

Florida Medicaid Program – Managed Care Compliance Deep Dive

Provide a comprehensive overview of Florida Med...

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Analysis

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Florida Medicaid Managed Care Requirements: A Comprehensive Overview

Executive Summary

Based on the available statutory provisions, Florida operates a **dual managed care system** with two distinct programs: the **Managed Medical Assistance (MMA) program** under Florida Statute 409.975 and the **Long-term Care Managed Care program** under Florida Statute 409.982. Both programs operate under the broader framework established in Florida Statute 409.967, creating a comprehensive managed care delivery system for different populations and service categories.

Florida's managed care structure emphasizes **strong network adequacy requirements**, particularly through its "essential provider" framework that ensures access to critical safety-net providers. The state has implemented sophisticated provider payment mechanisms and quality oversight systems, with specific protections for vulnerable populations through mandatory network inclusions and performance measurement requirements.

Program Structure

Managed Medical Assistance Program

Florida's **Managed Medical Assistance (MMA) program**, governed by Florida Statute 409.975, serves as the primary managed care delivery system for standard Medicaid services. This program operates in conjunction with the requirements established in Florida Statute 409.967(2)(c), which sets the foundational standards for managed care plan accountability.

The MMA program is structured around **regional service areas** where managed care organizations (MCOs) compete to serve Medicaid enrollees. Plans must demonstrate capacity to serve the medical needs of enrollees while maintaining provider networks that meet state-established standards for geographic and specialty access.

Long-term Care Managed Care Program

The **Long-term Care Managed Care program**, codified in Florida Statute 409.982, represents a specialized delivery system focused on long-term services and supports. This program serves enrollees requiring nursing facility care, home and community-based services, and other long-term care interventions.

The long-term care program operates with **heightened provider network requirements**, recognizing the specialized nature of long-term care services and the importance of maintaining relationships between enrollees and established care providers.

MCO Obligations and Network Requirements

Essential Provider Framework

Florida has implemented one of the most comprehensive **essential provider frameworks** in the nation through Florida Statute 409.975(1)(a). This system requires MCOs to include specific categories of providers that are deemed critical for serving Medicaid enrollees:

Regional Essential Providers that must be included in network contracts:

- **Federally Qualified Health Centers (FQHCs)** - Community-based primary care providers serving

underserved populations

- **Statutory teaching hospitals** as defined in Florida Statute 408.07(46) - Academic medical centers providing specialized care and training
- **Trauma centers** as defined in Florida Statute 395.4001(15) - Hospitals providing emergency and specialized trauma care
- **Rural hospitals** located at least **25 miles** from any other hospital with similar services - Critical access points in underserved areas

Statewide Essential Providers that must be included in all MCO networks across all regions:

- **Faculty plans of Florida medical schools** - Academic physician practices affiliated with state medical schools
- **Regional perinatal intensive care centers** as defined in Florida Statute 383.16(2) - Specialized facilities for high-risk pregnancies and neonatal care
- **Specialty children's hospitals** as defined in Florida Statute 395.002(28) - Dedicated pediatric facilities
- **Accredited integrated systems serving medically complex children** - Comprehensive care systems providing medical group homes, nursing care, pharmacy services, and durable medical equipment
- **Florida cancer hospitals** meeting federal criteria under 42 U.S.C. - Specialized oncology facilities

Good Faith Negotiation Requirements

MCOs must engage in **good faith negotiations** with essential providers for a minimum of **one year** or until an agreement is reached, whichever occurs first. During this period, payments for services rendered by non-participating essential providers must be made at the **applicable Medicaid rate** as of the first day of the contract between the agency and the plan.

If MCOs cannot reach agreements with essential providers after one year, they must:

1. **Notify the agency** of the negotiation failure
2. **Propose alternative arrangements** for securing essential services through other participating providers
3. Accept modified payment rates based on agency approval of the alternative arrangement

Payment Rate Structure for Non-Participating Essential Providers

Florida has established a **tiered payment system** for non-participating essential providers:

- **110% of Medicaid rate:** When alternative arrangements are not approved by the agency
- **100% of Medicaid rate:** During the initial one-year good faith negotiation period
- **90% of Medicaid rate:** When alternative arrangements are approved by the agency

This structure incentivizes network participation while ensuring continued access to essential services.

