Florida Health Care Association
2013 Annual Conference

The Westin Diplomat Resort & Spa

Session #13 – Medicaid Managed Care Update

Monday, August 5 – 10:45 a.m. to 12:45 p.m.

Atlantic 3

Upon completion of this presentation, the learner will be able to:

- identify a series of contractual points to consider and review in Medicaid managed care contracts;
- describe the most up-to-date transitional and operational issues; and
- understand how to enter into open dialogue and foster relationships with managed care organizations.

Seminar Description:

As the statewide Medicaid Managed Long Term Care program unfolds, questions still remain about the impact on long term care. FHCA continues to actively participate in the transition process and is making all efforts to keep its members informed. This can’t-miss session will provide the latest information on the Medicaid Managed Care program, including the implications of changes to service delivery and operations, with tips to ease transition. The presenters will detail the legal implications for providers and deliver the most up-to-date transitional and operational information.

Presenter Bio(s):

Karen Goldsmith, Esq. is a partner in Goldsmith & Grout, PA, and has been Florida Health Care Association’s Legal Consultant since 1980. She is actively involved on the American Health Care Association Legal Subcommittee and served as its chair for three years. She is also a member of the American Health Lawyers Association and served as chair of its Long Term Care Division for two terms.

Tony Marshall serves as Senior Director of Reimbursement for Florida Health Care Association. On behalf of FHCA, he serves as a liaison to the Florida Legislature, Agency for Health Care Administration, Department of Elder Affairs, Centers for Medicare & Medicaid Services, American Health Care Association, FHCA Reimbursement Committee and other relevant state and federal entities regarding issues of reimbursement and healthcare finance policy.

Jennifer Ziolkowski is Senior Vice President of Finance for Opis Management Resources, LLC, where she oversees all functions of accounting, payroll, accounts payable, accounts receivable and Medicare/Medicaid reimbursement issues. She is responsible for company performance analysis and participating in developing corporate strategies and efficiencies. Jennifer has over 19 years of
long term care experience in various finance/reimbursement roles from Accountant, Reimbursement Specialist, Vice President of Reimbursement and Billing. Previously, she served as Corporate Vice President of Operational Reimbursement for Genesis ElderCare. In this role, she was responsible for development and implementation of reimbursement strategies and regulatory compliance for Medicare and state Medicaid programs. Her role also encompassed the management of 35 nurses and therapists across 13 states. Jennifer is Vice-Chair of the Florida Healthcare Association Reimbursement Committee where she participates in the review and recommendation of policy changes to the state Medicaid plan. Jennifer has a B.S. in Management with a concentration in Accounting from Virginia Wesleyan College. She also earned a Master's Degree in Business Administration in 2001 from the University of Phoenix.
The Florida Medicaid program is implementing a new system through which Medicaid enrollees will receive long-term care services.

This program is called the Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) Program.
Who is required to participate?

- Medicaid individuals are required to enroll in the Long-term Care Managed Care Program if they are:
  - 65 years of age or older AND need nursing facility level of care
  - 18 years of age or older AND are eligible for Medicaid by reason of disability AND need nursing facility level of care
  - Individuals enrolled in the Aged and Disabled Adult (A/DA) Waiver

Who is required to participate?

- Individuals who are enrolled in the Consumer-Directed Care Plus for individuals in the A/DA waiver
- Individuals who are enrolled in the Assisted Living Waiver
- Individuals who are enrolled in the Nursing Home Diversion Waiver
- Individuals who are enrolled in the Frail Elder Option

Who is not required to participate?

- Developmental Disabilities Waiver Program
- Traumatic Brain & Spinal Cord Injury Waiver
- Project AIDS Care Waiver
- Adult Cystic Fibrosis Waiver
- Program of All-Inclusive Care for the Elderly (PACE)
- Familial Dysautonomia Waiver
- Model Waiver
What Services are Provided Under SMMC LTC?

