

Four Tier Medicaid Waiver

- Four tiers have annual caps:
  - Tier 1 $150,000/yr. for most intensive needs;
  - Tier 2 $53,625/yr. severe needs in residential care;
  - Tier 3 $34,125/yr. less severe needs in residential care or at home or independent living;
  - Tier 4 $14,442 least needs including persons from family and supported living waiver.
- 2007 Legislature also eliminated 5 services and placed utilization limits on 4 services.

Results of Legislation on Deficits

- $150 million deficit was reduced to $12.3 million (1.3% of budget) for FY 2007-08.
- Projections for FY 2008-09 and FY 2009-10 were for deficits to remain within 1.5% of budget.
- However, actual deficits were greater:
  - ($26.7 million) for FY 2008-09 (3% of budget)
  - ($45.1 million) for FY 2009-10 (5% of budget)

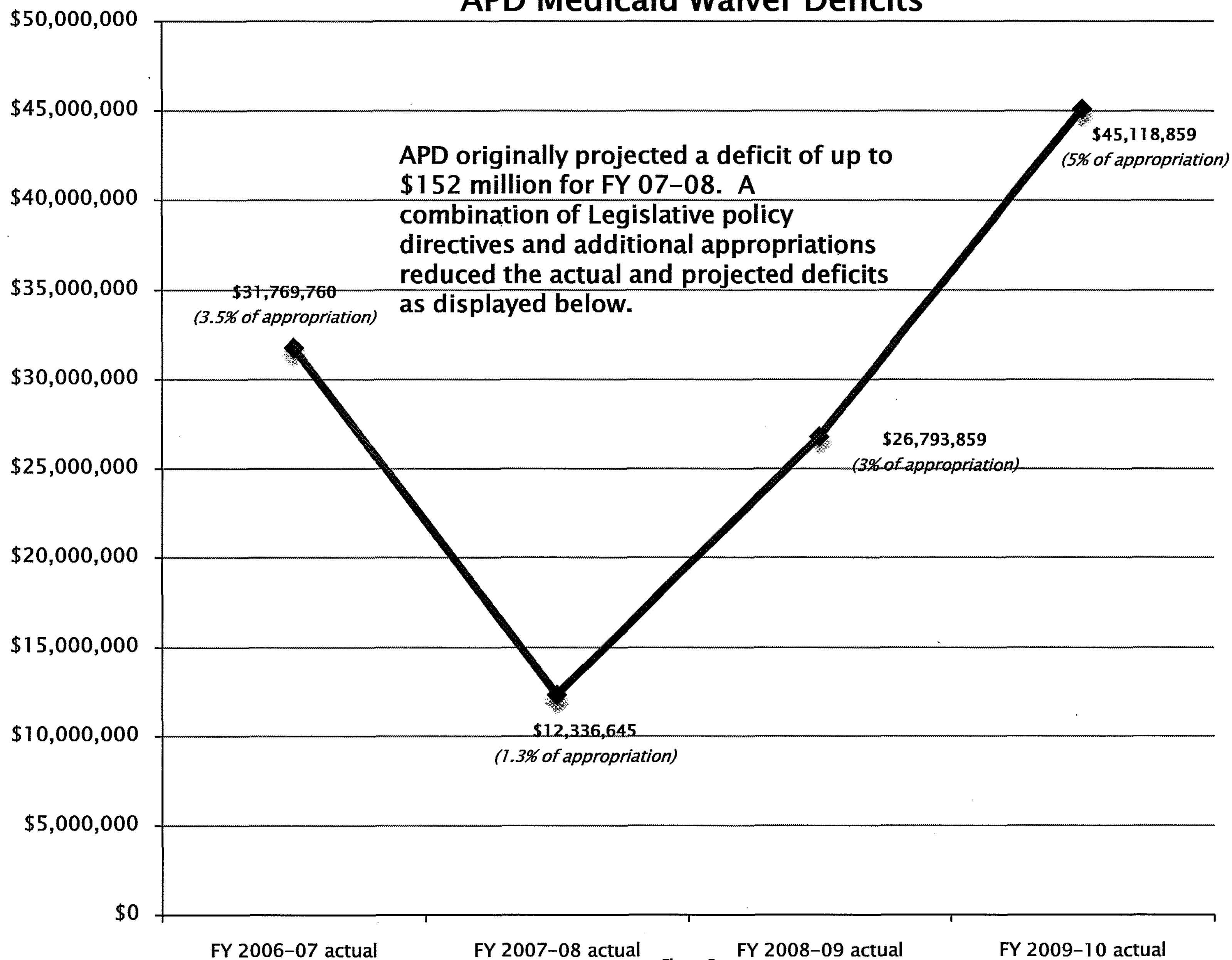

Figure 5

Individual budget (ibudget Florida)

- 2009 Legislature directed APD to develop ibudget plan.
- 2010 Legislature directed APD and AHCA to implement ibudgets as basis for allocating funds to individuals in Medicaid waiver programs.
- AHCA is seeking federal approval (Medicaid waiver)to implement ibudget program.

ibudget Florida

- Allocates funds to individuals using an algorithim based on individual characteristics which predicts a person's need for services.
- ibudget allocation places a cap on individual spending.
- ibudget allocation may be increased if extraordinary needs exists (e.g. health and safety in jeopardy).

ibudget Florida

- If approved by the federal government, the ibudget program may be phased in gradually throughout the state and would replace the four-tier Medicaid waiver program.
- Preliminary estimates of impact on current enrollees:
  - 64% would receive an increase in funding.
  - 36% would receive a decrease in funding.

APD Presentation

Health and Human Services Access Subcommittee
APD Presentation
February 9, 2011 9:00 a.m. – 12:00 p.m.

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iBudget Florida

- iBudget Florida will replace the tier waiver system.
- Implementing iBudget Florida requires federal government approval of a new Home and Community Based Services Waiver.
- The federal government is currently reviewing our waiver application and we could receive approval as soon as the next few days.
- APD has worked hard to lay the groundwork for iBudget Florida. For instance, we have developed an online system to support the waiver and are creating policies, processes, forms, communication materials, and trainings.
- Because the waiver is not yet approved, APD has not enrolled or provided services to any consumers through the iBudget Florida waiver.
- However, four families and one support coordinator are doing a test run of iBudget Florida in coordination with the Agency.
- We plan to implement first in Area 2, which is in North Florida. We would immediately begin preparing individuals and families for enrollment upon receiving approval, with the target of a small group beginning to receive services through iBudget Florida on April 1 if approval is received by the end of February. After fine-tuning our processes, we would begin to enroll the rest of the area on July 1.
- On our current schedule, other areas would be transitioned every 3-6 months, with the final areas coming on board by July 1, 2012.
- We are, however, exploring options for accelerating the implementation of iBudget Florida.

Implementation of the Four Tier Medicaid Waiver

Timeframes:

APD Tier Assignment Summary

Tier assigned as of Oct 15, 2008	Consumers	Tier Assigned as of Jul 1, 2009	Consumers	Tier Assigned as of Jul 1, 2010	Consumers	Tier Assigned as of Feb 1, 2011	Consumers
1	3,454	1	3,689	1	4,235	1	5,394
2	3,434	2	3,480	2	3,584	2	4,355
3	5,227	3	5,272	3	5,264	3	6,361
4	13,262	4	12,659	4	11,936	4	11,945
TBD	4,608	TBD	4,751	TBD	5,020	TBD	2,007
Total	**29,985**	**Total**	**29,851**	**Total**	**30,039**	**Total**	**30,062**

The February 2011 data reflecting 2,007 clients in the "To be Determined" status includes new APD clients who have been placed on the waiver through crisis and clients who are receiving emergency services. The "To be Determined" status also includes persons who have already had hearings, have hearings pending, or have withdrawn their hearing requests, but whose tier placements have not yet been finalized in APD's database.

- July 1, 2007 - Section 393.0661, F.S. creating the four-tier waiver system.
- July 30, 2007 - Class action federal lawsuit for preliminary injunction on notice and hearing rights for tier implementation.
- September 9, 2007 - Application for waivers for four-tier system filed with the Center for Medicaid Services (CMS).
- February 12, 2008 - Waiver applications approved by CMS.
- June 2008 - Tier rules challenged in Moreland at DOAH. Hearing Officer determined that tier rules are valid.
- September 2008 - Tier assignment notices mailed, 5500 hearing requests filed. Of those, 1800 were filed by individuals who would not have a reduction as a result of their tier assignment.
- October 20, 2008 - Tier rules become effective.
- May 22, 2009 - Washington federal lawsuit filed challenging the dismissal of insufficient hearing requests.
- August 21, 2009 - First DCA throws out tier rules in Moreland appeal. As a result with no rules to rely on for tier assignments, all tier assignment activity stops. Prior Service Authorizations with tier implications were also placed on hold.
- October 1, 2009 - In Washington case, Judge Hinkle required hearings for anyone who asked for one.
- March 7, 2010 - New tier rules final and effective.
- March - June 2010 - Amended tier assignment notices were issued to individuals not yet placed in their tier.
- June 2010 – 4,513 amended tier assignment notices were issued which resulted in approximately 1,300 tier hearing requests that were filed at DOAH. 4,513 is less than the original 5,500 individuals who had previously requested hearings because some individuals had withdrawn their hearing request, cases had been settled by the agency, and persons no longer on the waiver were subtracted.
- July 1, 2010 - Effective date of the transfer of jurisdiction to hear APD "fair hearings" to the Department of Children and Families (DCF).

Update on current tier cases at DCF

625 tier cases remain to be heard at DCF for individuals who have not been placed in tiers (all of these are projected to be completed Spring of 2011). This does not reflect all APD clients with "To Be Determined" (TBD) status. This number also does not include new APD clients who have been placed on the waiver through crisis, clients who are receiving emergency services, or individuals who have already had hearings or withdrawn their hearing requests but whose tier placements have not yet been finalized in APD's ABC database.

How factions worked against legislation

- 2 federal lawsuits: *Washington v. DeBeaugrine*, Filed by Southern Legal Counsel, Inc.; *London v. AHCA and APD,* filed by the Advocacy Center for Persons with Disabilities; Southern Legal Counsel, Inc.
- 2 rule challenges: *Moreland v. APD,* Filed by The Advocacy Center for Persons with Disabilities; Southern Legal Counsel, Inc.; *V.S. v. APD,* filed by Southern Legal Counsel, Inc., and Three Rivers Legal Services, Inc.
- 1 District Court Appeal: *Moreland v. APD*: Filed by The Advocacy Center for Persons with Disabilities; Southern Legal Counsel, Inc.; ARC of Florida as Amicus Curiae.
- More than 6,800 cases filed for "fair hearings" This number reflects the original 5,500 fair hearing requests plus the additional 1,300 hearing requests as a result of the amended tier review process in 2010.

- Workshops are also routinely held to encourage and train self advocates and waiver support coordinators on how to appeal tier assignments. Advocates regularly conduct training on how to move APD waiver clients up the "tier ladder." Courses entitled, "Don't be Denied – Get Help From the Advocacy Center"; "The Self Advocacy Grassroots Movement in Florida"; "Your Life, Your Way and Managing Medicaid Waiver Services"; and "The Change Agent Network"; held at this year's Family Café Summit on Disabilities, included instruction on tier change strategy.

Tier Change Strategy

1. Clients request hearings in order to delay being placed within their tier assignment which results in being given "To Be Determined" (TBD) status.
2. Clients file PSA requests for various programs. A high percentage of PSA requests are approved by APS, the corporation that has been contracted to make "medical necessity" determinations for the agency. In the three months from July to October 2010, APS received 13,758 PSA requests and approved 9,237.
   - Speech and Personal Care Assistance (PCA) programs will usually move clients from tier 4 to tier 3.
   - High levels of Residential Habilitation (Res Hab), PCA, Behavioral Services, and Physical or Occupational Therapy will often move clients to Tier 1.
3. By the time of the hearing, the client will have already been placed in a higher tier or will be entitled to an adjustment to a higher tier prior to the hearing (often on "the courtroom steps").

Rebasing Implementation

- February - July 2010 - Upon implementation of the statute in January 2010, the agency received in excess of 4,000 hearing requests. As part of the hearing process the agency provided informal reconsideration before the agency upon request and numerous reconsideration proceedings took place before the agency between February and July 2010. This resulted in a significant delay before hearings could take place. All of the hearing requests that remained outstanding (approximately 3,500) were filed before DOAH in late June 2010.
- September 2010 - DOAH judges (sitting as DCF hearing officers) dismissed three rebasing cases concluding that APD's notice did not allow the agency to carry out the mandate after the end of the 2009/2010 fiscal year. The judges also ruled that rebasing cannot be carried over into the next cost plan year.
- September 30, 2010 - October 1, 2010 - Advocacy groups filed Petition for Writs of Prohibition at the First DCA on the 3 cases dismissed by the DOAH hearing officers.[1]
- October 1, 2010 - October 4, 2010 - First DCA denied the extraordinary writs.
- October 14, 2010 - APD issued new notices for rebasing.
- As of today, 368 rebasing cases have been filed at DCF.

Rebasing Strategy

1. Clients request a hearing to delay implementation.
2. Clients file PSA requests for various programs to change their cost plan by 5%.
3. With a 5% change in cost plan, clients are now statutorily exempt from rebasing.

[1] Originally the DOAH hearing officers filed what they purported to be "final orders." The Agency treated those orders as recommended orders and entered its own final orders

Fiscal Impact

- **The tier savings lost due to the delay in implementing tiers due to appeals was $129.2 million over 2 ½ years.**
  Estimations are based on claim expenditures.

	TBD Consumers	Tier Savings Projected	Tier Savings Actual	Tier Savings Loss due to Appeals
FY 08-09	4590	71,791,300	32,414,120	39,377,180
FY 09-10	4540	91,731,120	43,815,437	47,915,683
FY 10-11 Projected	4167	70,731,120	28,730,810	42,000,311
				129,293,174

- **The tier savings lost due to tier jumping was approximately $30 million.**
  Estimations based on claim expenditures.

Tier Jump Analysis as of September 2010

Statistics	Tier 1	Tier 2	Tier 3	Tier 4	TBD
11/01/08	3459	3436	5245	13241	4606
09/01/10	4,530	3,809	5,603	12,022	4024
Consumers Increased	1,071	373	358		
Average Annual Tier Cost	$ 74,938	$ 46,200	$ 24,798	$ 9,840	$ 34,607
Total Cost	$ 80,258,577	$ 17,232,779	$ 8,877,849		
Extra Annual Cost Due to Tier Jump Estimated	$ 21,353,577	$ 4,177,779	$ 3,582,313		
Total Cost Estimated due to Jumping the Tiers Annually	**$ 29,113,668**				

- **Cost Plan Rebasing**
  The initial calculation performed in December 2008 indicated that 7,000 consumers needed to be rebased and the annual savings were estimated at $40 million.

