By the Committee on Health Regulation; and Senators Negron, Gaetz, Garcia, and Hays

588-03381A-11 20111972c1

1 A bill to be entitled
2 An act relating to health and human services; amending
3 s. 163.387, F.S.; exempting hospital districts from
4 the requirement to provide funding to a community
5 redevelopment agency; creating s. 200.186, F.S.;
6 requiring hospital district ad valorem revenues
7 dispersed to other entities to be spent only on health
8 care services; amending s. 393.0661, F.S.; conforming
9 provisions to changes made by the act; amending s.
10 409.016, F.S.; conforming provisions to changes made
11 by the act; creating s. 409.16713, F.S.; providing for
12 medical assistance for children in out-of-home care
13 and adopted children; specifying how those services
14 will be funded under certain circumstances; providing
15 legislative intent; providing a directive to the
16 Division of Statutory Revision; transferring,
17 renumbering, and amending s. 624.91, F.S.; decreasing
18 the administrative cost and raising the minimum loss
19 ratio for health plans; increasing compensation to the
20 insurer or provider for dental contracts; requiring
21 the Florida Healthy Kids Corporation to include use of
22 the school breakfast and lunch application form in the
23 corporation’s plan for publicizing the program;
24 conforming provisions to changes made by the act;
25 amending ss. 409.813, 409.8132, 409.815, 409.818,
26 154.503, and 408.915, F.S.; conforming provisions to
27 changes made by the act; amending s. 1006.06, F.S.;
28 requiring school districts to collaborate with the
29 Florida Kidcare program to use the application form

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30 for the school breakfast and lunch programs to provide
31 information about the Florida Kidcare program and to
32 authorize data on the application form be shared with
33 state agencies and the Florida Healthy Kids
34 Corporation and its agents; authorizing each school
35 district the option to share the data electronically;
36 requiring interagency agreements to ensure that the
37 data exchanged is protected from unauthorized
38 disclosure and is used only for enrollment in the
39 Florida Kidcare program; amending s. 409.901, F.S.;
40 revising definitions relating to Medicaid; amending s.
41 409.902, F.S.; revising provisions relating to the
42 designation of the Agency for Health Care
43 Administration as the state Medicaid agency;
44 specifying that eligibility and state funds for
45 medical services apply only to citizens and certain
46 noncitizens; providing exceptions; providing a
47 limitation on persons transferring assets in order to
48 become eligible for certain services; amending s.
49 409.9021, F.S.; revising provisions relating to
50 conditions for Medicaid eligibility; increasing the
51 number of years a Medicaid applicant forfeits
52 entitlements to the Medicaid program if he or she has
53 committed fraud; providing for the payment of monthly
54 premiums by Medicaid recipients; providing exemptions
55 to the premium requirement; requiring applicants to
56 agree to participate in certain health programs;
57 prohibiting a recipient who has access to employer-
58 sponsored health care from obtaining services

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59 reimbursed through the Medicaid fee-for-service
60 system; requiring the agency to develop a process to
61 allow the Medicaid premium that would have been
62 received to be used to pay employer premiums;
63 requiring that the agency allow opt-out opportunities
64 for certain recipients; creating s. 409.9022, F.S.;
65 specifying procedures to be implemented by a state
66 agency if the Medicaid expenditures exceed
67 appropriations; amending s. 409.903, F.S.; conforming
68 provisions to changes made by the act; deleting
69 obsolete provisions; amending s. 409.904, F.S.;
70 conforming provisions to changes made by the act;
71 renaming the “medically needy” program as the
72 “Medicaid nonpoverty medical subsidy”; narrowing the
73 subsidy to cover only certain services for a family,
74 persons age 65 or older, or blind or disabled persons;
75 revising the criteria for the agency’s assessment of
76 need for private duty nursing services; amending s.
77 409.905, F.S.; conforming provisions to changes made
78 by the act; requiring prior authorization for home
79 health services; amending s. 409.906, F.S.; providing
80 for a parental fee based on family income to be
81 assessed against the parents of children with
82 developmental disabilities served by home and
83 community-based waivers; prohibiting the agency from
84 paying for certain psychotropic medications prescribed
85 for a child; conforming provisions to changes made by
86 the act; amending ss. 409.9062 and 409.907, F.S.;
87 conforming provisions to changes made by the act;

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88 amending s. 409.908, F.S.; modifying the nursing home
89 patient care per diem rate to include dental care,
90 vision care, hearing care, and podiatric care;
91 directing the agency to seek a waiver to treat a
92 portion of the nursing home per diem as capital for
93 self-insurance purposes; requiring primary physicians
94 to be paid the Medicare fee-for-service rate by a
95 certain date; deleting the requirement that the agency
96 contract for transportation services with the
97 community transportation system; authorizing qualified
98 plans to contract for transportation services;
99 deleting obsolete provisions; conforming provisions to
100 changes made by the act; amending s. 409.9081, F.S.;
101 revising copayments for physician visits; requiring
102 the agency to seek a waiver to allow the increase of
103 copayments for nonemergency services furnished in a
104 hospital emergency department; amending s. 409.912,
105 F.S.; requiring Medicaid-eligible children who have
106 open child welfare cases and who reside in AHCA area
107 10 to be enrolled in specified capitated managed care
108 plans; expanding the number of children eligible to
109 receive behavioral health care services through a
110 specialty prepaid plan; repealing provisions relating
111 to a provider lock-in program; eliminating obsolete
112 provisions and updating provisions; conforming cross-
113 references; amending s. 409.915, F.S.; conforming
114 provisions to changes made by the act; transferring,
115 renumbering, and amending s. 409.9301, F.S.;
116 conforming provisions to changes made by the act;

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117 amending s. 409.9126, F.S.; conforming a cross-
118 reference; providing a directive to the Division of
119 Statutory Revision; creating s. 409.961, F.S.;
120 providing for statutory construction of provisions
121 relating to Medicaid managed care; creating s.
122 409.962, F.S.; providing definitions; creating s.
123 409.963, F.S.; establishing the Medicaid managed care
124 program as the statewide, integrated managed care
125 program for medical assistance and long-term care
126 services; directing the agency to apply for and
127 implement waivers; providing for public notice and
128 comment; providing for a limited managed care program
129 if waivers are not approved; creating s. 409.964,
130 F.S.; requiring all Medicaid recipients to be enrolled
131 in Medicaid managed care; providing exemptions;
132 prohibiting a recipient who has access to employer-
133 sponsored health care from enrolling in Medicaid
134 managed care; requiring the agency to develop a
135 process to allow the Medicaid premium that would have
136 been received to be used to pay employer premiums;
137 requiring that the agency allow opt-out opportunities
138 for certain recipients; providing for voluntary
139 enrollment; creating s. 409.965, F.S.; providing
140 requirements for qualified plans that provide services
141 in the Medicaid managed care program; requiring the
142 agency to issue an invitation to negotiate; requiring
143 the agency to compile and publish certain information;
144 establishing regions for separate procurement of
145 plans; establishing selection criteria for plan

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146 selection; limiting the number of plans in a region;
147 authorizing the agency to conduct negotiations if
148 funding is insufficient; specifying circumstances
149 under which the agency may issue a new invitation to
150 negotiate; providing that the Children’s Medical
151 Service Network is a qualified plan; directing the
152 agency to assign Medicaid provider agreements for a
153 limited time to a provider services network
154 participating in the managed care program in a rural
155 area; creating s. 409.966, F.S.; providing managed
156 care plan contract requirements; establishing contract
157 terms; providing for annual rate setting; providing
158 for contract extension under certain circumstances;
159 establishing access requirements; requiring the agency
160 to establish performance standards for plans;
161 requiring each plan to publish specified measures on
162 the plan’s website; providing for program integrity;
163 requiring plans to provide encounter data; providing
164 penalties for failure to submit data; requiring plans
165 to accept electronic claims and electronic prior
166 authorization requests for medication exceptions;
167 requiring plans to provide the criteria for approval
168 and reasons for denial of prior authorization
169 requests; providing for prompt payment; providing for
170 payments to noncontract emergency providers; requiring
171 a qualified plan to post a surety bond or establish a
172 letter of credit or a deposit in a trust account;
173 requiring plans to establish a grievance resolution
174 process; requiring plan solvency; requiring guaranteed

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175 savings; providing costs and penalties for early
176 termination of contracts or reduction in enrollment
177 levels; requiring the agency to terminate qualified
178 plans for noncompliance under certain circumstances;
179 requiring plans to adopt and publish a preferred drug
180 list; creating s. 409.967, F.S.; providing for managed
181 care plan accountability; requiring plans to use a
182 uniform method of accounting for medical costs;
183 establishing a medical loss ratio; requiring that a
184 plan pay back to the agency a specified amount in
185 specified circumstances; authorizing plans to limit
186 providers in networks; mandating that certain
187 providers be offered contracts during the first year;
188 authorizing plans to exclude certain providers in
189 certain circumstances; requiring plans to monitor the
190 quality and performance history of providers;
191 requiring plans to hold primary care physicians
192 responsible for certain activities; requiring plans to
193 offer certain programs and procedures; requiring plans
194 to pay primary care providers the same rate as
195 Medicare by a certain date; providing for conflict
196 resolution between plans and providers; creating s.
197 409.968, F.S.; providing for managed care plan
198 payments on a per-member, per-month basis; requiring
199 the agency to establish a methodology to ensure the
200 availability of certain types of payments to specified
201 providers; requiring the development of rate cells;
202 requiring that the amount paid to the plans for
203 supplemental payments or enhanced rates be reconciled

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204 to the amount required to pay providers; requiring
205 that plans make certain payments to providers within a
206 certain time; creating s. 409.969, F.S.; authorizing
207 Medicaid recipients to select any plan within a
208 region; providing for automatic enrollment of
209 recipients by the agency in specified circumstances;
210 providing criteria for automatic enrollment;
211 authorizing disenrollment under certain circumstances;
212 providing for a grievance process; defining the term
213 “good cause” for purposes of disenrollment; requiring
214 recipients to stay in plans for a specified time;
215 providing for reenrollment of recipients who move out
216 of a region; creating s. 409.970, F.S.; requiring the
217 agency to maintain an encounter data system; providing
218 requirements for prepaid plans to submit data in a
219 certain format; requiring the agency to analyze the
220 data; requiring the agency to test the data for
221 certain purposes by a certain date; creating s.
222 409.971, F.S.; providing for managed care medical
223 assistance; providing deadlines for beginning and
224 finalizing implementation; creating s. 409.972, F.S.;
225 establishing minimum services for the managed medical
226 assistance; providing for optional services;
227 authorizing plans to customize benefit packages;
228 requiring the agency to provide certain services to
229 hemophiliacs; creating s. 409.973, F.S.; providing for
230 managed long-term care; providing deadlines for
231 beginning and finalizing implementation; providing
232 duties for the Department of Elderly Affairs relating

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233 to the program; creating s. 409.974, F.S.; providing
234 recipient eligibility requirements for managed long-
235 term care; listing programs for which certain
236 recipients are eligible; specifying that an
237 entitlement to home and community-based services is
238 not created; creating s. 409.975, F.S.; establishing
239 minimum services for managed long-term care; creating
240 s. 409.976, F.S.; providing criteria for the selection
241 of plans to provide managed long-term care; creating
242 s. 409.977, F.S.; providing for managed long-term care
243 plan accountability; requiring the agency to establish
244 standards for specified providers; creating s.
245 409.978, F.S.; requiring that the agency operate the
246 Comprehensive Assessment and Review for Long-Term Care
247 Services program through an interagency agreement with
248 the Department of Elderly Affairs; providing duties of
249 the program; requiring the program to assign plan
250 enrollees to a level of care; providing for the
251 evaluation of dually eligible nursing home residents;
252 transferring, renumbering, and amending ss. 409.91207,
253 409.91211, and 409.9122, F.S.; conforming provisions
254 to changes made by the act; updating provisions and
255 deleting obsolete provisions; transferring and
256 renumbering ss. 409.9123 and 409.9124, F.S.; amending
257 s. 430.04, F.S.; eliminating outdated provisions;
258 requiring the Department of Elderly Affairs to develop
259 a transition plan for specified elders and disabled
260 adults receiving long-term care Medicaid services if
261 qualified plans become available; amending s.

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262 430.2053, F.S.; eliminating outdated provisions;
263 providing additional duties of aging resource centers;
264 providing an additional exception to direct services
265 that may not be provided by an aging resource center;
266 providing for the cessation of specified payments by
267 the department as qualified plans become available;
268 eliminating provisions requiring reports; amending s.
269 39.407, F.S.; requiring a motion by the Department of
270 Children and Family Services to provide psychotropic
271 medication to a child 10 years of age or younger to
272 include a review by a child psychiatrist; providing
273 that a court may not authorize the administration of
274 such medication absent a finding of compelling state
275 interest based on the review; amending s. 216.262,
276 F.S.; providing that limitations on an agency's total
277 number of positions does not apply to certain
278 positions in the Department of Health; amending s.
279 381.06014, F.S.; redefining the term "blood
280 establishment" and defining the term "volunteer
281 donor"; requiring that blood establishments disclose
282 specified information on their Internet website;
283 providing an exception for certain hospitals;
284 authorizing the Department of Legal Affairs to assess
285 a civil penalty against a blood establishment that
286 fails to disclose the information; providing that the
287 civil penalty accrues to the state and requiring that
288 it be deposited into the General Revenue Fund;
289 prohibiting local governments from restricting access
290 to public facilities or infrastructure for certain

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291 activities based on whether a blood establishment is
292 operating as a for-profit or not-for-profit
293 organization; prohibiting a blood establishment from
294 considering whether certain customers are operating as
295 for-profit or not-for-profit organizations when
296 determining service fees for blood or blood
297 components; amending s. 400.023, F.S.; requiring the
298 trial judge to conduct an evidentiary hearing to
299 determine the sufficiency of evidence for claims
300 against certain persons relating to a nursing home;
301 limiting noneconomic damages in a wrongful death
302 action against the nursing home; amending s. 400.0237,
303 F.S.; revising provisions relating to punitive damages
304 against a nursing home; authorizing a defendant to
305 proffer admissible evidence to refute a claimant's
306 proffer of evidence for punitive damages; requiring
307 the trial judge to conduct an evidentiary hearing and
308 the plaintiff to demonstrate that a reasonable basis
309 exists for the recovery of punitive damages;
310 prohibiting discovery of the defendant's financial
311 worth until the judge approves the pleading on
312 punitive damages; revising definitions; amending s.
313 408.7057, F.S.; requiring that the dispute resolution
314 program include a hearing in specified circumstances;
315 providing that the dispute resolution program
316 established to resolve claims disputes between
317 providers and health plans does not provide an
318 independent right of recovery; requiring that the
319 conclusions of law in the written recommendation of

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320 the resolution organization identify certain
321 information; providing a directive to the Division of
322 Statutory Revision; amending s. 409.1671, F.S.;
323 modifying the amount and limits of general liability
324 coverage, automobile coverage, and tort coverage that
325 must be carried by eligible community lead agency
326 providers and their subcontractors; providing that the
327 Department of Children and Family Services is not
328 liable for the acts or omissions of such lead agencies
329 and that the agencies may not be required to indemnify
330 the department; creating ss. 458.3167 and 459.0078,
331 F.S.; providing for an expert witness certificate for
332 allopathic and osteopathic physicians licensed in
333 other states or Canada which authorizes such
334 physicians to provide expert medical opinions in this
335 state; providing application requirements and
336 timeframes for approval or denial by the Board of
337 Medicine and Board of Osteopathic Medicine,
338 respectively; requiring the boards to adopt rules and
339 set fees; providing for expiration of a certificate;
340 amending ss. 458.331 and 459.015, F.S.; providing
341 grounds for disciplinary action for providing
342 misleading, deceptive, or fraudulent expert witness
343 testimony relating to the practice of medicine and of
344 osteopathic medicine, respectively; providing for
345 construction with respect to the doctrine of
346 incorporation by reference; amending s. 499.003, F.S.;
347 redefining the term “health care entity” to clarify
348 that a blood establishment is a health care entity

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349 that may engage in certain activities; amending s.
350 499.005, F.S.; clarifying provisions that prohibit the
351 unauthorized wholesale distribution of a prescription
352 drug that was purchased by a hospital or other health
353 care entity or donated or supplied at a reduced price
354 to a charitable organization, to conform to changes
355 made by the act; amending s. 499.01, F.S.; exempting
356 certain blood establishments from the requirements to
357 be permitted as a prescription drug manufacturer and
358 register products; requiring that certain blood
359 establishments obtain a restricted prescription drug
360 distributor permit under specified conditions;
361 limiting the prescription drugs that a blood
362 establishment may distribute under a restricted
363 prescription drug distributor permit; authorizing the
364 Department of Health to adopt rules regarding the
365 distribution of prescription drugs by blood
366 establishments; amending s. 626.9541, F.S.;
367 authorizing insurers to offer rewards or incentives to
368 health benefit plan members to encourage or reward
369 participation in wellness or health improvement
370 programs; authorizing insurers to require plan members
371 not participating in programs to provide verification
372 that their medical condition warrants
373 nonparticipation; providing application; amending s.
374 627.4147, F.S.; deleting a requirement that a medical
375 malpractice insurance contract include a clause
376 authorizing an insurer to admit liability and make a
377 settlement offer if the offer is within policy limits

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378 without the insured's permission; amending s. 766.102,
379 F.S.; providing that a physician who is an expert
380 witness in a medical malpractice presuit action must
381 meet certain requirements; amending s. 766.104, F.S.;
382 requiring a good faith demonstration in a medical
383 malpractice case that there has been a breach of the
384 standard of care; amending s. 766.106, F.S.;
385 clarifying that a physician acting as an expert
386 witness is subject to disciplinary actions; amending
387 s. 766.1115, F.S.; conforming provisions to changes
388 made by the act; creating s. 766.1183, F.S.; defining
389 terms; providing for the recovery of civil damages by
390 Medicaid recipients according to a modified standard
391 of care; providing for recovery of certain excess
392 judgments by act of the Legislature; requiring the
393 Department of Children and Family Services to provide
394 notice to program applicants; creating s. 766.1184,
395 F.S.; defining terms; providing for the recovery of
396 civil damages by certain recipients of primary care
397 services at primary care clinics receiving specified
398 low-income pool funds according to a modified standard
399 of care; providing for recovery of certain excess
400 judgments by act of the Legislature; providing
401 requirements of health care providers receiving such
402 funds in order for the liability provisions to apply;
403 requiring notice to low-income pool recipients;
404 amending s. 766.203, F.S.; requiring the presuit
405 investigations conducted by the claimant and the
406 prospective defendant in a medical malpractice action

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407 to provide grounds for a breach of the standard of
408 care; amending s. 768.28, F.S.; revising a definition;
409 providing that certain colleges and universities that
410 own or operate an accredited medical school and their
411 employees and agents providing patient services in a
412 teaching hospital pursuant to an affiliation agreement
413 or contract with the teaching hospital are considered
414 agents of the hospital for the purposes of sovereign
415 immunity; providing definitions; requiring patients of
416 such hospitals to be provided with notice of their
417 remedies under sovereign immunity; providing an
418 exception; providing that providers and vendors
419 providing services to certain persons with
420 disabilities on behalf of the state are agents of the
421 state for the purposes of sovereign immunity;
422 providing legislative findings and intent with respect
423 to including certain colleges and universities and
424 their employees and agents under sovereign immunity;
425 providing a statement of public necessity; amending s.
426 1004.41, F.S.; clarifying provisions relating to
427 references to the corporation known as Shands Teaching
428 Hospital and Clinics, Inc.; clarifying provisions
429 regarding the purpose of the corporation; authorizing
430 the corporation to create corporate subsidiaries and
431 affiliates; providing that Shands Teaching Hospital
432 and Clinics, Inc., Shands Jacksonville Medical Center,
433 Inc., Shands Jacksonville Healthcare, Inc., and any
434 not-for-profit subsidiary of such entities are
435 instrumentalities of the state for purposes of

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436 sovereign immunity; repealing s. 409.9121, F.S.,
437 relating to legislative intent concerning managed
438 care; repealing s. 409.919, F.S., relating to rule
439 authority; repealing s. 624.915, F.S., relating to the
440 Florida Healthy Kids Corporation operating fund;
441 renumbering and transferring ss. 409.942, 409.944,
442 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.
443 414.29, 163.464, 163.465, 163.466, 402.81, and 402.82,
444 F.S., respectively; amending s. 443.111, F.S.;
445 conforming a cross-reference; directing the Agency for
446 Health Care Administration to submit a reorganization
447 plan to the Legislature; providing for the state's
448 withdrawal from the Medicaid program under certain
449 circumstances; providing for severability; providing
450 an effective date.
451
452 Be It Enacted by the Legislature of the State of Florida:
453
454 Section 1. Paragraph (c) of subsection (2) of section
455 163.387, Florida Statutes, is amended to read:
456 163.387 Redevelopment trust fund.—
457 (2)
458 (c) The following public bodies or taxing authorities are
459 exempt from paragraph (a):
460 1. A special district that levies ad valorem taxes on
461 taxable real property in more than one county.
462 2. A special district for which the sole available source
463 of revenue the district has the authority to levy is ad valorem
464 taxes at the time an ordinance is adopted under this section.

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465 However, revenues or aid that may be dispensed or appropriated
466 to a district as defined in s. 388.011 at the discretion of an
467 entity other than such district shall not be deemed available.
468 3. A library district, except a library district in a
469 jurisdiction where the community redevelopment agency had
470 validated bonds as of April 30, 1984.
471 4. A neighborhood improvement district created under the
472 Safe Neighborhoods Act.
473 5. A metropolitan transportation authority.
474 6. A water management district created under s. 373.069.
475 7. A hospital district that is a special district as
476 defined in s. 189.403, a county hospital that has taxing
477 authority under chapter 155, or a public health trust
478 established pursuant to s. 154.07.
479 Section 2. Section 200.186, Florida Statutes, is created to
480 read:
481 200.186 Hospital districts.—Notwithstanding any special act
482 or other law governing the expenditure of ad valorem revenues,
483 ad valorem revenues raised pursuant to a special act
484 establishing a hospital district, by a county hospital pursuant
485 to chapter 155, or a public health trust established pursuant to
486 s. 154.07, and disbursed by the district, county hospital, or
487 trust to municipalities or other organizations, may be used only
488 to pay for health care services.
489 Section 3. Present subsections (7) and (8) of section
490 393.0661, Florida Statutes, are redesignated as subsections (8)
491 and (9), respectively, a new subsection (7) is added to that
492 section, and present subsection (7) of that section is amended,
493 to read:

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494 393.0661 Home and community-based services delivery system;
495 comprehensive redesign.—The Legislature finds that the home and
496 community-based services delivery system for persons with
497 developmental disabilities and the availability of appropriated
498 funds are two of the critical elements in making services
499 available. Therefore, it is the intent of the Legislature that
500 the Agency for Persons with Disabilities shall develop and
501 implement a comprehensive redesign of the system.
502 (7) The agency shall impose and collect the fee authorized
503 by s. 409.906(13)(d) upon approval by the Centers for Medicare
504 and Medicaid Services.
505 (8) ~~(7)~~ ~~Nothing in~~ This section or related ~~in any~~
506 ~~administrative~~ rule does not ~~shall be construed to~~ prevent or
507 limit the Agency for Health Care Administration, in consultation
508 with the Agency for Persons with Disabilities, from adjusting
509 fees, reimbursement rates, lengths of stay, number of visits, or
510 number of services, or from limiting enrollment, or making any
511 other adjustment necessary to comply with the availability of
512 moneys and any limitations or directions provided ~~for~~ in the
513 General Appropriations Act or pursuant to s. 409.9022.
514 Section 4. The Division of Statutory Revision is requested
515 to designate ss. 409.016-409.803, Florida Statutes, as part I of
516 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC
517 ASSISTANCE."
518 Section 5. Section 409.016, Florida Statutes, is amended to
519 read:
520 409.016 Definitions.—As used in this part, the term
521 ~~chapter~~:
522 (1) "Department~~,~~" ~~unless otherwise specified,~~ means the

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523 Department of Children and Family Services.
524 (2) "Secretary" means the Secretary of ~~the Department of~~
525 Children and Family Services.
526 (3) "Social and economic services~~,~~" ~~within the meaning of~~
527 ~~this chapter,~~ means the providing of financial assistance as
528 well as preventive and rehabilitative social services for
529 children, adults, and families.
530 Section 6. Section 409.16713, Florida Statutes, is created
531 to read:
532 409.16713 Medical assistance for children in out-of-home
533 care and adopted children.—
534 (1) A child who is eligible under Title IV-E of the Social
535 Security Act, as amended, for subsidized board payments, foster
536 care, or adoption subsidies, and a child for whom the state has
537 assumed temporary or permanent responsibility and who does not
538 qualify for Title IV-E assistance but is in foster care, shelter
539 or emergency shelter care, or subsidized adoption is eligible
540 for medical assistance as provided in s. 409.903(4). This
541 includes a young adult who is eligible to receive services under
542 s. 409.1451(5) until the young adult reaches 21 years of age,
543 and a person who was eligible, as a child, under Title IV-E for
544 foster care or the state-provided foster care and who is a
545 participant in the Road-to-Independence Program.
546 (2) If medical assistance under Title XIX of the Social
547 Security Act, as amended, is not available due to the refusal of
548 the federal Department of Health and Human Services to provide
549 federal funds, a child or young adult described in subsection
550 (1) is eligible for medical services under the Medicaid managed
551 care program established in s. 409.963. Such medical assistance

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552 shall be obtained by the community-based care lead agencies
553 established under s. 409.1671 and is subject to the availability
554 of funds appropriated for such purpose in the General
555 Appropriations Act.
556 (3) It is the intent of the Legislature that the provision
557 of medical assistance meet the requirements of s. 471(a)(21) of
558 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),
559 related to eligibility for Title IV-E of the Social Security
560 Act, and that compliance with such provisions meet the
561 requirements of s. 402(a)(3) of the Social Security Act, as
562 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary
563 Assistance for Needy Families Block Grant Program.
564 Section 7. The Division of Statutory Revision is requested
565 to designate ss. 409.810-409.821, Florida Statutes, as part II
566 of chapter 409, Florida Statutes, entitled "KIDCARE."
567 Section 8. Section 624.91, Florida Statutes, is
568 transferred, renumbered as section 409.8115, Florida Statutes,
569 paragraph (b) of subsection (5) of that section is amended, and
570 subsection (8) is added to that section, to read:
571 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.—
572 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
573 (b) The Florida Healthy Kids Corporation shall:
574 1. Arrange for the collection of any family, local
575 contributions, or employer payment or premium, in an amount to
576 be determined by the board of directors, to provide for payment
577 of premiums for comprehensive insurance coverage and for the
578 actual or estimated administrative expenses.
579 2. Arrange for the collection of any voluntary
580 contributions ~~to provide~~ for payment of ~~Florida~~ Kidcare program

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581 premiums for children who are not eligible for medical
582 assistance under Title XIX or Title XXI of the Social Security
583 Act.
584 3. Subject to ~~the provisions of~~ s. 409.8134, accept
585 voluntary supplemental local match contributions that comply
586 with ~~the requirements of~~ Title XXI of the Social Security Act
587 for the purpose of providing additional ~~Florida~~ Kidcare coverage
588 in contributing counties under Title XXI.
589 4. Establish the administrative and accounting procedures
590 for the operation of the corporation.
591 5. Establish, with consultation from appropriate
592 professional organizations, standards for preventive health
593 services and providers and comprehensive insurance benefits
594 appropriate to children if~~, provided that~~ such standards for
595 rural areas do ~~shall~~ not limit primary care providers to board-
596 certified pediatricians.
597 6. Determine eligibility for children seeking to
598 participate in the Title XXI-funded components of the ~~Florida~~
599 Kidcare program consistent with the requirements specified in s.
600 409.814, as well as the non-Title-XXI-eligible children as
601 provided in subsection (3).
602 7. Establish procedures under which providers of local
603 match to, applicants to, and participants in the program may
604 have grievances reviewed by an impartial body and reported to
605 the board of directors of the corporation.
606 8. Establish participation criteria and, if appropriate,
607 contract with an authorized insurer, health maintenance
608 organization, or third-party administrator to provide
609 administrative services to the corporation.

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610 9. Establish enrollment criteria that include penalties or
611 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage
612 upon voluntary cancellation for nonpayment of family premiums.
613 10. Contract with authorized insurers or providers ~~any~~
614 ~~provider~~ of health care services, who meet ~~meeting~~ standards
615 established by the corporation, for the provision of
616 comprehensive insurance coverage to participants. Such standards
617 must ~~shall~~ include criteria under which the corporation may
618 contract with more than one provider of health care services in
619 program sites. Health plans shall be selected through a
620 competitive bid process. The Florida Healthy Kids Corporation
621 shall purchase goods and services in the most cost-effective
622 manner consistent with the delivery of quality medical care. The
623 maximum administrative cost for a Florida Healthy Kids
624 Corporation contract shall be 10 ~~15~~ percent. For health care
625 contracts, the minimum medical loss ratio for a Florida Healthy
626 Kids Corporation contract shall be 90 ~~85~~ percent. For dental
627 contracts, the remaining compensation to be paid to the
628 authorized insurer or provider must be at least 90 ~~under a~~
629 ~~Florida Healthy Kids Corporation contract shall be no less than~~
630 ~~an amount which is 85~~ percent of the premium, and~~;~~ to the extent
631 any contract provision does not provide for this minimum
632 compensation, this section prevails ~~shall prevail~~. The health
633 plan selection criteria and scoring system, and the scoring
634 results, shall be available upon request for inspection after
635 the bids have been awarded.
636 11. Establish disenrollment criteria if ~~in the event~~ local
637 matching funds are insufficient to cover enrollments.
638 12. Develop and implement a plan to publicize the Florida

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639 Kidcare program, the eligibility requirements of the program,
640 and the procedures for enrollment in the program and to maintain
641 public awareness of the corporation and the program. Such plan
642 must include using the application form for the school lunch and
643 breakfast programs as provided under s. 1006.06(7).
644 13. Secure staff necessary to properly administer the
645 corporation. Staff costs shall be funded from state and local
646 matching funds and such other private or public funds as become
647 available. The board of directors shall determine the number of
648 staff members necessary to administer the corporation.
649 14. In consultation with the partner agencies, provide an
650 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the
651 Governor, the Chief Financial Officer, the Commissioner of
652 Education, the President of the Senate, the Speaker of the House
653 of Representatives, and the Minority Leaders of the Senate and
654 the House of Representatives.
655 15. Provide information on a quarterly basis to the
656 Legislature and the Governor which compares the costs and
657 utilization of the full-pay enrolled population and the Title
658 XXI-subsidized enrolled population in the Florida Kidcare
659 program. ~~The information,~~ At a minimum, the information must
660 include:
661 a. The monthly enrollment and expenditure for full-pay
662 enrollees in the Medikids and Florida Healthy Kids programs
663 compared to the Title XXI-subsidized enrolled population; and
664 b. The costs and utilization by service of the full-pay
665 enrollees in the Medikids and Florida Healthy Kids programs and
666 the Title XXI-subsidized enrolled population.
667

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668 By February 1, 2010, the Florida Healthy Kids Corporation shall
669 provide a study to the Legislature and the Governor on premium
670 impacts to the subsidized portion of the program from the
671 inclusion of the full-pay program, which must ~~shall~~ include
672 recommendations on how to eliminate or mitigate possible impacts
673 to the subsidized premiums.
674 16. Establish benefit packages that conform to ~~the~~
675 ~~provisions of~~ the Florida Kidcare program, as created under this
676 part ~~in ss. 409.810-409.821~~.
677 (8) OPERATING FUND.—The Florida Healthy Kids Corporation
678 may establish and manage an operating fund for the purposes of
679 addressing the corporation's unique cash-flow needs and
680 facilitating the fiscal management of the corporation. At any
681 given time, the corporation may accumulate and maintain in the
682 operating fund a cash balance reserve equal to no more than 25
683 percent of its annualized operating expenses. Upon dissolution
684 of the corporation, any remaining cash balances of state funds
685 shall revert to the General Revenue Fund, or such other state
686 funds consistent with the appropriated funding, as provided by
687 law.
688 Section 9. Subsection (1) of section 409.813, Florida
689 Statutes, is amended to read:
690 409.813 Health benefits coverage; program components;
691 entitlement and nonentitlement.—
692 (1) The Florida Kidcare program includes health benefits
693 coverage provided to children through the following program
694 components, which shall be marketed as the Florida Kidcare
695 program:
696 (a) Medicaid.~~;~~

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697 (b) Medikids as created in s. 409.8132.~~;~~
698 (c) The Florida Healthy Kids Corporation as created in s.
699 409.8115. ~~624.91;~~
700 (d) Employer-sponsored group health insurance plans
701 approved under this part. ~~ss. 409.810-409.821; and~~
702 (e) The Children's Medical Services network ~~established in~~
703 ~~chapter 391~~.
704 Section 10. Subsection (4) of section 409.8132, Florida
705 Statutes, is amended to read:
706 409.8132 Medikids program component.—
707 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
708 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
709 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,
710 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,
711 409.987, 409.988, and 409.989 apply to the administration of the
712 Medikids program component of the Florida Kidcare program,
713 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified
714 by ~~the provisions of~~ subsection (7).
715 Section 11. Subsection (1) of section 409.815, Florida
716 Statutes, is amended to read:
717 409.815 Health benefits coverage; limitations.—
718 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare
719 program, benefits available under Medicaid and Medikids include
720 those goods and services provided under the medical assistance
721 program authorized by Title XIX of the Social Security Act, and
722 regulations thereunder, as administered in this state by the
723 agency. This includes those mandatory Medicaid services
724 authorized under s. 409.905 and optional Medicaid services
725 authorized under s. 409.906, rendered on behalf of eligible

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726 individuals by qualified providers, in accordance with federal
727 requirements ~~for Title XIX~~, subject to any limitations or
728 directions provided ~~for~~ in the General Appropriations Act, ~~or~~
729 chapter 216, or s. 409.9022, and according to methodologies and
730 limitations set forth in agency rules and policy manuals and
731 handbooks incorporated by reference ~~thereto~~.
732 Section 12. Subsection (5) of section 409.818, Florida
733 Statutes, is amended to read:
734 409.818 Administration.—In order to implement ss. 409.810-
735 409.821, the following agencies shall have the following duties:
736 (5) The Florida Healthy Kids Corporation shall retain its
737 functions as authorized in s. 409.8115 ~~624.91~~, including
738 eligibility determination for participation in the Healthy Kids
739 program.
740 Section 13. Paragraph (e) of subsection (2) of section
741 154.503, Florida Statutes, is amended to read:
742 154.503 Primary Care for Children and Families Challenge
743 Grant Program; creation; administration.—
744 (2) The department shall:
745 (e) Coordinate with the primary care program developed
746 pursuant to s. 154.011, the Florida Healthy Kids Corporation
747 program created in s. 409.8115 ~~624.91~~, the school health
748 services program created in ss. 381.0056 and 381.0057, the
749 Healthy Communities, Healthy People Program created in s.
750 381.734, and the volunteer health care provider program
751 established ~~developed~~ pursuant to s. 766.1115.
752 Section 14. Paragraph (c) of subsection (4) of section
753 408.915, Florida Statutes, is amended to read:
754 408.915 Eligibility pilot project.—The Agency for Health

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755 Care Administration, in consultation with the steering committee
756 established in s. 408.916, shall develop and implement a pilot
757 project to integrate the determination of eligibility for health
758 care services with information and referral services.
759 (4) The pilot project shall include eligibility
760 determinations for the following programs:
761 (c) Florida Healthy Kids as described in s. 409.8115 ~~624.91~~
762 and within eligibility guidelines provided in s. 409.814.
763 Section 15. Subsection (7) is added to section 1006.06,
764 Florida Statutes, to read:
765 1006.06 School food service programs.—
766 (7) Each school district shall collaborate with the Florida
767 Kidcare program created pursuant to ss. 409.810-409.821 to:
768 (a) At a minimum:
769 1. Provide application information about the Kidcare
770 program or an application for Kidcare to students at the
771 beginning of each school year.
772 2. Modify the school district's application form for the
773 lunch program under subsection (4) and the breakfast program
774 under subsection (5) to incorporate a provision that permits the
775 school district to share data from the application form with the
776 state agencies and the Florida Healthy Kids Corporation and its
777 agents that administer the Kidcare program unless the child's
778 parent or guardian opts out of the provision.
779 (b) At the option of the school district, share income and
780 other demographic data through an electronic interchange with
781 the Florida Healthy Kids Corporation and other state agencies in
782 order to determine eligibility for the Kidcare program on a
783 regular and periodic basis.