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult companion care</td>
<td>Intermittent and skilled nursing</td>
</tr>
<tr>
<td>Adult day health care</td>
<td>Medical equipment and supplies</td>
</tr>
<tr>
<td>Assisted living</td>
<td>Medication administration</td>
</tr>
<tr>
<td>Assistive care services</td>
<td>Medication management</td>
</tr>
<tr>
<td>Attendant care</td>
<td>Nursing Facility (Room &amp; Board)</td>
</tr>
<tr>
<td>Behavioral management</td>
<td>Nutritional assessment/ risk reduction</td>
</tr>
<tr>
<td>Care coordination/ Case management</td>
<td>Personal care</td>
</tr>
<tr>
<td>Caregiver training</td>
<td>Personal emergency response system</td>
</tr>
<tr>
<td>Home accessibility adaptation</td>
<td>Respite care</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td>Occupational, physical, respiratory &amp; speech therapy</td>
</tr>
<tr>
<td>Homemaker</td>
<td>Transportation, Non-emergency</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
</tbody>
</table>

When will SMMC LTC begin?

- SMMC LTC will be implemented on a regional basis across the State
- Managed care plan services in Region 7 (Brevard, Orange, Osceola, and Seminole counties) started August 1, 2013

When does enrollment begin?

<table>
<thead>
<tr>
<th>Region</th>
<th>1st Notification Letter</th>
<th>Welcome Letter</th>
<th>Final Notification Letter</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11/1/2013</td>
<td>12/12/2013</td>
<td>1/19/2014</td>
<td>3/1/2014</td>
</tr>
<tr>
<td>2</td>
<td>1/1/2013</td>
<td>1/28/2013</td>
<td>1/19/2014</td>
<td>3/1/2014</td>
</tr>
<tr>
<td>7</td>
<td>7/1/2013</td>
<td>5/20/2013</td>
<td>6/24/2013</td>
<td>8/1/2013</td>
</tr>
<tr>
<td>8</td>
<td>5/1/2013</td>
<td>6/24/2013</td>
<td>7/22/2013</td>
<td>9/1/2013</td>
</tr>
<tr>
<td>9</td>
<td>5/1/2013</td>
<td>6/24/2013</td>
<td>7/22/2013</td>
<td>9/1/2013</td>
</tr>
<tr>
<td>10</td>
<td>5/1/2013</td>
<td>6/24/2013</td>
<td>7/22/2013</td>
<td>9/1/2013</td>
</tr>
</tbody>
</table>
What Plans are in each Region?

<table>
<thead>
<tr>
<th>Region</th>
<th>American Eldercare</th>
<th>Amerigroup</th>
<th>Coventry</th>
<th>Humana</th>
<th>Molina</th>
<th>Sunshine</th>
<th>United</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How do Residents choose a SMMC LTC plan?

- Resident / legal representative should have received a letter and packet from Florida Agency for Healthcare Administration (AHCA) regarding SMMC LTC enrollment instructions
- Follow the three steps on the letter to enroll in a SMMC LTC plan. Look, Choose and Enroll

How do Residents choose a SMMC LTC plan?

- Look at the information in the packet. It includes:
  - A list of plans in your region
  - Information on the SMMC LTC program
  - The steps they need to take to join a plan
  - How to enroll via phone call or online
How do Residents choose a SMMC LTC plan?

- If they need assistance in selecting a plan, call a Medicaid Choice Counselor at: 1-877-711-3662
- Residents need to select a managed care plan by date specified in the letter they receive based on their region.

How do Residents choose a SMMC LTC plan?

- Resident can enroll either by phone or online:
  - Phone: Call 1-877-711-3662 and talk to a Medicaid Choice Counselor
  - Online: www.flmedicaidmanagedcare.com

Can Residents change plans once they make a selection?