FY 2007-2008 Deficit

	Total Fund	GR/State Fund	Federal Match
FY 07-08 Appropriation	$959,823,565.98	$ 414,355,833.44	$ 545,467,732.55
Expenditures as of Sep 30, 2008	$940,390,451.17	$ 405,966,557.77	$ 534,423,893.40
Deficit from FY 06-07	$ 31,769,760.00	$ 13,715,005.39	$ 18,054,754.61
Total FY 07-08 SVC Paid	$972,160,211.17	$ 419,681,563.16	$ 552,478,648.01
FY 07-08 Final Deficit	**$ (12,336,645.19)**	**$ (5,325,729.73)**	**$ (7,010,915.46)**

FY 2008-2009 Final Deficit

	Total Fund	GR/State Fund	Federal Match
FY 08-09 Appropriation	$ 833,529,770	$ 269,730,234	$ 563,799,536
Expenditures as of Sep 30, 2008	$ 847,670,852	$ 274,306,288	$ 573,364,564
Deficit from FY 07-08	$ 12,336,645	$ 3,992,138	$ 8,344,507
Total FY 08-09 SVC Paid	$ 860,007,497	$ 278,298,426	$ 581,709,071
FY 08-09 Final Deficit	**$ (26,477,727)**	**$ (8,568,193)**	**$ (17,909,535)**

FY 2009-2010 Final Deficit

	Total Fund	GR/State Fund	Federal Match
FY 09-10Appropriation	$ 849,699,685	$ 274,962,818	$ 574,736,867
Amendments to Transfer Cash	$ 41,866,208	$ 13,547,905	$ 28,318,303
Total Available Fund	$ 891,565,893	$ 288,510,723	$ 603,055,170
Expenditures as of Sep 30, 2009	$ 909,890,893	$ 294,440,693	$ 615,450,200
Deficit from FY 08-09	$ (26,793,859)	$ (8,670,493)	$ (18,123,366)
Total FY 09-10 Services Paid	$ 936,684,752	$ 303,111,186	$ 633,573,566
FY 09-10 Final Deficit	**$ (45,118,859)**	**$ (14,600,463)**	**$ (30,518,396)**

Managed Long Term Care

Managed Long-term Care for Persons with Developmental Disabilities

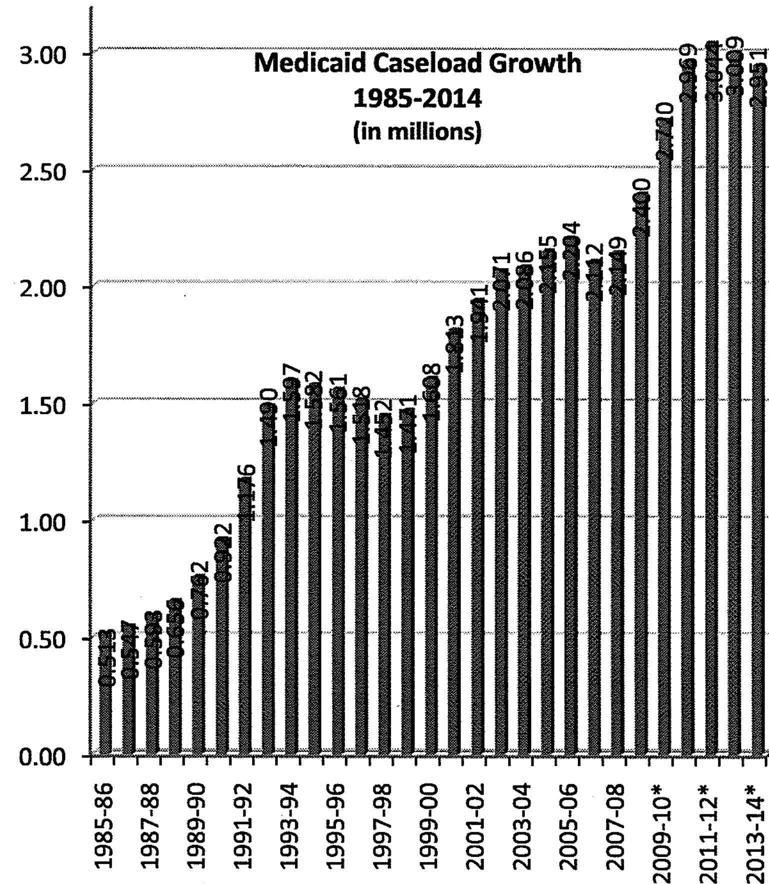
Health and Human Services Access Subcommittee

February 9, 2011

Facts about Florida Medicaid

- By the end of Fiscal Year 2011, more than 2.9 million Floridians will be enrolled.

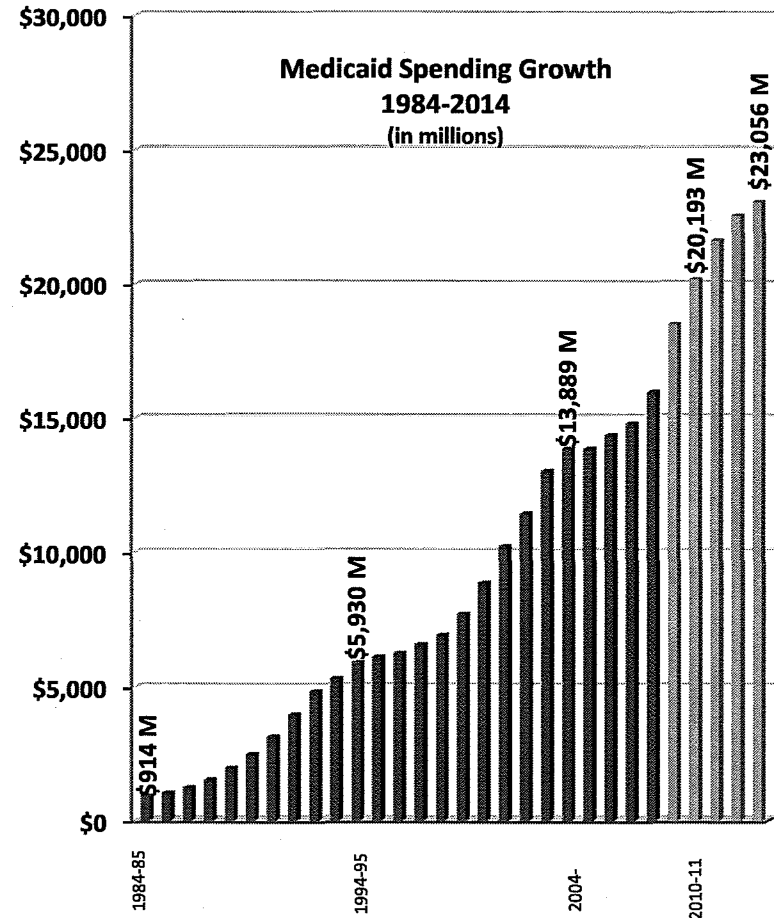
- Federal health reform is expected to increase enrollment to 5 million in 2014.



Facts about Florida Medicaid

- Medicaid is expected to spend $20.2 billion in Fiscal Year 2010-11, up 9.2% over the previous fiscal year despite $832.2 reductions authorized by the General Appropriations Act.

- By Fiscal Year 2013-14 the program is expected to grow to $23.1 billion. An additional $2.0 billion in state and federal dollars will be required to implement the Affordable Care Act.



Proposed Timeline

- Year 1: Waiver modifications;
- Year 2: Begin LTC plan procurement;
- Year 3: Complete LTC procurement and begin enrollment; begin medical care procurement;
- Year 4: Complete medical care procurement and begin enrollment; **begin procurement of DD plans;**
- Year 5: **Complete procurement of DD plans and begin enrollment.**

What is Managed Care?

- Managed care includes, but is more than HMOs.
- Managed care organizations include HMOs, provider service networks, preferred provider organizations, exclusive provider organizations, accountable health plans, medical homes, and others.
- Management techniques include:
  - Provider contracting;
  - Negotiated discounts;
  - Utilization management;
  - Care coordination;
  - Incentivizing quality improvement.

Managed Long-term Care for Persons with Developmental Disabilities

- APD is currently responsible for managing the care for Medicaid waiver enrollees.
- House proposal would create partnerships with managed care organizations to manage the care of enrollees.
- Managed care organizations would be a risk to provide needed services to enrollees.
- AHCA would provide capitated payments to managed care organizations based on risk adjusted actuarially sound rates.

Managed Long-term care for Persons with Developmental Disabilities

- Administration: Program to be administered by AHCA in partnership with APD.
- Enrollment: 30,000 current Medicaid waiver participants and residents of private institutional care facilities (ICF/DD).
- Eligibility criteria: Same as current four-tier Medicaid waiver.

Managed Long-term care for Persons with Developmental Disabilities

- Two types of Plans:
  - Comprehensive plan – includes medical assistance and home and community based care services;
  - Developmental disabilities long-term care plans – only includes home and community based care services.
- Benefits: essentially the same home and community based services in current Medicaid waiver program.

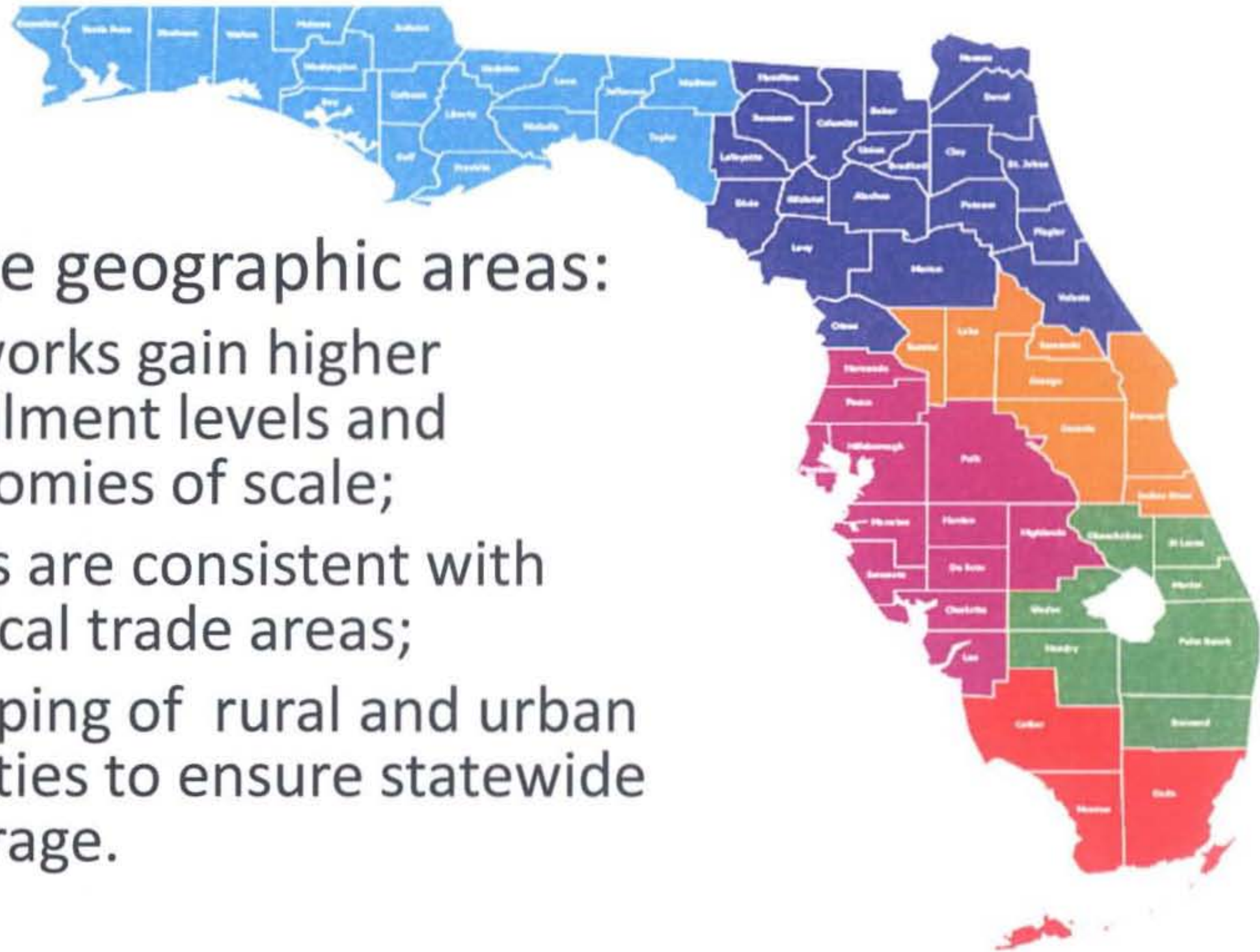
Managed Long-term care for Persons with Developmental Disabilities

- Qualified plans:
  - Only provider service networks and Childrens Medical Services may offer long-term care plans for DD;
  - HMOs and other insurers can offer comprehensive plans that include long-term care plans for DD.
- Provider service networks: must have ownership with 10 yrs experience working with DD population.

Managed Long-term care for Persons with Developmental Disabilities

- AHCA will procure specific number of plans per region.
- At least one provider service network must be procured per region.
- Examples of preferences in selection criteria:
  - Expertise and experience with DD population;
  - Plans that offer consumer directed care services;
  - Comprehensive plans that offer DD long-term care.

What regions might look like...



- Six large geographic areas:
  - Networks gain higher enrollment levels and economies of scale;
  - Areas are consistent with medical trade areas;
  - Grouping of rural and urban counties to ensure statewide coverage.

Managed Long-term care for Persons with Developmental Disabilities

- Medical Loss Ratio: At least 92% of premium revenue must be spent by the plans on covered services.
- For comprehensive plans, savings from coordinated medical care will need to be reinvested in HCBS due to the 92% requirement.

Managed Long-term care for Persons with Developmental Disabilities

- Plan Networks:
  - Must demonstrate adequate provider coverage.
  - To minimize disruptions, all licensed residential providers and institutions (ICF/DDs) must be offered contracts.
  - Consumer and family involvement in program design and oversight.

- Performance Measurement
  - Plans must have metrics for measuring provider performance.
  - Providers must demonstrate quality and performance for continued network participation.

Managed Long-term care for Persons with Developmental Disabilities

- Provider payments:
  - Most rates negotiated between plans and providers;
  - Institutional care (ICF/DD) and intensive behavior provider rates will be set by AHCA.
- Managed Care Plan payment
  - Risk adjusted, actuarially sound capitated rates based on historical utilization of services;
  - 5 level of care payments.

HB 7223 Summary and Bill

Summary of HB 7223 and HB 7225, Engrossed

I. The House Medicaid proposal consists of two bills:

a. **HB 7223** creates a new part and numerous new sections of law in Chapter 409 that will be phased in over a 5-year period.

b. **HB 7225** makes date-specific, conforming changes to current law (e.g., set expiration dates for certain sections of existing law). The bill also authorizes some immediate changes in the Medicaid program.

II. The Florida Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care. AHCA is authorized to apply for and implement waivers necessary for this program.

III. General provisions that apply across the Medicaid program:

a. **All Medicaid recipients are enrolled in managed care** unless explicitly exempt. Exempt populations include those who receive limited benefits (e.g. women only eligible for family planning or breast and cervical cancer cervices; aliens eligible for emergency services).

b. **Plans qualified** to participate include

i. provider service networks (**PSN**),

ii. exclusive provider organizations,

iii. health maintenance organizations (**HMO**),

iv. health insurers

c. Plans may target special populations based on age, medical condition or diagnosis, but **all plans must cover or arrange for all services** for enrollees. The bill eliminates the existence of "carve-out" plans.

d. In order to ensure plans have a sufficient number of enrollees to be viable, a limited number of plans will be selected through a **competitive selection process**.

   i. Each region will have a **minimum** number of plans (3-5).

   ii. Each region will have a **maximum** number of plans (7-10).

   iii. Each region will have a **guaranteed participation for one or two PSNs**, provided there are responsive bidders, to ensure consumer choice and competition between different models of managed care (PSN v HMO).

   iv. Each region will have a guaranteed number of plans for the developmentally disabled population (2-6).

e. Medicaid payment rates will be negotiated as part of the selection process but will be based on historic utilization and spending, adjusted for clinical risk ("**risk adjusted rates**").

f. **In addition to price**, the competitive selection process will also evaluate a managed care organization's

   i. Accreditation;

   ii. Experience with similar populations;

   iii. Availability and accessibility of primary care providers;

   iv. Community partnerships that create re-investment opportunities;

   v. Commitment to quality improvement;

   vi. Additional benefits, particularly dental care, disease management and other enhanced services;

   vii. History of voluntary or involuntary withdrawals.

viii. Pre-bid agreements with physicians to meet network requirements or provide sufficient compensation to meet network requirements over the 5-year contract term.

ix. Pre-bid agreements with select providers of critical services required to participate in the chosen plans in each program (e.g., teaching hospitals, nursing homes and ICF/DDs).

g. **Preference** will be given in the competitive selection process to

i. Organizations that are **medical homes**. Plans must assist and incentivize primary care providers to become medical homes.

ii. Organizations that **recruit minority providers**.

iii. Organizations that cover both acute and long term care services.

h. Plans will be selected on a **regional basis**

i. **The Panhandle Region:** Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington

1. The smallest region with a little more than 200,000 current Medicaid enrollees. Region 1 would be capped at a maximum of 3 managed care plans.

ii. **The North Central/ Northeast Florida Region:** Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, Union, Volusia.

iii. **The West Central Florida Region:** Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, Sarasota.