Provider Network Development Standards

Under Florida Statute 409.975(1), MCOs must develop and maintain provider networks that meet medical needs of enrollees according to standards established pursuant to Florida Statute 409.967(2)(c). Plans may limit providers in their networks based on:

- **Credentials and qualifications**
- **Quality indicators and performance metrics**
- **Price and cost-effectiveness**

However, these limitations are subject to the essential provider requirements and cannot compromise access to necessary services.

Long-term Care Managed Care Specific Requirements

Specialized Provider Network Standards

Florida Statute 409.982(4) establishes specific network standards for long-term care managed care plans, requiring inclusion of:

- **Adult day care centers** - Community-based supportive services for adults
- **Adult family-care homes** - Residential care settings for adults needing assistance
- **Assisted living facilities** - Residential facilities providing personal care services
- **Health care services pools** - Networks of home care providers
- **Home health agencies** - Skilled nursing and therapy services in the home
- **Homemaker and companion services** - Supportive services for daily living
- **Hospices** - End-of-life care services
- **Community care for the elderly lead agencies** - Coordinators of aging network services
- **Nurse registries** - Networks of independent nursing professionals
- **Nursing homes** - Skilled nursing facilities

Provider Transition Period Requirements

Florida Statute 409.982(1) establishes a **transition period** from October 1, 2013, through September 30, 2014, during which selected long-term care managed care plans must offer network contracts to all:

- **Nursing homes** in the region
- **Hospices** in the region
- **Aging network service providers** that previously participated in home and community-based waivers or community service programs

After **12 months** of active participation, plans may exclude providers for failure to meet quality or performance criteria, but must provide **30 days written notice** to affected recipients.

Mandatory Provider Participation Requirements

Under Florida Statute 409.982(2), certain providers have **mandatory participation obligations**:

- **Nursing homes** that are enrolled Medicaid providers must participate in all eligible plans selected by the agency in their region
- **Hospices** that are enrolled Medicaid providers must participate in all eligible plans selected by the agency in their region

This ensures broad network availability for these critical long-term care services.

Payment and Financial Requirements

Long-term Care Payment Provisions

Florida Statute 409.982(5) establishes detailed payment requirements for long-term care managed care:

Nursing Facility Payments:

- Plans must pay nursing homes **facility-specific payment rates** set by the agency
- **Higher rates may be negotiated** for medically complex care
- Mutually acceptable rates, methods, and terms must be negotiated between plans and providers

Hospice Payments:

- Plans must pay hospice providers through a **prospective payment system**
- Payment equals the **per diem rate** set by the agency for each enrollee
- For recipients in nursing facilities receiving hospice services:
- Hospice receives **per diem rate minus nursing facility component**

- Nursing facility receives **applicable state rate**

Claims Processing Requirements

Both nursing home and hospice electronic claims containing **sufficient information for processing** must be paid within **10 business days** after receipt, ensuring prompt payment to providers.

Performance Measurement and Quality Oversight

Florida Statute 409.982(3) requires each long-term care managed care plan to **monitor quality and performance** of participating providers using:

- **Measures adopted and collected by the agency** - State-standardized quality metrics
- **Additional measures mutually agreed upon** by the provider and plan - Customized performance indicators

This dual approach ensures both standardized quality assessment and flexibility for provider-specific quality improvement initiatives.

Network Adequacy and Access Standards

Geographic and Specialty Access Requirements

While the retrieved statutory provisions reference network adequacy standards established pursuant to Florida Statute 409.967(2)(c), the specific geographic distance, appointment availability, and specialty access requirements are not detailed in the available text. However, the essential provider framework creates a robust foundation for access by ensuring critical safety-net providers are available in all MCO networks.

Emergency Services Access

The retrieved provisions indicate that **emergency services** are subject to specific payment rules for non-participating essential providers, suggesting that emergency care access is protected through the essential provider framework, though detailed emergency access standards are not specified in the available text.

Provider Network Continuity

The statute provides mechanisms for **provider network transitions**, particularly in long-term care where continuity of care relationships is critical. The 30-day notice requirement for provider exclusions and agency-established contract provisions for transferring recipients from excluded residential providers demonstrate Florida's focus on minimizing care disruptions.