- Yes!
  - After joining a plan, the resident has 90 days to change to another plan offered in their region
  - After 90 days, resident may only change for “good cause” reasons
  - After initial 12 month period, resident may change during open enrollment period
### Care Coordination

- A case manager will be assigned to each resident
  - Visit each resident to assess the health care and long-term needs of the resident
  - Plan of care

### Continuity of Care

- Plans must continue residents’ current services for up to 60 days until a new assessment and care plan are complete and services are in place
- If a provider does not have a contract with a plan, the provider must continue service for up to 60 days or until the resident picks another provider and a new plan of care is developed

### Continuity of Care cont.

- LTC plan must authorize and pay for services rendered by the non-contracted provider until:
  - A contracted provider is in place
  - The LTC plan notifies the non-contracted provider in writing that reimbursement will end on a specific date
Continuity of Care cont.

- Residents in nursing facilities can choose to remain in that facility as long as they continue to meet nursing facility level of care requirements.

Operational Considerations - what happens now?

- Starting August 1st, State Medicaid Eligibility system will be updated to include plan info on each resident.
- When your region “goes live”:
  - You will need to check eligibility and plan enrollment for each resident
  - It will be a good idea to continue rechecking plan enrollment for at least 90 days

Operational Considerations - what happens now? cont.

- Nursing home Medicaid Eligibility
  - Process has not changed
  - What has changed?
    - Once a resident has been deemed eligible, they then have 30 days to select a Medicaid Managed Care plan
    - The state will continue to pay FFS until the effective enrollment date of the plan
Operational Considerations – what happens now? cont.

- Billing
  - Must bill each resident’s plan for Medicaid services after their enrollment date
  - Plans have agreed to keep same codes as current Medicaid bill
  - Legislatively mandated 10 business day payment for claims that contain sufficient information for processing

Operational Considerations – what happens now? cont.

- Build solid relationships with each Plan
- Know your contract
- Use your resources
  - FHCA Medicaid Managed Care Resource Center
    - Correspondence from Emmett, checklists, presentations

MEDICAID MANAGED CARE CONTRACTING

Karen Goldsmith
Goldsmith & Grout, PA
Overview

- Facilities in Regions 7, 8, and 9 are in contract or close to signing contracts.
- What FHCA has done to assist you.
- Contracts can be negotiated!
- Each of the Managed Care Companies in those regions has worked with providers in tailoring their contracts to fit the facility’s needs.

Things you should know in negotiating contracts

- MCOs are bound by certain things in their contracts with the State.
- AHCA has issued certain mandates to the MCOs as things they must have in their contracts in certain ways.
- Even if State mandated, language can be negotiated in anticipation of future changes or different interpretations.

Things you should know in negotiating contracts

- Reimbursement is determined the same way it has been.
  - Cost reports are filed.
  - Per diem is determined with ceiling and caps.
  - State calculates it.
- If you have medically complex you can increase the fee through negotiation.
### Have available/understand
- The MCO’s contract with the State.
- The Mandates (on FHCA website).
- Florida Law (Chapter 409 primarily).
- Medicaid Plan Revisions to implement Managed Care.
- Know the MCOs/American Eldercare is a PSN, which means it does not have a provider number and does not pay claims directly.

### Things you can do
- Negotiate the contract even though all Providers must participate with each MCO.
- Ensure contract complies with your own internal policies and procedures, such as transfer.
- Have changes made to fit your particular needs.
- Negotiate rates – statutory amount is minimum.

### Cautions
- Know what each MCO will accept as a clean claim so your claims are processed timely.
- Make sure the “covered services” include only what you are currently providing, unless there is extra payment.
- Make sure the contract correctly defines what the patient’s responsibility is that you can collect.
Cautions

- Determine proper payback time for overpayments.
- What is the QA program - State is working on defining that further.
- How can you be terminated:
  - If decertified.
  - If delicensed.
  - After 12 months of active participation, for quality issues.

Cautions

- How are enrollee grievances handled?
- Look at how contract treats CHOWs.
- Liability insurance.
- Read Handbook or Manual.
- Create a contract manager to review progress, “tickle” timeframes, and ensure current information being used.

Cautions

- That contracts are approved by AHCA is misleading, because they are only “approved” as it relates to meeting State contract and mandates.
- You can be out-of-network provider if you have not signed a contract.
- CARES team makes initial determination of eligibility based on need.
- Managed Care case manager then follows up.
Interesting issues

- Contracting across regional lines.