1. The largest region, with nearly 700,000 current Medicaid enrollees.

iv. **The Central Florida Region:** Brevard, Lake, Orange, Osceola, Seminole, Sumter.

v. **The Southeast Florida Region:** Broward, Hendry, Indian River, Martin, Okeechobee, Palm Beach, St. Lucie.

vi. **The South Florida Region:** Collier, Miami-Dade, Monroe

Medical/Long Term	**Area 1**	**Area 2**	**Area 3**	**Area 4**	**Area 5**	**Area 6**	**Total Statewide**
Total Enrollees	203,337	433,428	692,564	370,747	426,008	552,024	2,678,108
Minimum plans	3	4	5	4	4	5	25
PSN plans if responsive	1	1	2	1	1	2	8
Maximum plans	3	7	10	8	7	9	44
DD plans Min – Max (1 PSN each)	2	2 – 5	3 – 6	3 – 6	3 – 6	3 – 6	16 – 31

i. Managed care plans will be held **accountable**.

i. AHCA will establish 5-year contracts with **no renewals**.

ii. Plans will be required to **pay for emergency services**.

iii. Plans will be required to meet **network adequacy standards** and maintain an accurate database of providers online and accessible to AHCA and the public. The public will have the opportunity to post feedback about providers.

iv. **Performance standards** will be established and raised over the term of the contract.

v. Plans will be required to maintain program integrity functions including specific activities that **reduce fraud and abuse**:

1. Provider credentialing and monitoring

2. Prepayment and post payment reviews;

3. Reporting procedures;

4. Mandatory compliance plans;

5. Designation of a program integrity compliance officer.

vi. **Grievance resolution process** will be required and AHCA will maintain a process for those recipient complaints that are not resolved by the plans.

vii. **Penalties for reducing enrollment or early withdrawal**, including reimbursement of transition costs and a fine of up to 5% of the capitation payment.

viii. **Specific requirements for enrollment, choice counseling, automatic assignment and disenrollment are established**. When a recipient with a specific condition or diagnosis does not choose a plan, the recipient will be automatically enrolled into a specialty plan if one is available.

ix. Plans must provide **30-days written notice to recipients** prior to the recipient's provider being excluded from the plan for failure to meet quality or performance criteria.

x. **Ongoing Medicaid encounter data analysis** by AHCA to determine whether there has been systemic under-utilization, inappropriate utilization, or systemic claim denials.

xi. **Repayment of intergovernmental transfers** is guaranteed by ensuring that providers are paid the exact amount the agency determines and are paid within 15 days.

IV. Specific provisions that apply to managed medical assistance – primary and acute care

a. **Implementation** shall begin January 1, 2012, with full implementation by **October 1, 2013**.

b. Enrollment

i. All non-exempt Medicaid recipients will be required to enroll in a managed care organization (PSN, HMO).

ii. Exempt persons who may **voluntarily enroll** include:
   1. Recipients with other creditable coverage.
   2. Recipients in residential placements.
   3. Refugee assistance recipients.
   4. Residents of a developmental disability center

iii. Fee-for-service Medicaid is maintained only for exempt persons and those who may, but do not, voluntarily enroll.

c. Benefits

i. All current mandatory and optional services.

ii. Plans may customize benefits, subject to review by AHCA.

iii. Plans are required to maintain an enhanced benefits program.

d. **Children's Medical Services** is a qualified plan statewide and exempt from competitive procurement, but must meet other plan requirements.

e. **Accountability measures** specific to managed medical assistance

i. **Medical loss ratio** thresholds

   1. Less than 75% = payback up to 85% and no auto-enrollment

   2. 75%-85% = payback up to 85%

   3. Greater than 92% = evaluation to determine effectiveness of care management

4. 95% or more and determined to be failing to adequately manage care = no auto-enrollment

ii. Plans are required to have specific p**rograms for pregnant women and infants**.

iii. Plans must achieve an **EPSDT screening** rate of at least 80%.

f. **Rules** for plans and providers:

i. **Plans may** limit providers

1. Must offer a contract in first period to:

a. FQHCs
b. Medical home primary care providers
c. Select providers of critical services

2. After 12 months, these providers may be excluded for failure to meet quality standards

ii. **Providers may** limit plans, but providers with special state-granted designations must agree to contract with qualified plans:

1. Statutory teaching hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)

2. Trauma hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)

3. RIPCCs (must ensure that center has adequate medical staff to fulfill contractual obligations)

4. Specialty licensed children's hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)

5. Providers with an active Medicaid agreement and CON (hospitals and hospices)

iii. **Hospital payments** must be a minimum of the Medicaid rate up to 150% of Medicaid unless approved by AHCA.

iv. Requires **performance measurement** of providers with transparent metrics.

v. The **Medicaid Resolution Board** will resolve disputes between plans and hospitals, and plans and hospital medical staff.

g. **Medically needy** recipients shall be enrolled in managed care.

i. Plans **must accept and provide 12 months continuous eligibility** to Medically Needy enrollees;

ii. Enrollees must **pay the premium up to their share of cost**; contingent on federal approval

iii. Plans must provide at least a **120-day grace period** before disenrolling for failure to pay premiums.

V. Specific provisions that apply to long-term care

a. **Implementation** will begin July 1, 2011, and be complete in all regions by October 1, 2012.

b. **Eligibility**

i. Medicaid recipients who are 65+ or disabled and meet level of care standards as determined by CARES

ii. All recipients in a nursing facility or enrolled in a waiver on the day managed care plans become available in their region

c. Two **types of plans**

   i. Comprehensive plans that combine medical and home and community based services

   ii. Long-term care plans that only provide home and community based services

d. Long-term care managed care **plan requirements**

   i. Must provide both residential care (nursing facility or other) and a comprehensive range of home and community based services.

   ii. Medicare plans are qualified plans for long-term care managed care.

   iii. PACE plans are qualified but exempt from procurement.

   iv. Qualified plans must have specialized staffing with experience in serving elders and the disabled.

   v. A limited number of plans are selected in specific regions.

   vi. Follow specific standards for availability and accessibility of home and community based services.

e. **Home and community based care**:

   i. **Payment rates** reflect an adjustment to create incentives for keeping individuals out of nursing homes as long as possible; at least 3% up to 5% re-balancing of nursing home and home and community based care is expected each year.

   ii. **CARES staff** will continue to evaluate whether an individual needs a nursing facility level of care and will initially assign the individual to a level of care.

f. **Medical loss ratio** thresholds

i. Less than 75% = payback up to 85% and no auto-enrollment

ii. 75% - 85% = payback up to 85%

iii. Greater than 92% = evaluation to determine effectiveness of care management

iv. 95% or more and determined to be failing to adequately manage care = no auto-enrollment

g. Auto-assignments can be quality based.

h. **Preservation of roles for traditional aging service providers**

i. Aging Resources Centers will be a community access point for seniors seeking services and will either offer choice counseling to enrollees through a contract with AHCA, or will work cooperatively with choice counseling vendors.

ii. Plans must include all nursing homes and hospices and these providers are must agree to participate in a plan's network if offered a contract.

iii. Nursing homes and hospices will receive a "pass through" payment for services from the plan.

iv. A plan's network must include:

1. Adult Day Center Centers
2. Adult Family Care Homes
3. Assisted Living Facilities
4. Health Care Services Pools
5. Home Health Agencies
6. Homemaker and Companion Services
7. Hospices
8. Lead Agencies
9. Nurse Registries
10. Nursing Homes

i. **Hospice Services**

   i. Recipients referred for hospice services will have 30 days to select another plan to access a preferred hospice

VI. Specific provisions that apply to developmental disabilities

a. **Implementation** will begin January 1, 2014, and be complete in all regions by October 1, 2015.

b. Two **types of plans**

   i. Comprehensive plans that combine medical and home and community based services

   ii. Long-term care plans that only provide home and community based services

c. **Eligibility**

   i. Criteria are the same as the current Medicaid waiver program and the Intermediate Care for the Developmental Disabilities program.

   ii. All recipients of these services on the date the plans become available in their region will be eligible to enroll in the Plans.

d. The **benefits** that will be required of participating plans are substantially the same as those currently offered under the four-tier Medicaid waiver program and the Intermediate Care for Developmental Disabilities program.

e. To be **qualified**, a managed care plan must

   i. Have staffing with experience serving persons with developmental disabilities

ii. Provider service networks must include certain licensed residential providers with 10 years of experience in developmental disabilities.

iii. Plans must involve consumers and families in design and oversight of plans.

iv. Plans must contract with all residential providers upon implementation of the new program to ensure no disruption in living situations.

v. AHCA will give preference to those plans that have pre-bid agreements with providers to meet network requirements.

vi. Plans must provide 90-days' written notice to recipients prior to the recipient's provider being excluded from the plan for failure to meet quality or performance criteria.

f. **Medical loss ratio** thresholds

i. At least 92% of premiums must be spent on direct care cost and services

g. **Payment**

i. AHCA will pay plans based on five specific levels of care for enrolled individuals.

ii. APD will perform the initial assessment and assignment of persons into levels of care.

iii. Rates paid to intermediate care for the developmental disabilities facilities and intensive behavior residential habilitation facilities will be determined by AHCA.

h. Residents of Sunland Marianna, Tacachale and the mentally retarded defendant program are exempt from mandatory enrollment in the new program, but may voluntarily enroll if they so choose.

VII. Immediate changes to begin transition of current Medicaid system

a. The agency is directed to seek an **extension and modification of the 1115 waiver**.

b. The **reform pilot is expanded to Miami-Dade County**, beginning July 1, 2010, with full implementation expected by June 30, 2011.

c. **Payment** of existing managed care plans will change in two ways

  i. All plans (whether in reform counties or elsewhere in the state) will begin a **3-year transition to risk-adjusted rates**.

  ii. The agency will begin a 3-year process to modify the basis for setting capitation rates to include **consideration of encounter data**. AHCA is required to review available encounter data to establish actuarially sound rates prior to using the encounter data to adjust rates for prepaid plans.

  iii. Rates will be **immediately risk-adjusted for public hospitals** in Miami-Dade County

d. **Miami-Dade County IGTs are preserved** by directing the agency to develop a methodology, such as a supplemental capitation rate, to be paid to prepaid plans or providers under contract with trauma, children's or safety net hospitals.

e. All plans statewide (both in reform areas and elsewhere) are required to **develop enhanced benefit plans** and **report encounter data**.

f. All Medicaid recipients statewide will be permitted to use their Medicaid premium to **purchase private insurance**.

g. The agency will establish a **uniform method of accounting and reporting medical and non-medical expenses** and the plans will begin reporting.

h. Provisions for **designation of medical homes** are established.

i. **Prepaid PSNs are permitted to provide comprehensive behavioral health** and specific requirements are established for the reconciliation process that determines shared savings.

j. AHCA is required to contract with **prepaid dental plans** until the Medicaid Managed Medical Assistance prgram is fully implemented in all regions.

k. AHCA is **authorized to accept Medicare plans as Medicaid plans** and make appropriate payments for dually eligible enrollees. Medicare crossover providers can be enrolled as Medicaid providers for both payment and claims processing.

l. Area One of APD will participate in an **ibudget (individual budget) demonstration project** to test the effectiveness of the ibudget proposal serving people with developmental disabilities in the Medicaid program.

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

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29 providing limitations on serving recipients during the
30 pendency of litigation; providing that a qualified plan
31 that participates in an invitation to negotiate in more
32 than one region may not serve Medicaid recipients until
33 all administrative challenges are finalized; creating s.
34 409.967, F.S.; providing for managed care plan
35 accountability; establishing contract terms; providing for
36 contract extension under certain circumstances;
37 establishing payments to noncontract providers;
38 establishing requirements for access; requiring plans to
39 establish and maintain an electronic database;
40 establishing requirements for the database; requiring
41 plans to provide encounter data; requiring the agency to
42 establish performance standards for plans; providing
43 program integrity requirements; establishing a grievance
44 resolution process; providing for penalties for early
45 termination of contracts or reduction in enrollment
46 levels; creating s. 409.968, F.S.; establishing managed
47 care plan payments; providing payment requirements for
48 provider service networks; creating s. 409.969, F.S.;
49 requiring enrollment in managed care plans by specified
50 Medicaid recipients; creating requirements for plan
51 selection by recipients; providing for choice counseling;
52 establishing choice counseling requirements; authorizing
53 disenrollment under certain circumstances; defining the
54 term "good cause" for purposes of disenrollment; providing
55 time limits on an internal grievance process; providing
56 requirements for agency determination regarding

57 disenrollment; requiring recipients to stay in plans for a
58 specified time; creating s. 409.970, F.S.; requiring the
59 agency to maintain an encounter data system; providing
60 requirements for prepaid plans to submit data; creating s.
61 409.971, F.S.; creating the managed medical assistance
62 program; providing deadlines to begin and finalize
63 implementation of the program; creating s. 409.972, F.S.;
64 providing for mandatory and voluntary enrollment; creating
65 s. 409.973, F.S.; establishing minimum benefits for
66 managed care plans to cover; authorizing plans to
67 customize benefit packages; requiring plans to establish
68 enhanced benefits programs; providing terms for enhanced
69 benefits package; establishing reserve requirements for
70 plans to fund enhanced benefits programs; creating s.
71 409.974, F.S.; establishing a specified number of
72 qualified plans to be selected in each region;
73 establishing a deadline for issuing invitations to
74 negotiate; establishing quality selection criteria;
75 establishing the Children's Medical Service Network as a
76 qualified plan; creating s. 409.975; establishing managed
77 care plan accountability; creating a medical loss ratio
78 requirement; authorizing plans to limit providers in
79 networks; mandating certain providers be offered contracts
80 in the first year; requiring certain provider types to
81 participate in plans; requiring plans to monitor the
82 quality and performance history of providers; requiring
83 specified programs and procedures be established by plans;
84 establishing provider payments for hospitals; establishing

85 conflict resolution procedures; establishing the Medicaid
86 Resolution Board for specified purposes; establishing plan
87 requirements for medically needy recipients; creating s.
88 409.976, F.S.; providing for managed care plan payment;
89 requiring the agency to establish a methodology to ensure
90 certain types of payments to specified providers;
91 establishing eligibility for payments; requiring the
92 agency to establish payment rates for statewide inpatient
93 psychiatric programs; requiring payments to managed care
94 plans to be reconciled to reimburse actual payments to
95 statewide inpatient psychiatric programs; creating s.
96 409.977, F.S.; providing for enrollment; establishing
97 choice counseling requirements; providing for automatic
98 enrollment of certain recipients; establishing opt-out
99 opportunities for recipients; creating s. 409.978, F.S.;
100 requiring the Agency for Health Care Administration be
101 responsible for administering the long-term care managed
102 care program; providing implementation dates for the long-
103 term care managed care program; providing duties for the
104 Department of Elderly Affairs relating to assisting the
105 agency in implementing the program; creating s. 409.979,
106 F.S.; providing eligibility requirements for the long-term
107 care managed care program; creating s. 409.980, F.S.;
108 providing the benefits that a managed care plan shall
109 provide when participating in the long-term care managed
110 care program; creating s. 409.981, F.S.; providing
111 criteria for qualified plans; designating regions for plan
112 implementation throughout the state; providing criteria

113 for the selection of plans to participate in the long-term
114 care managed care program; creating s. 409.982, F.S.;
115 providing the agency shall establish a uniform accounting
116 and reporting methods for plans; providing spending
117 thresholds and consequences relating to spending
118 thresholds; providing for mandatory participation in plans
119 of certain service providers; providing providers can be
120 excluded from plans for failure to meet quality or
121 performance criteria; providing the plans must monitor
122 participating providers using specified criteria;
123 providing certain providers that must be included in plan
124 networks; providing provider payment specifications for
125 nursing homes and hospices; creating s. 409.983, F.S.;
126 providing for negotiation of rates between the agency and
127 the plans participating in the long-term care managed care
128 program; providing specific criteria for calculating and
129 adjusting plan payments; allowing the CARES program to
130 assign plan enrollees to a level of care ; providing
131 incentives for adjustments of payment rates; providing the
132 agency shall establish nursing facility-specific and
133 hospice services payment rates; creating s. 409.984, F.S.;
134 providing that prior to contracting with another vender,
135 the agency shall offer to contract with the aging resource
136 centers to provide choice counseling for the long-term
137 care managed care program; providing criteria for
138 automatic assignments of plan enrollees who fail to chose
139 a plan; creating s. 409.985, F.S.; providing that the
140 agency shall operate the Comprehensive Assessment and