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784 (c) Establish interagency agreements ensuring that data
785 exchanged under this subsection is used only to enroll eligible
786 children in the Florida Kidcare program and is protected from
787 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).
788 Section 16. The Division of Statutory Revision is requested
789 to designate ss. 409.901 through 409.9205, Florida Statutes, as
790 part III of chapter 409, Florida Statutes, entitled "MEDICAID."
791 Section 17. Section 409.901, Florida Statutes, is amended
792 to read:
793 409.901 Definitions~~; ss. 409.901-409.920~~.—As used in this
794 part and part IV ~~ss. 409.901-409.920, except as otherwise~~
795 ~~specifically provided~~, the term:
796 (1) "Affiliate" or "affiliated person" means any person who
797 directly or indirectly manages, controls, or oversees the
798 operation of a corporation or other business entity that is a
799 Medicaid provider, regardless of whether such person is a
800 partner, shareholder, owner, officer, director, agent, or
801 employee of the entity.
802 (2) "Agency" means the Agency for Health Care
803 Administration. ~~The agency is the Medicaid agency for the state,~~
804 ~~as provided under federal law.~~
805 (3) "Applicant" means an individual whose written
806 application for medical assistance provided by Medicaid ~~under~~
807 ~~ss. 409.903-409.906~~ has been submitted to the Department of
808 Children and Family Services, or to the Social Security
809 Administration if the application is for Supplemental Security
810 Income, but has not received final action. The ~~This~~ term
811 includes an individual, who need not be alive at the time of
812 application, and whose application is submitted through a

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813 representative or a person acting for the individual.
814 (4) “Benefit” means any benefit, assistance, aid,
815 obligation, promise, debt, liability, or the like, related to
816 any covered injury, illness, or necessary medical care, goods,
817 or services.
818 (5) “Capitation” means a prospective per-member, per-month
819 payment designed to represent, in the aggregate, an actuarially
820 sound estimate of expenditures required for the management and
821 provision of a specified set of medical services or long-term
822 care services needed by members enrolled in a prepaid health
823 plan.
824 (6) ~~(5)~~ “Change of ownership” has the same meaning as in s.
825 408.803 and includes ~~means:~~
826 ~~(a) An event in which the provider ownership changes to a~~
827 ~~different individual entity as evidenced by a change in federal~~
828 ~~employer identification number or taxpayer identification~~
829 ~~number;~~
830 ~~(b) An event in which 51 percent or more of the ownership,~~
831 ~~shares, membership, or controlling interest of a provider is in~~
832 ~~any manner transferred or otherwise assigned. This paragraph~~
833 ~~does not apply to a licensee that is publicly traded on a~~
834 ~~recognized stock exchange; or~~
835 ~~(c) When the provider is licensed or registered by the~~
836 ~~agency,~~ an event considered a change of ownership under part II
837 of chapter 408 ~~for licensure as defined in s. 408.803~~.
838
839 ~~A change solely in the management company or board of directors~~
840 ~~is not a change of ownership.~~
841 (7) ~~(6)~~ “Claim” means any communication, whether written or

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842 electronic (electronic impulse or magnetic), which is used by
843 any person to apply for payment from the Medicaid program, ~~or~~
844 its fiscal agent, or a qualified plan under part IV of this
845 chapter for each item or service purported ~~by any person~~ to have
846 been provided ~~by a person~~ to a ~~any~~ Medicaid recipient.
847 (8) ~~(7)~~ "Collateral" means:
848 (a) Any and all causes of action, suits, claims,
849 counterclaims, and demands that accrue to a ~~the~~ recipient or to
850 a ~~the~~ recipient's legal representative, related to any covered
851 injury, illness, or necessary medical care, goods, or services
852 that resulted in ~~necessitated that~~ Medicaid providing ~~provide~~
853 medical assistance.
854 (b) All judgments, settlements, and settlement agreements
855 rendered or entered into and related to ~~such~~ causes of action,
856 suits, claims, counterclaims, demands, or judgments.
857 (c) Proceeds, as defined in this section.
858 (9) ~~(8)~~ "Convicted" or "conviction" means a finding of
859 guilt, with or without an adjudication of guilt, in any federal
860 or state trial court ~~of record relating to charges brought by~~
861 ~~indictment or information,~~ as a result of a jury verdict,
862 nonjury trial, or entry of a plea of guilty or nolo contendere,
863 regardless of whether an appeal from judgment is pending.
864 (10) ~~(9)~~ "Covered injury or illness" means any sickness,
865 injury, disease, disability, deformity, abnormality disease,
866 necessary medical care, pregnancy, or death for which a third
867 party is, may be, could be, should be, or has been liable, and
868 for which Medicaid is, or may be, obligated to provide, or has
869 provided, medical assistance.
870 (11) ~~(10)~~ "Emergency medical condition" has the same meaning

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871 as in s. 395.002. ~~means:~~
872 ~~(a) A medical condition manifesting itself by acute~~
873 ~~symptoms of sufficient severity, which may include severe pain~~
874 ~~or other acute symptoms, such that the absence of immediate~~
875 ~~medical attention could reasonably be expected to result in any~~
876 ~~of the following:~~
877 ~~1. Serious jeopardy to the health of a patient, including a~~
878 ~~pregnant woman or a fetus.~~
879 ~~2. Serious impairment to bodily functions.~~
880 ~~3. Serious dysfunction of any bodily organ or part.~~
881 ~~(b) With respect to a pregnant woman:~~
882 ~~1. That there is inadequate time to effect safe transfer to~~
883 ~~another hospital prior to delivery.~~
884 ~~2. That a transfer may pose a threat to the health and~~
885 ~~safety of the patient or fetus.~~
886 ~~3. That there is evidence of the onset and persistence of~~
887 ~~uterine contractions or rupture of the membranes.~~
888 (12) ~~(11)~~ "Emergency services and care" has the same meaning
889 as in s. 395.002 ~~means medical screening, examination, and~~
890 ~~evaluation by a physician, or, to the extent permitted by~~
891 ~~applicable laws, by other appropriate personnel under the~~
892 ~~supervision of a physician, to determine whether an emergency~~
893 ~~medical condition exists and, if it does, the care, treatment,~~
894 ~~or surgery for a covered service by a physician which is~~
895 ~~necessary to relieve or eliminate the emergency medical~~
896 ~~condition, within the service capability of a hospital~~.
897 (13) ~~(12)~~ "Legal representative" means a guardian,
898 conservator, survivor, or personal representative of a recipient
899 or applicant, or of the property or estate of a recipient or

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900 applicant.
901 (14)~~(13)~~ "Managed care plan" means a health insurer
902 authorized under chapter 624, an exclusive provider organization
903 authorized under chapter 627, a health maintenance organization
904 authorized under chapter 641, a provider service network
905 authorized under s. 409.912(4)(d), or an accountable care
906 organization authorized under federal law ~~health maintenance~~
907 ~~organization authorized pursuant to chapter 641 or a prepaid~~
908 ~~health plan authorized pursuant to s. 409.912~~.
909 (15)~~(14)~~ "Medicaid" or Medicaid program means the medical
910 assistance program authorized by Title XIX of the Social
911 Security Act, 42 U.S.C. s. 1396 et seq., and regulations
912 thereunder, as administered in this state by the agency.
913 ~~(15) "Medicaid agency" or "agency" means the single state~~
914 ~~agency that administers or supervises the administration of the~~
915 ~~state Medicaid plan under federal law.~~
916 ~~(16) "Medicaid program" means the program authorized under~~
917 ~~Title XIX of the federal Social Security Act which provides for~~
918 ~~payments for medical items or services, or both, on behalf of~~
919 ~~any person who is determined by the Department of Children and~~
920 ~~Family Services, or, for Supplemental Security Income, by the~~
921 ~~Social Security Administration, to be eligible on the date of~~
922 ~~service for Medicaid assistance.~~
923 (16)~~(17)~~ "Medicaid provider" or "provider" means a person
924 or entity that has a Medicaid provider agreement in effect with
925 the agency and is in good standing with the agency. The term
926 also includes a person or entity that provides medical services
927 to a Medicaid recipient under the Medicaid managed care program
928 in part IV of this chapter.

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929 (17)~~(18)~~ “Medicaid provider agreement” or “provider
930 agreement” means a contract between the agency and a provider
931 for the provision of services or goods, or both, to Medicaid
932 recipients pursuant to Medicaid.
933 (18)~~(19)~~ “Medicaid recipient” or “recipient” means an
934 individual whom the Department of Children and Family Services,
935 or, for Supplemental Security Income, ~~by~~ the Social Security
936 Administration, determines is eligible, pursuant to federal and
937 state law, to receive medical assistance and related services
938 for which the agency may make payments under the Medicaid
939 program. For the purposes of determining third-party liability,
940 the term includes an individual formerly determined to be
941 eligible for Medicaid, an individual who has received medical
942 assistance under ~~the~~ Medicaid ~~program~~, or an individual on whose
943 behalf Medicaid has become obligated.
944 (19)~~(20)~~ “Medicaid-related records” means records that
945 relate to the provider’s business or profession and to a
946 Medicaid recipient. The term includes ~~Medicaid-related records~~
947 ~~include~~ records related to non-Medicaid customers, clients, or
948 patients but only to the extent that the documentation is shown
949 by the agency to be necessary for determining ~~to determine~~ a
950 provider’s entitlement to payments under the Medicaid program.
951 (20)~~(21)~~ “Medical assistance” means any provision of,
952 payment for, or liability for medical services or care by
953 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.
954 (21)~~(22)~~ “Medical services” or “medical care” means medical
955 or medically related institutional or noninstitutional care,
956 goods, or services covered by the Medicaid program. The term
957 includes any services authorized and funded in the General

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958 Appropriations Act.
959 (22)~~(23)~~ “MediPass” means a primary care case management
960 program operated by the agency.
961 (23)~~(24)~~ “Minority physician network” means a network of
962 primary care physicians with experience in managing Medicaid or
963 Medicare recipients which ~~that~~ is predominantly owned by
964 minorities, as defined in s. 288.703, and which may have a
965 collaborative partnership with a public college or university
966 and a tax-exempt charitable corporation.
967 (24)~~(25)~~ “Payment,” as it relates to third-party benefits,
968 means performance of a duty, promise, or obligation, or
969 discharge of a debt or liability, by the delivery, provision, or
970 transfer of third-party benefits for medical services. To “pay”
971 means to do any of the acts set forth in this subsection.
972 (25)~~(26)~~ “Proceeds” means whatever is received upon the
973 sale, exchange, collection, or other disposition of the
974 collateral or proceeds thereon and includes insurance payable by
975 reason of loss or damage to the collateral or proceeds. Money,
976 checks, deposit accounts, and the like are “cash proceeds.” All
977 other proceeds are “noncash proceeds.”
978 (26)~~(27)~~ “Third party” means an individual, entity, or
979 program, excluding Medicaid, that is, may be, could be, should
980 be, or has been liable for all or part of the cost of medical
981 services related to any medical assistance covered by Medicaid.
982 A third party includes a third-party administrator or a pharmacy
983 benefits manager.
984 (27)~~(28)~~ “Third-party benefit” means any benefit that is or
985 may be available at any time through contract, court award,
986 judgment, settlement, agreement, or any arrangement between a

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987 third party and any person or entity, including, without
988 limitation, a Medicaid recipient, a provider, another third
989 party, an insurer, or the agency, for any Medicaid-covered
990 injury, illness, goods, or services, including costs of medical
991 services related thereto, for personal injury or for death of
992 the recipient, but specifically excluding policies of life
993 insurance on the recipient, unless available under terms of the
994 policy to pay medical expenses prior to death. The term
995 includes, without limitation, collateral, as defined in this
996 section, health insurance, any benefit under a health
997 maintenance organization, a preferred provider arrangement, a
998 prepaid health clinic, liability insurance, uninsured motorist
999 insurance or personal injury protection coverage, medical
1000 benefits under workers' compensation, and any obligation under
1001 law or equity to provide medical support.
1002 Section 18. Section 409.902, Florida Statutes, is amended
1003 to read:
1004 409.902 Designated single state agency; eligibility
1005 determinations; rules ~~payment requirements; program title;~~
1006 ~~release of medical records~~.
1007 (1) The agency ~~for Health Care Administration~~ is designated
1008 as the single state agency authorized to administer the Medicaid
1009 state plan and to make payments for medical assistance and
1010 related services under Title XIX of the Social Security Act.
1011 These payments shall be made, subject to any limitations or
1012 directions provided for in the General Appropriations Act, only
1013 for services included in the Medicaid program, ~~shall be made~~
1014 only on behalf of eligible individuals, and ~~shall be made~~ only
1015 to qualified providers in accordance with federal requirements

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1016 under ~~for~~ Title XIX of the Social Security Act and ~~the~~
1017 ~~provisions of~~ state law.
1018 (a) The agency must notify the Legislature before seeking
1019 an amendment to the state plan for purposes of implementing
1020 provisions authorized by the Deficit Reduction Act of 2005.
1021 (b) The agency shall adopt any rules necessary to carry out
1022 its statutory duties under this subsection and any other
1023 statutory provisions related to its responsibility for the
1024 Medicaid program and state compliance with federal Medicaid
1025 requirements, including the Medicaid managed care program. ~~This~~
1026 ~~program of medical assistance is designated the "Medicaid~~
1027 ~~program."~~
1028 (2) The Department of Children and Family Services is
1029 responsible for determining Medicaid eligibility ~~determinations~~,
1030 including, but not limited to, policy, rules, and the agreement
1031 with the Social Security Administration for Medicaid eligibility
1032 ~~determinations~~ for Supplemental Security Income recipients, as
1033 well as the actual determination of eligibility. ~~As a condition~~
1034 ~~of Medicaid eligibility, subject to federal approval, the agency~~
1035 ~~for Health Care Administration and the Department of Children~~
1036 ~~and Family Services shall ensure that each recipient of Medicaid~~
1037 ~~consents to the release of her or his medical records to the~~
1038 ~~agency for Health Care Administration and the Medicaid Fraud~~
1039 ~~Control Unit of the Department of Legal Affairs.~~
1040 (a) Eligibility is restricted to United States citizens and
1041 to lawfully admitted noncitizens who meet the criteria provided
1042 in s. 414.095(3).
1043 1. Citizenship or immigration status must be verified. For
1044 noncitizens, this includes verification of the validity of

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1045 documents with the United States Citizenship and Immigration
1046 Services using the federal SAVE verification process.
1047 2. State funds may not be used to provide medical services
1048 to individuals who do not meet the requirements of this
1049 paragraph unless the services are necessary to treat an
1050 emergency medical condition or are for pregnant women. Such
1051 services are authorized only to the extent provided under
1052 federal law and in accordance with federal regulations as
1053 provided in 42 C.F.R. s. 440.255.
1054 (b) When adopting rules relating to eligibility for
1055 institutional care services, hospice services, and home and
1056 community-based waiver programs, and regardless of whether a
1057 penalty will be applied due to the unlawful transfer of assets,
1058 the payment of fair compensation by an applicant for a personal
1059 care services contract entered into on or after October 1, 2011,
1060 shall be evaluated using the following criteria:
1061 1. The contracted services do not duplicate services
1062 available through other sources or providers, such as Medicaid,
1063 Medicare, private insurance, or another legally obligated third
1064 party;
1065 2. The contracted services directly benefit the individual
1066 and are not services normally provided out of love and
1067 consideration for the individual;
1068 3. The actual cost to deliver services is computed in a
1069 manner that clearly reflects the actual number of hours to be
1070 expended, and the contract clearly identifies each specific
1071 service and the average number of hours of each service to be
1072 delivered each month;
1073 4. The hourly rate for each contracted service is equal to

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1074 or less than the amount normally charged by a professional who
1075 traditionally provides the same or similar services;
1076 5. The contracted services are provided on a prospective
1077 basis only and not for services provided in the past; and
1078 6. The contract provides fair compensation to the
1079 individual in his or her lifetime as set forth in life
1080 expectancy tables adopted in rule 65A-1.716, Florida
1081 Administrative Code.
1082 (c) The department shall adopt any rules necessary to carry
1083 out its statutory duties under this subsection for receiving and
1084 processing Medicaid applications and determining Medicaid
1085 eligibility, and any other statutory provisions related to
1086 responsibility for the determination of Medicaid eligibility.
1087 Section 19. Section 409.9021, Florida Statutes, is amended
1088 to read:
1089 409.9021 Conditions for Medicaid ~~Forfeiture of~~ eligibility
1090 ~~agreement.~~ ~~—~~As a condition of Medicaid eligibility, subject to
1091 federal regulation and approval:~~,~~
1092 (1) A Medicaid applicant must consent ~~shall agree~~ in
1093 writing to:
1094 (a) Have her or his medical records released to the agency
1095 and the Medicaid Fraud Control Unit of the Department of Legal
1096 Affairs.
1097 (b) Forfeit all entitlements to any goods or services
1098 provided through the Medicaid program for the next 10 years if
1099 he or she has been found to have committed Medicaid fraud~~,~~
1100 through judicial or administrative determination~~, two times in a~~
1101 ~~period of 5 years~~. This provision applies only to the Medicaid
1102 recipient found to have committed or participated in Medicaid

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1103 ~~the~~ fraud and does not apply to any family member of the
1104 recipient who was not involved in the fraud.
1105 (2) A Medicaid applicant must pay a $10 monthly premium
1106 that covers all Medicaid-eligible recipients in the applicant's
1107 family. However, an individual who is eligible for the
1108 Supplemental Security Income related Medicaid and is receiving
1109 institutional care payments is exempt from this requirement. The
1110 agency shall seek a federal waiver to authorize the imposition
1111 and collection of this premium effective December 31, 2011. Upon
1112 approval, the agency shall establish by rule procedures for
1113 collecting premiums from recipients, advance notice of
1114 cancellation, and waiting periods for reinstatement of coverage
1115 upon voluntary cancellation for nonpayment of premiums.
1116 (3) A Medicaid applicant must participate, in good faith,
1117 in:
1118 (a) A medically approved smoking cessation program if the
1119 applicant smokes.
1120 (b) A medically directed weight loss program if the
1121 applicant is or becomes morbidly obese.
1122 (c) A medically approved alcohol or substance abuse
1123 recovery program if the applicant is or becomes diagnosed as a
1124 substance abuser.
1125
1126 The agency shall seek a federal waiver to authorize the
1127 implementation of this subsection in order to assist the
1128 recipient in mitigating lifestyle choices and avoiding behaviors
1129 associated with the use of high-cost medical services.
1130 (4) A person who is eligible for Medicaid services and who
1131 has access to health care coverage through an employer-sponsored

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1132 health plan may not receive Medicaid services reimbursed under
1133 s. 409.908, s. 409.912,or s. 409.986, but may use Medicaid
1134 financial assistance to pay the cost of premiums for the
1135 employer-sponsored health plan for the eligible person and his
1136 or her Medicaid-eligible family members.
1137 (5) A Medicaid recipient who has access to other insurance
1138 or coverage created pursuant to state or federal law may opt out
1139 of the Medicaid services provided under s. 409.908, s. 409.912,
1140 or s. 409.986 and use Medicaid financial assistance to pay the
1141 cost of premiums for the recipient and the recipient's Medicaid
1142 eligible family members.
1143 (6) Subsections (4) and (5) shall be administered by the
1144 agency in accordance with s. 409.964(1)(j). The maximum amount
1145 available for the Medicaid financial assistance shall be
1146 calculated based on the Medicaid capitated rate as if the
1147 Medicaid recipient and the recipient's eligible family members
1148 participated in a qualified plan for Medicaid managed care under
1149 part IV of this chapter.
1150 Section 20. Section 409.9022, Florida Statutes, is created
1151 to read:
1152 409.9022 Limitations on Medicaid expenditures.—
1153 (1) Except as specifically authorized in this section, a
1154 state agency may not obligate or expend funds for the Medicaid
1155 program in excess of the amount appropriated in the General
1156 Appropriations Act.
1157 (2) If, at any time during the fiscal year, a state agency
1158 determines that Medicaid expenditures may exceed the amount
1159 appropriated during the fiscal year, the state agency shall
1160 notify the Social Services Estimating Conference, which shall

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1161 meet to estimate Medicaid expenditures for the remainder of the
1162 fiscal year. If, pursuant to this paragraph or for any other
1163 purpose, the conference determines that Medicaid expenditures
1164 will exceed appropriations for the fiscal year, the state agency
1165 shall develop and submit a plan for revising Medicaid
1166 expenditures in order to remain within the annual appropriation.
1167 The plan must include cost-mitigating strategies to negate the
1168 projected deficit for the remainder of the fiscal year and shall
1169 be submitted in the form of a budget amendment to the
1170 Legislative Budget Commission. The conference shall also
1171 estimate the amount of savings which will result from such cost-
1172 mitigating strategies proposed by the state agency as well as
1173 any other strategies the conference may consider and recommend.
1174 (3) In preparing the budget amendment to revise Medicaid
1175 expenditures in order to remain within appropriations, a state
1176 agency shall include the following revisions to the Medicaid
1177 state plan, in the priority order listed below:
1178 (a) Reduction in administrative costs.
1179 (b) Elimination of optional benefits.
1180 (c) Elimination of optional eligibility groups.
1181 (d) Reduction to institutional and provider reimbursement
1182 rates.
1183 (e) Reduction in the amount, duration, and scope of
1184 mandatory benefits.
1185
1186 The state agency may not implement any of these cost-containment
1187 measures until the amendment is approved by the Legislative
1188 Budget Commission.
1189 (4) In order to remedy a projected expenditure in excess of

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1190 the amount appropriated in a specific appropriation within the
1191 Medicaid budget, a state agency may, consistent with chapter
1192 216:
1193 (a) Submit a budget amendment to transfer budget authority
1194 between appropriation categories;
1195 (b) Submit a budget amendment to increase federal trust
1196 authority or grants and donations trust authority if additional
1197 federal or local funds are available; or
1198 (c) Submit any other budget amendment consistent with
1199 chapter 216.
1200 (5) The agency shall amend the Medicaid state plan to
1201 incorporate the provisions of this section.
1202 (6) Chapter 216 does not permit the transfer of funds from
1203 any other program into the Medicaid program or the transfer of
1204 funds out of the Medicaid program into any other program.
1205 Section 21. Section 409.903, Florida Statutes, is amended
1206 to read:
1207 409.903 Mandatory payments for eligible persons.—The agency
1208 shall make payments for medical assistance and related services
1209 on behalf of the following categories of persons who the
1210 Department of Children and Family Services, or the Social
1211 Security Administration by contract with the department ~~of~~
1212 ~~Children and Family Services~~, determines to be eligible for
1213 Medicaid, subject to the income, assets, and categorical
1214 eligibility tests set forth in federal and state law. Payment on
1215 behalf of these recipients ~~Medicaid eligible persons~~ is subject
1216 to the availability of moneys and any limitations established by
1217 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1218 (1) Low-income families with children if ~~are eligible for~~

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1219 ~~Medicaid provided~~ they meet the following requirements:
1220 (a) The family includes a dependent child who is living
1221 with a caretaker relative.
1222 (b) The family's income does not exceed the gross income
1223 test limit.
1224 (c) The family's countable income and resources do not
1225 exceed the applicable Aid to Families with Dependent Children
1226 (AFDC) income and resource standards under the AFDC state plan
1227 in effect on ~~in~~ July 1996, except as amended in the Medicaid
1228 state plan to conform as closely as possible to the requirements
1229 of the welfare transition program, to the extent permitted by
1230 federal law.
1231 (2) A person who receives payments from, who is determined
1232 eligible for, or who was eligible for but lost cash benefits
1233 from the federal program known as the Supplemental Security
1234 Income program (SSI). This ~~category~~ includes a low-income person
1235 age 65 or over and a low-income person under age 65 considered
1236 to be permanently and totally disabled.
1237 (3) A child under age 21 living in a low-income, two-parent
1238 family, and a child under age 7 living with a nonrelative~~,~~ if
1239 the income and assets of the family or child, as applicable, do
1240 not exceed the resource limits under the Temporary Cash
1241 Assistance Program.
1242 (4) A child who is eligible under Title IV-E of the Social
1243 Security Act for subsidized board payments, foster care, or
1244 adoption subsidies, and a child for whom the state has assumed
1245 temporary or permanent responsibility and who does not qualify
1246 for Title IV-E assistance but is in foster care, shelter or
1247 emergency shelter care, or subsidized adoption. This ~~category~~

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1248 includes a young adult who is eligible to receive services under
1249 s. 409.1451(5), until the young adult reaches 21 years of age~~,~~
1250 without regard to any income, resource, or categorical
1251 eligibility test that is otherwise required. This ~~category~~ also
1252 includes a person who as a child was eligible under Title IV-E
1253 of the Social Security Act for foster care or the state-provided
1254 foster care and who is a participant in the Road-to-Independence
1255 Program.
1256 (5) A pregnant woman for the duration of her pregnancy and
1257 for the postpartum period as defined in federal law and rule, or
1258 a child under age 1, if either is living in a family that has an
1259 income which is at or below ~~150 percent of the most current~~
1260 ~~federal poverty level, or, effective January 1, 1992, that has~~
1261 ~~an income which is at or below~~ 185 percent of the most current
1262 federal poverty level. Such a person is not subject to an assets
1263 test. ~~Further,~~ A pregnant woman who applies for eligibility for
1264 the Medicaid program through a qualified Medicaid provider must
1265 be offered the opportunity, subject to federal rules, to be made
1266 presumptively eligible for the Medicaid program.
1267 (6) A child ~~born after September 30, 1983,~~ living in a
1268 family that has an income which is at or below 100 percent of
1269 the current federal poverty level, who has attained the age of
1270 6, but has not attained the age of 19. In determining the
1271 eligibility of such a child, an assets test is not required. A
1272 child who is eligible ~~for Medicaid~~ under this subsection must be
1273 offered the opportunity, subject to federal rules, to be made
1274 presumptively eligible. A child who has been deemed
1275 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in
1276 a managed care plan until the child's full eligibility

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1277 ~~determination~~ for Medicaid has been determined ~~completed~~.
1278 (7) A child living in a family that has an income that
1279 ~~which~~ is at or below 133 percent of the current federal poverty
1280 level, who has attained the age of 1, but has not attained the
1281 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an
1282 assets test is not required. A child who is eligible ~~for~~
1283 ~~Medicaid~~ under this subsection must be offered the opportunity,
1284 subject to federal rules, to be made presumptively eligible. A
1285 child who has been deemed presumptively eligible may ~~for~~
1286 ~~Medicaid shall~~ not be enrolled in a managed care plan until the
1287 child's full eligibility ~~determination~~ for Medicaid has been
1288 determined ~~completed~~.
1289 (8) A person who is age 65 or over or is determined by the
1290 agency to be disabled, whose income is at or below 100 percent
1291 of the most current federal poverty level and whose assets do
1292 not exceed limitations established by the agency. However, the
1293 agency may only pay for premiums, coinsurance, and deductibles,
1294 as required by federal law, unless additional coverage is
1295 provided for any or all members of this group under ~~by~~ s.
1296 409.904(1).
1297 Section 22. Section 409.904, Florida Statutes, is amended
1298 to read:
1299 409.904 Optional payments for eligible persons.—The agency
1300 may make payments for medical assistance and related services on
1301 behalf of the following categories of persons who are determined
1302 to be eligible for Medicaid, subject to the income, assets, and
1303 categorical eligibility tests set forth in federal and state
1304 law. Payment on behalf of these ~~Medicaid eligible~~ persons is
1305 subject to the availability of moneys and any limitations

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1306 established by the General Appropriations Act, ~~or~~ chapter 216,
1307 or s. 409.9022.
1308 (1) ~~Effective January 1, 2006, and~~ Subject to federal
1309 waiver approval, a person who is age 65 or older or is
1310 determined to be disabled, whose income is at or below 88
1311 percent of the federal poverty level, whose assets do not exceed
1312 established limitations, and who is not eligible for Medicare
1313 or, if eligible for Medicare, is also eligible for and receiving
1314 Medicaid-covered institutional care services, hospice services,
1315 or home and community-based services. The agency shall seek
1316 federal authorization through a waiver to provide this coverage.
1317 This subsection expires June 30, 2011.
1318 (2) The following persons who are eligible for the Medicaid
1319 nonpoverty medical subsidy, which includes the same services as
1320 those provided to other Medicaid recipients, with the exception
1321 of services in skilled nursing facilities and intermediate care
1322 facilities for the developmentally disabled:
1323 (a) A family, a pregnant woman, a child under age 21, a
1324 person age 65 or over, or a blind or disabled person, who would
1325 be eligible under any group listed in s. 409.903(1), (2), or
1326 (3), except that the income or assets of such family or person
1327 exceed established limitations. For a family or person in one of
1328 these coverage groups, medical expenses are deductible from
1329 income in accordance with federal requirements in order to make
1330 a determination of eligibility. ~~A family or person eligible~~
1331 ~~under the coverage known as the "medically needy," is eligible~~
1332 ~~to receive the same services as other Medicaid recipients, with~~
1333 ~~the exception of services in skilled nursing facilities and~~
1334 ~~intermediate care facilities for the developmentally disabled.~~