---

TRANSITION AND
OPERATION ISSUES

Tony Marshall
Florida Health Care Association

---

Payment and Rate Setting
Rates and Supplemental Payments

- Payment rates to providers - 409.982(5)
- Rate setting periods
- Bed hold and therapeutic leave days
- Interim rate adjustments
- Retroactive rate adjustment
- Supplemental payments
  - AIDS/HIV eliminated 7/1/13
  - Medically complex services

---
Payment and Rate Setting
Rates and Supplemental Payments
- Change of ownership
- Emergency payments

Payment and Rate Setting
Medicare Coinsurance Crossover
- Medicare crossover payments
  - Part A coinsurance
  - Part B coinsurance
- State payment process or Plan payment process
- Automatic crossover process or provider billing

Payment and Rate Setting
Prompt Payment/Timeliness
- Claims submission
  - Weekly or monthly billing
  - Timely filing limits (Rule vs. Statute)
- Prompt payment
  - 409.982(5) – 10 business days after receipt for electronic nursing home and hospice claims containing sufficient information for processing
  - 641.3155 – 40 days after receipt for nonelectronically submitted claims
- Claims denial/appeal
Payment and Rate Setting
Prompt Payment/Timeliness
- Uniform claims processing/EFT
  - HIPAA compliant, nationally recognized billing software
  - Electronic funds transfer required
  - Plan portal vs. clearinghouse

Payment and Rate Setting
Patient Responsibility
- Collection of patient responsibility amounts - Plan or provider
- Notification/verification
- System edits
- Third party liability audits

Accessing Services
Eligibility Determination
- CARES
- Choice counseling/Plan selection
- Care coordinator/case manager
  - Access to residents prior to enrollment date
- Presumptive eligibility/Medicaid pending
  - Retroactive eligibility
  - Enrollment date
- Prior authorization
Other Issues

- Credentialing
- Quality assurance review/monitoring
- Balancing Institutional and HCBS
- Transition – Contract Status
  - July 22, 2013 AHCA Letter

Transition
Area 7 Weekly Provider-Specific Calls

- 1-888-670-3525; 3501628939#
- Nursing Facility and Hospice Providers
  - 8/5/13, 8/12/13, 8/19/13, 8/26/13, 9/9/13
  - 2:00 pm to 3:00 pm
- Assisted Living Providers
  - 8/7/13, 8/14/13, 8/21/13, 8/28/13, 9/4/13
  - 10:00 am to 11:00 am
- Aging Network Service Providers
  - 8/8/13, 8/15/13, 8/22/13, 8/29/13, 9/5/13
  - 2:00 pm to 3:00 pm

Resources

- FHCA Medicaid Managed Care Resource Center
  www.fhca.org/facility_operations/medicaid_managed_care
- SMMC Homepage
  ahca.myflorida.com/Medicaid/statewide_rx/index.shtml
- SMMC Event Calendar/Materials
  ahca.myflorida.com/Medicaid/statewide_rx/index.shtml#NEWS
- SMMC LTC Program Page
  ahca.myflorida.com/Medicaid/statewide_rx/index.shtml#LTCMC
- SMMC LTC Program Snapshot
- AHCA YouTube Channel (Webinars)
  www.youtube.com/AHCAFlorida
Medicaid Managed Care

- Questions???

CONTACT INFORMATION

Karen L. Goldsmith  
Attorney at Law (FHCA Regulatory Counsel)  
Goldsmith & Grout, P.A.  
Post Office Box 870  
Cape Canaveral, FL  32920  
(407) 312-4938  
KGoldsmith@ggfllawfirm.com

Tony Marshall  
Senior Director of Reimbursement  
Florida Health Care Association  
307 W. Park Avenue  
Tallahassee, FL  32301  
(850) 224-3907  
(850) 556-9349  
tmarshall@fhca.org