141 Review for Long-Term Care Services program through an
142 interagency agreement with the Department of Elderly
143 Affairs; providing duties of the program; defining the
144 term "nursing facility care"; creating s. 409.986, F.S.;
145 providing authority and agency duties related to long-term
146 care plans; creating s. 409.987, F.S.; providing
147 eligibility requirements for long-term care plans;
148 creating s. 409.988, F.S.; providing benefits for long-
149 term care plans; creating s. 409.989, F.S.; establishing
150 criteria for qualified plans; specifying minimum and
151 maximum number of plans and selection criteria; creating
152 s. 409.990, F.S.; providing requirements for managed care
153 plan accountability; specifying limitations on providers
154 in plan networks; providing for evaluation and payment of
155 network providers; creating s. 409.991, F.S.; providing
156 for payment of managed care plans; providing duties for
157 the Agency for Persons with Disabilities to assign plan
158 enrollees into a payment rate level of care; establishing
159 level of care criteria; providing payment requirements for
160 intensive behavior residential habilitation providers and
161 intermediate care facilities for the developmentally
162 disabled; creating s. 409.992, F.S.; providing
163 requirements for enrollment and choice counseling;
164 specifying enrollment exceptions for certain Medicaid
165 recipients; providing an effective date.
166
167 Be It Enacted by the Legislature of the State of Florida:
168

169 Section 1. Sections 409.961 through 409.992, Florida
170 Statutes, are designated as part IV of chapter 409, Florida
171 Statutes, entitled "Medicaid Managed Care."
172 Section 2. Section 409.961, Florida Statutes, is created
173 to read:
174 409.961 Statutory construction; applicability; rules.—It
175 is the intent of the Legislature that if any conflict exists
176 between the provisions contained in this part and provisions
177 contained in other parts of this chapter, the provisions
178 contained in this part shall control. The provisions of ss.
179 409.961-409.970 apply only to the Medicaid managed medical
180 assistance program, long-term care managed care program, and
181 managed long-term care for persons with developmental
182 disabilities program, as provided in this part. The agency shall
183 adopt any rules necessary to comply with or administer this part
184 and all rules necessary to comply with federal requirements. In
185 addition, the department shall adopt and accept the transfer of
186 any rules necessary to carry out the department's
187 responsibilities for receiving and processing Medicaid
188 applications and determining Medicaid eligibility and for
189 ensuring compliance with and administering this part, as those
190 rules relate to the department's responsibilities, and any other
191 provisions related to the department's responsibility for the
192 determination of Medicaid eligibility.
193 Section 3. Section 409.962, Florida Statutes, is created
194 to read:
195 409.962 Definitions.—As used in this part, except as
196 otherwise specifically provided, the term:

197 (1) "Agency" means the Agency for Health Care
198 Administration. The agency is the Medicaid agency for the state,
199 as provided under federal law.
200 (2) "Benefit" means any benefit, assistance, aid,
201 obligation, promise, debt, liability, or the like, related to
202 any covered injury, illness, or necessary medical care, goods,
203 or services.
204 (3) "Direct care management" means care management
205 activities that involve direct interaction between providers and
206 patients.
207 (4) "Long-term care comprehensive plan" means a long-term
208 care plan that also provides the services described in s.
209 409.973.
210 (5) "Long-term care plan" means a specialty plan that
211 provides institutional and home and community-based services.
212 (6) "Long term care provider service network" means an
213 entity certified pursuant to s. 409.912(4)(d), of which a
214 controlling interest is owned by one or more licensed nursing
215 homes, assisted living facilities with 17 or more beds, home
216 health agencies, community care for the elderly lead agencies,
217 or hospices.
218 (7) "Managed care plan" means a qualified plan under
219 contract with the agency to provide services in the Medicaid
220 program.
221 (8) "Medicaid" means the medical assistance program
222 authorized by Title XIX of the Social Security Act, 42 U.S.C. s.
223 1396 et seq., and regulations thereunder, as administered in
224 this state by the agency.

225 (9) "Medicaid recipient" or "recipient" means an
226 individual who the department or, for Supplemental Security
227 Income, the Social Security Administration determines is
228 eligible pursuant to federal and state law to receive medical
229 assistance and related services for which the agency may make
230 payments under the Medicaid program. For the purposes of
231 determining third-party liability, the term includes an
232 individual formerly determined to be eligible for Medicaid, an
233 individual who has received medical assistance under the
234 Medicaid program, or an individual on whose behalf Medicaid has
235 become obligated.
236 (10) "Medical home network" means a qualified plan
237 designated by the agency as a medical home network in accordance
238 with the criteria established in s. 409.91207.
239 (11) "Prepaid plan" means a qualified plan that is
240 licensed or certified as a risk-bearing entity in the state and
241 is paid a prospective per-member, per-month payment by the
242 agency.
243 (12) "Provider service network" means an entity certified
244 pursuant to s. 409.912(4)(d) of which a controlling interest is
245 owned by a health care provider, or group of affiliated
246 providers, or a public agency or entity that delivers health
247 services. Health care providers include Florida-licensed health
248 care professionals or licensed health care facilities, federally
249 qualified health care centers, and home health care agencies.
250 (13) "Qualified plan" means a health insurer authorized
251 under chapter 624, an exclusive provider organization authorized
252 under chapter 627, a health maintenance organization authorized

253 under chapter 641, or a provider service network authorized
254 under s. 409.912(4)(d) that is eligible to participate in the
255 statewide managed care program.
256 (14) "Specialty plan" means a qualified plan that serves
257 Medicaid recipients who meet specified criteria based on age,
258 medical condition, or diagnosis.
259 Section 4. Section 409.963, Florida Statutes, is created
260 to read:
261 409.963 Single state agency.—The Agency for Health Care
262 Administration is designated as the single state agency
263 authorized to manage, operate, and make payments for medical
264 assistance and related services under Title XIX of the Social
265 Security Act. Subject to any limitations or directions provided
266 for in the General Appropriations Act, these payments shall be
267 made only for services included in the program, only on behalf
268 of eligible individuals, and only to qualified providers in
269 accordance with federal requirements for Title XIX of the Social
270 Security Act and the provisions of state law. This program of
271 medical assistance is designated as the "Medicaid program." The
272 department is responsible for Medicaid eligibility
273 determinations, including, but not limited to, policy, rules,
274 and the agreement with the Social Security Administration for
275 Medicaid eligibility determinations for Supplemental Security
276 Income recipients, as well as the actual determination of
277 eligibility. As a condition of Medicaid eligibility, subject to
278 federal approval, the agency and the department shall ensure
279 that each Medicaid recipient consents to the release of her or

280 his medical records to the agency and the Medicaid Fraud Control
281 Unit of the Department of Legal Affairs.
282 Section 5. Section 409.964, Florida Statutes is created to
283 read:
284 409.964 Managed care program; state plan; waivers.—The
285 Medicaid program is established as a statewide, integrated
286 managed care program for all covered services, including long-
287 term care services. The agency shall apply for and implement
288 state plan amendments or waivers of applicable federal laws and
289 regulations necessary to implement the program. Prior to seeking
290 a waiver, the agency shall provide public notice and the
291 opportunity for public comment and shall include public feedback
292 in the waiver application. The agency shall include the public
293 feedback in the application. The agency shall hold one public
294 meeting in each of the regions described in s. 409.966(2) and
295 the time period for public comment for each region shall end no
296 sooner than 30 days after the completion of the public meeting
297 in that region.
298 Section 6. Section 409.965, Florida Statutes, is created
299 to read:
300 409.965 Mandatory enrollment.—All Medicaid recipients
301 shall receive covered services through the statewide managed
302 care program, except as provided by this part pursuant to an
303 approved federal waiver. The following Medicaid recipients are
304 exempt from participation in the statewide managed care program:
305 (1) Women who are only eligible for family planning
306 services.

307 (2) Women who are only eligible for breast and cervical
308 cancer services.
309 (3) Persons who are eligible for emergency Medicaid for
310 aliens.
311 Section 7. Section 409.966, Florida Statutes, is created
312 to read:
313 409.966 Qualified plans; selection.—
314 (1) QUALIFIED PLANS.-Services in the Medicaid managed care
315 program shall be provided by qualified plans.
316 (a) A qualified plan may request the agency to designate
317 the plan as a medical home network if it meets the criteria
318 established in s. 409.91207.
319 (b) A provider service network must be capable of
320 providing all covered services to a mandatory Medicaid managed
321 care enrollee or may limit the provision of services to a
322 specific target population based on the age, chronic disease
323 state, or the medical condition of the enrollee to whom the
324 network will provide services. A specialty provider service
325 network must be capable of coordinating care and delivering or
326 arranging for the delivery of all covered services to the target
327 population. A provider service network may partner with an
328 insurer licensed under chapter 627 or a health maintenance
329 organization licensed under chapter 641 to meet the requirements
330 of a Medicaid contract.
331 (2) QUALIFIED PLAN SELECTION.-The agency shall select a
332 limited number of qualified plans to participate in the Medicaid
333 program using invitations to negotiate in accordance with s.
334 287.057(3)(a). At least 30 days prior to issuing an invitation

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335 to negotiate, the agency shall compile and publish a databook
336 consisting of a comprehensive set of utilization and spending
337 data for the 3 most recent contract years consistent with the
338 rate-setting periods for all Medicaid recipients by region or
339 county. The source of the data in the report shall include both
340 historic fee-for-service claims and validated data from the
341 Medicaid Encounter Data System. The report shall be made
342 available in electronic form and shall delineate utilization use
343 by age, gender, eligibility group, geographic area, and
344 aggregate clinical risk score. Separate and simultaneous
345 procurements shall be conducted in each of the following
346 regions:
347 (a) Region I, which shall consist of Bay, Calhoun,
348 Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson,
349 Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla,
350 Walton, and Washington Counties.
351 (b) Region II, which shall consist of Alachua, Baker,
352 Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler,
353 Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam,
354 St. Johns, Suwannee, Union, and Volusia Counties.
355 (c) Region III, which shall consist of Charlotte, DeSoto,
356 Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco,
357 Pinellas, Polk, and Sarasota Counties.
358 (d) Region IV, which shall consist of Brevard, Indian
359 River, Lake, Orange, Osceola, Seminole, and Sumter Counties.
360 (e) Region V, which shall consist of Broward, Glades,
361 Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

362 (f) Region VI, which shall consist of Collier, Dade, and
363 Monroe Counties.
364 (3) QUALITY SELECTION CRITERIA.-The invitation to
365 negotiate must specify the criteria and the relative weight of
366 the criteria that will be used for determining the acceptability
367 of the reply and guiding the selection of the organizations with
368 which the agency negotiates. In addition to criteria established
369 by the agency, the agency shall consider the following factors
370 in the selection of qualified plans:
371 (a) Accreditation by the National Committee for Quality
372 Assurance or another nationally recognized accrediting body.
373 (b) Experience serving similar populations, including the
374 organization's record in achieving specific quality standards
375 with similar populations.
376 (c) Availability and accessibility of primary care and
377 specialty physicians in the provider network.
378 (d) Establishment of community partnerships with providers
379 that create opportunities for reinvestment in community-based
380 services.
381 (e) Organization commitment to quality improvement and
382 documentation of achievements in specific quality improvement
383 projects, including active involvement by organization
384 leadership.
385 (f) Provision of additional benefits, particularly dental
386 care and disease management, and other enhanced-benefit
387 programs.
388 (g) History of voluntary or involuntary withdrawal from
389 any state Medicaid program or program area.

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390 (h) Evidence that a qualified plan has written agreements
391 or signed contracts or has made substantial progress in
392 establishing relationships with providers prior to the plan
393 submitting a response. The agency shall evaluate and give
394 special weight to such evidence, and the evaluation shall be
395 based on the following factors:
396 1. Contracts with primary and specialty physicians in
397 sufficient numbers to meet the specific standards established
398 pursuant to s. 409.967(2)(b).
399 2. Specific arrangements that provide evidence that the
400 compensation offered is sufficient to retain primary and
401 specialty physicians in sufficient numbers to continue to comply
402 with the standards established pursuant to s. 409.967(2)
403 throughout the 5-year contract term.
404 3. Contracts with community pharmacies located in rural
405 areas; contracts with community pharmacies servicing specialty
406 disease populations, including, but not limited to, HIV/AIDS
407 patients, hemophiliacs, patients suffering from end-stage renal
408 disease, diabetes, or cancer; community pharmacies located
409 within distinct cultural communities that reflect the unique
410 cultural dynamics of such communities, including, but not
411 limited to, languages spoken, ethnicities served, unique disease
412 states serviced, and geographic location within neighborhoods of
413 such culturally distinct populations; and community pharmacies
414 providing value-added services to patients, such as free
415 delivery, immunizations, disease management, diabetes education,
416 and medication utilization review.
417 4. Contracts with multiple and diverse suppliers of home

418 medical equipment and supplies distributed throughout the region
419 that ensure patient choice, continuity of services, and
420 redundant capacity to prevent service disruption during disaster
421 response. The network of home medical equipment and supply
422 providers shall include fully accredited and locally owned and
423 operated companies with a proven ability to provide quality
424 products, personalized service, 24-hour access to service, and
425 appropriate response time.
426
427 After negotiations are conducted, the agency shall select the
428 qualified plans that are determined to be responsive and provide
429 the best value to the state. Preference shall be given to
430 organizations designated as medical home networks pursuant to s.
431 409.91207 or organizations with the greatest number of primary
432 care providers that are recognized as patient-centered medical
433 homes by the National Committee for Quality Assurance or
434 organizations with networks that reflect recruitment of minority
435 physicians and other minority providers.
436 (4) ADMINISTRATIVE CHALLENGE.—Any qualified plan that
437 participates in an invitation to negotiate in more than one
438 region and is selected in at least one region may not begin
439 serving Medicaid recipients in any region for which it was
440 selected until all administrative challenges to procurements
441 required by this section to which the qualified plan is a party
442 have been finalized. For purposes of this subsection, an
443 administrative challenge is finalized if an order granting
444 voluntary dismissal with prejudice has been entered by any court
445 established under Article V of the State Constitution or by the

446 Division of Administrative Hearings, a final order has been
447 entered into by the agency and the deadline for appeal has
448 expired, a final order has been entered by the First District
449 Court of Appeal and the time to seek any available review by the
450 Florida Supreme Court has expired, or a final order has been
451 entered by the Florida Supreme Court and a warrant has been
452 issued.
453 Section 8. Section 409.967, Florida Statutes, is created
454 to read:
455 409.967 Managed care plan accountability.—
456 (1) The agency shall establish a 5-year contract with each
457 of the qualified plans selected through the procurement process
458 described in s. 409.966. A plan contract may not be renewed;
459 however, the agency may extend the terms of a plan contract to
460 cover any delays in transition to a new plan.
461 (2) The agency shall establish such contract requirements
462 as are necessary for the operation of the statewide managed care
463 program. In addition to any other provisions the agency may deem
464 necessary, the contract shall require:
465 (a) Emergency services.—Plans shall pay for services
466 required by ss. 395.1041 and 401.45 and rendered by a
467 noncontracted provider within 30 days after receipt of a
468 complete and correct claim. Plans must give providers of these
469 services a specific explanation for each claim denied for being
470 incomplete or incorrect. Providers shall have an opportunity to
471 resubmit corrected claims for reconsideration within 30 days
472 after receiving notice from the managed care plans of the claims
473 being incomplete or incorrect. Payments for noncontracted