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1335 This paragraph expires June 30, 2011.
1336 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a
1337 child younger than 21 years of age who would be eligible under
1338 any group listed in s. 409.903, except that the income or assets
1339 of such group exceed established limitations. For a person in
1340 one of these coverage groups, medical expenses are deductible
1341 from income in accordance with federal requirements in order to
1342 make a determination of eligibility. ~~A person eligible under the~~
1343 ~~coverage known as the "medically needy" is eligible to receive~~
1344 ~~the same services as other Medicaid recipients, with the~~
1345 ~~exception of services in skilled nursing facilities and~~
1346 ~~intermediate care facilities for the developmentally disabled.~~
1347 (c) A family, a person age 65 or older, or a blind or
1348 disabled person, who would be eligible under any group listed in
1349 s. 409.903(1), (2), or (3), except that the income or assets of
1350 such family or person exceed established limitations. For a
1351 family or person in one of these coverage groups, medical
1352 expenses are deductible from income in accordance with federal
1353 requirements in order to make a determination of eligibility. A
1354 family, a person age 65 or older, or a blind or disabled person,
1355 covered under the Medicaid nonpoverty medical subsidy, is
1356 eligible to receive physician services only.
1357 (3) A person who is in need of the services of a licensed
1358 nursing facility, a licensed intermediate care facility for the
1359 developmentally disabled, or a state mental hospital, whose
1360 income does not exceed 300 percent of the SSI income standard,
1361 and who meets the assets standards established under federal and
1362 state law. In determining the person's responsibility for the
1363 cost of care, the following amounts must be deducted from the

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1364 person's income:
1365 (a) The monthly personal allowance for residents as set
1366 based on appropriations.
1367 (b) The reasonable costs of medically necessary services
1368 and supplies that are not reimbursable by the Medicaid program.
1369 (c) The cost of premiums, copayments, coinsurance, and
1370 deductibles for supplemental health insurance.
1371 (4) A low-income person who meets all other requirements
1372 for Medicaid eligibility except citizenship and who is in need
1373 of emergency medical services. The eligibility of such a
1374 recipient is limited to the period of the emergency, in
1375 accordance with federal regulations.
1376 (5) Subject to specific federal authorization, a woman
1377 living in a family that has an income that is at or below 185
1378 percent of the most current federal poverty level. Coverage is
1379 limited to ~~is eligible for~~ family planning services as specified
1380 in s. 409.905(3) for a period of up to 24 months following a
1381 loss of Medicaid benefits.
1382 (6) A child who has not attained the age of 19 who has been
1383 determined eligible for the Medicaid program is deemed to be
1384 eligible for a total of 6 months, regardless of changes in
1385 circumstances other than attainment of the maximum age.
1386 ~~Effective January 1, 1999,~~ A child who has not attained the age
1387 of 5 and who has been determined eligible for the Medicaid
1388 program is deemed to be eligible for a total of 12 months
1389 regardless of changes in circumstances other than attainment of
1390 the maximum age.
1391 (7) A child under 1 year of age who lives in a family that
1392 has an income above 185 percent of the most recently published

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1393 federal poverty level, but which is at or below 200 percent of
1394 such poverty level. In determining the eligibility ~~of such~~
1395 ~~child~~, an assets test is not required. A child who is eligible
1396 ~~for Medicaid~~ under this subsection must be offered the
1397 opportunity, subject to federal rules, to be made presumptively
1398 eligible.
1399 (8) An eligible person ~~A Medicaid-eligible individual~~ for
1400 the individual's health insurance premiums, if the agency
1401 determines that such payments are cost-effective.
1402 (9) Eligible women with incomes at or below 200 percent of
1403 the federal poverty level and under age 65, for cancer treatment
1404 pursuant to the federal Breast and Cervical Cancer Prevention
1405 and Treatment Act of 2000, screened through the Mary Brogan
1406 Breast and Cervical Cancer Early Detection Program established
1407 under s. 381.93.
1408 Section 23. Section 409.905, Florida Statutes, is amended
1409 to read:
1410 409.905 Mandatory Medicaid services.—The agency shall ~~may~~
1411 make payments for the following services, which are required ~~of~~
1412 ~~the state~~ by Title XIX of the Social Security Act, furnished by
1413 Medicaid providers to recipients who are ~~determined to be~~
1414 eligible on the dates on which the services were provided. Any
1415 service under this section shall be provided only when medically
1416 necessary and in accordance with state and federal law.
1417 Mandatory services rendered by providers in mobile units to
1418 Medicaid recipients may be restricted by the agency. This
1419 section does not ~~Nothing in this section shall be construed to~~
1420 prevent or limit the agency from adjusting fees, reimbursement
1421 rates, lengths of stay, number of visits, number of services, or

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1422 any other adjustments necessary to comply with the availability
1423 of moneys and any limitations or directions provided ~~for~~ in the
1424 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1425 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The
1426 agency shall pay for services provided to a recipient by a
1427 licensed advanced registered nurse practitioner who has a valid
1428 collaboration agreement with a licensed physician on file with
1429 the Department of Health or who provides anesthesia services in
1430 accordance with established protocol required by state law and
1431 approved by the medical staff of the facility in which the
1432 ~~anesthetic~~ service is performed. Reimbursement for such services
1433 must be provided in an amount that equals at least ~~not less than~~
1434 80 percent of the reimbursement to a physician who provides the
1435 same services, unless otherwise provided ~~for~~ in the General
1436 Appropriations Act.
1437 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
1438 SERVICES.—The agency shall pay for early and periodic screening
1439 and diagnosis of a recipient under age 21 to ascertain physical
1440 and mental problems and conditions and ~~provide treatment to~~
1441 ~~correct or ameliorate these problems and conditions. These~~
1442 ~~services include~~ all services determined by the agency to be
1443 medically necessary for the treatment, correction, or
1444 amelioration of these problems and conditions, including
1445 personal care, private duty nursing, durable medical equipment,
1446 physical therapy, occupational therapy, speech therapy,
1447 respiratory therapy, and immunizations.
1448 (3) FAMILY PLANNING SERVICES.—The agency shall pay for
1449 services necessary to enable a recipient voluntarily to plan
1450 family size or to space children. These services include

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1451 information; education; counseling regarding the availability,
1452 benefits, and risks of each method of pregnancy prevention;
1453 drugs and supplies; and necessary medical care and followup.
1454 Each recipient participating in ~~the~~ family planning ~~portion of~~
1455 ~~the Medicaid program~~ must be provided the choice of ~~freedom to~~
1456 ~~choose~~ any alternative method of family planning, as required by
1457 federal law.
1458 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
1459 nursing and home health aide services, supplies, appliances, and
1460 durable medical equipment, necessary to assist a recipient
1461 living at home. An entity that provides such services must
1462 ~~pursuant to this subsection shall~~ be licensed under part III of
1463 chapter 400. These services, equipment, and supplies, or
1464 reimbursement therefor, may be limited as provided in the
1465 General Appropriations Act and do not include services,
1466 equipment, or supplies provided to a person residing in a
1467 hospital or nursing facility.
1468 (a) ~~In providing home health care services,~~ The agency
1469 shall ~~may~~ require prior authorization of home health services
1470 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing
1471 rates. ~~The agency shall require prior authorization for visits~~
1472 ~~for home health services that are not associated with a skilled~~
1473 ~~nursing visit when the home health agency billing rates exceed~~
1474 ~~the state average by 50 percent or more.~~ The home health agency
1475 must submit the recipient’s plan of care and documentation that
1476 supports the recipient’s diagnosis to the agency when requesting
1477 prior authorization.
1478 (b) The agency shall implement a comprehensive utilization
1479 management program ~~that requires prior authorization~~ of all

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1480 private duty nursing services, an individualized treatment plan
1481 that includes information about medication and treatment orders,
1482 treatment goals, methods of care to be used, and plans for care
1483 coordination by nurses and other health professionals. The
1484 utilization management program must ~~shall~~ also include a process
1485 for periodically reviewing the ongoing use of private duty
1486 nursing services. The assessment of need shall be based on a
1487 child's condition;~~,~~ family support and care supplements;~~,~~ a
1488 family's ability to provide care;~~, and~~ a family's and child's
1489 schedule regarding work, school, sleep, and care for other
1490 family dependents; and a determination of the medical necessity
1491 for private duty nursing instead of other more cost-effective
1492 in-home services. When implemented, the private duty nursing
1493 utilization management program shall replace the current
1494 authorization program used by the agency ~~for Health Care~~
1495 ~~Administration~~ and the Children's Medical Services program of
1496 the Department of Health. The agency may competitively bid ~~on~~ a
1497 contract to select a qualified organization to provide
1498 utilization management of private duty nursing services. The
1499 agency may ~~is authorized to~~ seek federal waivers to implement
1500 this initiative.
1501 (c) The agency may not pay for home health services unless
1502 the services are medically necessary and:
1503 1. The services are ordered by a physician.
1504 2. The written prescription for the services is signed and
1505 dated by the recipient's physician before the development of a
1506 plan of care and before any request requiring prior
1507 authorization.
1508 3. The physician ordering the services is not employed,

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1509 under contract with, or otherwise affiliated with the home
1510 health agency rendering the services. However, this subparagraph
1511 does not apply to a home health agency affiliated with a
1512 retirement community, of which the parent corporation or a
1513 related legal entity owns a rural health clinic certified under
1514 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
1515 under part II of chapter 400, or an apartment or single-family
1516 home for independent living. For purposes of this subparagraph,
1517 the agency may, on a case-by-case basis, provide an exception
1518 for medically fragile children who are younger than 21 years of
1519 age.
1520 4. The physician ordering the services has examined the
1521 recipient within the 30 days preceding the initial request for
1522 the services and biannually thereafter.
1523 5. The written prescription for the services includes the
1524 recipient’s acute or chronic medical condition or diagnosis, the
1525 home health service required, and, for skilled nursing services,
1526 the frequency and duration of the services.
1527 6. The national provider identifier, Medicaid
1528 identification number, or medical practitioner license number of
1529 the physician ordering the services is listed on the written
1530 prescription for the services, the claim for home health
1531 reimbursement, and the prior authorization request.
1532 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1533 all covered services provided for the medical care and treatment
1534 of a recipient who is admitted as an inpatient by a licensed
1535 physician or dentist to a hospital licensed under part I of
1536 chapter 395. However, the agency shall limit the payment for
1537 inpatient hospital services for a Medicaid recipient 21 years of

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1538 age or older to 45 days or the number of days necessary to
1539 comply with the General Appropriations Act.
1540 (a) The agency may ~~is authorized to~~ implement reimbursement
1541 and utilization management reforms in order to comply with any
1542 limitations or directions in the General Appropriations Act,
1543 which may include, but are not limited to~~:~~ prior authorization
1544 for inpatient psychiatric days; prior authorization for
1545 nonemergency hospital inpatient admissions for individuals 21
1546 years of age and older; authorization of emergency and urgent-
1547 care admissions within 24 hours after admission; enhanced
1548 utilization and concurrent review programs for highly utilized
1549 services; reduction or elimination of covered days of service;
1550 adjusting reimbursement ceilings for variable costs; adjusting
1551 reimbursement ceilings for fixed and property costs; and
1552 implementing target rates of increase. The agency may limit
1553 prior authorization for hospital inpatient services to selected
1554 diagnosis-related groups, based on an analysis of the cost and
1555 potential for unnecessary hospitalizations represented by
1556 certain diagnoses. Admissions for normal delivery and newborns
1557 are exempt from requirements for prior authorization. In
1558 implementing the provisions of this section related to prior
1559 authorization, the agency must ~~shall~~ ensure that the process for
1560 authorization is accessible 24 hours per day, 7 days per week
1561 and that authorization is automatically granted if ~~when~~ not
1562 denied within 4 hours after the request. Authorization
1563 procedures must include steps for reviewing ~~review of~~ denials.
1564 Upon implementing the prior authorization program for hospital
1565 inpatient services, the agency shall discontinue its hospital
1566 retrospective review program.

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1567 (b) A licensed hospital maintained primarily for the care
1568 and treatment of patients having mental disorders or mental
1569 diseases may ~~is~~ not ~~eligible to~~ participate in the hospital
1570 inpatient portion of the Medicaid program except as provided in
1571 federal law. However, the Department of Children and Family
1572 Services shall apply for a waiver~~, within 9 months after June 5,~~
1573 ~~1991,~~ designed to provide hospitalization services for mental
1574 health reasons to children and adults in the most cost-effective
1575 and lowest cost setting possible. Such waiver shall include a
1576 request for the opportunity to pay for care in hospitals known
1577 under federal law as "institutions for mental disease" or
1578 "IMD's." The waiver proposal shall propose no additional
1579 aggregate cost to the state or Federal Government, and shall be
1580 conducted in Hillsborough County, Highlands County, Hardee
1581 County, Manatee County, and Polk County. The waiver proposal may
1582 incorporate competitive bidding for hospital services,
1583 comprehensive brokering, prepaid capitated arrangements, or
1584 other mechanisms deemed by the department to show promise in
1585 reducing the cost of acute care and increasing the effectiveness
1586 of preventive care. When developing the waiver proposal, the
1587 department shall take into account price, quality,
1588 accessibility, linkages of the hospital to community services
1589 and family support programs, plans of the hospital to ensure the
1590 earliest discharge possible, and the comprehensiveness of the
1591 mental health and other health care services offered by
1592 participating providers.
1593 (c) The agency shall adjust a hospital's current inpatient
1594 per diem rate to reflect the cost of serving the Medicaid
1595 population at that institution if:

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1596 1. The hospital experiences an increase in Medicaid
1597 caseload by more than 25 percent in any year, primarily
1598 resulting from the closure of a hospital in the same service
1599 area occurring after July 1, 1995;
1600 2. The hospital's Medicaid per diem rate is at least 25
1601 percent below the Medicaid per patient cost for that year; or
1602 3. The hospital is located in a county that has six or
1603 fewer general acute care hospitals, began offering obstetrical
1604 services on or after September 1999, and has submitted a request
1605 in writing to the agency for a rate adjustment after July 1,
1606 2000, but before September 30, 2000, in which case such
1607 hospital's Medicaid inpatient per diem rate shall be adjusted to
1608 cost, effective July 1, 2002. By October 1 of each year, the
1609 agency must provide estimated costs for any adjustment in a
1610 hospital inpatient per diem rate to the Executive Office of the
1611 Governor, the House of Representatives General Appropriations
1612 Committee, and the Senate Appropriations Committee. Before the
1613 agency implements a change in a hospital's inpatient per diem
1614 rate pursuant to this paragraph, the Legislature must have
1615 specifically appropriated sufficient funds in the General
1616 Appropriations Act to support the increase in cost as estimated
1617 by the agency.
1618 (d) The agency shall implement a hospitalist program in
1619 nonteaching hospitals, select counties, or statewide. The
1620 program shall require hospitalists to manage Medicaid
1621 recipients' hospital admissions and lengths of stay. Individuals
1622 who are dually eligible for Medicare and Medicaid are exempted
1623 from this requirement. Medicaid participating physicians and
1624 other practitioners with hospital admitting privileges shall

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1625 coordinate and review admissions of Medicaid recipients with the
1626 hospitalist. The agency may competitively bid a contract for
1627 selection of a single qualified organization to provide
1628 hospitalist services. The agency may procure hospitalist
1629 services by individual county or may combine counties in a
1630 single procurement. The qualified organization shall contract
1631 with or employ board-eligible physicians in Miami-Dade, Palm
1632 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency
1633 may ~~is authorized to~~ seek federal waivers to implement this
1634 program.
1635 (e) The agency shall implement a comprehensive utilization
1636 management program for hospital neonatal intensive care stays in
1637 certain high-volume participating hospitals, select counties, or
1638 statewide, and shall replace existing hospital inpatient
1639 utilization management programs for neonatal intensive care
1640 admissions. The program shall be designed to manage the lengths
1641 of stay for children being treated in neonatal intensive care
1642 units and must seek the earliest medically appropriate discharge
1643 to the child’s home or other less costly treatment setting. The
1644 agency may competitively bid a contract for selection of a
1645 qualified organization to provide neonatal intensive care
1646 utilization management services. The agency may ~~is authorized to~~
1647 seek any federal waivers to implement this initiative.
1648 (f) The agency may develop and implement a program to
1649 reduce the number of hospital readmissions among the non-
1650 Medicare population eligible in areas 9, 10, and 11.
1651 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for
1652 preventive, diagnostic, therapeutic, or palliative care and
1653 other services provided to a recipient in the outpatient portion

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1654 of a hospital licensed under part I of chapter 395, and provided
1655 under the direction of a licensed physician or licensed dentist,
1656 except that payment for such care and services is limited to
1657 $1,500 per state fiscal year per recipient, unless an exception
1658 has been made by the agency, and with the exception of a
1659 Medicaid recipient under age 21, in which case the only
1660 limitation is medical necessity.
1661 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay
1662 for medically necessary diagnostic laboratory procedures ordered
1663 by a licensed physician or other licensed health care
1664 practitioner ~~of the healing arts~~ which are provided for a
1665 recipient in a laboratory that meets the requirements for
1666 Medicare participation and is licensed under chapter 483, if
1667 required.
1668 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-
1669 hour-a-day nursing and rehabilitative services for a recipient
1670 in a nursing facility licensed under part II of chapter 400 or
1671 in a rural hospital, as defined in s. 395.602, or in a Medicare
1672 certified skilled nursing facility operated by a general
1673 hospital, as defined in ~~by~~ s. 395.002~~(10)~~, which ~~that~~ is
1674 licensed under part I of chapter 395, and in accordance with
1675 ~~provisions set forth in~~ s. 409.908(2)(a), which services are
1676 ordered by and provided under the direction of a licensed
1677 physician. However, if a nursing facility has been destroyed or
1678 otherwise made uninhabitable by natural disaster or other
1679 emergency and another nursing facility is not available, the
1680 agency must pay for similar services temporarily in a hospital
1681 licensed under part I of chapter 395 provided federal funding is
1682 approved and available. The agency shall pay only for bed-hold

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1683 days if the facility has an occupancy rate of 95 percent or
1684 greater. The agency is authorized to seek any federal waivers to
1685 implement this policy.
1686 (9) PHYSICIAN SERVICES.—The agency shall pay for covered
1687 services and procedures rendered to a Medicaid recipient by, or
1688 under the personal supervision of, a person licensed under state
1689 law to practice medicine or osteopathic medicine. These services
1690 may be furnished in the physician's office, the ~~Medicaid~~
1691 recipient's home, a hospital, a nursing facility, or elsewhere,
1692 but must ~~shall~~ be medically necessary for the treatment of a
1693 covered ~~an~~ injury or~~,~~ illness~~, or disease~~ within the scope of
1694 the practice of medicine or osteopathic medicine as defined by
1695 state law. The agency may ~~shall~~ not pay for services that are
1696 clinically unproven, experimental, or for purely cosmetic
1697 purposes.
1698 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for
1699 professional and technical portable radiological services
1700 ordered by a licensed physician or other licensed health care
1701 practitioner ~~of the healing arts~~ which are provided by a
1702 licensed professional in a setting other than a hospital,
1703 clinic, or office of a physician or practitioner ~~of the healing~~
1704 ~~arts~~, on behalf of a recipient.
1705 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for
1706 outpatient primary ~~health~~ care services for a recipient provided
1707 by a clinic certified by and participating in the Medicare
1708 program which is located in a federally designated, rural,
1709 medically underserved area and has on its staff one or more
1710 licensed primary care nurse practitioners or physician
1711 assistants, and a licensed staff supervising physician or a

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1712 consulting supervising physician.
1713 (12) TRANSPORTATION SERVICES.—The agency shall ensure that
1714 appropriate transportation services are available for a Medicaid
1715 recipient in need of transport to a qualified Medicaid provider
1716 for medically necessary ~~and Medicaid-compensable~~ services, if
1717 the recipient's ~~provided a client's~~ ability to choose a specific
1718 transportation provider is ~~shall be~~ limited to those options
1719 resulting from policies established by the agency to meet the
1720 fiscal limitations of the General Appropriations Act. The agency
1721 may pay for necessary transportation and other related travel
1722 expenses ~~as necessary~~ only if these services are not otherwise
1723 available.
1724 Section 24. Section 409.906, Florida Statutes, is amended
1725 to read:
1726 409.906 Optional Medicaid services.—Subject to specific
1727 appropriations, the agency may make payments for services which
1728 are optional to the state under Title XIX of the Social Security
1729 Act and are furnished by Medicaid providers to recipients who
1730 are determined to be eligible on the dates on which the services
1731 were provided. Any optional service that is provided shall be
1732 provided only when medically necessary and in accordance with
1733 state and federal law. Optional services rendered by providers
1734 in mobile units to Medicaid recipients may be restricted or
1735 prohibited by the agency. ~~Nothing in~~ This section does not ~~shall~~
1736 ~~be construed to~~ prevent or limit the agency from adjusting fees,
1737 reimbursement rates, lengths of stay, number of visits, or
1738 number of services, or making any other adjustments necessary to
1739 comply with the availability of moneys and any limitations or
1740 directions provided for in the General Appropriations Act, ~~or~~

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1741 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~
1742 ~~state's systems of providing services to elderly and disabled~~
1743 ~~persons and subject to the notice and review provisions of s.~~
1744 ~~216.177, the Governor may direct the Agency for Health Care~~
1745 ~~Administration to amend the Medicaid state plan to delete the~~
1746 ~~optional Medicaid service known as "Intermediate Care Facilities~~
1747 ~~for the Developmentally Disabled."~~ Optional services may
1748 include:
1749 (1) ADULT DENTAL SERVICES.—For a recipient who is 21 years
1750 of age or older:
1751 (a) The agency may pay for medically necessary, emergency
1752 dental procedures to alleviate pain or infection. Emergency
1753 dental care is ~~shall be~~ limited to emergency oral examinations,
1754 necessary radiographs, extractions, and incision and drainage of
1755 abscess~~, for a recipient who is 21 years of age or older~~.
1756 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or
1757 partial dentures, the procedures required to seat full or
1758 partial dentures, and the repair and reline of full or partial
1759 dentures, provided by or under the direction of a licensed
1760 dentist~~, for a recipient who is 21 years of age or older~~.
1761 (c) ~~However,~~ Medicaid will not provide reimbursement for
1762 dental services provided in a mobile dental unit, except for a
1763 mobile dental unit:
1764 1. Owned by, operated by, or having a contractual agreement
1765 with the Department of Health and complying with Medicaid's
1766 county health department clinic services program specifications
1767 as a county health department clinic services provider.
1768 2. Owned by, operated by, or having a contractual
1769 arrangement with a federally qualified health center and

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1770 complying with Medicaid's federally qualified health center
1771 specifications as a federally qualified health center provider.
1772 3. Rendering dental services to Medicaid recipients, 21
1773 years of age and older, at nursing facilities.
1774 4. Owned by, operated by, or having a contractual agreement
1775 with a state-approved dental educational institution.
1776 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for
1777 an annual routine physical examination, conducted by or under
1778 the direction of a licensed physician, for a recipient age 21 or
1779 older, without regard to medical necessity, in order to detect
1780 and prevent disease, disability, or other health condition or
1781 its progression.
1782 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay
1783 for services provided to a recipient in an ambulatory surgical
1784 center licensed under part I of chapter 395, by or under the
1785 direction of a licensed physician or dentist.
1786 (4) BIRTH CENTER SERVICES.—The agency may pay for
1787 examinations and delivery, recovery, ~~and~~ newborn assessment, and
1788 related services, provided in a licensed birth center staffed
1789 with licensed physicians, certified nurse midwives, and midwives
1790 licensed in accordance with chapter 467, to a recipient expected
1791 to experience a low-risk pregnancy and delivery.
1792 (5) CASE MANAGEMENT SERVICES.—The agency may pay for
1793 primary care case management services rendered to a recipient
1794 pursuant to a federally approved waiver~~,~~ and targeted case
1795 management services for specific groups of targeted recipients,
1796 for which funding has been provided and which are rendered
1797 pursuant to federal guidelines. The agency may ~~is authorized to~~
1798 limit reimbursement for targeted case management services in

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1799 order to comply with any limitations or directions provided for
1800 in the General Appropriations Act.
1801 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
1802 diagnostic, preventive, or corrective procedures, including
1803 orthodontia in severe cases, provided to a recipient under age
1804 21, by or under the supervision of a licensed dentist. Services
1805 ~~provided under this program~~ include treatment of the teeth and
1806 associated structures of the oral cavity, as well as treatment
1807 of disease, injury, or impairment that may affect the oral or
1808 general health of the individual. However, Medicaid may ~~will~~ not
1809 provide reimbursement for dental services provided in a mobile
1810 dental unit, except for a mobile dental unit:
1811 (a) Owned by, operated by, or having a contractual
1812 agreement with the Department of Health and complying with
1813 Medicaid's county health department clinic services program
1814 specifications as a county health department clinic services
1815 provider.
1816 (b) Owned by, operated by, or having a contractual
1817 arrangement with a federally qualified health center and
1818 complying with Medicaid's federally qualified health center
1819 specifications as a federally qualified health center provider.
1820 (c) Rendering dental services to Medicaid recipients, 21
1821 years of age and older, at nursing facilities.
1822 (d) Owned by, operated by, or having a contractual
1823 agreement with a state-approved dental educational institution.
1824 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
1825 manipulation of the spine and initial services, screening, and X
1826 rays provided to a recipient by a licensed chiropractic
1827 physician.

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1828 (8) COMMUNITY MENTAL HEALTH SERVICES.—
1829 ~~(a)~~ The agency may pay for rehabilitative services provided
1830 to a recipient by a mental health or substance abuse provider
1831 under contract with the agency or the Department of Children and
1832 Family Services to provide such services. ~~Those~~ Services that
1833 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or
1834 recommended by a psychiatrist, and ~~those~~ services that ~~which~~ are
1835 medical in nature must ~~shall~~ be rendered or recommended by a
1836 physician or psychiatrist.
1837 (a) The agency shall ~~must~~ develop a provider enrollment
1838 process for community mental health providers which bases
1839 provider enrollment on an assessment of service need. The
1840 provider enrollment process shall be designed to control costs,
1841 prevent fraud and abuse, consider provider expertise and
1842 capacity, and assess provider success in managing utilization of
1843 care and measuring treatment outcomes. Providers must ~~will~~ be
1844 selected through a competitive procurement or selective
1845 contracting process. In addition ~~to other community mental~~
1846 ~~health providers~~, the agency shall consider enrolling ~~for~~
1847 ~~enrollment~~ mental health programs licensed under chapter 395 and
1848 group practices licensed under chapter 458, chapter 459, chapter
1849 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~
1850 continue the operation of its behavioral health utilization
1851 management program and ~~may~~ develop new services, if ~~these~~
1852 ~~actions are~~ necessary, to ensure savings from the implementation
1853 of the utilization management system. The agency shall
1854 coordinate the implementation of this enrollment process with
1855 the Department of Children and Family Services and the
1856 Department of Juvenile Justice. The agency may use ~~is authorized~~

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1857 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,
1858 ~~to~~ preauthorize certain high-cost or highly utilized services,
1859 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make
1860 any other adjustments necessary to comply with any limitations
1861 or directions provided for in the General Appropriations Act.
1862 (b) The agency may ~~is authorized to~~ implement reimbursement
1863 and use management reforms in order to comply with any
1864 limitations or directions in the General Appropriations Act,
1865 which may include, but are not limited to~~:~~ prior authorization
1866 of treatment and service plans; prior authorization of services;
1867 enhanced use review programs for highly used services; and
1868 limits on services for recipients ~~those~~ determined to be abusing
1869 their benefit coverages.
1870 (9) DIALYSIS FACILITY SERVICES.—Subject to specific
1871 appropriations being provided for this purpose, the agency may
1872 pay a dialysis facility that is approved as a dialysis facility
1873 in accordance with Title XVIII of the Social Security Act, for
1874 dialysis services that are provided to a Medicaid recipient
1875 under the direction of a physician licensed to practice medicine
1876 or osteopathic medicine in this state, including dialysis
1877 services provided in the recipient's home by a hospital-based or
1878 freestanding dialysis facility.
1879 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize
1880 and pay for certain durable medical equipment and supplies
1881 provided to a Medicaid recipient as medically necessary.
1882 (11) HEALTHY START SERVICES.—The agency may pay for a
1883 continuum of risk-appropriate medical and psychosocial services
1884 for the Healthy Start program in accordance with a federal
1885 waiver. The agency may not implement the federal waiver unless

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1886 the waiver permits the state to limit enrollment or the amount,
1887 duration, and scope of services to ensure that expenditures will
1888 not exceed funds appropriated by the Legislature or available
1889 from local sources. If ~~the Health Care Financing Administration~~
1890 ~~does not approve~~ a federal waiver for Healthy Start services is
1891 not approved, the agency, in consultation with the Department of
1892 Health and the Florida Association of Healthy Start Coalitions,
1893 may ~~is authorized to~~ establish a Medicaid certified-match
1894 program for Healthy Start services. Participation in the Healthy
1895 Start certified-match program is ~~shall be~~ voluntary, and
1896 reimbursement is ~~shall be~~ limited to the federal Medicaid share
1897 provided to Medicaid-enrolled Healthy Start coalitions for
1898 services provided to Medicaid recipients. The agency may not
1899 ~~shall~~ take ~~no~~ action to implement a certified-match program
1900 without ensuring that the amendment and review requirements of
1901 ss. 216.177 and 216.181 have been met.
1902 (12) HEARING SERVICES.—The agency may pay for hearing and
1903 related services, including hearing evaluations, hearing aid
1904 devices, dispensing of the hearing aid, and related repairs~~, if~~
1905 provided to a recipient by a licensed hearing aid specialist,
1906 otolaryngologist, otologist, audiologist, or physician.
1907 (13) HOME AND COMMUNITY-BASED SERVICES.—
1908 (a) The agency may pay for home-based or community-based
1909 services that are rendered to a recipient in accordance with a
1910 federally approved waiver program. The agency may limit or
1911 eliminate coverage for certain services, preauthorize high-cost
1912 or highly utilized services, or make any other adjustments
1913 necessary to comply with any limitations or directions provided
1914 ~~for~~ in the General Appropriations Act.

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1915 (b) The agency may consolidate types of services offered in
1916 the Aged and Disabled Waiver, the Channeling Waiver, the Project
1917 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury
1918 Waiver programs in order to group similar services under a
1919 single service, or continue a service upon evidence of the need
1920 for including a particular service type in a particular waiver.
1921 The agency may ~~is authorized to~~ seek a Medicaid state plan
1922 amendment or federal waiver approval to implement this policy.
1923 (c) The agency may implement a utilization management
1924 program designed to prior-authorize home and community-based
1925 service plans which ~~and~~ includes, but is not limited to,
1926 assessing proposed quantity and duration of services and
1927 monitoring ongoing service use by participants in the program.
1928 The agency may ~~is authorized to~~ competitively procure a
1929 qualified organization to provide utilization management of home
1930 and community-based services. The agency may ~~is authorized to~~
1931 seek any federal waivers to implement this initiative.
1932 (d) The agency shall assess a fee against the parents of a
1933 child who is being served by a waiver under this subsection if
1934 the adjusted household income is greater than 100 percent of the
1935 federal poverty level. The amount of the fee shall be calculated
1936 using a sliding scale based on the size of the family, the
1937 amount of the parent’s adjusted gross income, and the federal
1938 poverty guidelines. The agency shall seek a federal waiver to
1939 implement this provision.
1940 (14) HOSPICE CARE SERVICES.—The agency may pay for all
1941 reasonable and necessary services for the palliation or
1942 management of a recipient’s terminal illness, if the services
1943 are provided by a hospice that is licensed under part IV of

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1944 chapter 400 and meets Medicare certification requirements.
1945 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
1946 DISABLED SERVICES.—The agency may pay for health-related care
1947 and services provided on a 24-hour-a-day basis by a facility
1948 licensed and certified as a Medicaid Intermediate Care Facility
1949 for the Developmentally Disabled, for a recipient who needs such
1950 care because of a developmental disability. Payment may ~~shall~~
1951 not include bed-hold days except in facilities with occupancy
1952 rates of 95 percent or greater. The agency may ~~is authorized to~~
1953 seek any federal waiver approvals to implement this policy. If
1954 necessary to safeguard the state's systems of providing services
1955 to elderly and disabled persons and subject to notice and review
1956 under s. 216.177, the Governor may direct the agency to amend
1957 the Medicaid state plan to delete these services.
1958 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-
1959 hour-a-day intermediate care nursing and rehabilitation services
1960 rendered to a recipient in a nursing facility licensed under
1961 part II of chapter 400~~,~~ if the services are ordered by and
1962 provided under the direction of a physician.
1963 (17) OPTOMETRIC SERVICES.—The agency may pay for services
1964 provided to a recipient, including examination, diagnosis,
1965 treatment, and management, related to ocular pathology~~,~~ if the
1966 services are provided by a licensed optometrist or physician.
1967 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for
1968 all services provided to a recipient by a physician assistant
1969 licensed under s. 458.347 or s. 459.022. Reimbursement for such
1970 services must be at least ~~not less than~~ 80 percent of the
1971 reimbursement that would be paid to a physician who provided the
1972 same services.