Jennifer Ziolkowski  
Senior Vice President, Finance  
Opis Management Resources, LLC  
(813) 558-8209  
jennifer.ziolkowski@opismr.com
## Checklist for Review of Medicaid Managed Care Contracts

This checklist includes some major contractual points for nursing homes to consider and review in Medicaid managed care contracts. While comprehensive, the list is not all-inclusive and many of the issues may not apply to any one individual provider. Each nursing home provider should negotiate the points that its management believes to be important to its operation, and all contracts should be reviewed and understood before agreement to the terms. The checklist is designed to provide basic information and to assist in starting the negotiation process and does not replace the advice of qualified legal counsel. This document does not reflect the opinions of Florida Health Care Association or any of its agents. Further, FHCA does not take a position on these issues during the individual provider’s negotiation process.

### Basic Elements

- Know the party with which you are contracting.
  - If not an approved Medicaid Plan, determine what the authority of that party is to act for the Plan.
  - Determine if you still have recourse against the approved Plan if issues arise.
- Determine the timeframes you must meet in negotiating and signing a contract.
- Establish a contracting team with knowledge of all of the components of the contract.
- Has the contract been reviewed by legal counsel?
- Contracts must be signed before a nursing home provider renders services.

### Terms and Termination

- Provisions should be clear and concise.
  - Quality of care issues adequate for termination should be clearly defined.
- Provisions should be fair to both parties (the same).
- Provisions should only require as much notice as fair to both parties, but have adequate notice to comply with law.