474 emergency services and care shall be made at the rate the agency
475 would pay for such services from the same provider. Claims from
476 noncontracted providers shall be accepted by the qualified plan
477 for at least 1 year after the date the services are provided.
478 (b) Access.—The agency shall establish specific standards
479 for the number, type, and regional distribution of providers in
480 plan networks to ensure access to care. Each plan must maintain
481 a region-wide network of providers in sufficient numbers to meet
482 the access standards for specific medical services for all
483 recipients enrolled in the plan. Each plan shall establish and
484 maintain an accurate and complete electronic database of
485 contracted providers, including information about licensure or
486 registration, locations and hours of operation, specialty
487 credentials and other certifications, specific performance
488 indicators, and such other information as the agency deems
489 necessary. The database shall be available online to both the
490 agency and the public and shall have the capability to compare
491 the availability of providers to network adequacy standards and
492 to accept and display feedback from each provider's patients.
493 Each plan shall submit quarterly reports to the agency
494 identifying the number of enrollees assigned to each primary
495 care provider.
496 (c) Encounter data.—Each prepaid plan must comply with the
497 agency's reporting requirements for the Medicaid Encounter Data
498 System. The agency shall develop methods and protocols for
499 ongoing analysis of the encounter data that adjusts for
500 differences in characteristics of plans' enrollees to allow
501 comparison of service utilization among plans and against

502 expected levels of use. The analysis shall be used to identify
503 possible cases of systemic under-utilization or denials of
504 claims and inappropriate service utilization such as higher than
505 expected emergency department encounters. The analysis shall
506 provide periodic feedback to the plans and enable the agency to
507 establish corrective action plans when necessary. One of the
508 primary focus areas for the analysis shall be the use of
509 prescription drugs.
510 (d) Continuous improvement.—The agency shall establish
511 specific performance standards and expected milestones or
512 timelines for improving performance over the term of the
513 contract. Each plan shall establish an internal health care
514 quality improvement system, including enrollee satisfaction and
515 disenrollment surveys. The quality improvement system shall
516 include incentives and disincentives for network providers.
517 (e) Program integrity.—Each plan shall establish program
518 integrity functions and activities to reduce the incidence of
519 fraud and abuse, including, at a minimum:
520 1. A provider credentialing system and ongoing provider
521 monitoring;
522 2. An effective prepayment and postpayment review process
523 including, but not limited to, data analysis, system editing,
524 and auditing of network providers;
525 3. Procedures for reporting instances of fraud and abuse
526 pursuant to chapter 641;
527 4. Administrative and management arrangements or
528 procedures, including a mandatory compliance plan, designed to
529 prevent fraud and abuse; and

530 5. Designation of a program integrity compliance officer.
531 (f) Grievance resolution.—Each plan shall establish and
532 the agency shall approve an internal process for reviewing and
533 responding to grievances from enrollees consistent with the
534 requirements of s. 641.511. Each plan shall submit quarterly
535 reports on the number, description, and outcome of grievances
536 filed by enrollees. The agency shall maintain a process for
537 provider service networks consistent with s. 408.7056.
538 (g) Penalties.—Plans that reduce enrollment levels or
539 leave a region prior to the end of the contract term shall
540 reimburse the agency for the cost of enrollment changes and
541 other transition activities, including the cost of additional
542 choice counseling services. If more than one plan leaves a
543 region at the same time, costs shall be shared by the departing
544 plans proportionate to their enrollments. In addition to the
545 payment of costs, departing plans shall pay a per enrollee
546 penalty not to exceed 5 percent of 1 month's payment. Plans
547 shall provide the agency notice no less than 180 days prior to
548 withdrawing from a region.
549 (h) Prompt payment.—All managed care plans shall comply
550 with ss. 641.315, 641.3155, and 641.513.
551 (i) Electronic claims.-Plans shall accept electronic
552 claims in compliance with federal standards.
553 (j) Medical home development.-The managed care plan, if
554 not designated as a medical home network pursuant to s.
555 409.91207, must develop a plan to assist and to provide
556 incentives for its primary care providers to become recognized

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557 as patient-centered medical homes by the National Committee for
558 Quality Assurance.
559 Section 9. Section 409.968, Florida Statutes, is created
560 to read:
561 409.968 Managed care plan payment.—
562 (1) Prepaid plans shall receive per-member, per-month
563 payments negotiated pursuant to the procurements described in s.
564 409.966. Payments shall be risk-adjusted rates based on
565 historical utilization and spending data, projected forward, and
566 adjusted to reflect the eligibility category, geographic area,
567 and the clinical risk profile of the recipients.
568 (2) Beginning September 1, 2010, the agency shall update
569 the rate-setting methodology by initiating a transition to rates
570 based on statewide encounter data submitted by Medicaid managed
571 care plans pursuant to s. 409.970. Prior to this transition, the
572 agency shall conduct appropriate tests and establish specific
573 milestones in order to determine that the Medicaid Encounter
574 Data system consists of valid, complete, and sound data for a
575 sufficient period of time to provide a reliable basis for
576 establishing actuarially sound payment rates. The transition
577 shall be implemented within 3 years or less, and shall utilize
578 such other data sources as necessary and reliable to make
579 appropriate adjustments during the transition. The agency shall
580 establish a technical advisory panel to obtain input from the
581 prepaid plans regarding the incorporation of encounter data in
582 the rate setting process.
583 (3) Provider service networks may be prepaid plans and
584 receive per-member, per-month payments negotiated pursuant to

585 the procurement process described in s. 409.966. Provider
586 service networks that choose not to be prepaid plans shall
587 receive fee-for-service rates with a shared savings settlement.
588 The fee-for-service option shall be available to a provider
589 service network only for the first 5 years of the plan's
590 operation in a given region or until the contract year that
591 begins on October 1, 2015, whichever is later. The agency shall
592 annually conduct cost reconciliations to determine the amount of
593 cost savings achieved by fee-for-service provider service
594 networks for the dates of service within the period being
595 reconciled. Only payments for covered services for dates of
596 service within the reconciliation period and paid within 6
597 months after the last date of service in the reconciliation
598 period shall be included. The agency shall perform the necessary
599 adjustments for the inclusion of incurred but not reported
600 claims within the reconciliation period for claims that could be
601 received and paid by the agency after the 6-month claims
602 processing time lag. The agency shall provide the results of the
603 reconciliations to the fee-for-service provider service networks
604 within 45 days after the end of the reconciliation period. The
605 fee-for-service provider service networks shall review and
606 provide written comments or a letter of concurrence to the
607 agency within 45 days after receipt of the reconciliation
608 results. This reconciliation shall be considered final.
609 Section 10. Section 409.969, Florida Statutes, is created
610 to read:
611 409.969 Enrollment; choice counseling; automatic
612 assignment; disenrollment.—

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613 (1) ENROLLMENT.—All Medicaid recipients shall be enrolled
614 in a managed care plan unless specifically exempted in this
615 part. Each recipient shall have a choice of plans and may select
616 any available plan unless that plan is restricted by contract to
617 a specific population that does not include the recipient.
618 Medicaid recipients shall have 30 days in which to make a choice
619 of plans. All recipients shall be offered choice counseling
620 services in accordance with this section.
621 (2) CHOICE COUNSELING.—The agency shall provide choice
622 counseling for Medicaid recipients. The agency may contract for
623 the provision of choice counseling. Any such contract shall be
624 for a period of 5 years. The agency may renew a contract for an
625 additional 5-year period; however, prior to renewal of the
626 contract the agency shall hold at least one public meeting in
627 each of the regions covered by the choice counseling vendor. The
628 agency may extend the term of the contract to cover any delays
629 in transition to a new contractor. Printed choice information
630 and choice counseling shall be offered in the native or
631 preferred language of the recipient, consistent with federal
632 requirements. The manner and method of choice counseling shall
633 be modified as necessary to assure culturally competent,
634 effective communication with people from diverse cultural
635 backgrounds. The agency shall maintain a record of the
636 recipients who receive such services, identifying the scope and
637 method of the services provided. The agency shall make available
638 clear and easily understandable choice information to Medicaid
639 recipients that includes:

640 (a) An explanation that each recipient has the right to
641 choose a managed care plan at the time of enrollment in Medicaid
642 and again at regular intervals set by the agency, and that if a
643 recipient does not choose a plan, the agency will assign the
644 recipient to a plan according to the criteria specified in this
645 section.
646 (b) A list and description of the benefits provided in
647 each plan.
648 (c) An explanation of benefit limits.
649 (d) A current list of providers participating in the
650 network, including location and contact information.
651 (e) Plan performance data.
652 (3) DISENROLLMENT; GRIEVANCES.—After a recipient has
653 enrolled in a managed care plan, the recipient shall have 90
654 days to voluntarily disenroll and select another plan. After 90
655 days, no further changes may be made except for good cause. Good
656 cause includes, but is not limited to, poor quality of care,
657 lack of access to necessary specialty services, an unreasonable
658 delay or denial of service, or fraudulent enrollment. The agency
659 must make a determination as to whether good cause exists. The
660 agency may require a recipient to use the plan's grievance
661 process prior to the agency's determination of good cause,
662 except in cases in which immediate risk of permanent damage to
663 the recipient's health is alleged.
664 (a) The managed care plan internal grievance process, when
665 utilized, must be completed in time to permit the recipient to
666 disenroll by the first day of the second month after the month
667 the disenrollment request was made. If the result of the

668 grievance process is approval of an enrollee's request to
669 disenroll, the agency is not required to make a determination in
670 the case.
671 (b) The agency must make a determination and take final
672 action on a recipient's request so that disenrollment occurs no
673 later than the first day of the second month after the month the
674 request was made. If the agency fails to act within the
675 specified timeframe, the recipient's request to disenroll is
676 deemed to be approved as of the date agency action was required.
677 Recipients who disagree with the agency's finding that good
678 cause does not exist for disenrollment shall be advised of their
679 right to pursue a Medicaid fair hearing to dispute the agency's
680 finding.
681 (c) Medicaid recipients enrolled in a managed care plan
682 after the 90-day period shall remain in the plan for the
683 remainder of the 12-month period. After 12 months, the recipient
684 may select another plan. However, nothing shall prevent a
685 Medicaid recipient from changing primary care providers within
686 the plan during that period.
687 (d) On the first day of the next month after receiving
688 notice from a recipient that the recipient has moved to another
689 region, the agency shall automatically disenroll the recipient
690 from the plan the recipient is currently enrolled in and treat
691 the recipient as if the recipient is a new Medicaid enrollee. At
692 that time, the recipient may choose another plan pursuant to the
693 enrollment process established in this section.
694 Section 11. Section 409.970, Florida Statutes, is created
695 to read:

696 409.970 Encounter data.—The agency shall maintain and
697 operate the Medicaid Encounter Data System to collect, process,
698 store, and report on covered services provided to all Medicaid
699 recipients enrolled in prepaid plans. Prepaid plans shall submit
700 encounter data electronically in a format that complies with the
701 Health Insurance Portability and Accountability Act provisions
702 for electronic claims and in accordance with deadlines
703 established by the agency. Prepaid plans must certify that the
704 data reported is accurate and complete. The agency is
705 responsible for validating the data submitted by the plans. The
706 agency shall make encounter data available to those plans
707 accepting enrollees who are assigned to them from other plans
708 leaving a region.
709 Section 12. Section 409.971, Florida Statutes, is created
710 to read:
711 409.971 Managed medical assistance program.—The agency
712 shall make payments for primary and acute medical assistance and
713 related services using a managed care model. By January 1, 2012,
714 the agency shall begin implementation of the statewide managed
715 medical assistance program, with full implementation in all
716 regions by October 1, 2013.
717 Section 13. Section 409.972, Florida Statutes, is created
718 to read:
719 409.972 Mandatory and voluntary enrollment.—
720 (1) Persons eligible for the program known as "medically
721 needy" pursuant to s. 409.904(2)(a) shall enroll in managed care
722 plans. Medically needy recipients shall meet the share of cost

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723 by paying the plan premium, up to the share of cost amount,
724 contingent upon federal approval.
725 (2) The following Medicaid-eligible persons are exempt
726 from mandatory managed care enrollment required by s. 409.965,
727 and may voluntarily choose to participate in the managed medical
728 assistance program:
729 (a) Medicaid recipients who have other creditable health
730 care coverage, excluding Medicare.
731 (b) Medicaid recipients residing in residential commitment
732 facilities operated through the Department of Juvenile Justice,
733 group care facilities operated by the Department of Children and
734 Families, and treatment facilities funded through the Substance
735 Abuse and Mental Health program of the Department of Children
736 and Families.
737 (c) Persons eligible for refugee assistance.
738 (d) Medicaid recipients who are residents of a
739 developmental disability center including Sunland Center in
740 Marianna and Tacachale in Gainesville.
741 (3) Persons eligible for Medicaid but exempt from
742 mandatory participation who do not choose to enroll in managed
743 care shall be served in the Medicaid fee-for-service program as
744 provided in part III of this chapter.
745 Section 14. Section 409.973, Florida Statutes, is created
746 to read:
747 409.973 Benefits.—
748 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a
749 minimum, the following services:
750 (a) Advanced registered nurse practitioner services.

751 (b) Ambulatory surgical treatment center services.
752 (c) Birthing center services.
753 (d) Chiropractic services.
754 (e) Dental services.
755 (f) Early periodic screening diagnosis and treatment
756 services for recipients under age 21.
757 (g) Emergency services.
758 (h) Family planning services and supplies.
759 (i) Healthy start services.
760 (j) Hearing services.
761 (k) Home health agency services.
762 (l) Hospice services.
763 (m) Hospital inpatient services.
764 (n) Hospital outpatient services.
765 (o) Laboratory and imaging services.
766 (p) Medical supplies, equipment, prostheses, and orthoses.
767 (q) Mental health services.
768 (r) Nursing care.
769 (s) Optical services and supplies.
770 (t) Optometrist services.
771 (u) Physical, occupational, respiratory, and speech
772 therapy services.
773 (v) Physician services.
774 (w) Podiatric services.
775 (x) Prescription drugs.
776 (y) Renal dialysis services.
777 (z) Respiratory equipment and supplies.
778 (aa) Rural health clinic services.

779 (bb) Substance abuse treatment services.
780 (cc) Transportation to access covered services.
781 (2) CUSTOMIZED BENEFITS.—Managed care plans may customize
782 benefit packages for nonpregnant adults, vary cost-sharing
783 provisions, and provide coverage for additional services. The
784 agency shall evaluate the proposed benefit packages to ensure
785 services are sufficient to meet the needs of the plans'
786 enrollees and to verify actuarial equivalence.
787 (3) ENHANCED BENEFITS.—Each plan operating in the managed
788 medical assistance program shall establish an incentive program
789 that rewards specific healthy behaviors with credits in a
790 flexible spending account.
791 (a) At the discretion of the recipient, credits shall be
792 used to purchase otherwise uncovered health and related services
793 during the entire period of, and for a maximum of 3 years after,
794 the recipient's Medicaid eligibility, whether or not the
795 recipient remains continuously enrolled in the plan in which the
796 credits were earned.
797 (b) Enhanced benefits shall be structured to provide
798 greater incentives for those diseases linked with lifestyle and
799 conditions or behaviors associated with avoidable utilization of
800 high-cost services.
801 (c) To fund these credits, each plan must maintain a
802 reserve account in an amount of up to 2 percent of the plan's
803 Medicaid premium revenue, or benchmark premium revenue in the
804 case of provider service networks, based on an actuarial
805 assessment of the value of the enhanced benefits program.