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1973 (19) PODIATRIC SERVICES.—The agency may pay for services,
1974 including diagnosis and medical, surgical, palliative, and
1975 mechanical treatment, related to ailments of the human foot and
1976 lower leg, if provided to a recipient by a podiatric physician
1977 licensed under state law.
1978 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for
1979 medications that are prescribed for a recipient by a physician
1980 or other licensed health care practitioner ~~of the healing arts~~
1981 authorized to prescribe medications and that are dispensed to
1982 the recipient by a licensed pharmacist or physician in
1983 accordance with applicable state and federal law. However, the
1984 agency may not pay for any psychotropic medication prescribed
1985 for a child younger than the age for which the federal Food and
1986 Drug Administration has approved its use.
1987 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency
1988 may pay for all services provided to a recipient by a registered
1989 nurse first assistant as described in s. 464.027. Reimbursement
1990 for such services must be at least ~~may not be less than~~ 80
1991 percent of the reimbursement that would be paid to a physician
1992 providing the same services.
1993 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-
1994 inclusive psychiatric inpatient hospital care provided to a
1995 recipient age 65 or older in a state mental hospital.
1996 (23) VISUAL SERVICES.—The agency may pay for visual
1997 examinations, eyeglasses, and eyeglass repairs for a recipient
1998 if they are prescribed by a licensed physician specializing in
1999 diseases of the eye or by a licensed optometrist. Eyeglass
2000 frames for adult recipients are ~~shall be~~ limited to one pair per
2001 recipient every 2 years, except a second pair may be provided

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2002 ~~during that period~~ after prior authorization. Eyeglass lenses
2003 for adult recipients are ~~shall be~~ limited to one pair per year
2004 except a second pair may be provided ~~during that period~~ after
2005 prior authorization.
2006 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~
2007 ~~Health Care Administration~~, in consultation with the Department
2008 of Children and Family Services, may establish a targeted case-
2009 management project in those counties identified by the
2010 department ~~of Children and Family Services~~ and for all counties
2011 with a community-based child welfare project, as authorized
2012 under s. 409.1671, which have been specifically approved by the
2013 department. The covered group that is ~~of individuals who are~~
2014 eligible for ~~to receive~~ targeted case management include
2015 children who are eligible for Medicaid; who are between the ages
2016 of birth through 21; and who are under protective supervision or
2017 postplacement supervision, under foster-care supervision, or in
2018 shelter care or foster care. The number of eligible children
2019 ~~individuals who are eligible to receive targeted case management~~
2020 is limited to the number for whom the department ~~of Children and~~
2021 ~~Family Services~~ has matching funds to cover the costs. The
2022 general revenue funds required to match the funds for services
2023 provided by the community-based child welfare projects are
2024 limited to funds available for services described under s.
2025 409.1671. The department ~~of Children and Family Services~~ may
2026 transfer the general revenue matching funds as billed by the
2027 agency ~~for Health Care Administration~~.
2028 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for
2029 assistive-care services provided to recipients with functional
2030 or cognitive impairments residing in assisted living facilities,

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2031 adult family-care homes, or residential treatment facilities.
2032 These services may include health support, assistance with the
2033 activities of daily living and the instrumental acts of daily
2034 living, assistance with medication administration, and
2035 arrangements for health care.
2036 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM
2037 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~
2038 ~~authorized to~~ seek federal approval through a Medicaid waiver or
2039 a state plan amendment for the provision of occupational
2040 therapy, speech therapy, physical therapy, behavior analysis,
2041 and behavior assistant services to individuals who are 5 years
2042 of age and under and have a diagnosed developmental disability
2043 as defined in s. 393.063, or autism spectrum disorder as defined
2044 in s. 627.6686~~, or Down syndrome, a genetic disorder caused by~~
2045 ~~the presence of extra chromosomal material on chromosome 21~~.
2046 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~
2047 ~~Robertsonian Translocation, and other duplications of a portion~~
2048 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited
2049 to $36,000 annually and may not exceed $108,000 in total
2050 lifetime benefits. The agency shall submit an annual report
2051 beginning ~~on~~ January 1, 2009, to the President of the Senate,
2052 the Speaker of the House of Representatives, and the relevant
2053 committees of the Senate and the House of Representatives
2054 regarding progress on obtaining federal approval and
2055 recommendations for the implementation of these home and
2056 community-based services. The agency may not implement this
2057 subsection without prior legislative approval.
2058 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may
2059 pay for all services provided to a recipient by an

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2060 anesthesiologist assistant licensed under s. 458.3475 or s.
2061 459.023. Reimbursement for such services must be at least ~~not~~
2062 ~~less than~~ 80 percent of the reimbursement that would be paid to
2063 a physician who provided the same services.
2064 Section 25. Section 409.9062, Florida Statutes, is amended
2065 to read:
2066 409.9062 Lung transplant services for Medicaid recipients.—
2067 Subject to the availability of funds and ~~subject to~~ any
2068 limitations or directions provided ~~for~~ in the General
2069 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~
2070 ~~for Health Care Administration~~ Medicaid program shall pay for
2071 medically necessary lung transplant services for Medicaid
2072 recipients. These payments must be used to reimburse approved
2073 lung transplant facilities a global fee for providing lung
2074 transplant services to Medicaid recipients.
2075 Section 26. Paragraph (h) of subsection (3) of section
2076 409.907, Florida Statutes, is amended to read:
2077 409.907 Medicaid provider agreements.—The agency may make
2078 payments for medical assistance and related services rendered to
2079 Medicaid recipients only to an individual or entity who has a
2080 provider agreement in effect with the agency, who is performing
2081 services or supplying goods in accordance with federal, state,
2082 and local law, and who agrees that no person shall, on the
2083 grounds of handicap, race, color, or national origin, or for any
2084 other reason, be subjected to discrimination under any program
2085 or activity for which the provider receives payment from the
2086 agency.
2087 (3) The provider agreement developed by the agency, in
2088 addition to the requirements specified in subsections (1) and

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2089 (2), shall require the provider to:
2090 (h) Be liable for and indemnify, defend, and hold the
2091 agency harmless from all claims, suits, judgments, or damages,
2092 including court costs and attorney's fees, arising out of the
2093 negligence or omissions of the provider in the course of
2094 providing services to a recipient or a person believed to be a
2095 recipient, subject to s. 766.1183 or s. 766.1184.
2096 Section 27. Section 409.908, Florida Statutes, is amended
2097 to read:
2098 409.908 Reimbursement of Medicaid providers.—Subject to
2099 specific appropriations, the agency shall reimburse Medicaid
2100 providers, in accordance with state and federal law, according
2101 to methodologies set forth in the rules of the agency and in
2102 policy manuals and handbooks incorporated by reference therein.
2103 These methodologies may include fee schedules, reimbursement
2104 methods based on cost reporting, negotiated fees, competitive
2105 bidding pursuant to s. 287.057, and other mechanisms the agency
2106 considers efficient and effective for purchasing services or
2107 goods on behalf of recipients. ~~If a provider is reimbursed based~~
2108 ~~on cost reporting and submits a cost report late and that cost~~
2109 ~~report would have been used to set a lower reimbursement rate~~
2110 ~~for a rate semester, then the provider's rate for that semester~~
2111 ~~shall be retroactively calculated using the new cost report, and~~
2112 ~~full payment at the recalculated rate shall be effected~~
2113 ~~retroactively. Medicare-granted extensions for filing cost~~
2114 ~~reports, if applicable, shall also apply to Medicaid cost~~
2115 ~~reports.~~ Payment for Medicaid compensable services made on
2116 behalf of Medicaid eligible persons is subject to the
2117 availability of moneys and any limitations or directions

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2118 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,
2119 or s. 409.9022. ~~Further, nothing in~~ This section does not ~~shall~~
2120 ~~be construed to~~ prevent or limit the agency from adjusting fees,
2121 reimbursement rates, lengths of stay, number of visits, or
2122 number of services, or making any other adjustments necessary to
2123 comply with the availability of moneys and any limitations or
2124 directions provided ~~for~~ in the General Appropriations Act if~~,~~
2125 ~~provided~~ the adjustment is consistent with legislative intent.
2126 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed
2127 under part I of chapter 395 must be made prospectively or on the
2128 basis of negotiation.
2129 (a) *Inpatient care.*—
2130 1. Reimbursement for inpatient care is limited as provided
2131 ~~for~~ in s. 409.905(5), except for:
2132 a.~~1.~~ The raising of rate reimbursement caps, excluding
2133 rural hospitals.
2134 b.~~2.~~ Recognition of the costs of graduate medical
2135 education.
2136 c.~~3.~~ Other methodologies recognized in the General
2137 Appropriations Act.
2138 2. If ~~During the years~~ funds are transferred from the
2139 Department of Health, any reimbursement supported by such funds
2140 is ~~shall be~~ subject to certification by the Department of Health
2141 that the hospital has complied with s. 381.0403. The agency may
2142 ~~is authorized to~~ receive funds from state entities, including,
2143 but not limited to, the Department of Health, local governments,
2144 and other local political subdivisions, for the purpose of
2145 making special exception payments, including federal matching
2146 funds, through the Medicaid inpatient reimbursement

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2147 methodologies. Funds received from state entities or local
2148 governments for this purpose shall be separately accounted for
2149 and may ~~shall~~ not be commingled with other state or local funds
2150 in any manner. The agency may certify all local governmental
2151 funds used as state match under Title XIX of the Social Security
2152 Act, to the extent that the identified local health care
2153 provider that is otherwise entitled to and is contracted to
2154 receive such local funds is the benefactor under the state's
2155 Medicaid program as determined under the General Appropriations
2156 Act and pursuant to an agreement between the agency ~~for Health~~
2157 ~~Care Administration~~ and the local governmental entity. The local
2158 governmental entity shall use a certification form prescribed by
2159 the agency. At a minimum, the certification form must ~~shall~~
2160 identify the amount being certified and describe the
2161 relationship between the certifying local governmental entity
2162 and the local health care provider. The agency shall prepare an
2163 annual statement of impact which documents the specific
2164 activities undertaken during the previous fiscal year pursuant
2165 to this paragraph, to be submitted to the Legislature annually
2166 by ~~no later than~~ January 1~~, annually~~.
2167 (b) *Outpatient care.*—
2168 1. Reimbursement for hospital outpatient care is limited to
2169 $1,500 per state fiscal year per recipient, except for:
2170 a.~~1.~~ ~~Such~~ Care provided to a Medicaid recipient under age
2171 21, in which case the only limitation is medical necessity.
2172 b.~~2.~~ Renal dialysis services.
2173 c.~~3.~~ Other exceptions made by the agency.
2174 2. The agency may ~~is authorized to~~ receive funds from state
2175 entities, including, but not limited to, the Department of

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2176 Health, the Board of Governors of the State University System,
2177 local governments, and other local political subdivisions, for
2178 the purpose of making payments, including federal matching
2179 funds, through the Medicaid outpatient reimbursement
2180 methodologies. Funds received ~~from state entities and local~~
2181 ~~governments~~ for this purpose shall be separately accounted for
2182 and may ~~shall~~ not be commingled with other state or local funds
2183 ~~in any manner~~.
2184 3. The agency may limit inflationary increases for
2185 outpatient hospital services as directed by the General
2186 Appropriations Act.
2187 (c) *Disproportionate share.*—Hospitals that provide services
2188 to a disproportionate share of low-income Medicaid recipients,
2189 ~~or~~ that participate in the regional perinatal intensive care
2190 center program under chapter 383, or that participate in the
2191 statutory teaching hospital disproportionate share program may
2192 receive additional reimbursement. The total amount of payment
2193 for disproportionate share hospitals shall be fixed by the
2194 General Appropriations Act. The computation of these payments
2195 must comply ~~be made in compliance~~ with all federal regulations
2196 and the methodologies described in ss. 409.911, 409.9112, and
2197 409.9113.
2198 ~~(d) The agency is authorized to limit inflationary~~
2199 ~~increases for outpatient hospital services as directed by the~~
2200 ~~General Appropriations Act.~~
2201 (2) NURSING HOME CARE.—
2202 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II
2203 of chapter 400 and state-owned-and-operated intermediate care
2204 facilities for the developmentally disabled licensed under part

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2205 VIII of chapter 400 must be made prospectively.
2206 (a)~~2.~~ Unless otherwise limited or directed in the General
2207 Appropriations Act, reimbursement to hospitals licensed under
2208 part I of chapter 395 for ~~the provision of~~ swing-bed nursing
2209 home services must be based ~~made~~ on ~~the basis of~~ the average
2210 statewide nursing home payment, and reimbursement to a hospital
2211 ~~licensed under part I of chapter 395~~ for ~~the provision of~~
2212 skilled nursing services must be based ~~made~~ on ~~the basis of~~ the
2213 average nursing home payment for those services in the county in
2214 which the hospital is located. If ~~When~~ a hospital is located in
2215 a county that does not have any community nursing homes,
2216 reimbursement shall be determined by averaging the nursing home
2217 payments in counties that surround the county in which the
2218 hospital is located. Reimbursement to hospitals, including
2219 Medicaid payment of Medicare copayments, for skilled nursing
2220 services is ~~shall be~~ limited to 30 days, unless a prior
2221 authorization has been obtained from the agency. Medicaid
2222 reimbursement may be extended by the agency beyond 30 days, and
2223 approval must be based upon verification by the patient's
2224 physician that the patient requires short-term rehabilitative
2225 and recuperative services only, in which case an extension of no
2226 more than 15 days may be approved. Reimbursement to a hospital
2227 ~~licensed under part I of chapter 395~~ for the temporary provision
2228 of skilled nursing services to nursing home residents who have
2229 been displaced as the result of a natural disaster or other
2230 emergency may not exceed the average county nursing home payment
2231 for those services in the county in which the hospital is
2232 located and is limited to the period of time which the agency
2233 considers necessary for continued placement of the nursing home

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2234 residents in the hospital.
2235 (b) Subject to any limitations or directions provided ~~for~~
2236 in the General Appropriations Act, the agency shall establish
2237 and implement a Florida Title XIX Long-Term Care Reimbursement
2238 Plan (Medicaid) for nursing home care in order to provide care
2239 and services that conform to ~~in conformance with the~~ applicable
2240 state and federal laws, rules, regulations, and quality and
2241 safety standards and to ensure that individuals eligible for
2242 medical assistance have reasonable geographic access to such
2243 care.
2244 1. The agency shall amend the long-term care reimbursement
2245 plan and cost reporting system to create direct care and
2246 indirect care subcomponents of the patient care component of the
2247 per diem rate. These two subcomponents together must ~~shall~~ equal
2248 the patient care component of the per diem rate. Separate cost-
2249 based ceilings shall be calculated for each patient care
2250 subcomponent. The direct care subcomponent of the per diem rate
2251 is ~~shall be~~ limited by the cost-based class ceiling, and the
2252 indirect care subcomponent may be limited by the lower of the
2253 cost-based class ceiling, the target rate class ceiling, or the
2254 individual provider target.
2255 2. The direct care subcomponent includes ~~shall include~~
2256 salaries and benefits of direct care staff providing nursing
2257 services, including registered nurses, licensed practical
2258 nurses, and certified nursing assistants who deliver care
2259 directly to residents in the nursing home facility. This
2260 excludes nursing administration, minimum data set, and care plan
2261 coordinators, staff development, and the staffing coordinator.
2262 The direct care subcomponent also includes medically necessary

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2263 dental care, vision care, hearing care, and podiatric care.
2264 3. All other patient care costs are ~~shall be~~ included in
2265 the indirect care cost subcomponent of the patient care per diem
2266 rate. ~~There shall be no~~ Costs may not be directly or indirectly
2267 allocated to the direct care subcomponent from a home office or
2268 management company.
2269 4. On July 1 of each year, the agency shall report to the
2270 Legislature direct and indirect care costs, including average
2271 direct and indirect care costs per resident per facility and
2272 direct care and indirect care salaries and benefits per category
2273 of staff member per facility.
2274 5. In order to offset the cost of general and professional
2275 liability insurance, the agency shall amend the plan to allow
2276 for interim rate adjustments to reflect increases in the cost of
2277 general or professional liability insurance for nursing homes.
2278 This provision shall be implemented to the extent existing
2279 appropriations are available.
2280
2281 It is the intent of the Legislature that the reimbursement plan
2282 achieve the goal of providing access to health care for nursing
2283 home residents who require large amounts of care while
2284 encouraging diversion services as an alternative to nursing home
2285 care for residents who can be served within the community. The
2286 agency shall base the establishment of any maximum rate of
2287 payment, whether overall or component, on the available moneys
2288 ~~as~~ provided ~~for~~ in the General Appropriations Act. The agency
2289 may base the maximum rate of payment on the results of
2290 scientifically valid analysis and conclusions derived from
2291 objective statistical data pertinent to the particular maximum

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2292 rate of payment.
2293 (c) The agency shall request and implement Medicaid waivers
2294 approved by the federal Centers for Medicare and Medicaid
2295 Services to advance and treat a portion of the Medicaid nursing
2296 home per diem as capital for creating and operating a risk-
2297 retention group for self-insurance purposes, consistent with
2298 federal and state laws and rules.
2299 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any
2300 limitations or directions provided ~~for~~ in the General
2301 Appropriations Act, the following Medicaid services and goods
2302 may be reimbursed on a fee-for-service basis. For each allowable
2303 service or goods furnished in accordance with Medicaid rules,
2304 policy manuals, handbooks, and state and federal law, the
2305 payment shall be the amount billed by the provider, the
2306 provider's usual and customary charge, or the maximum allowable
2307 fee established by the agency, whichever amount is less, with
2308 the exception of those services or goods for which the agency
2309 makes payment using a methodology based on capitation rates,
2310 average costs, or negotiated fees.
2311 (a) Advanced registered nurse practitioner services.
2312 (b) Birth center services.
2313 (c) Chiropractic services.
2314 (d) Community mental health services.
2315 (e) Dental services, including oral and maxillofacial
2316 surgery.
2317 (f) Durable medical equipment.
2318 (g) Hearing services.
2319 (h) Occupational therapy for Medicaid recipients under age
2320 21.

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2321 (i) Optometric services.
2322 (j) Orthodontic services.
2323 (k) Personal care for Medicaid recipients under age 21.
2324 (l) Physical therapy for Medicaid recipients under age 21.
2325 (m) Physician assistant services.
2326 (n) Podiatric services.
2327 (o) Portable X-ray services.
2328 (p) Private-duty nursing for Medicaid recipients under age
2329 21.
2330 (q) Registered nurse first assistant services.
2331 (r) Respiratory therapy for Medicaid recipients under age
2332 21.
2333 (s) Speech therapy for Medicaid recipients under age 21.
2334 (t) Visual services.
2335 (4) MANAGED CARE SERVICES.—Subject to any limitations or
2336 directions provided ~~for~~ in the General Appropriations Act,
2337 alternative health plans, health maintenance organizations, and
2338 prepaid health plans shall be reimbursed a fixed, prepaid amount
2339 negotiated, or competitively bid pursuant to s. 287.057, by the
2340 agency and prospectively paid to the provider monthly for each
2341 Medicaid recipient enrolled. The amount may not exceed the
2342 average amount the agency determines it would have paid, based
2343 on claims experience, for recipients in the same or similar
2344 category of eligibility. The agency shall calculate capitation
2345 rates on a regional basis and~~, beginning September 1, 1995,~~
2346 ~~shall~~ include age-band differentials in such calculations.
2347 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical
2348 center shall be reimbursed the lesser of the amount billed by
2349 the provider or the Medicare-established allowable amount for

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2350 the facility.
2351 (6) EPSDT SERVICES.—A provider of early and periodic
2352 screening, diagnosis, and treatment services to Medicaid
2353 recipients who are ~~children~~ under age 21 shall be reimbursed
2354 using an all-inclusive rate stipulated in a fee schedule
2355 established by the agency. A provider of the visual, dental, and
2356 hearing components of such services shall be reimbursed the
2357 lesser of the amount billed by the provider or the Medicaid
2358 maximum allowable fee established by the agency.
2359 (7) FAMILY PLANNING SERVICES.—A provider of family planning
2360 services shall be reimbursed the lesser of the amount billed by
2361 the provider or an all-inclusive amount per type of visit for
2362 physicians and advanced registered nurse practitioners, as
2363 established by the agency in a fee schedule.
2364 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-
2365 based or community-based services rendered pursuant to a
2366 federally approved waiver shall be reimbursed based on an
2367 established or negotiated rate for each service. These rates
2368 shall be established according to an analysis of the expenditure
2369 history and prospective budget developed by each contract
2370 provider participating in the waiver program, or under any other
2371 methodology adopted by the agency and approved by the Federal
2372 Government in accordance with the waiver. Privately owned and
2373 operated community-based residential facilities that ~~which~~ meet
2374 agency requirements and ~~which~~ formerly received Medicaid
2375 reimbursement for the optional intermediate care facility for
2376 the mentally retarded service may participate in the
2377 developmental services waiver as part of a home-and-community-
2378 based continuum of care for Medicaid recipients who receive

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2379 waiver services.
2380 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider
2381 of home health care services or of medical supplies and
2382 appliances shall be reimbursed on the basis of competitive
2383 bidding or for the lesser of the amount billed by the provider
2384 or the agency's established maximum allowable amount, except
2385 that~~, in the case of the rental of durable medical equipment,~~
2386 the total rental payments for durable medical equipment may not
2387 exceed the purchase price of the equipment over its expected
2388 useful life or the agency's established maximum allowable
2389 amount, whichever amount is less.
2390 (10) HOSPICE.—A hospice shall be reimbursed through a
2391 prospective system for each Medicaid hospice patient at Medicaid
2392 rates using the methodology established for hospice
2393 reimbursement pursuant to Title XVIII of the federal Social
2394 Security Act.
2395 (11) LABORATORY SERVICES.—A provider of independent
2396 laboratory services shall be reimbursed on the basis of
2397 competitive bidding or for the least of the amount billed by the
2398 provider, the provider's usual and customary charge, or the
2399 Medicaid maximum allowable fee established by the agency.
2400 (12) PHYSICIAN SERVICES.—
2401 (a) A physician shall be reimbursed the lesser of the
2402 amount billed by the provider or the Medicaid maximum allowable
2403 fee established by the agency.
2404 (b) The agency shall adopt a fee schedule, subject to any
2405 limitations or directions provided ~~for~~ in the General
2406 Appropriations Act, based on a resource-based relative value
2407 scale for pricing Medicaid physician services. Under the ~~this~~

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2408 fee schedule, physicians shall be paid a dollar amount for each
2409 service based on the average resources required to provide the
2410 service, including, but not limited to, estimates of average
2411 physician time and effort, practice expense, and the costs of
2412 professional liability insurance. The fee schedule must ~~shall~~
2413 provide increased reimbursement for preventive and primary care
2414 services and lowered reimbursement for specialty services by
2415 using at least two conversion factors, one for cognitive
2416 services and another for procedural services. The fee schedule
2417 may ~~shall~~ not increase total Medicaid physician expenditures
2418 unless moneys are available. The agency ~~for Health Care~~
2419 ~~Administration~~ shall seek the advice of a 16-member advisory
2420 panel in formulating and adopting the fee schedule. The panel
2421 shall consist of Medicaid physicians licensed under chapters 458
2422 and 459 and ~~shall~~ be composed of 50 percent primary care
2423 physicians and 50 percent specialty care physicians.
2424 (c) Notwithstanding paragraph (b), reimbursement fees to
2425 physicians for providing total obstetrical services to Medicaid
2426 recipients, which include prenatal, delivery, and postpartum
2427 care, must ~~shall~~ be at least $1,500 per delivery for a pregnant
2428 woman with low medical risk and at least $2,000 per delivery for
2429 a pregnant woman with high medical risk. However, reimbursement
2430 to physicians working in regional perinatal intensive care
2431 centers designated pursuant to chapter 383, for services to
2432 ~~certain~~ pregnant Medicaid recipients with a high medical risk,
2433 may be made according to obstetrical care and neonatal care
2434 groupings and rates established by the agency. Nurse midwives
2435 licensed under part I of chapter 464 or midwives licensed under
2436 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent

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2437 of the low medical risk fee. The agency shall by rule determine,
2438 for the purpose of this paragraph, what constitutes a high or
2439 low medical risk pregnant woman and may ~~shall~~ not pay more based
2440 solely on the fact that a caesarean section was performed,
2441 rather than a vaginal delivery. The agency shall by rule
2442 determine a prorated payment for obstetrical services ~~in cases~~
2443 where only part of the total prenatal, delivery, or postpartum
2444 care was performed. The Department of Health shall adopt rules
2445 for appropriate insurance coverage for midwives licensed under
2446 chapter 467. Before issuing and renewing ~~Prior to the issuance~~
2447 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~
2448 ~~of~~ an inactive license for midwives licensed under chapter 467,
2449 such licensees must ~~shall~~ submit proof of coverage with each
2450 application.
2451 (d) Effective January 1, 2013, Medicaid fee-for-service
2452 payments to primary care physicians for primary care services
2453 must be at least 100 percent of the Medicare payment rate for
2454 such services.
2455 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for
2456 persons eligible for both Medicare and Medicaid coverage shall
2457 be paid at the rates established by Title XVIII of the Social
2458 Security Act. For Medicare services rendered to Medicaid-
2459 eligible persons, Medicaid shall pay Medicare deductibles and
2460 coinsurance as follows:
2461 (a) Medicaid’s financial obligation for deductibles and
2462 coinsurance payments shall be based on Medicare allowable fees,
2463 not on a provider’s billed charges.
2464 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare
2465 deductibles and coinsurance if ~~when~~ payment that Medicare has

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2466 made for the service equals or exceeds what Medicaid would have
2467 paid if it had been the sole payor. The combined payment of
2468 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid
2469 would have paid had it been the sole payor. The Legislature
2470 finds that there has been confusion regarding the reimbursement
2471 for services rendered to dually eligible Medicare beneficiaries.
2472 Accordingly, the Legislature clarifies that it has always been
2473 the intent of the Legislature before and after 1991 that, in
2474 reimbursing in accordance with fees established by Title XVIII
2475 for premiums, deductibles, and coinsurance for Medicare services
2476 rendered by physicians to Medicaid eligible persons, physicians
2477 be reimbursed at the lesser of the amount billed by the
2478 physician or the Medicaid maximum allowable fee established by
2479 the agency ~~for Health Care Administration~~, as is permitted by
2480 federal law. It has never been the intent of the Legislature
2481 ~~with regard to such services rendered by physicians~~ that
2482 Medicaid be required to provide any payment for deductibles,
2483 coinsurance, or copayments for Medicare cost sharing, or any
2484 expenses incurred relating thereto, in excess of the payment
2485 amount provided for under the State Medicaid plan for physician
2486 services ~~such service~~. This payment methodology is applicable
2487 even in those situations in which the payment for Medicare cost
2488 sharing for a qualified Medicare beneficiary with respect to an
2489 item or service is reduced or eliminated. This expression of the
2490 Legislature clarifies ~~is in clarification of~~ existing law and
2491 applies ~~shall apply~~ to payment for, and with respect to provider
2492 agreements with respect to, items or services furnished on or
2493 after July 1, 2000 ~~the effective date of this act~~. This
2494 paragraph applies to payment by Medicaid for items and services

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2495 furnished before July 1, 2000, ~~the effective date of this act~~ if
2496 such payment is the subject of a lawsuit that is based on ~~the~~
2497 ~~provisions of~~ this section, and that is pending as of, or is
2498 initiated after that date~~, the effective date of this act~~.
2499 (c) Notwithstanding paragraphs (a) and (b):
2500 1. Medicaid payments for Nursing Home Medicare part A
2501 coinsurance are limited to the Medicaid nursing home per diem
2502 rate less any amounts paid by Medicare, but only up to the
2503 amount of Medicare coinsurance. The Medicaid per diem rate is
2504 ~~shall be~~ the rate in effect for the dates of service of the
2505 crossover claims and may not be subsequently adjusted due to
2506 subsequent per diem rate adjustments.
2507 2. Medicaid shall pay all deductibles and coinsurance for
2508 Medicare-eligible recipients receiving freestanding end stage
2509 renal dialysis center services.
2510 3. Medicaid payments for general and specialty hospital
2511 inpatient services are limited to the Medicare deductible and
2512 coinsurance per spell of illness. Medicaid payments for hospital
2513 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid
2514 hospital per diem rate less any amounts paid by Medicare, but
2515 only up to the amount of Medicare coinsurance. Medicaid payments
2516 for coinsurance are ~~shall be~~ limited to the Medicaid per diem
2517 rate in effect for the dates of service of the crossover claims
2518 and may not be subsequently adjusted due to subsequent per diem
2519 adjustments.
2520 4. Medicaid shall pay all deductibles and coinsurance for
2521 Medicare emergency transportation services provided by
2522 ambulances licensed pursuant to chapter 401.
2523 5. Medicaid shall pay all deductibles and coinsurance for

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2524 portable X-ray Medicare Part B services provided in a nursing
2525 home.
2526 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall
2527 be reimbursed the least of the amount billed by the provider,
2528 the provider's usual and customary charge, or the Medicaid
2529 maximum allowable fee established by the agency, plus a
2530 dispensing fee. The Medicaid maximum allowable fee for
2531 ingredient cost must ~~will~~ be based on the lower of the~~:~~ average
2532 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition
2533 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the
2534 state maximum allowable cost (SMAC), or the usual and customary
2535 (UAC) charge billed by the provider.
2536 (a) Medicaid providers must ~~are required to~~ dispense
2537 generic drugs if available at lower cost and the agency has not
2538 determined that the branded product is more cost-effective,
2539 unless the prescriber has requested and received approval to
2540 require the branded product.
2541 (b) The agency shall ~~is directed to~~ implement a variable
2542 dispensing fee for ~~payments for~~ prescribed medicines while
2543 ensuring continued access for Medicaid recipients. The variable
2544 dispensing fee may be based upon, but not limited to, either or
2545 both the volume of prescriptions dispensed by a specific
2546 pharmacy provider, the volume of prescriptions dispensed to an
2547 individual recipient, and dispensing of preferred-drug-list
2548 products.
2549 (c) The agency may increase the pharmacy dispensing fee
2550 authorized by statute and in the ~~annual~~ General Appropriations
2551 Act by $0.50 for the dispensing of a Medicaid preferred-drug-
2552 list product and reduce the pharmacy dispensing fee by $0.50 for

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2553 the dispensing of a Medicaid product that is not included on the
2554 preferred drug list.
2555 (d) The agency may establish a supplemental pharmaceutical
2556 dispensing fee to be paid to providers returning unused unit-
2557 dose packaged medications to stock and crediting the Medicaid
2558 program for the ingredient cost of those medications if the
2559 ingredient costs to be credited exceed the value of the
2560 supplemental dispensing fee.
2561 (e) The agency may ~~is authorized to~~ limit reimbursement for
2562 prescribed medicine in order to comply with any limitations or
2563 directions provided ~~for~~ in the General Appropriations Act, which
2564 may include implementing a prospective or concurrent utilization
2565 review program.
2566 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary
2567 care case management services rendered pursuant to a federally
2568 approved waiver shall be reimbursed by payment of a fixed,
2569 prepaid monthly sum for each Medicaid recipient enrolled with
2570 the provider.
2571 (16) RURAL HEALTH CLINICS.—A provider of rural health
2572 clinic services and federally qualified health center services
2573 shall be reimbursed a rate per visit based on total reasonable
2574 costs of the clinic, as determined by the agency in accordance
2575 with federal regulations.
2576 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case
2577 management services shall be reimbursed pursuant to an
2578 established fee, except where the Federal Government requires a
2579 public provider be reimbursed on the basis of average actual
2580 costs.
2581 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the