Grievance and Appeals Framework

Member Rights and Protections

While the retrieved statutory provisions do not contain detailed grievance and appeals procedures, they reference compliance with Florida Statute 409.967, which would contain the foundational requirements for member rights and complaint resolution processes. The essential provider framework and payment protections suggest a system designed to minimize access barriers that could lead to member grievances.

Provider Appeals and Dispute Resolution

The **good faith negotiation requirements** for essential providers create a structured approach to resolving network participation disputes. The tiered payment system and agency oversight of alternative arrangements provide administrative mechanisms for addressing provider concerns about network

participation and payment rates.

Quality Management and Oversight

Performance Monitoring Systems

Florida has established comprehensive **performance measurement requirements** under Florida Statute 409.982(3), requiring managed care plans to monitor provider quality and performance using both:

1. **State-adopted measures** collected by the agency
2. **Mutually agreed upon measures** between providers and plans

This dual approach ensures standardized quality assessment while allowing for customized performance improvement initiatives tailored to specific provider types and service categories.

Provider Quality Standards

MCOs may limit provider network participation based on **quality indicators**, providing a mechanism for maintaining high-quality networks while ensuring essential providers remain available for access. The 12-month participation period before exclusion for quality issues provides stability for provider-patient relationships.

Regulatory Compliance and Oversight

State Agency Oversight Role

The Florida Agency for Health Care Administration maintains significant oversight responsibilities, including:

- **Establishing network adequacy standards** pursuant to Florida Statute 409.967(2)(c)
- **Classifying essential providers** and maintaining rate schedules
- **Approving alternative arrangements** when MCOs cannot contract with essential providers
- **Setting facility-specific payment rates** for nursing homes
- **Establishing per diem rates** for hospice services
- **Collecting and adopting quality measures** for performance monitoring

Contract Compliance Monitoring

The statutory framework establishes clear **contract compliance requirements**, including rate schedules for essential providers that must be attached to contracts between the agency and MCOs. This ensures transparency and enforceability of network and payment requirements.

Data Limitations and Information Gaps

Missing Information

The retrieved statutory provisions do not contain specific details regarding:

- **Covered services definitions** and benefit packages
- **Member enrollment and disenrollment procedures**
- **Detailed grievance and appeals processes**
- **Specific network adequacy standards** (geographic distance, appointment availability)
- **Recent State Plan Amendment (SPA) activity**
- **Care coordination and case management requirements**
- **Quality improvement and corrective action procedures**

Additional Statutory References

The analysis is based primarily on Florida Statutes 409.975 and 409.982, with references to Florida Statute 409.967. A complete understanding of Florida's Medicaid managed care requirements would require review of:

- Florida Statute 409.967 (foundational managed care requirements)
- Relevant Florida Administrative Code provisions
- Current managed care contracts and amendments
- Recent State Plan Amendments and federal waiver authorities

Conclusions and Policy Implications

Florida's Medicaid managed care system represents a **sophisticated approach** to balancing managed care efficiency with access protection through its essential provider framework. The dual program structure recognizing the distinct needs of long-term care populations demonstrates policy sophistication in addressing different beneficiary populations and service types.

The **comprehensive essential provider requirements** create strong safety-net protections while the **tiered payment system** for non-participating providers balances fiscal responsibility with access assurance. The **good faith negotiation requirements** and agency oversight mechanisms provide structured approaches to resolving network participation disputes.

The **performance measurement and quality oversight systems** establish accountability mechanisms for both plans and providers, while the **specialized long-term care provisions** recognize the unique characteristics of long-term services and supports delivery.

Key Policy Strength: Florida's essential provider framework creates one of the most comprehensive safety-net protection systems in Medicaid managed care, ensuring that critical providers remain available to Medicaid enrollees regardless of commercial contract negotiations.

The statutory framework provides a **robust foundation** for managed care operations while maintaining strong member protections and provider network adequacy requirements. However, the complexity of the system requires careful ongoing oversight and monitoring to ensure policy objectives are achieved in practice.

Appendix A: Source References

[1] Florida Children's Initiatives.—

Statute

Jurisdiction: FL

https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0409/0409.html

409.147 Florida Children's Initiatives.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that:

1. There are neighborhoods in this state where the infrastructure and opportunities that middle-class communities take for granted are nonexistent or so marginal that they are ineffective...

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