806 Section 15. Section 409.974, Florida Statutes, is created
807 to read:
808 409.974 Qualified plans.—
809 (1) QUALIFIED PLAN SELECTION.-The agency shall select
810 qualified plans through the procurement described in s. 409.966.
811 The agency shall notice invitations to negotiate no later than
812 January 1, 2012.
813 (a) The agency shall procure three plans for Region I. At
814 least one plan shall be a provider service network, if any
815 provider service network submits a responsive bid.
816 (b) The agency shall procure at least four and no more
817 than seven plans for Region II. At least one plan shall be a
818 provider service network, if any provider service network
819 submits a responsive bid.
820 (c) The agency shall procure at least five plans and no
821 more than ten plans for Region III. At least two plans shall be
822 provider service networks, if any two provider service networks
823 submit a responsive bid.
824 (d) The agency shall procure at least four plans and no
825 more than eight plans for Region IV. At least one plan shall be
826 a provider service network if any provider service network
827 submits a responsive bid.
828 (e) The agency shall procure at least four plans and no
829 more than seven plans for Region V. At least one plan shall be a
830 provider service network, if any provider service network
831 submits a responsive bid.
832 (f) The agency shall procure at least five plans and no
833 more than ten plans for Region VI. At least two plans shall be

834 provider service networks, if any two provider service networks
835 submit a responsive bid.
836 If no provider service network submits a responsive bid, the
837 agency shall procure no more than one less than the maximum
838 number of qualified plans permitted in that region. Within 12
839 months after the initial invitation to negotiate, the agency
840 shall attempt to procure a qualified plan that is a provider
841 service network. The agency shall notice another invitation to
842 negotiate only with provider service networks in such region
843 where no provider service network has been selected.
844 (2) QUALITY SELECTION CRITERIA.-In addition to the
845 criteria established in s. 409.966, the agency shall consider
846 evidence that a qualified plan has written agreements or signed
847 contracts or has made substantial progress in establishing
848 relationships with providers prior to the plan submitting a
849 response. The agency shall evaluate and give special weight to
850 evidence of signed contracts with providers of critical services
851 pursuant to s. 409.975(3)(a)-(d). The agency shall also consider
852 whether the organization is a specialty plan. When all other
853 factors are equal, the agency shall consider whether the
854 organization has a contract to provide managed long-term care
855 services in the same region and shall exercise a preference for
856 such plans.
857 (3) CHILDREN'S MEDICAL SERVICES NETWORK.-The Children's
858 Medical Services Network authorized under chapter 391 is a
859 qualified plan for purposes of the managed medical assistance
860 program. Participation by the Children's Medical Services
861 Network shall be pursuant to a single, statewide contract with

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862 the agency that is not subject to the procurement requirements
863 or regional plan number limits of this section. The Children's
864 Medical Services Network must meet all other plan requirements
865 for the managed medical assistance program.
866 Section 16. Section 409.975, Florida Statutes, is created
867 to read:
868 409.975 Managed care plan accountability.—In addition to
869 the requirements of s. 409.967, plans and providers
870 participating in the managed medical assistance program shall
871 comply with the requirements of this section.
872 (1) MEDICAL LOSS RATIO.—The agency shall establish and
873 implement managed care plans that shall use a uniform method of
874 accounting for and reporting medical, direct care management,
875 and nonmedical costs. The agency shall evaluate plan spending
876 patterns beginning after the plan completes 2 full years of
877 operation and at least annually thereafter. The agency shall
878 implement the following thresholds and consequences of various
879 spending patterns:
880 (a) Plans that spend less than 75 percent of Medicaid
881 premium revenue on medical services and direct care management
882 as determined by the agency shall be excluded from automatic
883 enrollments and shall be required to pay back the amount between
884 actual spending and 85 percent of the Medicaid premium revenue.
885 (b) Plans that spend less than 85 percent of Medicaid
886 premium revenue on medical services and direct care management
887 as determined by the agency shall be required to pay back the
888 amount between actual spending and 85 percent of the Medicaid
889 premium revenue.

890 (c) Plans that spend more than 92 percent of Medicaid
891 premium revenue on medical services and direct care management
892 as determined by the agency shall be evaluated by the agency to
893 determine whether higher expenditures are the result of failures
894 in care management.
895 (d) Plans that spend 95 percent or more of Medicaid
896 premium revenue on medical services and direct care management
897 and are determined to be failing to appropriately manage care
898 shall be excluded from automatic enrollments.
899 (2) PROVIDER NETWORKS.—Plans may limit the providers in
900 their networks based on credentials, quality indicators, and
901 price. However, in the first contract period after a qualified
902 plan is selected in a region by the agency, the plan must offer
903 a network contract to the following providers in the region:
904 (a) Federally qualified health centers.
905 (b) Primary care providers certified as medical homes.
906 (c) Providers listed in paragraphs (3)(a)-(d).
907
908 After 12 months of active participation in a plan's network, the
909 plan may exclude any of the above-named providers from the
910 network for failure to meet quality or performance criteria. If
911 the plan excludes a provider from the plan, the plan must
912 provide written notice to all recipients who have chosen that
913 provider for care. The notice shall be provided at least 30 days
914 prior to the effective date of the exclusion.
915 (3) SELECT PROVIDER PARTICIPATION.—Providers may not be
916 required to participate in any qualified plan selected by the
917 agency except as provided in this subsection. The following

918 providers must agree to participate with each qualified plan
919 selected by the agency in the regions where they are located:
920 (a) Statutory teaching hospitals as defined in s.
921 408.07(45).
922 (b) Hospitals that are trauma centers as defined in s.
923 395.4001(14).
924 (c) Hospitals that are regional perinatal intensive care
925 centers as defined in s. 383.16(2).
926 (d) Hospitals licensed as specialty children's hospitals
927 as defined in s. 395.002(28).
928 (e) Hospitals with both an active Medicaid provider
929 agreement under s. 409.907 and a certificate of need.
930
931 The hospitals described in paragraphs (a)-(d) shall make
932 adequate arrangements for medical staff sufficient to fulfill
933 their contractual obligations with the plans.
934 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
935 quality and performance of each participating provider. At the
936 beginning of the contract period, each plan shall notify all its
937 network providers of the metrics used by the plan for evaluating
938 the provider's performance and determining continued
939 participation in the network.
940 (5) PREGNANCY AND INFANT HEALTH.—Each plan shall establish
941 specific programs and procedures to improve pregnancy outcomes
942 and infant health, including, but not limited to, coordination
943 with the Healthy Start program, immunization programs, and
944 referral to the Special Supplemental Nutrition Program for

945 Women, Infants, and Children, and the Children's Medical
946 Services program for children with special health care needs.
947 (6) SCREENING RATE.—Each plan shall achieve an annual
948 Early and Periodic Screening, Diagnosis, and Treatment Service
949 screening rate of at least 80 percent of those recipients
950 continuously enrolled for at least 8 months.
951 (7) PROVIDER PAYMENT.—Plans and hospitals shall negotiate
952 mutually acceptable rates, methods, and terms of payment. At a
953 minimum, plans shall pay hospitals the Medicaid rate. Payments
954 to hospitals shall not exceed 150 percent of the rate the agency
955 would have paid on the first day of the contract between the
956 provider and the plan, unless specifically approved by the
957 agency. Payment rates may be updated periodically.
958 (8) CONFLICT RESOLUTION.—In order to protect the continued
959 statewide operation of the Medicaid managed care program, the
960 Medicaid Resolution Board is established to resolve disputes
961 between managed care plans and hospitals and between managed
962 care plans and the medical staff of the providers listed in s.
963 409.975(3)(a)-(d). The board shall consist of two members
964 appointed by the Speaker of the House of Representatives, two
965 members appointed by the President of the Senate, and three
966 members appointed by the Governor. The costs of the board's
967 activities to review and resolve disputes shall be shared
968 equally by the parties to the dispute. Any managed care plan or
969 above-named provider may initiate a review by the board for any
970 conflict related to payment rates, contract terms, or other
971 conditions. The board shall make recommendations to the agency
972 regarding payment rates, procedures, or other contract terms to

973 resolve such conflicts. The agency may amend the terms of the
974 contracts with the parties to ensure compliance with these
975 recommendations. This process shall not be used to review and
976 reverse any managed care plan decision to exclude any provider
977 that fails to meet quality standards.
978 (9) MEDICALLY NEEDY ENROLLEES.—Each selected plan shall
979 accept any medically needy recipient who selects or is assigned
980 to the plan and provide that recipient with continuous
981 enrollment for 12 months. After the first month of qualifying as
982 a medically needy recipient and enrolling in a plan, and
983 contingent upon federal approval, the enrollee shall pay the
984 plan a portion of the monthly premium equal to the enrollee's
985 share of the cost as determined by the department. The agency
986 shall pay the remainder of the monthly premium. Plans must
987 provide a grace period of at least 120 days before disenrolling
988 recipients who fail to pay their shares of the premium.
989 Section 17. Section 409.976, Florida Statutes, is created
990 to read:
991 409.976 Managed care plan payment.—In addition to the
992 payment provisions of s. 409.968, the agency shall provide
993 payment to plans in the managed medical assistance program
994 pursuant to this section.
995 (1) Prepaid payment rates shall be negotiated between the
996 agency and the qualified plans as part of the procurement
997 described in s. 409.966.
998 (2) The agency shall develop a methodology to ensure the
999 availability of intergovernmental transfers in the statewide
1000 integrated managed care program to support providers that have

1001 historically served Medicaid recipients. Such providers include,
1002 but are not limited to, safety net providers, trauma hospitals,
1003 children's hospitals, statutory teaching hospitals, and medical
1004 and osteopathic physicians employed by or under contract with a
1005 medical school in this state. The agency may develop a
1006 supplemental capitation rate, risk pool, or incentive payment to
1007 plans that contract with these providers. A plan is eligible for
1008 a supplemental payment only if there are sufficient
1009 intergovernmental transfers available from allowable sources and
1010 the plan can demonstrate that it pays a reimbursement rate not
1011 less than the equivalent fee-for-service rate. The agency may
1012 develop the supplemental capitation rate to consider rates
1013 higher than the fee-for-service Medicaid rate when needed to
1014 ensure access and supported by funds provided by a locality. The
1015 agency shall evaluate the development of the rate cell to
1016 accurately reflect the underlying utilization to the maximum
1017 extent possible. This methodology may include interim rate
1018 adjustments as permitted under federal regulations. Any such
1019 methodology shall preserve federal funding to these entities and
1020 must be actuarially sound. In the absence of federal approval
1021 for the above methodology, the agency is authorized to set an
1022 enhanced rate and require that plans pay the enhanced rate, if
1023 the agency determines the enhanced rate is necessary to ensure
1024 access to care by the providers described in this subsection.
1025 The amount paid to the plans to make supplemental payments or to
1026 enhance provider rates pursuant to this subsection shall be
1027 reconciled to the exact amounts the plans are required to pay to
1028 providers. The plans shall make the designated payments to

1029 providers within 15 business days of notification by the agency
1030 regarding provider-specific distributions.
1031 (3) The agency shall establish payment rates for statewide
1032 inpatient psychiatric programs. Payments to managed care plans
1033 shall be reconciled to reimburse actual payments to statewide
1034 inpatient psychiatric programs.
1035 Section 18. Section 409.977, Florida Statutes, is created
1036 to read:
1037 409.977 Choice counseling and enrollment.—
1038 (1) CHOICE COUNSELING.-In addition to the choice
1039 counseling information required by s. 409.969, the agency shall
1040 make available clear and easily understandable choice
1041 information to Medicaid recipients that includes:
1042 (a) Information about earning credits in the plan's
1043 enhanced benefit program.
1044 (b) Information about cost sharing requirements of each
1045 plan.
1046 (2) AUTOMATIC ENROLLMENT.-The agency shall automatically
1047 enroll into a managed care plan those Medicaid recipients who do
1048 not voluntarily choose a plan pursuant to s. 409.969. The agency
1049 shall automatically enroll recipients in plans that meet or
1050 exceed the performance or quality standards established pursuant
1051 to s. 409.967, and shall not automatically enroll recipients in
1052 a plan that is deficient in those performance or quality
1053 standards. When a specialty plan is available to accommodate a
1054 specific condition or diagnosis of a recipient, the agency shall
1055 assign the recipient to that plan. The agency may not engage in
1056 practices that are designed to favor one managed care plan over

1057 another. When automatically enrolling recipients in plans, the
1058 agency shall automatically enroll based on the following
1059 criteria:
1060 (a) Whether the plan has sufficient network capacity to
1061 meet the needs of the recipients.
1062 (b) Whether the recipient has previously received services
1063 from one of the plan's primary care providers.
1064 (c) Whether primary care providers in one plan are more
1065 geographically accessible to the recipient's residence than
1066 those in other plans.
1067 (3) OPT-OUT OPTION.-The agency shall develop a process to
1068 enable any recipient with access to employer-sponsored insurance
1069 to opt out of all qualified plans in the Medicaid program and to
1070 use Medicaid financial assistance to pay for the recipient's
1071 share of the cost in any such plan. Contingent upon federal
1072 approval, the agency shall also enable recipients with access to
1073 other insurance or related products providing access to health
1074 care services created pursuant to state law, including any
1075 product available under the Cover Florida Health Access Program,
1076 the Florida Health Choices Program, or any health exchange, to
1077 opt out. The amount of financial assistance provided for each
1078 recipient may not exceed the amount of the Medicaid premium that
1079 would have been paid to a plan for that recipient.
1080 Section 19. Section 409.978, Florida Statutes, is created
1081 to read:
1082 409.978 Long-term care managed care program.—
1083 (1) Pursuant to s. 409.963, the agency shall administer
1084 the long-term care managed care program described in ss.

1085 409.978-409.985, but may delegate specific duties and
1086 responsibilities for the program to the Department of Elderly
1087 Affairs and other state agencies. By July 1, 2011, the agency
1088 shall begin implementation of the statewide long-term care
1089 managed care program, with full implementation in all regions by
1090 October 1, 2012.
1091 (2) The agency shall make payments for long-term care,
1092 including home and community-based services, using a managed
1093 care model. Unless otherwise specified, the provisions of ss.
1094 409.961-409.970 apply to the long-term care managed care
1095 program.
1096 (3) The Department of Elderly Affairs shall assist the
1097 agency to develop specifications for use in the invitation to
1098 negotiate and the model contract; determine clinical eligibility
1099 for enrollment in managed long-term care plans; monitor plan
1100 performance and measure quality of service delivery; assist
1101 clients and families to address complaints with the plans;
1102 facilitate working relationships between plans and providers
1103 serving elders and disabled adults; and perform other functions
1104 specified in a memorandum of agreement.
1105 Section 20. Section 409.979, Florida Statutes, is created
1106 to read:
1107 409.979 Eligibility.—
1108 (1) Medicaid recipients who meet all of the following
1109 criteria are eligible to participate in the long-term care
1110 managed care program. The recipient must be:
1111 (a) Sixty-five years of age or older or eligible for
1112 Medicaid by reason of a disability.

1113 (b) Determined by the Comprehensive Assessment Review and
1114 Evaluation for Long-Term Care Services (CARES) Program to
1115 require nursing facility care.
1116 (2) Medicaid recipients who on the date long-term care
1117 managed care plans becomes available in the recipient's region,
1118 are residing in a nursing home facility or enrolled in one of
1119 the following long-term care Medicaid waiver programs are
1120 eligible to participate in the long-term care managed care
1121 program:
1122 (a) The Assisted Living for the Frail Elderly Waiver.
1123 (b) The Aged and Disabled Adult Waiver.
1124 (c) The Adult Day Health Care Waiver.
1125 (d) The Consumer-Directed Care Plus Program as described
1126 in s. 409.221.
1127 (e) The Program of All-inclusive Care for the Elderly.
1128 (f) The Long-Term Care Community-Based Diversion Pilot
1129 Project as described in s. 430.705.
1130 (g) The Channeling Services Waiver for Frail Elders.
1131 Section 21. Section 409.980, Florida Statutes, is created
1132 to read:
1133 409.980 Benefits.—Managed care plans shall cover, at a
1134 minimum, the following services:
1135 (1) Nursing facility.
1136 (2) Assisted living facility.
1137 (3) Hospice.
1138 (4) Adult day care.
1139 (5) Medical equipment and supplies, including incontinence
1140 supplies.