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2582 General Appropriations Act, a provider of transportation
2583 services shall be reimbursed the lesser of the amount billed by
2584 the provider or the Medicaid maximum allowable fee established
2585 by the agency, except if ~~when~~ the agency has entered into a
2586 direct contract with the provider, or with a community
2587 transportation coordinator, for the provision of an all-
2588 inclusive service, or if ~~when~~ services are provided pursuant to
2589 an agreement negotiated between the agency and the provider. ~~The~~
2590 ~~agency, as provided for in s. 427.0135, shall purchase~~
2591 ~~transportation services through the community coordinated~~
2592 ~~transportation system, if available, unless the agency, after~~
2593 ~~consultation with the commission, determines that it cannot~~
2594 ~~reach mutually acceptable contract terms with the commission.~~
2595 ~~The agency may then contract for the same transportation~~
2596 ~~services provided in a more cost-effective manner and of~~
2597 ~~comparable or higher quality and standards. Nothing in~~
2598 (a) This subsection does not ~~shall be construed to~~ limit or
2599 preclude the agency from contracting for services using a
2600 prepaid capitation rate or from establishing maximum fee
2601 schedules, individualized reimbursement policies by provider
2602 type, negotiated fees, prior authorization, competitive bidding,
2603 increased use of mass transit, or any other mechanism that the
2604 agency considers efficient and effective for the purchase of
2605 services on behalf of Medicaid clients, including implementing a
2606 transportation eligibility process.
2607 (b) The agency may ~~shall~~ not ~~be required to~~ contract with
2608 any community transportation coordinator or transportation
2609 operator that has been determined by the agency, the Department
2610 of Legal Affairs Medicaid Fraud Control Unit, or any other state

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2611 or federal agency to have engaged in any abusive or fraudulent
2612 billing activities.
2613 (c) The agency shall ~~is authorized to~~ competitively procure
2614 transportation services or make other changes necessary to
2615 secure approval of federal waivers needed to permit federal
2616 financing of Medicaid transportation services at the service
2617 matching rate rather than the administrative matching rate.
2618 ~~Notwithstanding chapter 427, the agency is authorized to~~
2619 ~~continue contracting for Medicaid nonemergency transportation~~
2620 ~~services in agency service area 11 with managed care plans that~~
2621 ~~were under contract for those services before July 1, 2004.~~
2622 (d) Transportation to access covered services provided by a
2623 qualified plan pursuant to part IV of this chapter shall be
2624 contracted for by the plan. A qualified plan is not required to
2625 purchase such services through a coordinated transportation
2626 system established pursuant to part I of chapter 427.
2627 (19) COUNTY HEALTH DEPARTMENTS.—County health department
2628 services shall be reimbursed a rate per visit based on total
2629 reasonable costs of the clinic, as determined by the agency in
2630 accordance with federal regulations under the authority of 42
2631 C.F.R. s. 431.615.
2632 (20) DIALYSIS.—A renal dialysis facility that provides
2633 dialysis services under s. 409.906(9) must be reimbursed the
2634 lesser of the amount billed by the provider, the provider's
2635 usual and customary charge, or the maximum allowable fee
2636 established by the agency, whichever ~~amount~~ is less.
2637 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse
2638 school districts that ~~which~~ certify the state match pursuant to
2639 ss. 409.9071 and 1011.70 for the federal portion of the school

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2640 district's allowable costs to deliver the services, based on the
2641 reimbursement schedule. The school district shall determine the
2642 costs for delivering services as authorized in ss. 409.9071 and
2643 1011.70 for which the state match will be certified.
2644 Reimbursement of school-based providers is contingent on such
2645 providers being enrolled as Medicaid providers and meeting the
2646 qualifications contained in 42 C.F.R. s. 440.110, unless
2647 otherwise waived by the federal Centers for Medicare and
2648 Medicaid Services ~~Health Care Financing Administration~~. Speech
2649 therapy providers who are certified through the Department of
2650 Education pursuant to rule 6A-4.0176, Florida Administrative
2651 Code, are eligible for reimbursement for services that are
2652 provided on school premises. Any employee of the school district
2653 who has been fingerprinted and has received a criminal
2654 background check in accordance with Department of Education
2655 rules and guidelines is ~~shall be~~ exempt from any agency
2656 requirements relating to criminal background checks.
2657 ~~(22) The agency shall request and implement Medicaid~~
2658 ~~waivers from the federal Health Care Financing Administration to~~
2659 ~~advance and treat a portion of the Medicaid nursing home per~~
2660 ~~diem as capital for creating and operating a risk-retention~~
2661 ~~group for self-insurance purposes, consistent with federal and~~
2662 ~~state laws and rules.~~
2663 (22) ~~(23)(a)~~ LIMITATION ON REIMBURSEMENT RATES.—The agency
2664 shall establish rates at a level that ensures no increase in
2665 statewide expenditures resulting from a change in unit costs for
2666 2 fiscal years effective July 1, 2009. Reimbursement rates for
2667 the 2 fiscal years shall be as provided in the General
2668 Appropriations Act.

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2669 (a) ~~(b)~~ This subsection applies to the following provider
2670 types:
2671 1. Inpatient hospitals.
2672 2. Outpatient hospitals.
2673 3. Nursing homes.
2674 4. County health departments.
2675 5. Community intermediate care facilities for the
2676 developmentally disabled.
2677 6. Prepaid health plans.
2678 (b) The agency shall apply ~~the effect of~~ this subsection to
2679 the reimbursement rates for nursing home diversion programs.
2680 ~~(c) The agency shall create a workgroup on hospital~~
2681 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
2682 ~~and a workgroup on managed care plan payment. The workgroups~~
2683 ~~shall evaluate alternative reimbursement and payment~~
2684 ~~methodologies for hospitals, nursing facilities, and managed~~
2685 ~~care plans, including prospective payment methodologies for~~
2686 ~~hospitals and nursing facilities. The nursing facility workgroup~~
2687 ~~shall also consider price-based methodologies for indirect care~~
2688 ~~and acuity adjustments for direct care. The agency shall submit~~
2689 ~~a report on the evaluated alternative reimbursement~~
2690 ~~methodologies to the relevant committees of the Senate and the~~
2691 ~~House of Representatives by November 1, 2009.~~
2692 (c) ~~(d)~~ This subsection expires June 30, 2011.
2693 (23) PAYMENT METHODOLOGIES.—If a provider is reimbursed
2694 based on cost reporting and submits a cost report late and that
2695 cost report would have been used to set a lower reimbursement
2696 rate for a rate semester, the provider's rate for that semester
2697 shall be retroactively calculated using the new cost report, and

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2698 full payment at the recalculated rate shall be applied
2699 retroactively. Medicare-granted extensions for filing cost
2700 reports, if applicable, also apply to Medicaid cost reports.
2701 (24) RETURN OF PAYMENTS.—If a provider fails to notify the
2702 agency within 5 business days after suspension or disenrollment
2703 from Medicare, sanctions may be imposed pursuant to this
2704 chapter, and the provider may be required to return funds paid
2705 to the provider during the period of time that the provider was
2706 suspended or disenrolled ~~as a Medicare provider~~.
2707 Section 28. Subsection (1) of section 409.9081, Florida
2708 Statutes, is amended to read:
2709 409.9081 Copayments.—
2710 (1) ~~The agency shall require,~~ Subject to federal
2711 regulations and limitations, each Medicaid recipient must ~~to~~ pay
2712 at the time of service a nominal copayment for the following
2713 Medicaid services:
2714 (a) Hospital outpatient services: up to $3 for each
2715 hospital outpatient visit.
2716 (b) Physician services: up to $2 copayment for each visit
2717 with a primary care physician and up to $3 copayment for each
2718 visit with a specialty care physician ~~licensed under chapter~~
2719 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463~~.
2720 (c) Hospital emergency department visits for nonemergency
2721 care: 5 percent of up to the first $300 of the Medicaid payment
2722 for emergency room services, not to exceed $15. The agency shall
2723 seek a federal waiver of the requirement that cost-sharing
2724 amounts for nonemergency services and care furnished in a
2725 hospital emergency department be nominal. Upon waiver approval,
2726 a Medicaid recipient who requests such services and care, must

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2727 pay a $100 copayment to the hospital for the nonemergency
2728 services and care provided in the hospital emergency department.
2729 (d) Prescription drugs: a coinsurance equal to 2.5 percent
2730 of the Medicaid cost of the prescription drug at the time of
2731 purchase. The maximum coinsurance is ~~shall be~~ $7.50 per
2732 prescription drug purchased.
2733 Section 29. Paragraph (b) and (d) of subsection (4) and
2734 subsections (8), (34), (44), (47), and (53) of section 409.912,
2735 Florida Statutes, are amended, and subsections (48) through (52)
2736 of that section are renumbered as subsections (47) through (51)
2737 respectively, to read:
2738 409.912 Cost-effective purchasing of health care.—The
2739 agency shall purchase goods and services for Medicaid recipients
2740 in the most cost-effective manner consistent with the delivery
2741 of quality medical care. To ensure that medical services are
2742 effectively utilized, the agency may, in any case, require a
2743 confirmation or second physician's opinion of the correct
2744 diagnosis for purposes of authorizing future services under the
2745 Medicaid program. This section does not restrict access to
2746 emergency services or poststabilization care services as defined
2747 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2748 shall be rendered in a manner approved by the agency. The agency
2749 shall maximize the use of prepaid per capita and prepaid
2750 aggregate fixed-sum basis services when appropriate and other
2751 alternative service delivery and reimbursement methodologies,
2752 including competitive bidding pursuant to s. 287.057, designed
2753 to facilitate the cost-effective purchase of a case-managed
2754 continuum of care. The agency shall also require providers to
2755 minimize the exposure of recipients to the need for acute

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2756 inpatient, custodial, and other institutional care and the
2757 inappropriate or unnecessary use of high-cost services. The
2758 agency shall contract with a vendor to monitor and evaluate the
2759 clinical practice patterns of providers in order to identify
2760 trends that are outside the normal practice patterns of a
2761 provider’s professional peers or the national guidelines of a
2762 provider’s professional association. The vendor must be able to
2763 provide information and counseling to a provider whose practice
2764 patterns are outside the norms, in consultation with the agency,
2765 to improve patient care and reduce inappropriate utilization.
2766 The agency may mandate prior authorization, drug therapy
2767 management, or disease management participation for certain
2768 populations of Medicaid beneficiaries, certain drug classes, or
2769 particular drugs to prevent fraud, abuse, overuse, and possible
2770 dangerous drug interactions. The Pharmaceutical and Therapeutics
2771 Committee shall make recommendations to the agency on drugs for
2772 which prior authorization is required. The agency shall inform
2773 the Pharmaceutical and Therapeutics Committee of its decisions
2774 regarding drugs subject to prior authorization. The agency is
2775 authorized to limit the entities it contracts with or enrolls as
2776 Medicaid providers by developing a provider network through
2777 provider credentialing. The agency may competitively bid single-
2778 source-provider contracts if procurement of goods or services
2779 results in demonstrated cost savings to the state without
2780 limiting access to care. The agency may limit its network based
2781 on the assessment of beneficiary access to care, provider
2782 availability, provider quality standards, time and distance
2783 standards for access to care, the cultural competence of the
2784 provider network, demographic characteristics of Medicaid

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2785 beneficiaries, practice and provider-to-beneficiary standards,
2786 appointment wait times, beneficiary use of services, provider
2787 turnover, provider profiling, provider licensure history,
2788 previous program integrity investigations and findings, peer
2789 review, provider Medicaid policy and billing compliance records,
2790 clinical and medical record audits, and other factors. Providers
2791 shall not be entitled to enrollment in the Medicaid provider
2792 network. The agency shall determine instances in which allowing
2793 Medicaid beneficiaries to purchase durable medical equipment and
2794 other goods is less expensive to the Medicaid program than long-
2795 term rental of the equipment or goods. The agency may establish
2796 rules to facilitate purchases in lieu of long-term rentals in
2797 order to protect against fraud and abuse in the Medicaid program
2798 as defined in s. 409.913. The agency may seek federal waivers
2799 necessary to administer these policies.
2800 (4) The agency may contract with:
2801 (b) An entity that is providing comprehensive behavioral
2802 health care services to ~~certain~~ Medicaid recipients through a
2803 capitated, prepaid arrangement pursuant to the federal waiver
2804 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.
2805 Such entity must be licensed under chapter 624, chapter 636, or
2806 chapter 641, or authorized under paragraph (c) or paragraph (d),
2807 and must possess the clinical systems and operational competence
2808 to manage risk and provide comprehensive behavioral health care
2809 to Medicaid recipients. As used in this paragraph, the term
2810 “comprehensive behavioral health care services” means covered
2811 mental health and substance abuse treatment services that are
2812 available to Medicaid recipients. The Secretary ~~of the~~
2813 ~~Department~~ of Children and Family Services must ~~shall~~ approve

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2814 ~~provisions of~~ procurements related to children in the
2815 department's care or custody before enrolling such children in a
2816 prepaid behavioral health plan. Any contract awarded under this
2817 paragraph must be competitively procured. ~~In developing~~ The
2818 behavioral health care prepaid plan procurement document must
2819 require~~, the agency shall ensure that the procurement document~~
2820 ~~requires~~ the contractor to develop and implement a plan to
2821 ensure compliance with s. 394.4574 related to services provided
2822 to residents of licensed assisted living facilities that hold a
2823 limited mental health license. Except as provided in
2824 subparagraph 5. ~~8.~~, and except in counties where the Medicaid
2825 managed care pilot program is authorized pursuant to s. 409.986
2826 ~~409.91211~~, the agency shall seek federal approval to contract
2827 with a single entity ~~meeting these requirements~~ to provide
2828 comprehensive behavioral health care services to all Medicaid
2829 recipients not enrolled in a Medicaid managed care plan
2830 authorized under s. 409.986 ~~409.91211~~, a provider service
2831 network authorized under paragraph (d), or a Medicaid health
2832 maintenance organization in an AHCA area. In an AHCA area where
2833 the Medicaid managed care pilot program is authorized pursuant
2834 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may
2835 procure a contract with a single entity to serve the remaining
2836 counties as an AHCA area or the remaining counties may be
2837 included with an adjacent AHCA area and are subject to this
2838 paragraph. Each entity must offer a ~~sufficient~~ choice of
2839 providers in its network to ensure recipient access to care and
2840 the opportunity to select a provider with whom they are
2841 satisfied. The network shall include all public mental health
2842 hospitals. To ensure unimpaired access to behavioral health care

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2843 services by Medicaid recipients, all contracts issued pursuant
2844 to this paragraph must require that 90 ~~80~~ percent of the
2845 capitation paid to the managed care plan, including health
2846 maintenance organizations and capitated provider service
2847 networks, ~~to~~ be expended for the provision of behavioral health
2848 care services. If the managed care plan expends less than 90 ~~80~~
2849 percent ~~of the capitation paid~~ for the provision of behavioral
2850 health care services, the difference shall be returned to the
2851 agency. The agency shall provide the plan with a certification
2852 letter indicating the amount of capitation paid during each
2853 calendar year for behavioral health care services pursuant to
2854 this section. The agency may reimburse ~~for~~ substance abuse
2855 treatment services on a fee-for-service basis until the agency
2856 finds that adequate funds are available for capitated, prepaid
2857 arrangements.
2858 1. ~~By January 1, 2001,~~ The agency shall modify the
2859 contracts with the entities providing comprehensive inpatient
2860 and outpatient mental health care services to Medicaid
2861 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
2862 Counties, to include substance abuse treatment services.
2863 ~~2. By July 1, 2003, the agency and the Department of~~
2864 ~~Children and Family Services shall execute a written agreement~~
2865 ~~that requires collaboration and joint development of all policy,~~
2866 ~~budgets, procurement documents, contracts, and monitoring plans~~
2867 ~~that have an impact on the state and Medicaid community mental~~
2868 ~~health and targeted case management programs.~~
2869 2.~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~
2870 ~~2006,~~ the agency and the Department of Children and Family
2871 Services shall contract with managed care entities in each AHCA

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2872 area ~~except area 6~~ or arrange to provide comprehensive inpatient
2873 and outpatient mental health and substance abuse services
2874 through capitated prepaid arrangements to all Medicaid
2875 recipients who are eligible to participate in such plans under
2876 federal law and regulation. In AHCA areas where there are fewer
2877 than 150,000 eligible individuals ~~number less than 150,000~~, the
2878 agency shall contract with a single managed care plan to provide
2879 comprehensive behavioral health services to all recipients who
2880 are not enrolled in a Medicaid health maintenance organization,
2881 a provider service network authorized under paragraph (d), or a
2882 Medicaid capitated managed care plan authorized under s. 409.986
2883 ~~409.91211~~. The agency may contract with more than one
2884 comprehensive behavioral health provider to provide care to
2885 recipients who are not enrolled in a Medicaid capitated managed
2886 care plan authorized under s. 409.986 ~~409.91211~~, a provider
2887 service network authorized under paragraph (d), or a Medicaid
2888 health maintenance organization in AHCA areas where the eligible
2889 population exceeds 150,000. In an AHCA area where the Medicaid
2890 managed care pilot program is authorized pursuant to s. 409.986
2891 ~~409.91211~~ in one or more counties, the agency may procure a
2892 contract with a single entity to serve the remaining counties as
2893 an AHCA area or the remaining counties may be included with an
2894 adjacent AHCA area and shall be subject to this paragraph.
2895 Contracts for comprehensive behavioral health providers awarded
2896 pursuant to this section must ~~shall~~ be competitively procured.
2897 Both for-profit and not-for-profit corporations are eligible to
2898 compete. Managed care plans contracting with the agency under
2899 subsection (3) or paragraph (d), shall provide and receive
2900 payment for the same comprehensive behavioral health benefits as

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2901 provided in AHCA rules, including handbooks incorporated by
2902 reference. In AHCA area 11, the agency shall contract with at
2903 least two comprehensive behavioral health care providers to
2904 provide behavioral health care to recipients ~~in that area~~ who
2905 are enrolled in, or assigned to, the MediPass program. One of
2906 the ~~behavioral health care~~ contracts must be with the existing
2907 provider service network pilot project, as described in
2908 paragraph (d), for the purpose of demonstrating the cost-
2909 effectiveness of the provision of quality mental health services
2910 through a public hospital-operated managed care model. Payment
2911 shall be at an agreed-upon capitated rate to ensure cost
2912 savings. Of the recipients in area 11 who are assigned to
2913 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those
2914 MediPass-enrolled recipients shall be assigned to the existing
2915 provider service network in area 11 for their behavioral care.
2916 ~~4. By October 1, 2003, the agency and the department shall~~
2917 ~~submit a plan to the Governor, the President of the Senate, and~~
2918 ~~the Speaker of the House of Representatives which provides for~~
2919 ~~the full implementation of capitated prepaid behavioral health~~
2920 ~~care in all areas of the state.~~
2921 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
2922 ~~of the state where the agency is able to establish sufficient~~
2923 ~~capitation rates.~~
2924 ~~b. If the agency determines that the proposed capitation~~
2925 ~~rate in any area is insufficient to provide appropriate~~
2926 ~~services, the agency may adjust the capitation rate to ensure~~
2927 ~~that care will be available. The agency and the department may~~
2928 ~~use existing general revenue to address any additional required~~
2929 ~~match but may not over-obligate existing funds on an annualized~~

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2930 ~~basis.~~
2931 ~~c. Subject to any limitations provided in the General~~
2932 ~~Appropriations Act, the agency, in compliance with appropriate~~
2933 ~~federal authorization, shall develop policies and procedures~~
2934 ~~that allow for certification of local and state funds.~~
2935 3.~~5.~~ Children residing in a statewide inpatient psychiatric
2936 program, or in a Department of Juvenile Justice or a Department
2937 of Children and Family Services residential program approved as
2938 a Medicaid behavioral health overlay services provider may not
2939 be included in a behavioral health care prepaid health plan or
2940 any other Medicaid managed care plan pursuant to this paragraph.
2941 ~~6. In converting to a prepaid system of delivery, the~~
2942 ~~agency shall in its procurement document require an entity~~
2943 ~~providing only comprehensive behavioral health care services to~~
2944 ~~prevent the displacement of indigent care patients by enrollees~~
2945 ~~in the Medicaid prepaid health plan providing behavioral health~~
2946 ~~care services from facilities receiving state funding to provide~~
2947 ~~indigent behavioral health care, to facilities licensed under~~
2948 ~~chapter 395 which do not receive state funding for indigent~~
2949 ~~behavioral health care, or reimburse the unsubsidized facility~~
2950 ~~for the cost of behavioral health care provided to the displaced~~
2951 ~~indigent care patient.~~
2952 4.~~7.~~ Traditional community mental health providers under
2953 contract with the Department of Children and Family Services
2954 pursuant to part IV of chapter 394, ~~child welfare providers~~
2955 ~~under contract with the Department of Children and Family~~
2956 ~~Services in areas 1 and 6,~~ and inpatient mental health providers
2957 licensed pursuant to chapter 395 must be offered an opportunity
2958 to accept or decline a contract to participate in any provider

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2959 network for prepaid behavioral health services.
2960 5.~~8.~~ All Medicaid-eligible children, except children in
2961 area 1 and children in ~~Highlands County, Hardee County, Polk~~
2962 ~~County, or~~ Manatee County in ~~of~~ area 6, whose cases ~~that~~ are
2963 open for child welfare services in the statewide automated child
2964 welfare information ~~HomeSafeNet~~ system, shall receive their
2965 behavioral health care services through a specialty prepaid plan
2966 operated by community-based lead agencies through a single
2967 agency or formal agreements among several agencies. The
2968 specialty prepaid plan must result in savings to the state
2969 comparable to savings achieved in other Medicaid managed care
2970 and prepaid programs. Such plan must provide mechanisms to
2971 maximize state and local revenues. The specialty prepaid plan
2972 shall be developed by the agency and the Department of Children
2973 and Family Services. The agency may seek federal waivers to
2974 implement this initiative. Medicaid-eligible children whose
2975 cases are open for child welfare services in the statewide
2976 automated child welfare information ~~HomeSafeNet~~ system and who
2977 reside in AHCA area 10 shall be enrolled in a capitated managed
2978 care plan, which includes provider service networks, which, in
2979 coordination with available community-based care providers
2980 specified in s. 409.1671, shall provide sufficient medical,
2981 developmental, behavioral, and emotional services to meet the
2982 needs of these children, subject to funding as provided in the
2983 General Appropriations Act ~~are exempt from the specialty prepaid~~
2984 ~~plan upon the development of a service delivery mechanism for~~
2985 ~~children who reside in area 10 as specified in s.~~
2986 ~~409.91211(3)(dd)~~.
2987 (d) A provider service network, which may be reimbursed on

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2988 a fee-for-service or prepaid basis.
2989 1. A provider service network that ~~which~~ is reimbursed by
2990 the agency on a prepaid basis is ~~shall be~~ exempt from parts I
2991 and III of chapter 641, but must comply with the solvency
2992 requirements in s. 641.2261(2) and meet appropriate financial
2993 reserve, quality assurance, and patient rights requirements ~~as~~
2994 established by the agency.
2995 2. ~~Medicaid recipients assigned to a provider service~~
2996 ~~network shall be chosen equally from those who would otherwise~~
2997 ~~have been assigned to prepaid plans and MediPass.~~ The agency may
2998 ~~is authorized to~~ seek federal Medicaid waivers as necessary to
2999 implement ~~the provisions of~~ this section. ~~Any contract~~
3000 ~~previously awarded to a provider service network operated by a~~
3001 ~~hospital pursuant to this subsection shall remain in effect for~~
3002 ~~a period of 3 years following the current contract expiration~~
3003 ~~date, regardless of any contractual provisions to the contrary.~~
3004 3. A provider service network is a network established or
3005 organized and operated by a health care provider, or group of
3006 affiliated health care providers, including minority physician
3007 networks and emergency room diversion programs that meet the
3008 requirements of s. 409.986 ~~409.91211~~, which provides a
3009 substantial proportion of the health care items and services
3010 under a contract directly through the provider or affiliated
3011 group of providers and may make arrangements with physicians or
3012 other health care professionals, health care institutions, or
3013 any combination of such individuals or institutions to assume
3014 all or part of the financial risk on a prospective basis for the
3015 provision of basic health services by the physicians, by other
3016 health professionals, or through the institutions. The health

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3017 care providers must have a controlling interest in the governing
3018 body of the provider service network organization.
3019 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum
3020 basis with an exclusive provider organization to provide health
3021 care services to Medicaid recipients if ~~provided that~~ the
3022 exclusive provider organization meets applicable managed care
3023 plan requirements in this section, ss. 409.987, 409.988
3024 ~~409.9122, 409.9123~~, 409.9128, and 627.6472, and other applicable
3025 provisions of law.
3026 ~~(b) For a period of no longer than 24 months after the~~
3027 ~~effective date of this paragraph, when a member of an exclusive~~
3028 ~~provider organization that is contracted by the agency to~~
3029 ~~provide health care services to Medicaid recipients in rural~~
3030 ~~areas without a health maintenance organization obtains services~~
3031 ~~from a provider that participates in the Medicaid program in~~
3032 ~~this state, the provider shall be paid in accordance with the~~
3033 ~~appropriate fee schedule for services provided to eligible~~
3034 ~~Medicaid recipients. The agency may seek waiver authority to~~
3035 ~~implement this paragraph.~~
3036 (34) The agency and entities that contract with the agency
3037 to provide health care services to Medicaid recipients under
3038 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~
3039 must comply with the provisions of s. 641.513 in providing
3040 emergency services and care to Medicaid recipients and MediPass
3041 recipients. Where feasible, safe, and cost-effective, the agency
3042 shall encourage hospitals, emergency medical services providers,
3043 and other public and private health care providers to work
3044 together in their local communities to enter into agreements or
3045 arrangements to ensure access to alternatives to emergency

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3046 services and care for those Medicaid recipients who need
3047 nonemergent care. The agency shall coordinate with hospitals,
3048 emergency medical services providers, private health plans,
3049 capitated managed care networks as established in s. 409.986
3050 ~~409.91211~~, and other public and private health care providers to
3051 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),
3052 627.6405, and 641.31097 to develop and implement emergency
3053 department diversion programs for Medicaid recipients.
3054 (44) The agency ~~for Health Care Administration~~ shall ensure
3055 that any Medicaid managed care plan as defined in s.
3056 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis
3057 or a shared savings basis, is cost-effective. For purposes of
3058 this subsection, the term "cost-effective" means that a
3059 network's per-member, per-month costs to the state, including,
3060 but not limited to, fee-for-service costs, administrative costs,
3061 and case-management fees, if any, must be no greater than the
3062 state's costs associated with contracts for Medicaid services
3063 established under subsection (3), which may be adjusted for
3064 health status. The agency shall conduct actuarially sound
3065 adjustments for health status in order to ensure such cost-
3066 effectiveness and shall annually publish the results on its
3067 Internet website. Contracts established pursuant to this
3068 subsection which are not cost-effective may not be renewed.
3069 ~~(47) The agency shall conduct a study of available~~
3070 ~~electronic systems for the purpose of verifying the identity and~~
3071 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
3072 ~~to the Legislature a plan to implement an electronic~~
3073 ~~verification system for Medicaid recipients by January 31, 2005.~~
3074 ~~(53) Before seeking an amendment to the state plan for~~

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3075 ~~purposes of implementing programs authorized by the Deficit~~
3076 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~
3077 Section 30. Paragraph (a) of subsection (1) of section
3078 409.915, Florida Statutes, is amended to read:
3079 409.915 County contributions to Medicaid.—Although the
3080 state is responsible for the full portion of the state share of
3081 the matching funds required for the Medicaid program, in order
3082 to acquire a certain portion of these funds, the state shall
3083 charge the counties for certain items of care and service as
3084 provided in this section.
3085 (1) Each county shall participate in the following items of
3086 care and service:
3087 (a) For both health maintenance members and fee-for-service
3088 beneficiaries, payments for inpatient hospitalization in excess
3089 of 10 days, but not in excess of 45 days, with the exception of
3090 pregnant women and children whose income is greater than ~~in~~
3091 ~~excess of~~ the federal poverty level and who do not receive a
3092 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~
3093 ~~medically needy Program~~, and for adult lung transplant services.
3094 Section 31. Section 409.9301, Florida Statutes, is
3095 transferred, renumbered as section 409.9067, Florida Statutes,
3096 and subsections (1) and (2) of that section are amended, to
3097 read:
3098 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—
3099 (1) PROGRAM ESTABLISHED.—A program is established in the
3100 agency ~~for Health Care Administration~~ to provide pharmaceutical
3101 expense assistance to individuals diagnosed with cancer or
3102 individuals who have obtained ~~received~~ organ transplants who
3103 received a Medicaid nonpoverty medical subsidy before ~~were~~

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3104 ~~medically needy recipients prior to~~ January 1, 2006.
3105 (2) ELIGIBILITY.—Eligibility for the program is limited to
3106 an individual who:
3107 (a) Is a resident of this state;
3108 (b) Was a Medicaid recipient who received a nonpoverty
3109 medical subsidy before ~~under the Florida Medicaid medically~~
3110 ~~needy program prior to~~ January 1, 2006;
3111 (c) Is eligible for Medicare;
3112 (d) Is a cancer patient or an organ transplant recipient;
3113 and
3114 (e) Requests to be enrolled in the program.
3115 Section 32. Subsection (1) of section 409.9126, Florida
3116 Statutes, is amended to read:
3117 409.9126 Children with special health care needs.—
3118 (1) Except as provided in subsection (4), children eligible
3119 for Children's Medical Services who receive Medicaid benefits,
3120 and other Medicaid-eligible children with special health care
3121 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987
3122 ~~409.9122~~ and shall be served through the Children's Medical
3123 Services network established in chapter 391.
3124 Section 33. The Division of Statutory Revision is requested
3125 to create part IV of chapter 409, Florida Statutes, consisting
3126 of sections 409.961-409.978, Florida Statutes, entitled
3127 "MEDICAID MANAGED CARE."
3128 Section 34. Section 409.961, Florida Statutes, is created
3129 to read:
3130 409.961 Construction; applicability.—It is the intent of
3131 the Legislature that if any conflict exists between ss. 409.961-
3132 409.978 and other parts or sections of this chapter, the

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3133 provisions in ss. 409.961-409.978 control. Sections 409.961-
3134 409.978 apply only to the Medicaid managed care program, as
3135 provided in this part.
3136 Section 35. Section 409.962, Florida Statutes, is created
3137 to read:
3138 409.962 Definitions.—As used in this part, and including
3139 the terms defined in s. 409.901, the term:
3140 (1) "Direct care management" means care management
3141 activities that involve direct interaction between providers and
3142 patients.
3143 (2) "Home and community-based services" means a specific
3144 set of services designed to assist recipients qualifying under
3145 s. 409.974 in avoiding institutionalization.
3146 (3) "Medicaid managed care program" means the integrated,
3147 statewide Medicaid program created in this part, which includes
3148 the provision of managed care medical assistance services
3149 described in ss. 409.971 and 409.972 and managed long-term care
3150 services described in ss. 409.973-409.978.
3151 (4) "Provider service network" means an entity of which a
3152 controlling interest is owned by, or a controlling interest in
3153 the governing body of the entity is composed of, a health care
3154 provider, a group of affiliated providers, or a public agency or
3155 entity that delivers health services. For purposes of this
3156 chapter, health care providers include Florida-licensed health
3157 care professionals, Florida-licensed health care facilities,
3158 federally qualified health centers, and home health care
3159 agencies.
3160 (5) "Qualified plan" means a managed care plan that is
3161 determined eligible to participate in the Medicaid managed care

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3162 program pursuant to s. 409.965.
3163 (6) "Specialty plan" means a qualified plan that serves
3164 Medicaid recipients who meet specified criteria based on age,
3165 medical condition, or diagnosis.
3166 Section 36. Section 409.963, Florida Statutes, is created
3167 to read:
3168 409.963 Medicaid managed care program.—The Medicaid managed
3169 care program is established as a statewide, integrated managed
3170 care program for all covered medical assistance services and
3171 long-term care services as provided under this part. Pursuant to
3172 s. 409.902, the program shall be administered by the agency, and
3173 eligibility for the program shall be determined by the
3174 Department of Children and Family Services.
3175 (1) The agency shall submit amendments to the Medicaid
3176 state plan or to existing waivers, or submit new waiver requests
3177 under section 1115 or other applicable sections of the Social
3178 Security Act, by August 1, 2011, as needed to implement the
3179 managed care program. At a minimum, the waiver requests must
3180 include a waiver that allows home and community-based services
3181 to be preferred over nursing home services for persons who can
3182 be safely managed in the home and community, and a waiver that
3183 requires dually eligible recipients to participate in the
3184 Medicaid managed care program. The waiver requests must also
3185 include provisions authorizing the state to limit enrollment in
3186 managed long-term care, establish waiting lists, and limit the
3187 amount, duration, and scope of home and community-based services
3188 to ensure that expenditures for persons eligible for managed
3189 long-term care services do not exceed funds provided in the
3190 General Appropriations Act.