### Definitions

- Read and understand all defined terms.
  - CAPITALIZED terms should always be defined.
  - Make sure definitions are consistent with state and/or federal laws.
- Make certain that terms not defined are clear from the context or standard usage.
- Review terms carefully, such as “clean claim,” “medical necessity,” “eligible person,” etc.
<table>
<thead>
<tr>
<th>Reimbursement</th>
<th>Amendments, Appendices, Handbooks and Manuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Make sure the contract/appendix explains rates and services to be provided.</td>
<td>● Are all documents referenced in the contract attached or readily available for review?</td>
</tr>
<tr>
<td>● Does the contract make provision for rate changes during the contract term and payments retroactive to the rate effective date?</td>
<td>● Can the Plan unilaterally modify these documents without notice to the nursing home provider and an opportunity to provide feedback?</td>
</tr>
<tr>
<td>● The contract should clearly state when a member of the Medicaid Plan becomes a covered person/enrollee/member or other term used.</td>
<td>● Can the Plan unilaterally change the contract and, if so, does the nursing home provider have recourse other than termination?</td>
</tr>
<tr>
<td>● Is preadmission or other authorization simple and fair?</td>
<td>● Are appendices and other documents incorporated into the contract consistent with one another?</td>
</tr>
<tr>
<td>- When is it done?</td>
<td></td>
</tr>
<tr>
<td>- What happens when the person is already in your facility under another payer source and converts?</td>
<td></td>
</tr>
<tr>
<td>- Could there be a gap in payment when a person moves from one Plan to another?</td>
<td></td>
</tr>
<tr>
<td>- Is it clear which party assumes the risk if the Managed Care Plan determines a member ineligible and the member refuses to leave the nursing home?</td>
<td></td>
</tr>
<tr>
<td>- Determine which party assumes the risk if the member is deemed eligible upon admission and later determined ineligible.</td>
<td></td>
</tr>
<tr>
<td>● Know and understand the claims processing requirements and billing formats (including provisions related to timeliness of billing and payments).</td>
<td></td>
</tr>
<tr>
<td>● Determine which party assumes the risk for collecting patient responsibility.</td>
<td></td>
</tr>
<tr>
<td>● Does the contract set out what happens if either party becomes insolvent and is it fair to both sides?</td>
<td></td>
</tr>
<tr>
<td>● Review the elements of the itemized accounting (remittance advice) which will be sent to you relating to the payment, and determine if this is adequate for the nursing home to validate the Plan's decision.</td>
<td></td>
</tr>
<tr>
<td>● How are Medicaid-pending claims handled? Does the contract limit your ability to bill privately? (Medicaid pending provisions may not be necessary in a nursing home provider contract.)</td>
<td></td>
</tr>
</tbody>
</table>
| **Admission, Transfer, Discharges and Bed-hold** | • How does the contract address discharge when eligibility ends – is it consistent with state and federal law?  
• When a resident refuses to leave, who is responsible for the cost of care?  
  - Can you charge private pay?  
  - Will the Plan assist you in moving the resident and will the Plan follow discharge/transfer laws?  
• How is a transfer handled when you make the decision that the member needs to be transferred because you cannot meet his/her needs or he/she is a danger to himself and others?  
• Bed-hold policy should, at a minimum, comply with state law. |
| **Credentialing, Information Collection and Quality Assurance** | • Is there a credentialing process that goes beyond what is required by law?  
  - Can you abide by it?  
  - Do you have access to the data required?  
  - Does it require credentialing of third parties, such as subcontractors?  
  - Is it burdensome?  
• Determine if the contract requires you to submit documents protected by law.  
• Does the contract require all incidents be reported to the Plan?  
  - Does the language cause you to produce documents which should be maintained in a confidential manner?  
• Are surveys or reviews conducted by the Plan duplicative of that which you are currently undergoing?  
• Determine if there is a peer review plan. Can you work within it?  
• Know the scope of the audit of records permitted by the contract.  
• Are there burdensome record retention requirements that exceed the requirements of law?  
• Is the care planning process in the contract acceptable and in accordance with law? Does it clearly define the role of each party in the process?  
• How does the state and federal survey process affect participation? |
| **Fraud and Abuse/Overpayments** | • Determine the scope of the reporting requirements within the contract for fraud and abuse, overpayments, special audits (such as ZPIC).  
• Are reporting requirements consistent with state and federal law?  
• Are the reporting requirements reasonable?  
• Is there a limitation of rights of each party to correct under- or overpayments?  
  - Can you reasonably comply?  
• Does the contract terminate for failure to timely pay an overpayment?  
  - If so, is there a grace period or an opportunity for a repayment plan? |
| Notification/Assignment | • When must the Plan be notified and how?  
• What insurance is required to be carried or disclosed? (Are the provisions related to liability insurance consistent with the law?) 
• Are there requirements to report civil litigation claims information that is inconsistent with current law? 
• Are indemnification agreements fair to both parties? 
• Is notice required for insolvency and/or financial problems (by the Plan or facility)? 
• Can the contract be assigned and if so, how? What about CHOWs? |
| Disputes and Appeals | • Determine the process for appealing denials of coverage and/or payment  
  - Pay close attention to the timeframes.  
  - Is the process fair? 
• How do disputes regarding the contract itself get resolved?  
  - Does the system include due process?  
  - Is the period of time to come into compliance when a problem arises fair and reasonable?  
  - Is there an arbitration clause and is it reciprocal?  
  - Are there provisions related to the payment of attorneys fees? 
• Can you terminate the agreement for slow payment or successive denials?  
  - What other recourse do you have? |
| Global Issues as Addressed in Law | 1. “Plans shall pay nursing homes an amount equal to the nursing facility-specific rates set by the agency; however, mutually acceptable higher rates may be negotiated for medically complex care.” F.S. 409.982(5)  
2. “The agency shall establish nursing facility-specific payment rates for each licensed nursing home based on facility costs adjusted for inflation and other factors as authorized in the General Appropriations Act.” F.S. 409.982(6)  
3. “Plans must ensure that electronic nursing home and hospice claims that contain sufficient information for processing are paid within 10 business days after receipt.” F.S. 409.982(5).  
4. “The CARES program shall determine if an individual requires nursing facility care, and …assign the individual to a level of care….” F.S. 409.985(3)  
5. “For the period between October 1, 2013 and September 30, 2014, each selected plan must offer a network contract to…[n]ursing homes” (in the region). F.S. 409.982(1)  
6. “Nursing homes...that are enrolled Medicaid providers must participate in eligible plans selected by the agency in the region in which the provider is located.” 409.982(2) |