1141 (5) Personal care.
1142 (7) Home accessibility adaptation.
1143 (9) Behavior management.
1144 (9) Home delivered meals.
1145 (10) Case management.
1146 (11) Therapies:
1147 (a) Occupational therapy
1148 (b) Speech therapy
1149 (c) Respiratory therapy
1150 (d) Physical therapy.
1151 (12) Intermittent and skilled nursing.
1152 (13) Medication administration.
1153 (14) Medication management.
1154 (15) Nutritional assessment and risk reduction.
1155 (16) Caregiver training.
1156 (17) Respite care.
1157 (18) Transportation.
1158 (19) Personal emergency response system.
1159 Section 22. Section 409.981, Florida Statutes, is created
1160 to read:
1161 409.981 Qualified plans.—
1162 (1) QUALIFIED PLANS.—For purposes of the long-term care
1163 managed care program, qualified plans also include entities who
1164 are qualified under 42 C.F.R. part 422 as Medicare Advantage
1165 Preferred Provider Organizations, Medicare Advantage Provider-
1166 sponsored Organizations, and Medicare Advantage Special Needs
1167 Plans. Such plans are eligible to participate in the statewide
1168 long-term care managed care program. Qualified plans that are

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1169 provider service networks must be long-term care provider
1170 service networks. Qualified plans may either be long-term care
1171 plans that cover benefits pursuant to s. 409.980, or
1172 comprehensive long-term care plans that cover benefits pursuant
1173 to ss. 409.973 and 409.980.
1174 (2) QUALIFIED PLAN SELECTION.—The agency shall select
1175 qualified plans through the procurement described in s. 409.966.
1176 The agency shall notice invitations to negotiate no later than
1177 July 1, 2011.
1178 (a) The agency shall procure three plans for Region I. At
1179 least one plan shall be a provider service network, if any
1180 submit a responsive bid.
1181 (b) The agency shall procure at least four and no more
1182 than seven plans for Region II. At least one plan shall be a
1183 provider service network, if any submit a responsive bid.
1184 (c) The agency shall procure at least five plans and no
1185 more than ten plans for Region III. At least two plans shall be
1186 provider service networks, if any two submit a responsive bid.
1187 (d) The agency shall procure at least four plans and no
1188 more than eight plans for Region IV. At least one plan shall be
1189 a provider service network if any submit a responsive bid.
1190 (e) The agency shall procure at least four plans and no
1191 more than seven plans for Region V. At least one plan shall be a
1192 provider service network, if any submit a responsive bid.
1193 (f) The agency shall procure at least five plans and no
1194 more than ten plans for Region VI. At least two plans shall be
1195 provider service networks, if any two submit a responsive bid.

1196 If no provider service network submits a responsive bid, the
1197 agency shall procure one less qualified plan in each of the
1198 regions. Within 12 months after the initial invitation to
1199 negotiate, the agency shall attempt to procure a qualified plan
1200 that is a provider service network. The agency shall notice
1201 another invitation to negotiate only with provider service
1202 networks in such region where no provider service network has
1203 been selected.
1204 (3) QUALITY SELECTION CRITERIA.—In addition to the criteria
1205 established in s. 409.966, the agency shall consider the
1206 following factors in the selection of qualified plans:
1207 (a) Specialized staffing. Plan employment of executive
1208 managers with expertise and experience in serving aged and
1209 disabled persons who require long-term care.
1210 (b) Network qualifications. Plan establishment of a
1211 network of service providers dispersed throughout the region and
1212 in sufficient numbers to meet specific service standards
1213 established by the agency for specialty services for persons
1214 receiving home and community-based care.
1215 (c) Whether a plan is proposing to establish a
1216 comprehensive long-term care plan and whether the qualified plan
1217 has a contract to provide managed medical assistance services in
1218 the same region. The agency shall exercise a preference for such
1219 plans.
1220 (d) Whether a plan is designated as a medical home network
1221 pursuant to s. 409.91207 or offers consumer-directed care
1222 services to enrollees pursuant to s. 409.221. Consumer-directed
1223 care services provide a flexible budget which is managed by

1224 enrolled individuals and their families or representatives and
1225 allows them to choose providers of services, determine provider
1226 rates of payment and direct the delivery of services to best
1227 meet their special long-term care needs. When all other factors
1228 are equal among competing qualified plans, the agency shall
1229 exercise a preference for such plans.
1230 (e) Evidence that a qualified plan has written agreements
1231 or signed contracts or has made substantial progress in
1232 establishing relationships with providers prior to the plan
1233 submitting a response. The agency shall evaluate and give
1234 special weight to evidence of signed contracts with providers of
1235 critical services pursuant to s. 409.982(2)(a)-(c).
1236 (4) PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.—The
1237 Program for All-Inclusive Care for the Elderly (PACE) is a
1238 qualified plan for purposes of the long-term care managed care
1239 program. Participation by PACE shall be pursuant to a contract
1240 with the agency and not subject to the procurement requirements
1241 or regional plan number limits of this section. PACE plans may
1242 continue to provide services to individuals at such levels and
1243 enrollment caps as authorized by the General Appropriations Act.
1244 Section 23. Section 409.982, Florida Statutes, is created
1245 to read:
1246 409.982 Managed care plan accountability.—In addition to
1247 the requirements of s. 409.967, plans and providers
1248 participating in the long-term care managed care program shall
1249 comply with the requirements of this section.
1250 (1) MEDICAL LOSS RATIO.—The agency shall establish and
1251 plans shall use a uniform method of accounting and reporting

1252 long-term care service costs, direct care management costs, and
1253 administrative costs. The agency shall evaluate plan spending
1254 patterns beginning after the plan completes 2 full years of
1255 operation and at least annually thereafter. The agency shall
1256 implement the following thresholds and consequences of various
1257 spending patterns:
1258 (a) Plans that spend less than 75 percent of Medicaid
1259 premium revenue on long-term care services, including direct
1260 care management as determined by the agency shall be excluded
1261 from automatic enrollments and shall be required to pay back the
1262 amount between actual spending and 85 percent of the Medicaid
1263 premium revenue.
1264 (b) Plans that spend less than 85 percent of Medicaid
1265 premium revenue on long-term care services, including direct
1266 care management as determined by the agency shall be required to
1267 pay back the amount of the difference between actual spending
1268 and 85 percent of Medicaid premium revenue.
1269 (c) Plans that spend more than 92 percent of Medicaid
1270 premium revenue on long-term care services, including direct
1271 care management as determined by the agency, shall be evaluated
1272 by the agency to determine whether higher expenditures are the
1273 result of failures in care management.
1274 (d) Plans that spend 95 percent or more of Medicaid
1275 premium revenue on long-term care services, including direct
1276 care management as determined by the agency, and are determined
1277 to be failing to appropriately manage care shall be excluded
1278 from automatic enrollments.
1279 (2) PROVIDER NETWORKS.—Plans may limit the providers in

1280 their networks based on credentials, quality indicators, and
1281 price. However, in the first contract period after a qualified
1282 plan is selected in a region by the agency, the plan must offer
1283 a network contract to the following providers in the region:
1284 (a) Nursing homes.
1285 (b) Hospices.
1286 (c) Aging network service providers that have previously
1287 participated in home and community-based waivers serving elders
1288 or community-service programs administered by the Department of
1289 Elderly Affairs.
1290
1291 After 12 months of active participation in a plan's network, the
1292 plan may exclude any of the providers named in this subsection
1293 from the network for failure to meet quality or performance
1294 criteria. If the plan excludes a provider from the plan, the
1295 plan must provide written notice to all recipients who have
1296 chosen that provider for care. The notice shall be provided at
1297 least 30 days prior to the effective date of the exclusion.
1298 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
1299 this subsection, providers may limit the plans they join.
1300 Nursing homes and hospices must participate in all qualified
1301 plans selected by the agency in the region in which the provider
1302 is located.
1303 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
1304 quality and performance of each participating provider. At the
1305 beginning of the contract period, each plan shall notify all its
1306 network providers of the metrics used by the plan for evaluating

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1307 the provider's performance and determining continued
1308 participation in the network.
1309 (5) PROVIDER NETWORK STANDARDS.—The agency shall establish
1310 and each plan must comply with specific standards for the
1311 number, type, and regional distribution of providers in the
1312 plan's network, which must include:
1313 (a) Adult day centers.
1314 (b) Adult family care homes.
1315 (c) Assisted living facilities.
1316 (d) Health care services pools.
1317 (e) Home health agencies.
1318 (f) Homemaker and companion services.
1319 (g) Hospices.
1320 (h) Community Care for the Elderly Lead Agencies.
1321 (i) Nurse registries.
1322 (j) Nursing homes.
1323 (6) PROVIDER PAYMENT.—Plans and providers shall negotiate
1324 mutually acceptable rates, methods, and terms of payment. Plans
1325 shall pay nursing homes an amount equal to the nursing facility-
1326 specific payment rates set by the agency. Plans shall pay
1327 hospice providers an amount equal to the per diem rate set by
1328 the agency. For recipients residing in a nursing facility and
1329 receiving hospice services, the plan shall pay the hospice
1330 provider the per diem rate set by the agency minus the nursing
1331 facility component and shall pay the nursing facility the
1332 appropriate state rate.
1333 Section 24. Section 409.983, Florida Statutes, is created
1334 to read:

1335 409.983 Managed care plan payment.—In addition to the
1336 payment provisions of s. 409.968, the agency shall provide
1337 payment to plans in the long-term care managed care program
1338 pursuant to this section.
1339 (1) Prepaid payment rates for long-term care managed care
1340 plans shall be negotiated between the agency and the qualified
1341 plans as part of the procurement described in s. 409.966.
1342 (2) Payment rates for comprehensive long-term care plans
1343 covering services described in s. 409.973 shall be combined with
1344 rates for long-term care plans for services specified in s.
1345 409.980.
1346 (3) Payment rates for plans shall reflect historic
1347 utilization and spending for covered services projected forward
1348 and adjusted to reflect the level of care profile for enrollees
1349 of each plan. The payment shall be adjusted to provide an
1350 incentive for reducing institutional placements and increasing
1351 the utilization of home and community-based services.
1352 (4) The initial assessment of an enrollee's level of care
1353 shall be made by the Comprehensive Assessment and Review for
1354 Long-Term-Care Services (CARES) program, which shall assign the
1355 recipient into one of the following levels of care:
1356 (a) Level of care 1 consists of recipients residing in
1357 nursing homes or needing immediate placement in a nursing home.
1358 (b) Level of care 2 consists of recipients who require the
1359 constant availability of routine medical and nursing treatment
1360 and care, and require extensive health-related care and services
1361 because of mental or physical incapacitation.
1362 (c) Level of care 3 consists of recipients who require the

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1363 constant availability of routine medical and nursing treatment
1364 and care, have a limited need for health-related care and
1365 services, are mildly medically or physically incapacitated, and
1366 have a priority score of 5 or above.
1367
1368 The agency shall periodically adjust payment rates to account
1369 for changes in the level of care profile for each plan based on
1370 encounter data.
1371 (5) The incentive adjustment for reducing institutional
1372 placements shall be modified in each successive rate period
1373 during the contract in order to encourage a progressive
1374 rebalancing of the spending distribution for institutional and
1375 community services. The expected change toward more home and
1376 community-based services shall be at least a 3 percent, up to a
1377 5 percent, annual increase in the ratio of home and community-
1378 based service expenditures compared to nursing facility
1379 expenditures.
1380 (6) The agency shall establish nursing facility-specific
1381 payment rates for each licensed nursing home based on facility
1382 costs adjusted for inflation and other factors. Payments to
1383 long-term care managed care plans shall be reconciled to
1384 reimburse actual payments to nursing facilities.
1385 (7) The agency shall establish hospice payment rates.
1386 Payments to long-term care managed care plans shall be
1387 reconciled to reimburse actual payments to hospices.
1388 Section 25. Section 409.984, Florida Statutes, is created
1389 to read:
1390 409.984 Choice counseling; enrollment.—

1391 (1) CHOICE COUNSELING.—Before contracting with a vendor to
1392 provide choice counseling as authorized under s. 409.969, the
1393 agency shall offer to contract with aging resource centers
1394 established under s. 430.2053 for choice counseling services. If
1395 the aging resource center is determined not to be the vendor
1396 that provides choice counseling, the agency shall establish a
1397 memorandum of understanding with the aging resource center to
1398 coordinate staffing and collaborate with the choice counseling
1399 vendor.
1400 (2) AUTOMATIC ENROLLMENT.—The agency shall automatically
1401 enroll into a long-term care managed care plan those Medicaid
1402 recipients who do not voluntarily choose a plan pursuant to s.
1403 409.969. The agency shall automatically enroll recipients in
1404 plans that meet or exceed the performance or quality standards
1405 established pursuant to s. 409.967, and shall not automatically
1406 enroll recipients in a plan that is deficient in those
1407 performance or quality standards. The agency shall assign
1408 individuals who are deemed dually eligible for Medicaid and
1409 Medicare to a plan that provides both Medicaid and Medicare
1410 services. The agency may not engage in practices that are
1411 designed to favor one managed care plan over another. When
1412 automatically enrolling recipients in plans, the agency shall
1413 take into account the following criteria:
1414 (a) Whether the plan has sufficient network capacity to
1415 meet the needs of the recipients.
1416 (b) Whether the recipient has previously received services
1417 from one of the plan's home and community-based service
1418 providers.

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1419 (c) Whether the home and community-based providers in one
1420 plan are more geographically accessible to the recipient's
1421 residence than those in other plans.
1422 (3) Notwithstanding the provisions of s. 409.969(3)(c),
1423 when a recipient is referred for hospice services, the recipient
1424 shall have a 30-day period during which the recipient may select
1425 to enroll in another plan to access the hospice provider of the
1426 recipient's choice.
1427 Section 26. Section 409.985, Florida Statutes, is created
1428 to read:
1429 409.985 Comprehensive Assessment and Review for Long-Term
1430 Care Services (CARES) Program.—
1431 (1) The agency shall operate the Comprehensive Assessment
1432 and Review for Long-Term Care Services (CARES) preadmission
1433 screening program to ensure that only individuals whose
1434 conditions require long-term care services are enrolled in the
1435 long-term care managed care program.
1436 (2) The agency shall operate the CARES program through an
1437 interagency agreement with the Department of Elderly Affairs.
1438 The agency, in consultation with the Department of Elderly
1439 Affairs, may contract for any function or activity of the CARES
1440 program, including any function or activity required by 42
1441 C.F.R. part 483.20, relating to preadmission screening and
1442 review.
1443 (3) The CARES program shall determine if an individual
1444 requires nursing facility care and, if the individual requires
1445 such care, assign the individual to a level of care as described
1446 in s. 409.983(4). For the purposes of the long-term care managed

1447 care program, "nursing facility care" means the individual:
1448 (a) Requires the constant availability of routine medical
1449 and nursing treatment and care, and requires extensive health-
1450 related care and services because of mental or physical
1451 incapacitation; or
1452 (b) Requires the constant availability of routine medical
1453 and nursing treatment and care, has a limited need for health-
1454 related care and services, is mildly medically or physically
1455 incapacitated, and has a priority score of 5 or above.
1456 (4) For individuals whose nursing home stay is initially
1457 funded by Medicare and Medicare coverage is being terminated for
1458 lack of progress towards rehabilitation, CARES staff shall
1459 consult with the person making the determination of progress
1460 toward rehabilitation to ensure that the recipient is not being
1461 inappropriately disqualified from Medicare coverage. If, in
1462 their professional judgment, CARES staff believes that a
1463 Medicare beneficiary is still making progress toward
1464 rehabilitation, they may assist the Medicare beneficiary with an
1465 appeal of the disqualification from Medicare coverage. The use
1466 of CARES teams to review Medicare denials for coverage under
1467 this section is authorized only if it is determined that such
1468 reviews qualify for federal matching funds through Medicaid. The
1469 agency shall seek or amend federal waivers as necessary to
1470 implement this section.
1471 Section 27. Section 409.986, Florida Statutes, is created
1472 to read:
1473 409.986 Managed long-term care for persons with
1474 developmental disabilities.—

1475 (1) Pursuant to s. 409.963, the agency is responsible for
1476 administering the long-term care managed care program for
1477 persons with developmental disabilities described in ss.
1478 409.986-409.992, but may delegate specific duties and
1479 responsibilities for the program to the Agency for Persons with
1480 Disabilities and other state agencies. By January 1, 2014, the
1481 agency shall begin implementation of statewide long-term care
1482 managed care for persons with developmental disabilities, with
1483 full implementation in all regions by October 1, 2015.
1484 (2) The agency shall make payments for long-term care for
1485 persons with developmental disabilities, including home and
1486 community-based services, using a managed care model. Unless
1487 otherwise specified, the provisions of ss. 409.961-409.970 apply
1488 to the long-term care managed care program for persons with
1489 developmental disabilities.
1490 (3) The Agency for Persons with Disabilities shall assist
1491 the agency to develop the specifications for use in the
1492 invitations to negotiate and the model contract; determine
1493 clinical eligibility for enrollment in long-term care plans for
1494 persons with developmental disabilities; assist the agency to
1495 monitor plan performance and measure quality; assist clients and
1496 families to address complaints with the plans; facilitate
1497 working relationships between plans and providers serving
1498 persons with developmental disabilities; and perform other
1499 functions specified in a memorandum of agreement.
1500 Section 28. Section 409.987, Florida Statutes, is created
1501 to read:
1502 409.987 Eligibility.—

1503 (1) Medicaid recipients who meet all of the following
1504 criteria are eligible to be enrolled in a developmental
1505 disabilities comprehensive long-term care plan or developmental
1506 disabilities long-term care plan:
1507 (a) Medicaid eligible pursuant to income and asset tests
1508 in state and federal law.
1509 (b) A Florida resident who has a developmental disability
1510 as defined in s. 393.063.
1511 (c) Meets the level of care need including:
1512 1. The recipient's intelligence quotient is 59 or less;
1513 2. The recipient's intelligence quotient is 60-69,
1514 inclusive, and the recipient has a secondary handicapping
1515 condition that includes cerebral palsy, spina bifida, Prader-
1516 Willi syndrome, epilepsy, or autism; or ambulation, sensory,
1517 chronic health, and behavioral problems;
1518 3. The recipient's intelligence quotient is 60-69,
1519 inclusive, and the recipient has severe functional limitations
1520 in at least three major life activities including self-care,
1521 learning, mobility, self-direction, understanding and use of
1522 language, and capacity for independent living; or
1523 4. The recipient is eligible under a primary disability of
1524 autism, cerebral palsy, spina bifida, or Prader-Willi syndrome.
1525 In addition, the condition must result in substantial functional
1526 limitations in three or more major life activities, including
1527 self-care, learning, mobility, self-direction, understanding and
1528 use of language, and capacity for independent living.
1529 (d) Meets the level of care need for services in an
1530 intermediate care facility for the developmentally disabled.