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3191 (a) The agency shall initiate any necessary procurements
3192 required to implement the managed care program as soon as
3193 practicable, but no later than July 1, 2011, in anticipation of
3194 prompt approval of the waivers needed for the managed care
3195 program by the United States Department of Health and Human
3196 Services.
3197 (b) In submitting waivers, the agency shall work with the
3198 federal Centers for Medicare and Medicaid Services to accomplish
3199 approval of all waivers by December 1, 2011, in order to begin
3200 implementation of the managed care program by December 31, 2011.
3201 (c) Before seeking a waiver, the agency shall provide
3202 public notice and the opportunity for public comment and include
3203 public feedback in the waiver application.
3204 (2) The agency shall begin implementation of the Medicaid
3205 managed care program on December 31, 2011. If waiver approval is
3206 obtained, the program shall be implemented in accordance with
3207 the terms and conditions of the waiver. If necessary waivers
3208 have not been timely received, the agency shall notify the
3209 Centers for Medicare and Medicaid Services of the state's
3210 implementation of the managed care program and request the
3211 federal agency to continue providing federal funds equivalent to
3212 the funding level provided under the Federal Medical Assistance
3213 Percentage in order to implement the managed care program.
3214 (a) If the Centers for Medicare and Medicaid Services
3215 refuses to continue providing federal funds, the managed care
3216 program shall be implemented as a state-only funded program to
3217 the extent state funds are available.
3218 (b) If implemented as a state-only funded program, priority
3219 shall be given to providing:

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3220 1. Nursing home services to persons eligible for nursing
3221 home care.
3222 2. Medical services to persons served by the Agency for
3223 Persons with Disabilities.
3224 3. Medical services to pregnant women.
3225 4. Physician and hospital services to persons who are
3226 determined to be eligible for Medicaid subject to the income,
3227 assets, and categorical eligibility tests set forth in federal
3228 and state law.
3229 5. Services provided under the Healthy Start waiver.
3230 6. Medical services provided to persons in the Nursing Home
3231 Diversion waiver.
3232 7. Medical services provided to persons in intermediate
3233 care facilities for the developmentally disabled.
3234 8. Services to children in the child welfare system whose
3235 medical care is provided in accordance with s. 409.16713, as
3236 authorized by the General Appropriations Act.
3237 (c) If implemented as a state-only funded program pursuant
3238 to paragraph (b), provisions related to the eligibility
3239 standards of the state and federally funded Medicaid program
3240 remain in effect, except as otherwise provided under the managed
3241 care program.
3242 (d) If implemented as a state-only funded program pursuant
3243 to paragraph (a), provider agreements and other contracts that
3244 provide for Medicaid services to recipients identified in
3245 paragraph (b) continue in effect.
3246 Section 37. Section 409.964, Florida Statutes, is created
3247 to read:
3248 409.964 Enrollment.—All Medicaid recipients shall receive

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3249 medical services through the Medicaid managed care program
3250 established under this part unless excluded under this section.
3251 (1) The following recipients are excluded from
3252 participation in the Medicaid managed care program:
3253 (a) Women who are eligible only for family planning
3254 services.
3255 (b) Women who are eligible only for breast and cervical
3256 cancer services.
3257 (c) Persons who have a developmental disability as defined
3258 in s. 393.063.
3259 (d) Persons who are eligible for a Medicaid nonpoverty
3260 medical subsidy.
3261 (e) Persons who receive eligible services under emergency
3262 Medicaid for aliens.
3263 (f) Persons who are residing in a nursing home facility or
3264 are considered residents under the nursing home's bed-hold
3265 policy on or before July 1, 2011.
3266 (g) Persons who are eligible for and receiving prescribed
3267 pediatric extended care.
3268 (h) Persons who are dependent on a respirator by medical
3269 necessity and who meet the definition of a medically dependent
3270 or technologically dependent child under s. 400.902.
3271 (i) Persons who select the Medicaid hospice benefit and are
3272 receiving hospice services from a hospice licensed under part IV
3273 of chapter 400.
3274 (j) Children residing in a statewide inpatient psychiatric
3275 program.
3276 (k) A person who is eligible for services under the
3277 Medicaid program who has access to health care coverage through

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3278 an employer-sponsored health plan. Such person may not receive
3279 Medicaid services under the fee-for-service program but may use
3280 Medicaid financial assistance to pay the cost of premiums for
3281 the employer-sponsored health plan. For purposes of this
3282 paragraph, access to health care coverage through an employer-
3283 sponsored health plan means that the Medicaid financial
3284 assistance available to the person is sufficient to pay the
3285 premium for the employer-sponsored health plan for the eligible
3286 person and his or her Medicaid eligible family members.
3287 1. The agency shall develop a process that allows a
3288 recipient who has access to employer-sponsored health coverage
3289 to use Medicaid financial assistance to pay the cost of the
3290 premium for the recipient and the recipient's Medicaid-eligible
3291 family members for such coverage. The amount of financial
3292 assistance may not exceed the Medicaid capitated rate that would
3293 have been paid to a qualified plan for that recipient and the
3294 recipient's family members.
3295 2. Contingent upon federal approval, the agency shall also
3296 allow recipients who have access to other insurance or coverage
3297 created pursuant to state or federal law to opt out of Medicaid
3298 managed care and apply the Medicaid capitated rate that would
3299 have been paid to a qualified plan for that recipient and the
3300 recipient's family to pay for the other insurance product.
3301 (2) The following Medicaid recipients are exempt from
3302 mandatory enrollment in the managed care program but may
3303 volunteer to participate in the program:
3304 (a) Recipients residing in residential commitment
3305 facilities operated through the Department of Juvenile Justice,
3306 group care facilities operated by the Department of Children and

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3307 Family Services, or treatment facilities funded through the
3308 substance abuse and mental health program of the Department of
3309 Children and Family Services.
3310 (b) Persons eligible for refugee assistance.
3311 (3) Medicaid recipients who are exempt from mandatory
3312 participation under this section and who do not choose to enroll
3313 in the Medicaid managed care program shall be served though the
3314 Medicaid fee-for-service program as provided under part III of
3315 this chapter.
3316 Section 38. Section 409.965, Florida Statutes, is created
3317 to read:
3318 409.965 Qualified plans; regions; selection criteria.—
3319 Services in the Medicaid managed care program shall be provided
3320 by qualified plans.
3321 (1) The agency shall select qualified plans to participate
3322 in the Medicaid managed care program using an invitation to
3323 negotiate issued pursuant to s. 287.057.
3324 (a) The agency shall notice separate invitations to
3325 negotiate for the managed medical assistance component and the
3326 managed long-term care component of the managed care program.
3327 (b) At least 30 days before noticing the invitation to
3328 negotiate and annually thereafter, the agency shall compile and
3329 publish a databook consisting of a comprehensive set of
3330 utilization and spending data for the 3 most recent contract
3331 years, consistent with the rate-setting periods for all Medicaid
3332 recipients by region and county. Pursuant to s. 409.970, the
3333 source of the data must include both historic fee-for-service
3334 claims and validated data from the Medicaid Encounter Data
3335 System. The report shall be made available electronically and

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3336 must delineate utilization by age, gender, eligibility group,
3337 geographic area, and acuity level.
3338 (2) Separate and simultaneous procurements shall be
3339 conducted in each of the following regions:
3340 (a) Region 1, which consists of Escambia, Okaloosa, Santa
3341 Rosa, and Walton counties.
3342 (b) Region 2, which consists of Franklin, Gadsden,
3343 Jefferson, Leon, Liberty, and Wakulla counties.
3344 (c) Region 3, which consists of Columbia, Dixie, Hamilton,
3345 Lafayette, Madison, Suwannee, and Taylor counties.
3346 (d) Region 4, which consists of Baker, Clay, Duval, and
3347 Nassau counties.
3348 (e) Region 5, which consists of Citrus, Hernando, Lake,
3349 Marion, and Sumter counties.
3350 (f) Region 6, which consists of Pasco and Pinellas
3351 counties.
3352 (g) Region 7, which consists of Flagler, Putnam, St. Johns,
3353 and Volusia counties.
3354 (h) Region 8, which consists of Alachua, Bradford,
3355 Gilchrist, Levy, and Union counties.
3356 (i) Region 9, which consists of Orange and Osceola
3357 counties.
3358 (j) Region 10, which consists of Hardee, Highlands, and
3359 Polk counties.
3360 (k) Region 11, which consists of Miami-Dade and Monroe
3361 counties.
3362 (l) Region 12, which consists of DeSoto, Manatee, and
3363 Sarasota counties.
3364 (m) Region 13, which consists of Hillsborough County.

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3365 (n) Region 14, which consists of Bay, Calhoun, Gulf,
3366 Holmes, Jackson, and Washington counties.
3367 (o) Region 15, which consists of Palm Beach County.
3368 (p) Region 16, which consists of Broward County.
3369 (q) Region 17, which consists of Brevard and Seminole
3370 counties.
3371 (r) Region 18, which consists of Indian River, Martin,
3372 Okeechobee, and St. Lucie counties.
3373 (s) Region 19, which consists of Charlotte, Collier,
3374 Glades, Hendry, and Lee counties.
3375 (3) The invitation to negotiate must specify the criteria
3376 and the relative weight of the criteria to be used for
3377 determining the acceptability of a reply and guiding the
3378 selection of qualified plans with which the agency shall
3379 contract. In addition to other criteria developed by the agency,
3380 the agency shall give preference to the following factors in
3381 selecting qualified plans:
3382 (a) Accreditation by the National Committee for Quality
3383 Assurance or another nationally recognized accrediting body.
3384 (b) Experience serving similar populations, including the
3385 organization's record in achieving specific quality standards
3386 for similar populations.
3387 (c) Availability and accessibility of primary care and
3388 specialty physicians in the provider network.
3389 (d) Establishment of partnerships with community providers
3390 that provide community-based services.
3391 (e) The organization's commitment to quality improvement
3392 and documentation of achievements in specific quality-
3393 improvement projects, including active involvement by the

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3394 organization's leadership.
3395 (f) Provision of additional benefits, particularly dental
3396 care for all recipients, disease management, and other programs
3397 offering additional benefits.
3398 (g) Establishment of incentive programs that reward
3399 specific behaviors with health-related benefits not otherwise
3400 covered by the organizations' benefit plan. Such behaviors may
3401 include participation in smoking-cessation programs, weight-loss
3402 programs, or other activities designed to mitigate lifestyle
3403 choices and avoid behaviors associated with the use of high-cost
3404 medical services.
3405 (h) Organizations without a history of voluntary or
3406 involuntary withdrawal from any state Medicaid program or
3407 program area.
3408 (i) Evidence that an organization has written agreements or
3409 signed contracts or has made substantial progress in
3410 establishing relationships with providers before the
3411 organization submits a reply. The agency shall evaluate such
3412 evidence based on the following factors:
3413 1. Contracts with primary care and specialty physicians in
3414 sufficient numbers to meet the specific performance standards
3415 established pursuant to s. 409.966(2)(b).
3416 2. Specific arrangements that provide evidence that the
3417 compensation offered by the plan is sufficient to retain primary
3418 care and specialty physicians in sufficient numbers to comply
3419 with the performance standards established pursuant to s.
3420 409.966(2) throughout the 5-year contract term. The agency shall
3421 give preference to plans that provide evidence that primary care
3422 physicians within the plan's provider network will be

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3423 compensated for primary care services with payments equivalent
3424 to or greater than payments for such services under the Medicare
3425 program, whether compensation is made on a fee-for-service basis
3426 or by sub-capitation.
3427 3. Contracts with community pharmacies located in rural
3428 areas; contracts with community pharmacies serving specialty
3429 disease populations, including, but not limited to, HIV/AIDS
3430 patients, hemophiliacs, patients suffering from end-stage renal
3431 disease, diabetes, or cancer; community pharmacies located
3432 within distinct cultural communities that reflect the unique
3433 cultural dynamics of such communities, including, but not
3434 limited to, languages spoken, ethnicities served, unique disease
3435 states serviced, and geographic location within the
3436 neighborhoods of culturally distinct populations; and community
3437 pharmacies providing value-added services to patients, such as
3438 free delivery, immunizations, disease management, diabetes
3439 education, and medication utilization review.
3440 4. Contracts with cancer disease management programs that
3441 have a proven record of clinical efficiencies and cost savings.
3442 5. Contracts with diabetes disease management programs that
3443 have a proven record of clinical efficiencies and cost savings.
3444 (j) The capitated rates provided in the reply to the
3445 invitation to negotiate.
3446 (k) Establishment of a claims payment process to ensure
3447 that claims that are not contested or denied will be paid within
3448 20 days after receipt.
3449 (l) Utilizing a tiered approach, organizations that are
3450 based in Florida and have operational functions performed in
3451 Florida, either performed in-house or through contractual

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3452 arrangements, by Florida-employed staff. The highest number of
3453 points shall be awarded to any plan with all or substantially
3454 all of its operational functions performed in the state. The
3455 second highest number of points shall be awarded to any plan
3456 with a majority of its operational functions performed in the
3457 state. The agency may establish a third tier; however, no
3458 preference points shall be awarded to plans that perform only
3459 community outreach, medical director functions, and state
3460 administrative functions in the state. For purposes of this
3461 paragraph, operational functions include claims processing,
3462 member services, provider relations, utilization and prior
3463 authorization, case management, disease and quality functions,
3464 and finance and administration. For purposes of this paragraph,
3465 "based in Florida" means that the entity's principal office is
3466 in Florida and the plan is not a subsidiary, directly or
3467 indirectly through one or more subsidiaries of, or a joint
3468 venture with, any other entity whose principal office is not
3469 located in the state.
3470 (m) For long-term care plans, additional criteria as
3471 specified in s. 409.976(3).
3472 (4) Acceptable replies to the invitation to negotiate for
3473 each region shall be ranked, and the agency shall select the
3474 number of qualified plans with which to contract in each region.
3475 (a) The agency may not select more than one plan per 20,000
3476 Medicaid recipients residing in the region who are subject to
3477 mandatory managed care enrollment, except that, in addition to
3478 the Children's Medical Services Network, a region may not have
3479 more than 10 qualified plans for the managed medical assistance
3480 or the managed long-term care components of the program.

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3481 (b) If the funding available in the General Appropriations
3482 Act is not adequate to meet the proposed statewide requirement
3483 under the Medicaid managed care program, the agency shall enter
3484 into negotiations with qualified plans that responded to the
3485 invitation to negotiate. The negotiation process may alter the
3486 rank of a qualified plan. If negotiations are conducted, the
3487 agency shall select qualified plans that are responsive and
3488 provide the best value to the state.
3489 (5) The agency may issue a new invitation to negotiate in
3490 any region:
3491 (a) At any time if:
3492 1. Data becomes available to the agency indicating that the
3493 population of recipients residing in the region who are subject
3494 to mandatory managed care enrollment cannot be served by the
3495 plans under contract with the agency in that region or has
3496 increased by more than 20,000 since the most recent invitation
3497 to negotiate was issued in that region; and
3498 2. The agency has not contracted with the maximum number of
3499 plans authorized for that region.
3500 (b) At any time during the first 2 years after the initial
3501 contract period and upon the request of a qualified plan under
3502 contract in one or more regions if:
3503 1. Data becomes available to the agency indicating that the
3504 population of Medicaid recipients residing in the region who are
3505 subject to mandatory managed care enrollment has increased by
3506 more than 20,000 since the initial invitation to negotiate was
3507 issued for the contract period; and
3508 2. The agency has not contracted with the maximum number of
3509 plans authorized for that region.

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3511 The term of a contract executed under this subsection shall be
3512 for the remainder of the 5-year contract cycle.
3513 (6) The Children's Medical Services Network authorized
3514 under chapter 391 is a qualified plan for purposes of the
3515 managed care medical assistance component of the Medicaid
3516 managed care program. Participation by the network shall be
3517 pursuant to a single statewide contract with the agency which is
3518 not subject to the procurement requirements of this section. The
3519 network must meet all other plan requirements for the managed
3520 care medical assistance component of the program.
3521 (7) In order to allow a provider service network in rural
3522 areas sufficient time to develop an adequate provider network to
3523 participate in the Medicaid managed care program on a capitated
3524 basis, the network may submit an application or invitation to
3525 negotiate after July 1, 2011, as required by the agency, for a
3526 region where there was no Medicaid-contracted health maintenance
3527 organization or provider service network on July 1, 2011. For
3528 the first 12 months that the network operates in the region, the
3529 agency shall assign existing Medicaid provider agreements to the
3530 provider service network for purposes of administering managed
3531 care services and building an adequate provider network to meet
3532 the access standards established by the agency.
3533 Section 39. Section 409.966, Florida Statutes, is created
3534 to read:
3535 409.966 Plan contracts.—
3536 (1) The agency shall execute a 5-year contract with each
3537 qualified plan selected through the procurement process
3538 described in s. 409.965. A contract between the agency and the

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3539 qualified plan may be amended annually, or as needed, to reflect
3540 capitated rate adjustments due to funding availability pursuant
3541 to the General Appropriations Act and ss. 409.9022, 409.972, and
3542 409.975(2).
3543 (a) A plan contract may not be renewed; however, the agency
3544 may extend the term of a contract, keeping intact all
3545 operational provisions in the contract, including capitation
3546 rates, to cover any delays in transitioning to a new plan.
3547 (b) If a plan applies for a rate increase that is not the
3548 result of a solicitation from the agency and the application for
3549 rate increase is not timely withdrawn, the plan will be deemed
3550 to have submitted a notice of intent to leave the region before
3551 the end of the contract term.
3552 (2) The agency shall establish such contract requirements
3553 as are necessary for the operation of the Medicaid managed care
3554 program. In addition to any other provisions the agency may deem
3555 necessary, the contract must require:
3556 (a) *Access.*—The agency shall establish specific standards
3557 for the number, type, and regional distribution of providers in
3558 plan networks in order to ensure access to care. Each qualified
3559 plan shall:
3560 1. Maintain a network of providers in sufficient numbers to
3561 meet the access standards for specified services for all
3562 recipients enrolled in the plan.
3563 2. Establish and maintain an accurate and complete
3564 electronic database of contracted providers, including
3565 information about licensure or registration, locations and hours
3566 of operation, specialty credentials and other certifications,
3567 specific performance indicators, and such other information as

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3568 the agency deems necessary. The provider database must be
3569 available online to both the agency and the public and allow
3570 comparison of the availability of providers to network adequacy
3571 standards, and accept and display feedback from each provider's
3572 patients.
3573 3. Provide for reasonable and adequate hours of operation,
3574 including 24-hour availability of information, referral, and
3575 treatment for emergency medical conditions.
3576 4. Assign each new enrollee to a primary care provider and
3577 ensure that an appointment with that provider has been scheduled
3578 within 30 days after the enrollment in the plan.
3579 5. Submit quarterly reports to the agency identifying the
3580 number of enrollees assigned to each primary care provider.
3581 (b) *Performance standards.*—The agency shall establish
3582 specific performance standards and expected milestones or
3583 timelines for improving plan performance over the term of the
3584 contract.
3585 1. Each plan shall establish an internal health care
3586 quality improvement system that includes enrollee satisfaction
3587 and disenrollment surveys and incentives and disincentives for
3588 network providers.
3589 2. Each plan must collect and report the Health Plan
3590 Employer Data and Information Set (HEDIS) measures, as specified
3591 by the agency. These measures must be published on the plan's
3592 website in a manner that allows recipients to reliably compare
3593 the performance of plans. The agency shall use the HEDIS
3594 measures as a tool to monitor plan performance.
3595 3. A qualified plan that is not accredited when the
3596 contract is executed with the agency must become accredited or

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3597 have initiated the accreditation process within 1 year after the
3598 contract is executed. If the plan is not accredited within 18
3599 months after executing the contract, the plan shall be suspended
3600 from automated enrollments pursuant to s. 409.969(2).
3601 4. In addition to agency standards, a qualified plan must
3602 ensure that the agency is notified of the impending birth of a
3603 child to an enrollee or as soon as practicable after the child's
3604 birth. Upon the birth, the child is deemed enrolled with the
3605 qualified plan, regardless of the administrative enrollment
3606 procedures, and the qualified plan is responsible for providing
3607 Medicaid services to the child on a capitated basis.
3608 (c) *Program integrity.*—Each plan shall establish program
3609 integrity functions and activities in order to reduce the
3610 incidence of fraud and abuse, including, at a minimum:
3611 1. A provider credentialing system and ongoing provider
3612 monitoring. Each plan must verify at least annually that all
3613 providers have a valid and unencumbered license or permit to
3614 provide services to Medicaid recipients, and shall establish a
3615 procedure for providers to notify the plan when the provider has
3616 been notified by a licensing or regulatory agency that the
3617 provider's license or permit is to be revoked or suspended, or
3618 when an event has occurred which would prevent the provider from
3619 renewing its license or permit. The provider must also notify
3620 the plan if the license or permit is revoked or suspended, if
3621 renewal of the license or permit is denied or expires by
3622 operation of law, or if the provider requests that the license
3623 or permit be inactivated. The plan must immediately exclude a
3624 provider from the plan's provider network if the provider's
3625 license is suspended or invalid. However, this section does not

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3626 preclude a plan from contracting with a provider that is
3627 approved via a final order, has commenced construction, and will
3628 be licensed and operational within 18 months after the effective
3629 date of this act;
3630 2. An effective prepayment and postpayment review process
3631 that includes, at a minimum, data analysis, system editing, and
3632 auditing of network providers;
3633 3. Procedures for reporting instances of fraud and abuse
3634 pursuant to s. 409.91212;
3635 4. The establishment of an anti-fraud plan pursuant to s.
3636 409.91212; and
3637 5. Designation of a program integrity compliance officer.
3638 (d) *Encounter data.*—Each plan must comply with the agency's
3639 reporting requirements for the Medicaid Encounter Data System
3640 under s. 409.970. The agency shall assess a fine of $5,000 per
3641 day against a qualified plan for failing to comply with this
3642 requirement. If a plan fails to comply for more than 30 days,
3643 the agency shall assess a fine of $10,000 per day beginning on
3644 the 31st day. If a plan is fined $300,000 or more for failing to
3645 comply, in addition to paying the fine, the plan shall be
3646 disqualified from the Medicaid managed care program for 3 years.
3647 If the plan is disqualified, the plan shall be deemed to have
3648 terminated its contract before the scheduled end date and shall
3649 also be subject to applicable penalties under paragraph (l).
3650 However, the agency may waive or reduce the fine upon a showing
3651 of good cause for the failure to comply.
3652 (e) *Electronic claims and prior authorization requests.*—
3653 Plans shall accept electronic claims that are in compliance with
3654 federal standards and accept electronic prior authorization

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3655 requests from prescribers and pharmacists for medication
3656 exceptions to the preferred drug list or formulary. The criteria
3657 for the approval and the reasons for denial of prior
3658 authorization requests shall be made readily available to
3659 prescribers and pharmacists submitting the request.
3660 (f) *Prompt payment.*—All qualified plans must comply with
3661 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay
3662 nursing homes by the 10th day of the month for enrollees who are
3663 residing in the nursing home on the 1st day of the month.
3664 Payment for the month in which an enrollee initiates residency
3665 in a nursing home shall be in accordance with s. 641.3155. On an
3666 annual basis, qualified plans shall submit a report certifying
3667 compliance with the prompt payment requirements for the plan
3668 year.
3669 (g) *Emergency services.*—Qualified plans must pay for
3670 emergency services and care required under ss. 395.1041 and
3671 401.45 and rendered by a noncontracted provider in accordance
3672 with the prompt payment standards established in s. 641.3155.
3673 The payment rate shall be the fee-for-service rate the agency
3674 would pay the noncontracted provider for such services, unless
3675 the agency has developed an average rate for the noncontracted
3676 provider for such services under s. 409.967(3)(c). If the agency
3677 has developed an average rate for the noncontracted provider for
3678 such services under s. 409.967(3)(c), the payment rate for such
3679 services under this paragraph shall be the average rate
3680 developed by the agency for the noncontracted provider for such
3681 services under s. 409.967(3)(c).
3682 (h) *Surety bond.*—A qualified plan shall post and maintain a
3683 surety bond with the agency, payable to the agency, or in lieu

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3684 of a surety bond, establish and maintain an irrevocable letter
3685 of credit or a deposit in a trust account in a financial
3686 institution, payable to the agency.
3687 1. The amount of the surety bond, letter of credit, or
3688 trust account shall be 125 percent of the estimated annual
3689 guaranteed savings for each qualified plan, and at least $2
3690 million but no more than $15 million for each qualified plan.
3691 The estimated guaranteed savings shall be calculated before the
3692 execution of the contract as follows:
3693 a. The agreed-upon monthly contractual capitated rate for
3694 each level of acuity multiplied by the estimated population in
3695 the region for the plan for each level of acuity, multiplied by
3696 12 months, multiplied by 7 percent, multiplied by 125 percent.
3697 b. The estimated population in the region for the plan
3698 under sub-subparagraph a. shall be based on the maximum enrollee
3699 level that the agency initially authorizes. The factors that the
3700 agency may consider in determining the maximum enrollee level
3701 include, but are not limited to, requested capacity, projected
3702 enrollment, network adequacy, and the available budget in the
3703 General Appropriations Act.
3704 2. The purpose of the surety bond, letter of credit, or
3705 trust account is to protect the agency if the entity terminates
3706 its contract with the agency before the scheduled end date for
3707 the contract, if the plan fails to comply with the terms of the
3708 contract, including, but not limited to, the timely submission
3709 of encounter data, if the agency imposes fines or penalties for
3710 noncompliance, or if the plan fails to achieve the guaranteed
3711 savings. If any of those events occurs, the agency shall first
3712 request payment from the qualified plan. If the qualified plan

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3713 does not pay all costs, fines, penalties, or the differential in
3714 the guaranteed savings in full within 30 days, the agency shall
3715 pursue a claim against the surety bond, letter of credit, or
3716 trust account for all applicable moneys and the legal and
3717 administrative costs associated with pursuing such claim.
3718 (i) *Grievance resolution.*—Each plan shall establish and the
3719 agency shall approve an internal process for reviewing and
3720 responding to grievances from enrollees consistent with s.
3721 641.511. Each plan shall submit quarterly reports to the agency
3722 on the number, description, and outcome of grievances filed by
3723 enrollees.
3724 (j) *Solvency.*—A qualified plan must meet and maintain the
3725 surplus and solvency requirements under s. 409.912(17) and (18).
3726 A provider service network may satisfy the surplus and solvency
3727 requirements if the network's performance and financial
3728 obligations are guaranteed in writing by an entity licensed by
3729 the Office of Insurance Regulation which meets the surplus and
3730 solvency requirements of s. 624.408 or s. 641.225.
3731 (k) *Guaranteed savings.*—During the first contract period, a
3732 qualified plan must agree to provide a guaranteed minimum
3733 savings of 7 percent to the state. The agency shall conduct a
3734 cost reconciliation to determine the amount of cost savings
3735 achieved by the qualified plan compared with the reimbursements
3736 the agency would have incurred under fee-for-service provisions.
3737 (l) *Costs and penalties.*—Plans that reduce enrollment
3738 levels or leave a region before the end of the contract term
3739 must reimburse the agency for the cost of enrollment changes and
3740 other transition activities. If more than one plan leaves a
3741 region at the same time, costs shall be shared by the departing

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3742 plans proportionate to their enrollment. In addition to the
3743 payment of costs, departing plans must pay a penalty of 1
3744 month's payment calculated as an average of the past 12 months
3745 of payments, or since inception if the plan has not contracted
3746 with the agency for 12 months, plus the differential of the
3747 guaranteed savings based on the original contract term and the
3748 corresponding termination date. Plans must provide the agency
3749 with at least 180 days' notice before withdrawing from a region.
3750 (m) *Formulary.*—Upon recommendation of the Medicaid
3751 Pharmaceutical and Therapeutics Committee as defined in s.
3752 409.91195, all qualified plans must adopt a standard minimum
3753 preferred drug list as described in s. 409.912(39). A plan may
3754 offer additional products on its formulary. Each plan must
3755 publish an up-to-date listing of its formulary on a publicly
3756 available website.
3757 (3) If the agency terminates more than one regional
3758 contract with a qualified plan due to the plan's noncompliance
3759 with one or more requirements of this section, the agency shall
3760 terminate all regional contracts with the plan under the
3761 Medicaid managed care program, as well as any other contracts or
3762 agreements for other programs or services, and the plan may not
3763 be awarded new contracts for 3 years.
3764 Section 40. Section 409.967, Florida Statutes, is created
3765 to read:
3766 409.967 Plan accountability.—In addition to the contract
3767 requirements of s. 409.966, plans and providers participating in
3768 the Medicaid managed care program must comply with this section.
3769 (1) The agency shall require qualified plans to use a
3770 uniform method of reporting and accounting for medical, direct

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3771 care management, and nonmedical costs and shall evaluate plan-
3772 spending patterns after the plan completes 2 full years of
3773 operation and at least annually thereafter.
3774 (2) The agency shall implement the following thresholds and
3775 consequences of various spending patterns for qualified plans
3776 under the managed medical assistance component of the Medicaid
3777 managed care program:
3778 (a) The minimum medical loss ratio shall be 90 percent.
3779 (b) A plan and its subcontractors that spend less than 90
3780 percent of the plan's Medicaid capitation revenue on medical
3781 services and direct care management, as determined by the
3782 agency, must pay back to the agency a share of the dollar
3783 difference between the plan's actual medical loss ratio and the
3784 minimum medical loss ratio, as follows:
3785 1. If the plan's actual medical loss ratio is not lower
3786 than 87 percent, the plan must pay back 50 percent of the dollar
3787 difference between the actual medical loss ratio and the minimum
3788 medical loss ratio of 90 percent.
3789 2. If the plan's actual medical loss ratio is lower than 87
3790 percent, the plan must pay back 50 percent of the dollar
3791 difference between a medical loss ratio of 87 percent and the
3792 minimum medical loss ratio of 90 percent, plus 100 percent of
3793 the dollar difference between the actual medical loss ratio and
3794 a medical loss ratio of 87 percent.
3795 (c) To administer this subsection, the agency shall adopt
3796 rules that specify a methodology for calculating medical loss
3797 ratios and the requirements for plans to annually report
3798 information related to medical loss ratios. Repayments required
3799 by this subsection must be made annually.

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3800 (3) Plans may limit the providers in their networks.
3801 (a) However, during the first year in which a qualified
3802 plan is operating in a region after the initial plan procurement
3803 for that region, the plan must offer a network contract to the
3804 following providers in the region:
3805 1. Federally qualified health centers.
3806 2. Nursing homes if the plan is providing managed long-term
3807 care services.
3808 3. Aging network service providers that have previously
3809 participated in home and community-based waivers serving elders,
3810 or community-service programs administered by the Department of
3811 Elderly Affairs if the plan is providing managed long-term care
3812 services.
3813 (b) After 12 months of active participation in a plan's
3814 network, the plan may exclude any of the providers listed in
3815 paragraph (a) from the network while maintaining the network
3816 performance standards required under s. 409.966(2)(b). If the
3817 plan excludes a nursing home that meets the standards for
3818 ongoing Medicaid certification, the plan must provide an
3819 alternative residence in that community for Medicaid recipients
3820 residing in that nursing home. If a Medicaid recipient residing
3821 in an excluded nursing home does not choose to change residence,
3822 the plan must continue to pay for the recipient's care in that
3823 nursing home. If the plan excludes a provider, the plan must
3824 provide written notice to all enrollees who have chosen that
3825 provider for care. Notice to excluded providers must be
3826 delivered at least 30 days before the effective date of the
3827 exclusion.
3828 (c) Qualified plans and providers shall engage in good

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3829 faith negotiations to reach contract terms.
3830 1. If a qualified plan seeks to develop a provider network
3831 in a county or region that, as of June 30, 2011, does not have a
3832 capitated managed care plan providing comprehensive acute care
3833 for Medicaid recipients, and the qualified plan has made at
3834 least three documented, unsuccessful, good faith attempts to
3835 contract with a specific provider, the plan may request the
3836 agency to examine the negotiation process. During the
3837 examination, the agency shall consider similar counties or
3838 regions in which qualified plans have contracted with providers
3839 under similar circumstances, as well as the contracted rates
3840 between qualified plans and that provider and similar providers
3841 in the same region. If the agency determines that the plan has
3842 made three good faith attempts to contract with the provider,
3843 the agency shall consider that provider to be part of the
3844 qualified plan's provider network for the purpose of determining
3845 network adequacy, and the plan shall pay the provider for
3846 services to Medicaid recipients on a noncontracted basis at a
3847 rate or rates determined by the agency to be the average of
3848 rates for corresponding services paid by the qualified plan and
3849 other qualified plans in the region and in similar counties or
3850 regions under similar circumstances.
3851 2. The agency may continue to calculate Medicaid hospital
3852 inpatient per diem rates and outpatient rates. However, these
3853 rates may not be the basis for contract negotiations between a
3854 managed care plan and a hospital.
3855 (4) Each qualified plan shall monitor the quality and
3856 performance of each provider within its network based on metrics
3857 established by the agency for evaluating and documenting

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3858 provider performance and determining continued participation in
3859 the network. However, qualified plans are not required to
3860 conduct surveys of health care facilities that the agency
3861 surveys periodically for licensure or certification purposes and
3862 shall accept the results of such surveys. The agency shall
3863 establish requirements for qualified plans to report, at least
3864 annually, provider performance data compiled under this
3865 subsection. If a plan uses additional metrics to evaluate the
3866 provider's performance and to determine continued participation
3867 in the network, the plan must notify the network providers of
3868 these metrics at the beginning of the contract period.
3869 (a) At a minimum, a qualified plan shall hold primary care
3870 physicians responsible for the following activities:
3871 1. Supervision, coordination, and provision of care to each
3872 assigned enrollee.
3873 2. Initiation of referrals for medically necessary
3874 specialty care and other services.
3875 3. Maintaining continuity of care for each assigned
3876 enrollee.
3877 4. Maintaining the enrollee's medical record, including
3878 documentation of all medical services provided to the enrollee
3879 by the primary care physician, as well as any specialty or
3880 referral services.
3881 (b) Qualified plans shall establish and implement policies
3882 and procedures to monitor primary care physician activities and
3883 ensure that primary care physicians are adequately notified and
3884 receive documentation of specialty and referral services
3885 provided to enrollees by specialty physicians and other health
3886 care providers within the plan's provider network.

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3887 (5) Each qualified plan shall establish specific programs
3888 and procedures to improve pregnancy outcomes and infant health,
3889 including, but not limited to, coordination with the Healthy
3890 Start program, immunization programs, and referral to the
3891 Special Supplemental Nutrition Program for Women, Infants, and
3892 Children, and the Children's Medical Services Program for
3893 children with special health care needs.
3894 (a) Qualified plans must ensure that primary care
3895 physicians who provide obstetrical care are available to
3896 pregnant recipients and that an obstetrical care provider is
3897 assigned to each pregnant recipient for the duration of her
3898 pregnancy and postpartum care, by referral of the recipient's
3899 primary care physician if necessary.
3900 (b) Qualified plans within the managed long-term care
3901 component are exempt from this subsection.
3902 (6) Each qualified plan shall achieve an annual screening
3903 rate for early and periodic screening, diagnosis, and treatment
3904 services of at least 80 percent of those recipients continuously
3905 enrolled for at least 8 months. Qualified plans within the
3906 managed long-term care component are exempt from this
3907 requirement.
3908 (7) Effective January 1, 2013, qualified plans must
3909 compensate primary care physicians for primary care services at
3910 payment rates that are equivalent to or greater than payments
3911 under the federal Medicare program, whether compensation is made
3912 on a fee-for-service basis or by sub-capitation.
3913 (8) In order to protect the continued operation of the
3914 Medicaid managed care program, unresolved disputes, including
3915 claim and other types of disputes, between a qualified plan and

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3916 a provider shall proceed in accordance with s. 408.7057. This
3917 process may not be used to review or reverse a decision by a
3918 qualified plan to exclude a provider from its network if the
3919 decision does not conflict with s. 409.967(3).
3920 Section 41. Section 409.968, Florida Statutes, is created
3921 to read:
3922 409.968 Plan payment.—Payments for managed medical
3923 assistance and managed long-term care services under this part
3924 shall be made in accordance with a capitated managed care model.
3925 Qualified plans shall receive per-member, per-month payments
3926 pursuant to the procurements described in s. 409.965 and annual
3927 adjustments as described in s. 409.966(1). Payment rates must be
3928 based on the acuity level for each member pursuant to ss.
3929 409.972 and 409.978. Payment rates for managed long-term care
3930 plans shall be combined with rates for managed medical
3931 assistance plans.
3932 (1) The agency shall develop a methodology and request a
3933 waiver that ensures the availability of intergovernmental
3934 transfers and certified public expenditures in the Medicaid
3935 managed care program to support providers that have historically
3936 served Medicaid recipients. Such providers include, but are not
3937 limited to, safety net providers, trauma hospitals, children's
3938 hospitals, statutory teaching hospitals, and medical and
3939 osteopathic physicians employed by or under contract with a
3940 medical school in this state. The agency may develop a
3941 supplemental capitation rate, risk pool, or incentive payment
3942 for plans that contract with these providers. A plan is eligible
3943 for a supplemental payment only if there are sufficient
3944 intergovernmental transfers or certified public expenditures

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3945 available from allowable sources.
3946 (2) The agency shall evaluate the development of the rate
3947 cell to accurately reflect the underlying utilization to the
3948 maximum extent possible. This methodology may include interim
3949 rate adjustments as permitted under federal regulations. Any
3950 such methodology must preserve federal funding to these entities
3951 and be actuarially sound. In the absence of federal approval of
3952 the methodology, the agency may set an enhanced rate and require
3953 that plans pay the rate if the agency determines the enhanced
3954 rate is necessary to ensure access to care by the providers
3955 described in this subsection.
3956 (3) The amount paid to the plans to make supplemental
3957 payments or to enhance provider rates pursuant to this
3958 subsection must be reconciled to the exact amounts the plans are
3959 required to pay providers. The plans shall make the designated
3960 payments to providers within 15 business days after notification
3961 by the agency regarding provider-specific distributions.
3962 Section 42. Section 409.969, Florida Statutes, is created
3963 to read:
3964 409.969 Enrollment; disenrollment; grievance procedure.—
3965 (1) Each Medicaid recipient may choose any available plan
3966 within the region in which the recipient resides unless that
3967 plan is a specialty plan for which the recipient does not
3968 qualify. The agency may not provide or contract for choice
3969 counseling services for persons enrolling in the Medicaid
3970 managed care program.
3971 (2) If a recipient has not made a choice of plans within 30
3972 days after having been notified to choose a plan, the agency
3973 shall assign the recipient to a plan in accordance with the

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3974 following:
3975 (a) A recipient who was previously enrolled in a plan
3976 within the preceding 90 days shall automatically be enrolled in
3977 the same plan, if available.
3978 (b) Newborns of eligible mothers enrolled in a plan at the
3979 time of the child's birth shall be enrolled in the mother's
3980 plan; however, the mother may choose another plan for the
3981 newborn within 90 days after the child's birth.
3982 (c) If the recipient is diagnosed with HIV/AIDS and resides
3983 in region 11, region 15, or region 16, the agency shall assign
3984 the recipient to a plan that:
3985 1. Is a specialty plan under contract with the agency
3986 pursuant to s. 409.965; and
3987 2. Offers a delivery system through a teaching- and
3988 research-oriented organization that specializes in providing
3989 health care services and treatment for individuals diagnosed
3990 with HIV/AIDS.
3991
3992 The agency shall assign recipients under this paragraph on an
3993 even basis among all such plans within a region under contract
3994 with the agency.
3995 (d) A recipient who is currently receiving Medicare
3996 services from an entity qualified under 42 C.F.R. part 422 as a
3997 Medicare Advantage preferred provider organization, Medicare
3998 Advantage provider-sponsored organization, or Medicare Advantage
3999 special needs plan that is under contract with the agency shall
4000 be assigned to that plan for the Medicaid services not covered
4001 by Medicare for which the recipient is eligible.
4002 (e) Other recipients shall be enrolled into a qualified

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4003 plan in accordance with an auto-assignment enrollment algorithm
4004 that the agency develops by rule. The algorithm must heavily
4005 weigh family continuity.
4006 1. Automatic enrollment of recipients in plans must be
4007 based on the following criteria:
4008 a. Whether the plan has sufficient network capacity to meet
4009 the needs of recipients.
4010 b. Whether the recipient has previously received services
4011 from one of the plan's primary care providers.
4012 c. Whether primary care providers in one plan are more
4013 geographically accessible to the recipient's residence than
4014 providers in other plans.
4015 d. If a recipient is eligible for long-term care services,
4016 whether the recipient has previously received services from one
4017 of the plan's home and community-based service providers.
4018 e. If a recipient is eligible for long-term care services,
4019 whether the home and community-based providers in one plan are
4020 more geographically accessible to the recipient's residence than
4021 providers in other plans.
4022 2. The agency shall automatically enroll recipients in
4023 plans that meet or exceed the performance or quality standards
4024 established pursuant to s. 409.967, and may not automatically
4025 enroll recipients in a plan that is not meeting those standards.
4026 Except as provided by law or rule, the agency may not engage in
4027 practices that favor one qualified plan over another.
4028 (3) After a recipient has enrolled in a qualified plan, the
4029 enrollee shall have 90 days to voluntarily disenroll and select
4030 another plan. After 90 days, no further changes may be made
4031 except for good cause. Good cause includes, but is not limited

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4032 to, poor quality of care, lack of access to necessary specialty
4033 services, an unreasonable delay or denial of service, or
4034 fraudulent enrollment. The agency shall determine whether good
4035 cause exists. The agency may require an enrollee to use the
4036 plan's grievance process before the agency makes a determination
4037 of good cause, unless an immediate risk of permanent damage to
4038 the enrollee's health is alleged.
4039 (a) If used, the qualified plan's internal grievance
4040 process must be completed in time to allow the enrollee to
4041 disenroll by the first day of the second month after the month
4042 the disenrollment request was made. If the grievance process
4043 approves an enrollee's request to disenroll, the agency is not
4044 required to make a determination of good cause.
4045 (b) The agency must make a determination of good cause and
4046 take final action on an enrollee's request so that disenrollment
4047 occurs by the first day of the second month after the month the
4048 request was made. If the agency fails to act within this
4049 timeframe, the enrollee's request to disenroll is deemed
4050 approved as of the date agency action was required. Enrollees
4051 who disagree with the agency's finding that good cause for
4052 disenrollment does not exist shall be advised of their right to
4053 pursue a Medicaid fair hearing to dispute the agency's finding.
4054 (c) Medicaid recipients enrolled in a qualified plan after
4055 the 90-day period must remain in the plan for the remainder of
4056 the 12-month period. After 12 months, the enrollee may select
4057 another plan. However, a recipient who is referred for nursing
4058 home or assisted living facility services may change plans
4059 within 30 days after such referral. An enrollee may change
4060 primary care providers within the plan at any time.

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4061 (d) On the first day of the next month after receiving
4062 notice from a recipient that the recipient has moved to another
4063 region, the agency shall automatically disenroll the recipient
4064 from the plan the recipient is currently enrolled in and treat
4065 the recipient as if the recipient is a new enrollee. At that
4066 time, the recipient may choose another plan pursuant to the
4067 enrollment process established in this section.
4068 Section 43. Section 409.970, Florida Statutes, is created
4069 to read:
4070 409.970 Medicaid Encounter Data System.—The agency shall
4071 maintain and operate the Medicaid Encounter Data System to
4072 collect, process, and report on covered services provided to all
4073 Medicaid recipients enrolled in qualified plans.
4074 (1) Qualified plans shall submit encounter data
4075 electronically in a format that complies with provisions of the
4076 federal Health Insurance Portability and Accountability Act for
4077 electronic claims and in accordance with deadlines established
4078 by the agency. Plans must certify that the data reported is
4079 accurate and complete. The agency is responsible for validating
4080 the data submitted by the plans.
4081 (2) The agency shall develop methods and protocols for
4082 ongoing analysis of the encounter data, which must adjust for
4083 differences in the characteristics of enrollees in order to
4084 allow for the comparison of service utilization among plans. The
4085 analysis shall be used to identify possible cases of systemic
4086 overutilization, underutilization, inappropriate denials of
4087 claims, and inappropriate utilization of covered services, such
4088 as higher than expected emergency department and pharmacy
4089 encounters. One of the primary focus areas for the analysis

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4090 shall be the use of prescription drugs.
4091 (3) The agency shall provide periodic feedback to the plans
4092 based on the analysis and establish corrective action plans if
4093 necessary.
4094 (4) The agency shall make encounter data available to plans
4095 accepting enrollees who are reassigned to them from other plans
4096 leaving a region.
4097 (5) Beginning July 1, 2011, the agency shall conduct
4098 appropriate tests and establish specific criteria for
4099 determining whether the Medicaid Encounter Data System has
4100 valid, complete, and sound data for a sufficient period of time
4101 to provide qualified plans with a reliable basis for determining
4102 and proposing actuarially sound payment rates.
4103 Section 44. Section 409.971, Florida Statutes, is created
4104 to read:
4105 409.971 Managed care medical assistance.—Pursuant to s.
4106 409.902, the agency shall administer the managed care medical
4107 assistance component of the Medicaid managed care program
4108 described in this section and s. 409.972. Unless otherwise
4109 specified, the provisions of ss. 409.961-409.970 apply to the
4110 provision of managed care medical assistance. By December 31,
4111 2011, the agency shall begin implementation of managed care
4112 medical assistance, and full implementation in all regions must
4113 be completed by December 31, 2012.
4114 Section 45. Section 409.972, Florida Statutes, is created
4115 to read:
4116 409.972 Managed care medical assistance services.—
4117 (1) Qualified plans providing managed care medical
4118 assistance must, at a minimum, cover the following services:

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4119 (a) Ambulatory patient services.
4120 (b) Dental services for a recipient who is under age 21.
4121 (c) Dental services as provided in s. 627.419(7) for a
4122 recipient who is 21 years of age or older.
4123 (d) Dialysis services.
4124 (e) Durable medical equipment and supplies.
4125 (f) Early periodic screening diagnosis and treatment
4126 services, hearing services and hearing aids, and vision services
4127 and eyeglasses for enrollees under age 21.
4128 (g) Emergency services.
4129 (h) Family planning services.
4130 (i) Hearing services for a recipient who is under age 21.
4131 (j) Hearing services that are medically indicated for a
4132 recipient who is 21 years of age or older.
4133 (k) Home health services.
4134 (l) Hospital inpatient services.
4135 (m) Hospital outpatient services.
4136 (n) Laboratory and imaging services.
4137 (o) Maternity and newborn care and birth center services.
4138 (p) Mental health services, substance abuse disorder
4139 services, and behavioral health treatment.
4140 (q) Prescription drugs.
4141 (r) Primary care service, referred specialty care services,
4142 preventive services, and wellness services.
4143 (s) Skilled nursing facility or inpatient rehabilitation
4144 facility services.
4145 (t) Transplant services.
4146 (u) Transportation to access covered services.
4147 (v) Vision services for a recipient who is under age 21.

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4148 (w) Vision services that are medically indicated for a
4149 recipient who is 21 years of age or older.
4150 (2) Subject to specific appropriations, the agency may make
4151 payments for services that are optional.
4152 (3) Qualified plans may customize benefit packages for
4153 nonpregnant adults, vary cost-sharing provisions, and provide
4154 coverage for additional services. The agency shall evaluate the
4155 proposed benefit packages to ensure that services are sufficient
4156 to meet the needs of the plans' enrollees and to verify
4157 actuarial equivalence.
4158 (4) For Medicaid recipients diagnosed with hemophilia who
4159 have been prescribed anti-hemophilic-factor replacement
4160 products, the agency shall provide for those products and
4161 hemophilia overlay services through the agency's hemophilia
4162 disease management program authorized under s. 409.912.
4163 (5) Managed care medical assistance services provided under
4164 this section must be medically necessary and provided in
4165 accordance with state and federal law. This section does not
4166 prevent the agency from adjusting fees, reimbursement rates,
4167 lengths of stay, number of visits, or number of services, or
4168 from making any other adjustments necessary to comply with the
4169 availability of funding and any limitations or directions
4170 provided in the General Appropriations Act, chapter 216, or s.
4171 409.9022.
4172 Section 46. Section 409.973, Florida Statutes, is created
4173 to read:
4174 409.973 Managed long-term care.—
4175 (1) Qualified plans providing managed care medical
4176 assistance may also participate in the managed long-term care

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4177 component of the Medicaid managed care program. Unless otherwise
4178 specified, the provisions of ss. 409.961-409.970 apply to the
4179 managed long-term care component of the managed care program.
4180 (2) Pursuant to s. 409.902, the agency shall administer the
4181 managed long-term care component described in this section and
4182 ss. 409.974-409.978, but may delegate specific duties and
4183 responsibilities to the Department of Elderly Affairs and other
4184 state agencies. By March 31, 2012, the agency shall begin
4185 implementation of the managed long-term care component, with
4186 full implementation in all regions by March 31, 2013.
4187 (3) The Department of Elderly Affairs shall assist the
4188 agency in developing specifications for use in the invitation to
4189 negotiate and the model contract, determining clinical
4190 eligibility for enrollment in managed long-term care plans,
4191 monitoring plan performance and measuring quality of service
4192 delivery, assisting clients and families in order to address
4193 complaints with the plans, facilitating working relationships
4194 between plans and providers serving elders and disabled adults,
4195 and performing other functions specified in a memorandum of
4196 agreement.
4197 Section 47. Section 409.974, Florida Statutes, is created
4198 to read:
4199 409.974 Recipient eligibility for managed long-term care.—
4200 (1) Medicaid recipients shall receive covered long-term
4201 care services through the managed long-term care component of
4202 the Medicaid managed care program unless excluded pursuant to s.
4203 409.964. In order to participate in the managed long-term care
4204 component, the recipient must be:
4205 (a) Sixty-five years of age or older or eligible for

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4206 Medicaid by reason of a disability; and
4207 (b) Determined by the Comprehensive Assessment and Review
4208 for Long-Term Care Services (CARES) Program to meet the criteria
4209 for nursing facility care.
4210 (2) Medicaid recipients who are enrolled in one of the
4211 following Medicaid long-term care waiver programs on the date
4212 that a managed long-term care plan becomes available in the
4213 recipient's region may remain in that program if it is
4214 operational on that date:
4215 (a) The Assisted Living for the Frail Elderly Waiver.
4216 (b) The Aged and Disabled Adult Waiver.
4217 (c) The Adult Day Health Care Waiver.
4218 (d) The Consumer-Directed Care Program as described in s.
4219 409.221.
4220 (e) The Program of All-inclusive Care for the Elderly.
4221 (f) The Long-Term Care Community Diversion Pilot Project as
4222 described in s. 430.705.
4223 (g) The Channeling Services Waiver for Frail Elders.
4224 (3) If a long-term care waiver program in which the
4225 recipient is enrolled ceases to operate, the Medicaid recipient
4226 may transfer to another long-term care waiver program or to the
4227 Medicaid managed long-term care component of the Medicaid
4228 managed care program. If no waivers are operational in the
4229 recipient's region and the recipient continues to participate in
4230 Medicaid, the recipient must transfer to the managed long-term
4231 care component of the Medicaid managed care program.
4232 (4) New enrollment in a waiver program ends on the date
4233 that a managed long-term care plan becomes available in a
4234 region.

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4235 (5) Medicaid recipients who are residing in a nursing home
4236 facility on the date that a managed long-term care plan becomes
4237 available in the recipient's region are eligible for the long-
4238 term care Medicaid waiver programs.
4239 (6) This section does not create an entitlement to any home
4240 and community-based services provided under the managed long-
4241 term care component.
4242 Section 48. Section 409.975, Florida Statutes, is created
4243 to read:
4244 409.975 Managed long-term care services.—
4245 (1) Qualified plans participating in the managed long-term
4246 care component of the Medicaid managed care program, at a
4247 minimum, shall cover the following services:
4248 (a) The services listed in s. 409.972.
4249 (b) Nursing facility services.
4250 (c) Home and community-based services, including, but not
4251 limited to, assisted living facility services.
4252 (2) Services provided under this section must be medically
4253 necessary and provided in accordance with state and federal law.
4254 This section does not prevent the agency from adjusting fees,
4255 reimbursement rates, lengths of stay, number of visits, or
4256 number of services, or from making any other adjustments
4257 necessary to comply with the availability of funding and any
4258 limitations or directions provided in the General Appropriations
4259 Act, chapter 216, or s. 409.9022.
4260 Section 49. Section 409.976, Florida Statutes, is created
4261 to read:
4262 409.976 Qualified managed long-term care plans.—
4263 (1) For purposes of managed long-term care, qualified plans

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4264 also include:
4265 (a) Entities who are qualified under 42 C.F.R. part 422 as
4266 Medicare Advantage Preferred Provider Organizations, Medicare
4267 Advantage Provider-sponsored Organizations, and Medicare
4268 Advantage Special Needs Plans. Such plans may participate in the
4269 managed long-term care component. A plan submitting a response
4270 to the invitation to negotiate for the managed long-term care
4271 component may reference one or more of these entities as part of
4272 its demonstration of network adequacy for the provision of
4273 services required under s. 409.972 for dually eligible
4274 enrollees.
4275 (b) The Program of All-inclusive Care for the Elderly
4276 (PACE). Participation by PACE shall be pursuant to a contract
4277 with the agency and is not subject to the procurement
4278 requirements of this section. PACE plans may continue to provide
4279 services to recipients at such levels and enrollment caps as
4280 authorized by the General Appropriations Act.
4281 (2) The agency shall select qualified plans through the
4282 procurement described in s. 409.965. The agency shall notice the
4283 invitation to negotiate by November 14, 2011.
4284 (3) In addition to the criteria established in s. 409.965,
4285 the agency shall give preference to the following factors in
4286 selecting qualified plans:
4287 (a) The plan’s employment of executive managers having
4288 expertise and experience in serving aged and disabled persons
4289 who require long-term care.
4290 (b) The plan’s establishment of a network of service
4291 providers dispersed throughout the region and in sufficient
4292 numbers to meet specific service standards established by the

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4293 agency for a continuum of care, beginning from the provision of
4294 assistance with the activities of daily living at a recipient's
4295 home and the provision of other home and community-based care
4296 through the provision of nursing home care. These providers
4297 include:
4298 1. Adult day centers.
4299 2. Adult family care homes.
4300 3. Assisted living facilities.
4301 4. Health care services pools.
4302 5. Home health agencies.
4303 6. Homemaker and companion services.
4304 7. Community Care for the Elderly lead agencies.
4305 8. Nurse registries.
4306 9. Nursing homes.
4307
4308 All providers are not required to be located within the region;
4309 however, the provider network must be sufficient to ensure that
4310 services are available throughout the region.
4311 (c) Whether a plan offers consumer-directed care services
4312 to enrollees pursuant to s. 409.221 or includes attendant care
4313 or paid family caregivers in the benefit package. Consumer-
4314 directed care services must provide a flexible budget, which is
4315 managed by enrollees and their families or representatives, and
4316 allows them to choose service providers, determine provider
4317 rates of payment, and direct the delivery of services to best
4318 meet their special long-term care needs. If all other factors
4319 are equal among competing qualified plans, the agency shall give
4320 preference to such plans.
4321 (d) Evidence that a qualified plan has written agreements

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4322 or signed contracts or has made substantial progress in
4323 establishing relationships with providers before the plan
4324 submits a response.
4325 (e) The availability and accessibility of case managers in
4326 the plan and provider network.
4327 Section 50. Section 409.977, Florida Statutes, is created
4328 to read:
4329 409.977 Managed long-term plan and provider
4330 accountability.—In addition to the requirements of ss. 409.966
4331 and 409.967, plans and providers participating in managed long-
4332 term care must comply with s. 641.31(25) and with the specific
4333 standards established by the agency for the number, type, and
4334 regional distribution of the following providers in the plan's
4335 network, which must include:
4336 (1) Adult day centers.
4337 (2) Adult family care homes.
4338 (3) Assisted living facilities.
4339 (4) Health care services pools.
4340 (5) Home health agencies.
4341 (6) Homemaker and companion services.
4342 (7) Community Care for the Elderly lead agencies.
4343 (8) Nurse registries.
4344 (9) Nursing homes.
4345 Section 51. Section 409.978, Florida Statutes, is created
4346 to read:
4347 409.978 CARES program screening; levels of care.—
4348 (1) The agency shall operate the Comprehensive Assessment
4349 and Review for Long-Term Care Services (CARES) preadmission
4350 screening program to ensure that only recipients whose

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4351 conditions require long-term care services are enrolled in
4352 managed long-term care plans.
4353 (2) The agency shall operate the CARES program through an
4354 interagency agreement with the Department of Elderly Affairs.
4355 The agency, in consultation with the department, may contract
4356 for any function or activity of the CARES program, including any
4357 function or activity required by 42 C.F.R. part 483.20, relating
4358 to preadmission screening and review.
4359 (3) The CARES program shall determine if a recipient
4360 requires nursing facility care and, if so, assign the recipient
4361 to one of the following levels of care:
4362 (a) Level of care 1 consists of enrollees who require the
4363 constant availability of routine medical and nursing treatment
4364 and care, have a limited need for health-related care and
4365 services, are mildly medically or physically incapacitated, and
4366 cannot be managed at home due to inadequacy of home-based
4367 services.
4368 (b) Level of care 2 consists of enrollees who require the
4369 constant availability of routine medical and nursing treatment
4370 and care, and require extensive health-related care and services
4371 because of mental or physical incapacitation. Current enrollees
4372 in home and community-based waiver programs for persons who are
4373 elderly or adults with physical disability, or both, who remain
4374 financially eligible for Medicaid are not required to meet new
4375 level-of-care criteria except for immediate placement in a
4376 nursing home.
4377 (c) Level of care 3 consists of enrollees residing in
4378 nursing homes, or needing immediate placement in a nursing home,
4379 and who have a priority score of 5 or above as determined by

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4380 CARES.
4381 (4) For recipients whose nursing home stay is initially
4382 funded by Medicare and Medicare coverage is being terminated for
4383 lack of progress towards rehabilitation, CARES staff shall
4384 consult with the person determining the recipient's progress
4385 toward rehabilitation in order to ensure that the recipient is
4386 not being inappropriately disqualified from Medicare coverage.
4387 If, in their professional judgment, CARES staff believes that a
4388 Medicare beneficiary is still making progress, they may assist
4389 the Medicare beneficiary with appealing the disqualification
4390 from Medicare coverage. The CARES teams may review Medicare
4391 denials for coverage under this section only if it is determined
4392 that such reviews qualify for federal matching funds through
4393 Medicaid. The agency shall seek or amend federal waivers as
4394 necessary to implement this section.
4395 Section 52. Section 409.91207, Florida Statutes, is
4396 transferred, renumbered as section 409.985, Florida Statutes,
4397 and subsection (1) of that section is amended to read:
4398 409.985 ~~409.91207~~ Medical home pilot project.—
4399 (1) The agency shall develop a plan to implement a medical
4400 home pilot project that uses ~~utilizes~~ primary care case
4401 management enhanced by medical home networks to provide
4402 coordinated and cost-effective care that is reimbursed on a fee-
4403 for-service basis and to compare the performance of the medical
4404 home networks with other existing Medicaid managed care models.
4405 The agency may ~~is authorized to~~ seek a federal Medicaid waiver
4406 or an amendment to any existing Medicaid waiver, except for the
4407 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,
4408 as needed, to develop the pilot project created in this section

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4409 but must obtain approval of the Legislature before ~~prior to~~
4410 implementing the pilot project.
4411 Section 53. Section 409.91211, Florida Statutes, is
4412 transferred, renumbered as section 409.986, Florida Statutes,
4413 and paragraph (aa) of subsection (3) and paragraph (a) of
4414 subsection (4) of that section are amended, to read:
4415 409.986 ~~409.91211~~ Medicaid managed care pilot program.—
4416 (3) The agency shall have the following powers, duties, and
4417 responsibilities with respect to the pilot program:
4418 (aa) To implement a mechanism whereby Medicaid recipients
4419 who are already enrolled in a managed care plan or the MediPass
4420 program in the pilot areas are ~~shall be~~ offered the opportunity
4421 to change to capitated managed care plans on a staggered basis,
4422 as defined by the agency. All Medicaid recipients shall have 30
4423 days in which to make a choice of capitated managed care plans.
4424 Those Medicaid recipients who do not make a choice shall be
4425 assigned to a capitated managed care plan in accordance with
4426 paragraph (4)(a) and shall be exempt from s. 409.987 ~~409.9122~~.
4427 To facilitate continuity of care for a Medicaid recipient who is
4428 also a recipient of Supplemental Security Income (SSI), prior to
4429 assigning the SSI recipient to a capitated managed care plan,
4430 the agency shall determine whether the SSI recipient has an
4431 ongoing relationship with a provider or capitated managed care
4432 plan, and, if so, the agency shall assign the SSI recipient to
4433 that provider or capitated managed care plan where feasible.
4434 Those SSI recipients who do not have such a provider
4435 relationship shall be assigned to a capitated managed care plan
4436 provider in accordance with paragraph (4)(a) and shall be exempt
4437 from s. 409.987 ~~409.9122~~.