1531 (e) Is enrolled or has been offered enrollment in one of
1532 the four tier waivers established in s. 393.0661(3) or the
1533 recipient is a Medicaid-funded resident of a private
1534 intermediate care facility for the developmentally disabled on
1535 the date the managed long-term care plans for persons with
1536 disabilities become available in the recipient's region or the
1537 recipient has been offered enrollment in a developmental
1538 disabilities comprehensive long-term care plan or developmental
1539 disabilities long-term care plan.
1540 (2) Unless specifically exempted, all eligible persons
1541 must be enrolled in a developmental disabilities comprehensive
1542 long-term care plan or a developmental disabilities long-term
1543 care plan. Medicaid recipients who are residents of a
1544 developmental disability center, including Sunland Center in
1545 Marianna and Tacachale Center in Gainesville, are exempt from
1546 mandatory enrollment but may voluntarily enroll in a long-term
1547 care plan.
1548 Section 29. Section 409.988, Florida Statutes, is created
1549 to read:
1550 409.988 Benefits.-Managed care plans shall cover, at a
1551 minimum, the services in this section. Plans may customize
1552 benefit packages or offer additional benefits to meet the needs
1553 of enrollees in the plan.
1554 (1) Intermediate care for the developmentally disabled.
1555 (2) Alternative residential services, including, but not
1556 limited to:
1557 (a) Group homes and foster care homes licensed pursuant to
1558 chapters 393 and 409.

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1559 (b) Comprehensive transitional education programs licensed
1560 pursuant to chapter 393.
1561 (c) Residential habilitation centers licensed pursuant to
1562 chapter 393.
1563 (d) Assisted living facilities, and transitional living
1564 facilities licensed pursuant to chapters 400 and 429.
1565 (3) Adult day training.
1566 (4) Behavior analysis services.
1567 (5) Companion services.
1568 (6) Consumable medical supplies.
1569 (7) Durable medical equipment and supplies.
1570 (8) Environmental accessibility adaptations.
1571 (9) In-home support services.
1572 (10) Therapies, including occupational, speech,
1573 respiratory, and physical therapy.
1574 (11) Personal care assistance.
1575 (12) Residential habilitation services.
1576 (13) Intensive behavioral residential habilitation
1577 services.
1578 (14) Behavior focus residential habilitation services.
1579 (15) Residential nursing services.
1580 (16) Respite care.
1581 (17) Case management.
1582 (18) Supported employment.
1583 (19) Supported living coaching.
1584 (20) Transportation.
1585 Section 30. Section 409.989, Florida Statutes, is created
1586 to read:

1587 409.989 Qualified plans.—
1588 (1) QUALIFIED PLANS.—Qualified plans that are a provider
1589 service network or the Children's Medical Services Network
1590 authorized under chapter 391 may be either developmental
1591 disabilities long-term care plans that cover benefits pursuant
1592 to s. 409.988, or developmental disabilities comprehensive long-
1593 term care plans that cover benefits pursuant to ss. 409.973 and
1594 409.988. Other qualified plans may only be developmental
1595 disabilities comprehensive long-term care plans that cover
1596 benefits pursuant to ss. 409.973 and 409.988.
1597 (2) SPECIALTY PROVIDER SERVICE NETWORKS.—Provider service
1598 networks targeted to serve persons with disabilities must
1599 include one or more owners licensed pursuant to s. 393.067 or s.
1600 400.962 and with at least 10 years experience in serving this
1601 population.
1602 (3) QUALIFIED PLAN SELECTION.—The agency shall select
1603 qualified plans through the procurement described in s. 409.966.
1604 The agency shall notice invitations to negotiate no later than
1605 January 1, 2014.
1606 (a) The agency shall procure two plans for Region I. At
1607 least one plan shall be a provider service network, if any
1608 submit a responsive bid.
1609 (b) The agency shall procure at least two and no more than
1610 five plans for Region II. At least one plan shall be a provider
1611 service network, if any submit a responsive bid.
1612 (c) The agency shall procure at least three plans and no
1613 more than six plans for Region III. At least one plan shall be a
1614 provider service network, if any submit a responsive bid.

1615 (d) The agency shall procure at least three plans and no
1616 more than six plans for Region IV. At least one plan shall be a
1617 provider service network if any submit a responsive bid.
1618 (e) The agency shall procure at least three plans and no
1619 more than six plans for Region V. At least one plan shall be a
1620 provider service network, if any submit a responsive bid.
1621 (f) The agency shall procure at least three plans and no
1622 more than six plans for Region VI. At least one plan shall be a
1623 provider service network, if any submit a responsive bid.
1624 If no provider service network submits a responsive bid, the
1625 agency shall procure no more than one less than the maximum
1626 number of qualified plans permitted in that region. Within 12
1627 months after the initial invitation to negotiate, the agency
1628 shall attempt to procure a qualified plan that is a provider
1629 service network. The agency shall notice another invitation to
1630 negotiate only with provider service networks in such region
1631 where no provider service network has been selected.
1632 (4) QUALITY SELECTION CRITERIA.—In addition to the
1633 criteria established in s. 409.966, the agency shall consider
1634 the following factors in the selection of qualified plans:
1635 (a) Specialized staffing. Plan employment of executive
1636 managers with expertise and experience in serving persons with
1637 developmental disabilities.
1638 (b) Network qualifications. Plan establishment of a
1639 network of service providers dispersed throughout the region and
1640 in sufficient numbers to meet specific accessibility standards
1641 established by the agency for specialty services for persons
1642 with developmental disabilities.

1643 (c) Whether the plan has proposed to be a developmental
1644 disabilities comprehensive long-term care plan and has a
1645 contract to provide managed medical assistance services in the
1646 same region. The agency shall exercise a preference for such
1647 plans.
1648 (d) Whether the plan offers consumer-directed care
1649 services to enrollees pursuant to s. 409.221. Consumer-directed
1650 care services provide a flexible budget which is managed by
1651 enrolled individuals and their families or representatives and
1652 allows them to choose providers of services, determine provider
1653 rates of payment and direct the delivery of services to best
1654 meet their special long-term care needs. When all other factors
1655 are equal among competing qualified plans, the agency shall
1656 exercise a preference for such plans.
1657 (e) Evidence that a qualified plan has written agreements
1658 or signed contracts or has made substantial progress in
1659 establishing relationships with providers prior to the plan
1660 submitting a response. The agency shall evaluate and give
1661 special weight to evidence of signed contracts with providers of
1662 critical services pursuant to s. 409.990(2)a)-(b).
1663 (5) CHILDREN'S MEDICAL SERVICES NETWORK.—The Children's
1664 Medical Services Network authorized under chapter 391 is a
1665 qualified plan for purposes of the developmental disabilities
1666 long-term care plans and developmental disabilities
1667 comprehensive long-term care plans. Participation by the
1668 Children's Medical Services Network shall be pursuant to a
1669 single, statewide contract with the agency not subject to the
1670 procurement requirements or regional plan number limits of this

1671 section. The Children's Medical Services Network must meet all
1672 other plan requirements.
1673 Section 31. Section 409.990, Florida Statutes, is created
1674 to read:
1675 409.990 Managed care plan accountability.—In addition to
1676 the requirements of s. 409.967, qualified plans and providers
1677 shall comply with the requirements of this section.
1678 (1) MEDICAL LOSS RATIO.—The agency shall establish and
1679 plans shall use a uniform method of accounting and reporting
1680 long-term care service costs, direct care management costs, and
1681 administrative costs. The agency shall evaluate plan spending
1682 patterns beginning after the plan completes 2 full years of
1683 operation and at least annually thereafter. The agency shall
1684 implement the following thresholds and consequences of various
1685 spending patterns:
1686 (a) Plans that spend less than 75 percent of Medicaid
1687 premium revenue on long-term care services, including direct
1688 care management as determined by the agency shall be excluded
1689 from automatic enrollments and shall be required to pay back the
1690 amount between actual spending and 92 percent of the Medicaid
1691 premium revenue.
1692 (b) Plans that spend less than 92 percent of Medicaid
1693 premium revenue on long-term care services, including direct
1694 care management as determined by the agency shall be required to
1695 pay back the amount between actual spending and 92 percent of
1696 the Medicaid premium revenue.
1697 (2) PROVIDER NETWORKS.—Plans may limit the providers in
1698 their networks based on credentials, quality indicators, and

1699 price. However, in the first contract period after a qualified
1700 plan is selected in a region by the agency, the plan must offer
1701 a network contract to the following providers in the region:
1702 (a) Providers with licensed institutional care facilities
1703 for the developmentally disabled.
1704 (b) Providers of alternative residential facilities
1705 specified in s.409.988.
1706
1707 After 12 months of active participation in a plan's network, the
1708 plan may exclude any of the above-named providers from the
1709 network for failure to meet quality or performance criteria. If
1710 the plan excludes a provider from the plan, the plan must
1711 provide written notice to all recipients who have chosen that
1712 provider for care. The notice shall be issued at least 90 days
1713 before the effective date of the exclusion.
1714 (3) SELECT PROVIDER PARTICIPATION.—Except as provided in
1715 this subsection, providers may limit the plans they join.
1716 Licensed institutional care facilities for the developmentally
1717 disabled with an active Medicaid provider agreement must agree
1718 to participate in any qualified plan selected by the agency in
1719 the region in which the provider is located.
1720 (4) PERFORMANCE MEASUREMENT.—Each plan shall monitor the
1721 quality and performance of each participating provider. At the
1722 beginning of the contract period, each plan shall notify all its
1723 network providers of the metrics used by the plan for evaluating
1724 the provider's performance and determining continued
1725 participation in the network.

1726 (5) PROVIDER PAYMENT.—Plans and providers shall negotiate
1727 mutually acceptable rates, methods, and terms of payment. Plans
1728 shall pay intermediate care facilities for the developmentally
1729 disabled an amount equal to the facility-specific payment rate
1730 set by the agency.
1731 (6) CONSUMER AND FAMILY INVOLVEMENT.—Plans must establish
1732 a family advisory committee to participate in program design and
1733 oversight.
1734 Section 32. Section 409.991, Florida Statutes, is created
1735 to read:
1736 409.991 Managed care plan payment.—In addition to the
1737 payment provisions of s. 409.968, the agency shall provide
1738 payment to developmental disabilities comprehensive long-term
1739 care plans and developmental disabilities long-term care plans
1740 pursuant to this section.
1741 (1) Prepaid payment rates shall be negotiated between the
1742 agency and the qualified plans as part of the procurement
1743 described in s. 409.966.
1744 (2) Payment for developmental disabilities comprehensive
1745 long-term care plans covering services pursuant to s. 409.973
1746 shall be combined with payments for developmental disabilities
1747 long-term care plans for services specified in s. 409.988.
1748 (3) Payment rates for plans covering service specified in
1749 s. 409.988 shall be based on historical utilization and spending
1750 for covered services projected forward and adjusted to reflect
1751 the level of care profile of each plan's enrollees.
1752 (4) The Agency for Persons with Disabilities shall conduct
1753 the initial assessment of an enrollee's level of care. The

1754 evaluation of level of care shall be based on assessment and
1755 service utilization information from the most recent version of
1756 the Questionnaire for Situational Information and encounter
1757 data.
1758 (5) Payment rates for developmental disabilities long-term
1759 care plans shall be classified into five levels of care to
1760 account for variations in risk status and service needs among
1761 enrollees.
1762 (a) Level of care 1 consists of individuals receiving
1763 services in an intermediate care facility for the
1764 developmentally disabled.
1765 (b) Level of care 2 consists of individuals with intensive
1766 medical or adaptive needs and that are essential for avoiding
1767 institutionalization, or who possess behavioral problems that
1768 are exceptional in intensity, duration, or frequency and present
1769 a substantial risk of harm to themselves or others.
1770 (c) Level of care 3 consists of individuals with service
1771 needs, including a licensed residential facility and a moderate
1772 level of support for standard residential habilitation services
1773 or a minimal level of support for behavior focus residential
1774 habilitation services, or individuals in supported living who
1775 require more than 6 hours a day of in-home support services.
1776 (d) Level of care 4 consists of individuals requiring less
1777 than moderate level of residential habilitation support in a
1778 residential placement, or individuals in independent or
1779 supported living situations, or who live in their family home.
1780 (e) Level of care 5 consists of individuals requiring
1781 minimal support services while living in independent or

1782 supported living situations and individuals who live in their
1783 family home.
1784
1785 The agency shall periodically adjust payment rates to account
1786 for changes in the level of care profile of each plan's
1787 enrollees based on encounter data.
1788 (6) The agency shall establish intensive behavior
1789 residential habilitation rates for providers approved by the
1790 agency to provide this service. The agency shall also establish
1791 intermediate care facility for the developmentally disabled-
1792 specific payment rates for each licensed intermediate care
1793 facility based on facility costs adjusted for inflation and
1794 other factors. Payments to intermediate care facilities for the
1795 developmentally disabled and providers of intensive behavior
1796 residential habilitation service shall be reconciled to
1797 reimburse the plan's actual payments to the facilities.
1798 Section 33. Section 409.992, Florida Statutes, is created
1799 to read:
1800 409.992 Automatic enrollment.—
1801 (1) The agency shall automatically enroll into a
1802 developmental disabilities comprehensive long-term care plan or
1803 a developmental disabilities long-term care plan those Medicaid
1804 recipients who do not voluntarily choose a plan pursuant to s.
1805 409.969. The agency shall automatically enroll recipients in
1806 plans that meet or exceed the performance or quality standards
1807 established pursuant to s. 409.967, and shall not automatically
1808 enroll recipients in a plan that is deficient in those
1809 performance or quality standards. The agency shall assign

1810 individuals who are deemed dually eligible for Medicaid and
1811 Medicare, to a plan that provides both Medicaid and Medicare
1812 services. The agency may not engage in practices that are
1813 designed to favor one managed care plan over another. When
1814 automatically enrolling recipients in plans, the agency shall
1815 take into account the following criteria:
1816 (a) Whether the plan has sufficient network capacity to
1817 meet the needs of the recipients.
1818 (b) Whether the recipient has previously received services
1819 from one of the plan's home and community-based service
1820 providers.
1821 (c) Whether home and community-based providers in one plan
1822 are more geographically accessible to the recipient's residence
1823 than those in other plans.
1824 Section 34. This act shall take effect July 1, 2010.