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4438 (4)(a) A Medicaid recipient in the pilot area who is not
4439 currently enrolled in a capitated managed care plan upon
4440 implementation is not eligible for services as specified in ss.
4441 409.905 and 409.906, for the amount of time that the recipient
4442 does not enroll in a capitated managed care network. If a
4443 Medicaid recipient has not enrolled in a capitated managed care
4444 plan within 30 days after eligibility, the agency shall assign
4445 the Medicaid recipient to a capitated managed care plan based on
4446 the assessed needs of the recipient as determined by the agency
4447 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When
4448 making assignments, the agency shall take into account the
4449 following criteria:
4450 1. A capitated managed care network has sufficient network
4451 capacity to meet the needs of members.
4452 2. The capitated managed care network has previously
4453 enrolled the recipient as a member, or one of the capitated
4454 managed care network's primary care providers has previously
4455 provided health care to the recipient.
4456 3. The agency has knowledge that the member has previously
4457 expressed a preference for a particular capitated managed care
4458 network as indicated by Medicaid fee-for-service claims data,
4459 but has failed to make a choice.
4460 4. The capitated managed care network's primary care
4461 providers are geographically accessible to the recipient's
4462 residence.
4463 Section 54. Section 409.9122, Florida Statutes, is
4464 transferred, renumbered as section 409.987, and paragraph (a) of
4465 subsection (2) of that section is amended to read:
4466 409.987 ~~409.9122~~ Mandatory Medicaid managed care

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4467 enrollment; programs and procedures.—
4468 (2)(a) The agency shall enroll all Medicaid recipients in a
4469 managed care plan or MediPass ~~all Medicaid recipients~~, except
4470 ~~those Medicaid~~ recipients who are~~:~~ in an institution, receiving
4471 a Medicaid nonpoverty medical subsidy,~~; enrolled in the Medicaid~~
4472 ~~medically needy Program;~~ or eligible for both Medicaid and
4473 Medicare. Upon enrollment, recipients may ~~individuals will be~~
4474 ~~able to~~ change their managed care option during the 90-day opt
4475 out period required by federal Medicaid regulations. The agency
4476 may ~~is authorized to~~ seek the necessary Medicaid state plan
4477 amendment to implement this policy. ~~However, to the extent~~
4478 1. If permitted by federal law, the agency may enroll ~~in a~~
4479 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
4480 from mandatory managed care enrollment in a managed care plan or
4481 MediPass if~~, provided that~~:
4482 a.~~1.~~ The recipient's decision to enroll in a managed care
4483 plan or MediPass is voluntary;
4484 b.~~2.~~ ~~If~~ The recipient chooses to enroll in a managed care
4485 plan, the agency has determined that the ~~managed care~~ plan
4486 provides specific programs and services that ~~which~~ address the
4487 special health needs of the recipient; and
4488 c.~~3.~~ The agency receives the ~~any~~ necessary waivers from the
4489 federal Centers for Medicare and Medicaid Services.
4490 2. The agency shall develop rules to establish policies by
4491 which exceptions to the mandatory managed care enrollment
4492 requirement may be made on a case-by-case basis. The rules must
4493 ~~shall~~ include the specific criteria to be applied when
4494 determining ~~making a determination as to~~ whether to exempt a
4495 recipient from mandatory enrollment ~~in a managed care plan or~~

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4496 ~~MediPass~~.
4497 3. School districts participating in the certified school
4498 match program pursuant to ss. 409.908(21) and 1011.70 shall be
4499 reimbursed by Medicaid, subject to the limitations of s.
4500 1011.70(1), for a Medicaid-eligible child participating in the
4501 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
4502 409.9071, regardless of whether the child is enrolled in
4503 MediPass or a managed care plan. Managed care plans must ~~shall~~
4504 make a good faith effort to execute agreements with school
4505 districts regarding the coordinated provision of services
4506 authorized under s. 1011.70.
4507 4. County health departments delivering school-based
4508 services pursuant to ss. 381.0056 and 381.0057 shall be
4509 reimbursed by Medicaid for the federal share for a Medicaid-
4510 eligible child who receives Medicaid-covered services in a
4511 school setting, regardless of whether the child is enrolled in
4512 MediPass or a managed care plan. Managed care plans shall make a
4513 good faith effort to execute agreements with county health
4514 departments that coordinate the ~~regarding the coordinated~~
4515 provision of services to a Medicaid-eligible child. To ensure
4516 continuity of care for Medicaid patients, the agency, the
4517 Department of Health, and the Department of Education shall
4518 develop procedures for ensuring that a student's managed care
4519 plan or MediPass provider receives information relating to
4520 services provided in accordance with ss. 381.0056, 381.0057,
4521 409.9071, and 1011.70.
4522 Section 55. Section 409.9123, Florida Statutes, is
4523 transferred and renumbered as section 409.988, Florida Statutes.
4524 Section 56. Section 409.9124, Florida Statutes, is

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4525 transferred and renumbered as section 409.989.
4526 Section 57. Subsection (15) of section 430.04, Florida
4527 Statutes, is amended to read:
4528 430.04 Duties and responsibilities of the Department of
4529 Elderly Affairs.—The Department of Elderly Affairs shall:
4530 (15) Administer all Medicaid waivers and programs relating
4531 to elders and their appropriations. The waivers include, but are
4532 not limited to:
4533 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
4534 ~~established in s. 430.502(7), (8), and (9).~~
4535 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.
4536 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.
4537 (c) ~~(d)~~ The Adult Day Health Care Waiver.
4538 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined
4539 in s. 409.221.
4540 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.
4541 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
4542 Project as described in s. 430.705.
4543 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
4544
4545 The department shall develop a transition plan for recipients
4546 receiving services under long-term care Medicaid waivers for
4547 elders or disabled adults on the date qualified plans become
4548 available in each recipient's region pursuant to s. 409.973(2)
4549 in order to enroll those recipients in qualified plans.
4550 Section 58. Section 430.2053, Florida Statutes, is amended
4551 to read:
4552 430.2053 Aging resource centers.—
4553 (1) The department, in consultation with the Agency for

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4554 Health Care Administration and the Department of Children and
4555 Family Services, shall develop pilot projects for aging resource
4556 centers. ~~By October 31, 2004, the department, in consultation~~
4557 ~~with the agency and the Department of Children and Family~~
4558 ~~Services, shall develop an implementation plan for aging~~
4559 ~~resource centers and submit the plan to the Governor, the~~
4560 ~~President of the Senate, and the Speaker of the House of~~
4561 ~~Representatives. The plan must include qualifications for~~
4562 ~~designation as a center, the functions to be performed by each~~
4563 ~~center, and a process for determining that a current area agency~~
4564 ~~on aging is ready to assume the functions of an aging resource~~
4565 ~~center.~~
4566 ~~(2) Each area agency on aging shall develop, in~~
4567 ~~consultation with the existing community care for the elderly~~
4568 ~~lead agencies within their planning and service areas, a~~
4569 ~~proposal that describes the process the area agency on aging~~
4570 ~~intends to undertake to transition to an aging resource center~~
4571 ~~prior to July 1, 2005, and that describes the area agency's~~
4572 ~~compliance with the requirements of this section. The proposals~~
4573 ~~must be submitted to the department prior to December 31, 2004.~~
4574 ~~The department shall evaluate all proposals for readiness and,~~
4575 ~~prior to March 1, 2005, shall select three area agencies on~~
4576 ~~aging which meet the requirements of this section to begin the~~
4577 ~~transition to aging resource centers. Those area agencies on~~
4578 ~~aging which are not selected to begin the transition to aging~~
4579 ~~resource centers shall, in consultation with the department and~~
4580 ~~the existing community care for the elderly lead agencies within~~
4581 ~~their planning and service areas, amend their proposals as~~
4582 ~~necessary and resubmit them to the department prior to July 1,~~

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4583 ~~2005. The department may transition additional area agencies to~~
4584 ~~aging resource centers as it determines that area agencies are~~
4585 ~~in compliance with the requirements of this section.~~
4586 ~~(3) The Auditor General and the Office of Program Policy~~
4587 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
4588 ~~review and assess the department's process for determining an~~
4589 ~~area agency's readiness to transition to an aging resource~~
4590 ~~center.~~
4591 ~~(a) The review must, at a minimum, address the~~
4592 ~~appropriateness of the department's criteria for selection of an~~
4593 ~~area agency to transition to an aging resource center, the~~
4594 ~~instruments applied, the degree to which the department~~
4595 ~~accurately determined each area agency's compliance with the~~
4596 ~~readiness criteria, the quality of the technical assistance~~
4597 ~~provided by the department to an area agency in correcting any~~
4598 ~~weaknesses identified in the readiness assessment, and the~~
4599 ~~degree to which each area agency overcame any identified~~
4600 ~~weaknesses.~~
4601 ~~(b) Reports of these reviews must be submitted to the~~
4602 ~~appropriate substantive and appropriations committees in the~~
4603 ~~Senate and the House of Representatives on March 1 and September~~
4604 ~~1 of each year until full transition to aging resource centers~~
4605 ~~has been accomplished statewide, except that the first report~~
4606 ~~must be submitted by February 1, 2005, and must address all~~
4607 ~~readiness activities undertaken through December 31, 2004. The~~
4608 ~~perspectives of all participants in this review process must be~~
4609 ~~included in each report.~~
4610 (2) ~~(4)~~ The purposes of an aging resource center are ~~shall~~
4611 ~~be~~:

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4612 (a) To provide Florida's elders and their families with a
4613 locally focused, coordinated approach to integrating information
4614 and referral for all available services for elders with the
4615 eligibility determination entities for state and federally
4616 funded long-term-care services.
4617 (b) To provide for easier access to long-term-care services
4618 by Florida's elders and their families by creating multiple
4619 access points to the long-term-care network that flow through
4620 one established entity with wide community recognition.
4621 (3) ~~(5)~~ The duties of an aging resource center are to:
4622 (a) Develop referral agreements with local community
4623 service organizations, such as senior centers, existing elder
4624 service providers, volunteer associations, and other similar
4625 organizations, to better assist clients who do not need or do
4626 not wish to enroll in programs funded by the department or the
4627 agency. The referral agreements must also include a protocol,
4628 developed and approved by the department, which provides
4629 specific actions that an aging resource center and local
4630 community service organizations must take when an elder or an
4631 elder's representative seeking information on long-term-care
4632 services contacts a local community service organization prior
4633 to contacting the aging resource center. The protocol shall be
4634 designed to ensure that elders and their families are able to
4635 access information and services in the most efficient and least
4636 cumbersome manner possible.
4637 (b) Provide an initial screening of all clients who request
4638 long-term-care services to determine whether the person would be
4639 most appropriately served through any combination of federally
4640 funded programs, state-funded programs, locally funded or

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4641 community volunteer programs, or private funding for services.
4642 (c) Determine eligibility for the programs and services
4643 listed in subsection (9) ~~(11)~~ for persons residing within the
4644 geographic area served by the aging resource center and
4645 determine a priority ranking for services which is based upon
4646 the potential recipient's frailty level and likelihood of
4647 institutional placement without such services.
4648 (d) Manage the availability of financial resources for the
4649 programs and services listed in subsection (9) ~~(11)~~ for persons
4650 residing within the geographic area served by the aging resource
4651 center.
4652 (e) If ~~When~~ financial resources become available, refer a
4653 client to the most appropriate entity to begin receiving
4654 services. The aging resource center shall make referrals to lead
4655 agencies for service provision that ensure that individuals who
4656 are vulnerable adults in need of services pursuant to s.
4657 415.104(3)(b), or who are victims of abuse, neglect, or
4658 exploitation in need of immediate services to prevent further
4659 harm and are referred by the adult protective services program,
4660 are given primary consideration for receiving community-care-
4661 for-the-elderly services in compliance with the requirements of
4662 s. 430.205(5)(a) and that other referrals for services are in
4663 compliance with s. 430.205(5)(b).
4664 (f) Convene a work group to advise in the planning,
4665 implementation, and evaluation of the aging resource center. The
4666 work group shall be composed ~~comprised~~ of representatives of
4667 local service providers, Alzheimer's Association chapters,
4668 housing authorities, social service organizations, advocacy
4669 groups, representatives of clients receiving services through

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4670 the aging resource center, and ~~any~~ other persons or groups as
4671 determined by the department. The aging resource center, in
4672 consultation with the work group, must develop annual program
4673 improvement plans that shall be submitted to the department for
4674 consideration. The department shall review each annual
4675 improvement plan and make recommendations on how to implement
4676 the components of the plan.
4677 (g) Enhance the existing area agency on aging in each
4678 planning and service area by integrating, ~~either~~ physically or
4679 virtually, the staff and services of the area agency on aging
4680 with the staff of the department's local CARES Medicaid ~~nursing~~
4681 ~~home~~ preadmission screening unit and a sufficient number of
4682 staff from the Department of Children and Family Services'
4683 Economic Self-Sufficiency Unit necessary to determine the
4684 financial eligibility for all persons age 60 and older residing
4685 within the area served by the aging resource center who ~~that~~ are
4686 seeking Medicaid services, Supplemental Security Income, and
4687 food assistance.
4688 (h) Assist clients who request long-term care services in
4689 being evaluated for eligibility for the long-term care managed
4690 care component of the Medicaid managed care program as qualified
4691 plans become available in each of the regions pursuant to s.
4692 409.973(2).
4693 (i) Provide enrollment and coverage information to Medicaid
4694 managed long-term care enrollees as qualified plans become
4695 available in each of the regions pursuant to s. 409.973(2).
4696 (j) Assist enrollees in the Medicaid long-term care managed
4697 care program with informally resolving grievances with a managed
4698 care network and in accessing the managed care network's formal

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4699 grievance process as qualified plans become available in each of
4700 the regions pursuant to s. 409.973(2).
4701 (4) ~~(6)~~ The department shall select the entities to become
4702 aging resource centers based on each entity's readiness and
4703 ability to perform the duties listed in subsection (3) ~~(5)~~ and
4704 the entity's:
4705 (a) Expertise in the needs of each target population the
4706 center proposes to serve and a thorough knowledge of the
4707 providers that serve these populations.
4708 (b) Strong connections to service providers, volunteer
4709 agencies, and community institutions.
4710 (c) Expertise in information and referral activities.
4711 (d) Knowledge of long-term-care resources, including
4712 resources designed to provide services in the least restrictive
4713 setting.
4714 (e) Financial solvency and stability.
4715 (f) Ability to collect, monitor, and analyze data in a
4716 timely and accurate manner, along with systems that meet the
4717 department's standards.
4718 (g) Commitment to adequate staffing by qualified personnel
4719 to effectively perform all functions.
4720 (h) Ability to meet all performance standards established
4721 by the department.
4722 (5) ~~(7)~~ The aging resource center shall have a governing
4723 body which shall be the same entity described in s. 20.41(7),
4724 and an executive director who may be the same person as
4725 described in s. 20.41(7). The governing body shall annually
4726 evaluate the performance of the executive director.
4727 (6) ~~(8)~~ The aging resource center may not be a provider of

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4728 direct services other than information and referral services,
4729 and screening.
4730 (7) ~~(9)~~ The aging resource center must agree to allow the
4731 department to review any financial information the department
4732 determines is necessary for monitoring or reporting purposes,
4733 including financial relationships.
4734 (8) ~~(10)~~ The duties and responsibilities of the community
4735 care for the elderly lead agencies within each area served by an
4736 aging resource center shall be to:
4737 (a) Develop strong community partnerships to maximize the
4738 use of community resources for the purpose of assisting elders
4739 to remain in their community settings for as long as it is
4740 safely possible.
4741 (b) Conduct comprehensive assessments of clients that have
4742 been determined eligible and develop a care plan consistent with
4743 established protocols that ensures that the unique needs of each
4744 client are met.
4745 (9) ~~(11)~~ The services to be administered through the aging
4746 resource center shall include those funded by the following
4747 programs:
4748 (a) Community care for the elderly.
4749 (b) Home care for the elderly.
4750 (c) Contracted services.
4751 (d) Alzheimer’s disease initiative.
4752 (e) Aged and disabled adult Medicaid waiver.
4753 (f) Assisted living for the frail elderly Medicaid waiver.
4754 (g) Older Americans Act.
4755 (10) ~~(12)~~ The department shall, prior to designation of an
4756 aging resource center, develop by rule operational and quality

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4757 assurance standards and outcome measures to ensure that clients
4758 receiving services through all long-term-care programs
4759 administered through an aging resource center are receiving the
4760 appropriate care they require and that contractors and
4761 subcontractors are adhering to the terms of their contracts and
4762 are acting in the best interests of the clients they are
4763 serving, consistent with the intent of the Legislature to reduce
4764 the use of and cost of nursing home care. The department shall
4765 by rule provide operating procedures for aging resource centers,
4766 which shall include:
4767 (a) Minimum standards for financial operation, including
4768 audit procedures.
4769 (b) Procedures for monitoring and sanctioning of service
4770 providers.
4771 (c) Minimum standards for technology utilized by the aging
4772 resource center.
4773 (d) Minimum staff requirements which shall ensure that the
4774 aging resource center employs sufficient quality and quantity of
4775 staff to adequately meet the needs of the elders residing within
4776 the area served by the aging resource center.
4777 (e) Minimum accessibility standards, including hours of
4778 operation.
4779 (f) Minimum oversight standards for the governing body of
4780 the aging resource center to ensure its continuous involvement
4781 in, and accountability for, all matters related to the
4782 development, implementation, staffing, administration, and
4783 operations of the aging resource center.
4784 (g) Minimum education and experience requirements for
4785 executive directors and other executive staff positions of aging

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4786 resource centers.
4787 (h) Minimum requirements regarding any executive staff
4788 positions that the aging resource center must employ and minimum
4789 requirements that a candidate must meet in order to be eligible
4790 for appointment to such positions.
4791 (11) ~~(13)~~ In an area in which the department has designated
4792 an area agency on aging as an aging resource center, the
4793 department and the agency may ~~shall~~ not make payments for the
4794 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
4795 Community Diversion Project for ~~such~~ persons who were not
4796 screened and enrolled through the aging resource center. The
4797 department shall cease making these payments for enrollees in
4798 qualified plans as qualified plans become available in each of
4799 the regions pursuant to s. 409.973(2).
4800 (12) ~~(14)~~ Each aging resource center shall enter into a
4801 memorandum of understanding with the department for
4802 collaboration with the CARES unit staff. The memorandum of
4803 understanding must ~~shall~~ outline the staff person responsible
4804 for each function and ~~shall~~ provide the staffing levels
4805 necessary to carry out the functions of the aging resource
4806 center.
4807 (13) ~~(15)~~ Each aging resource center shall enter into a
4808 memorandum of understanding with the Department of Children and
4809 Family Services for collaboration with the Economic Self-
4810 Sufficiency Unit staff. The memorandum of understanding must
4811 ~~shall~~ outline which staff persons are responsible for which
4812 functions and ~~shall~~ provide the staffing levels necessary to
4813 carry out the functions of the aging resource center.
4814 (14) ~~(16)~~ If any of the state activities described in this

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4815 section are outsourced, ~~either~~ in part or in whole, the contract
4816 executing the outsourcing must ~~shall~~ mandate that the contractor
4817 or its subcontractors shall, ~~either~~ physically or virtually,
4818 execute the provisions of the memorandum of understanding
4819 instead of the state entity whose function the contractor or
4820 subcontractor now performs.
4821 (15) ~~(17)~~ In order to be eligible to begin transitioning to
4822 an aging resource center, an area agency on aging board must
4823 ensure that the area agency on aging which it oversees meets all
4824 of the minimum requirements set by law and in rule.
4825 ~~(18) The department shall monitor the three initial~~
4826 ~~projects for aging resource centers and report on the progress~~
4827 ~~of those projects to the Governor, the President of the Senate,~~
4828 ~~and the Speaker of the House of Representatives by June 30,~~
4829 ~~2005. The report must include an evaluation of the~~
4830 ~~implementation process.~~
4831 (16) ~~(19)~~ (a) Once an aging resource center is operational,
4832 the department, in consultation with the agency, may develop
4833 capitation rates for any of the programs administered through
4834 the aging resource center. Capitation rates for programs must
4835 ~~shall~~ be based on the historical cost experience of the state in
4836 providing those same services to the population age 60 or older
4837 residing within each area served by an aging resource center.
4838 Each capitated rate may vary by geographic area as determined by
4839 the department.
4840 (b) The department and the agency may determine for each
4841 area served by an aging resource center whether it is
4842 appropriate, consistent with federal and state laws and
4843 regulations, to develop and pay separate capitated rates for

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4844 each program administered through the aging resource center or
4845 to develop and pay capitated rates for service packages which
4846 include more than one program or service administered through
4847 the aging resource center.
4848 (c) Once capitation rates have been developed and certified
4849 as actuarially sound, the department and the agency may pay
4850 service providers the capitated rates for services if ~~when~~
4851 appropriate.
4852 (d) The department, in consultation with the agency, shall
4853 annually reevaluate and recertify the capitation rates,
4854 adjusting forward to account for inflation, programmatic
4855 changes.
4856 ~~(20) The department, in consultation with the agency, shall~~
4857 ~~submit to the Governor, the President of the Senate, and the~~
4858 ~~Speaker of the House of Representatives, by December 1, 2006, a~~
4859 ~~report addressing the feasibility of administering the following~~
4860 ~~services through aging resource centers beginning July 1, 2007:~~
4861 ~~(a) Medicaid nursing home services.~~
4862 ~~(b) Medicaid transportation services.~~
4863 ~~(c) Medicaid hospice care services.~~
4864 ~~(d) Medicaid intermediate care services.~~
4865 ~~(e) Medicaid prescribed drug services.~~
4866 ~~(f) Medicaid assistive care services.~~
4867 ~~(g) Any other long-term-care program or Medicaid service.~~
4868 (17) ~~(21)~~ This section does ~~shall~~ not ~~be construed to~~ allow
4869 an aging resource center to restrict, manage, or impede the
4870 local fundraising activities of service providers.
4871 Section 59. Paragraphs (c) and (d) of subsection (3) of
4872 section 39.407, Florida Statutes, are amended to read:

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4873 39.407 Medical, psychiatric, and psychological examination
4874 and treatment of child; physical, mental, or substance abuse
4875 examination of person with or requesting child custody.—
4876 (3)
4877 (c) Except as provided in paragraphs (b) and (e), the
4878 department must file a motion seeking the court's authorization
4879 to initially provide or continue to provide psychotropic
4880 medication to a child in its legal custody. The motion must be
4881 supported by a written report prepared by the department which
4882 describes the efforts made to enable the prescribing physician
4883 to obtain express and informed consent to provide ~~for providing~~
4884 the medication to the child and other treatments considered or
4885 recommended for the child. ~~In addition,~~ The motion must also be
4886 supported by the prescribing physician's signed medical report
4887 providing:
4888 1. The name of the child, the name and range of the dosage
4889 of the psychotropic medication, and the ~~that there is a~~ need to
4890 prescribe psychotropic medication to the child based upon a
4891 diagnosed condition for which such medication is being
4892 prescribed.
4893 2. A statement indicating that the physician has reviewed
4894 all medical information concerning the child which has been
4895 provided.
4896 3. A statement indicating that the psychotropic medication,
4897 at its prescribed dosage, is appropriate for treating the
4898 child's diagnosed medical condition, as well as the behaviors
4899 and symptoms the medication, at its prescribed dosage, is
4900 expected to address.
4901 4. An explanation of the nature and purpose of the

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4902 treatment; the recognized side effects, risks, and
4903 contraindications of the medication; drug-interaction
4904 precautions; the possible effects of stopping the medication;
4905 and how the treatment will be monitored, followed by a statement
4906 indicating that this explanation was provided to the child if
4907 age appropriate and to the child's caregiver.
4908 5. Documentation addressing whether the psychotropic
4909 medication will replace or supplement any other currently
4910 prescribed medications or treatments; the length of time the
4911 child is expected to be taking the medication; and any
4912 additional medical, mental health, behavioral, counseling, or
4913 other services that the prescribing physician recommends.
4914 6. For a child 10 years of age or younger who is in an out-
4915 of-home placement, the results of a review of the administration
4916 of the medication by a child psychiatrist who is licensed under
4917 chapter 458 or chapter 459. The review must be provided to the
4918 child and the parent or legal guardian before final express and
4919 informed consent is given. The review must include a
4920 determination of the following:
4921 a. The presence of a genetic psychiatric disorder or a
4922 family history of a psychiatric disorder;
4923 b. Whether the cause of a psychiatric disorder is physical
4924 or environmental; and
4925 c. The likelihood of the child being an imminent danger to
4926 self or others.
4927 (d)~~1.~~ The department must notify all parties of the
4928 proposed action taken under paragraph (c) in writing or by
4929 whatever other method best ensures that all parties receive
4930 notification of the proposed action within 48 hours after the

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4931 motion is filed. If any party objects to the department's
4932 motion, that party shall file the objection within 2 working
4933 days after being notified of the department's motion. If any
4934 party files an objection to the authorization of the proposed
4935 psychotropic medication, the court shall hold a hearing as soon
4936 as possible before authorizing the department to initially
4937 provide or to continue providing psychotropic medication to a
4938 child in the legal custody of the department.
4939 1. At such hearing and notwithstanding s. 90.803, the
4940 medical report described in paragraph (c) is admissible in
4941 evidence. The prescribing physician need not attend the hearing
4942 or testify unless the court specifically orders such attendance
4943 or testimony, or a party subpoenas the physician to attend the
4944 hearing or provide testimony.
4945 2. If, after considering any testimony received, the court
4946 finds that the department's motion and the physician's medical
4947 report meet the requirements of this subsection and that it is
4948 in the child's best interests, the court may order that the
4949 department provide or continue to provide the psychotropic
4950 medication to the child without additional testimony or
4951 evidence.
4952 3. At any hearing held under this paragraph, the court
4953 shall ~~further~~ inquire of the department as to whether additional
4954 medical, mental health, behavioral, counseling, or other
4955 services are being provided to the child by the department which
4956 the prescribing physician considers to be necessary or
4957 beneficial in treating the child's medical condition and which
4958 the physician recommends or expects to provide to the child in
4959 concert with the medication. The court may order additional

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4960 medical consultation, including consultation with the MedConsult
4961 line at the University of Florida, if available, or require the
4962 department to obtain a second opinion within a reasonable
4963 timeframe as established by the court, not to exceed 21 calendar
4964 days, ~~after such order~~ based upon consideration of the best
4965 interests of the child. The department must make a referral for
4966 an appointment for a second opinion with a physician within 1
4967 working day.
4968 4. The court may not order the discontinuation of
4969 prescribed psychotropic medication if such order is contrary to
4970 the decision of the prescribing physician unless the court first
4971 obtains an opinion from a licensed psychiatrist, if available,
4972 or, if not available, a physician licensed under chapter 458 or
4973 chapter 459, stating that more likely than not, discontinuing
4974 the medication would not cause significant harm to the child.
4975 If, however, the prescribing psychiatrist specializes in mental
4976 health care for children and adolescents, the court may not
4977 order the discontinuation of prescribed psychotropic medication
4978 unless the required opinion is also from a psychiatrist who
4979 specializes in mental health care for children and adolescents.
4980 The court may also order the discontinuation of prescribed
4981 psychotropic medication if a child's treating physician,
4982 licensed under chapter 458 or chapter 459, states that
4983 continuing the prescribed psychotropic medication would cause
4984 significant harm to the child due to a diagnosed nonpsychiatric
4985 medical condition.
4986 5. If a child who is in out-of-home placement is 10 years
4987 of age or younger, psychotropic medication may not be authorized
4988 by the court absent a finding of a compelling governmental

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4989 interest. In making such finding, the court shall review the
4990 psychiatric review described in subparagraph (c)6.
4991 6.~~2.~~ The burden of proof at any hearing held under this
4992 paragraph shall be by a preponderance of the evidence.
4993 Section 60. Paragraph (a) of subsection (1) of section
4994 216.262, Florida Statutes, is amended to read:
4995 216.262 Authorized positions.—
4996 (1)(a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by
4997 law, the total number of authorized positions may not exceed the
4998 total provided in the appropriations acts. If a ~~In the event any~~
4999 state agency or entity of the judicial branch finds that the
5000 number of positions so provided is not sufficient to administer
5001 its authorized programs, it may file an application with the
5002 Executive Office of the Governor or the Chief Justice~~;~~ and, if
5003 the Executive Office of the Governor or Chief Justice certifies
5004 that there are no authorized positions available for addition,
5005 deletion, or transfer within the agency or entity as provided in
5006 paragraph (c), may recommend ~~and recommends~~ an increase in the
5007 number of positions.~~,~~
5008 1. The Governor or the Chief Justice may recommend an
5009 increase in the number of positions for the following reasons
5010 only:
5011 a.~~1.~~ To implement or provide for continuing federal grants
5012 or changes in grants not previously anticipated.
5013 b.~~2.~~ To meet emergencies pursuant to s. 252.36.
5014 c.~~3.~~ To satisfy new federal regulations or changes therein.
5015 d.~~4.~~ To take advantage of opportunities to reduce operating
5016 expenditures or to increase the revenues of the state or local
5017 government.

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5018 e.~~5.~~ To authorize positions that were not fixed by the
5019 Legislature due to ~~through~~ error in drafting the appropriations
5020 acts.
5021 2. Actions recommended pursuant to this paragraph are
5022 subject to approval by the Legislative Budget Commission. The
5023 certification and the final authorization shall be provided to
5024 the Legislative Budget Commission, the legislative
5025 appropriations committees, and the Auditor General.
5026 3. The provisions of this paragraph do not apply to
5027 positions in the Department of Health which are funded by the
5028 County Health Department Trust Fund.
5029 Section 61. Section 381.06014, Florida Statutes, is amended
5030 to read:
5031 381.06014 Blood establishments.—
5032 (1) As used in this section, the term:
5033 (a) "Blood establishment" means any person, entity, or
5034 organization, operating within the state, which examines an
5035 individual for the purpose of blood donation or which collects,
5036 processes, stores, tests, or distributes blood or blood
5037 components collected from the human body for the purpose of
5038 transfusion, for any other medical purpose, or for the
5039 production of any biological product. A person, entity, or
5040 organization that uses a mobile unit to conduct such activities
5041 within the state is also a blood establishment.
5042 (b) "Volunteer donor" means a person who does not receive
5043 remuneration, other than an incentive, for a blood donation
5044 intended for transfusion, and the product container of the
5045 donation from the person qualifies for labeling with the
5046 statement "volunteer donor" under 21 C.F.R. s. 606.121.

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5047 (2) An entity or organization may not hold itself out and
5048 engage in the activities of a ~~Any~~ blood establishment in this
5049 state ~~operating in the state may not conduct any activity~~
5050 ~~defined in subsection (1)~~ unless it operates in accordance ~~that~~
5051 ~~blood establishment is operated in a manner consistent~~ with ~~the~~
5052 ~~provisions of~~ Title 21 C.F.R. parts 211 and 600-640~~, Code of~~
5053 ~~Federal Regulations~~.
5054 (3) A ~~Any~~ blood establishment determined to be operating in
5055 the state in a manner not consistent with ~~the provisions of~~
5056 Title 21 C.F.R. parts 211 and 600-640, ~~Code of Federal~~
5057 ~~Regulations,~~ and in a manner that constitutes a danger to the
5058 health or well-being of donors or recipients as evidenced by the
5059 federal Food and Drug Administration's inspection reports and
5060 the revocation of the blood establishment's license or
5061 registration is ~~shall be~~ in violation of this chapter, ~~and shall~~
5062 ~~immediately cease all operations in the state.~~
5063 ~~(4) The operation of a blood establishment in a manner not~~
5064 ~~consistent with the provisions of Title 21 parts 211 and 600-~~
5065 ~~640, Code of Federal Regulations, and in a manner that~~
5066 ~~constitutes a danger to the health or well-being of blood donors~~
5067 ~~or recipients as evidenced by the federal Food and Drug~~
5068 ~~Administration's inspection process~~ is declared a nuisance and
5069 inimical to the public health, welfare, and safety, and must
5070 immediately cease all operations in this state. The Agency for
5071 Health Care Administration or any state attorney may bring an
5072 action for an injunction to restrain such operations or enjoin
5073 the future operation of the blood establishment.
5074 (4) A local government may not restrict access to or the
5075 use of any public facility or infrastructure for the collection

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5076 of blood or blood components from volunteer donors based on
5077 whether the blood establishment is operating as a for-profit or
5078 not-for-profit organization.
5079 (5) In determining the service fee of blood or blood
5080 components received from volunteer donors and sold to hospitals
5081 or other health care providers, a blood establishment may not
5082 base the service fee of the blood or blood component solely on
5083 whether the purchasing entity is a for-profit or not-for-profit
5084 organization.
5085 (6) A blood establishment that collects blood or blood
5086 components from volunteer donors must disclose the following
5087 information on its Internet website in order to educate and
5088 inform donors and the public about the blood establishment's
5089 activities, and the information required to be disclosed may be
5090 cumulative for all blood establishments within a business
5091 entity:
5092 (a) A description of the steps involved in collecting,
5093 processing, and distributing volunteer donations.
5094 (b) By March 1 of each year, the number of units of blood
5095 components which were:
5096 1. Produced by the blood establishment during the preceding
5097 calendar year;
5098 2. Obtained from other sources during the preceding
5099 calendar year;
5100 3. Distributed during the preceding calendar year to health
5101 care providers located outside this state. However, if the blood
5102 establishment collects donations in a county outside this state,
5103 distributions to health care providers in that county are
5104 excluded. Such information shall be reported in the aggregate

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5105 for health care providers located within the United States and
5106 its territories or outside the United States and its
5107 territories; and
5108 4. Distributed during the preceding calendar year to
5109 entities that are not health care providers. Such information
5110 shall be reported in the aggregate for purchasers located within
5111 the United States and its territories or outside the United
5112 States and its territories.
5113 (c) The blood establishment's conflict-of-interest policy,
5114 policy concerning related-party transactions, whistleblower
5115 policy, and policy for determining executive compensation. If a
5116 change occurs to any of these documents, the revised document
5117 must be available on the blood establishment's website by the
5118 following March 1.
5119 (d) Except for a hospital that collects blood or blood
5120 components from volunteer donors:
5121 1. The most recent 3 years of the Return of Organization
5122 Exempt from Income Tax, Internal Revenue Service Form 990, if
5123 the business entity for the blood establishment is eligible to
5124 file such return. The Form 990 must be available on the blood
5125 establishment's website within 60 calendar days after it is
5126 filed with the Internal Revenue Service; or
5127 2. If the business entity for the blood establishment is
5128 not eligible to file the Form 990 return, a balance sheet,
5129 income statement, and statement of changes in cash flow, along
5130 with the expression of an opinion thereon by an independent
5131 certified public accountant who audited or reviewed such
5132 financial statements. Such documents must be available on the
5133 blood establishment's website within 120 days after the end of

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5134 the blood establishment's fiscal year and must remain on the
5135 blood establishment's website for at least 36 months.
5136
5137 A hospital that collects blood or blood components to be used
5138 only by that hospital's licensed facilities or by a health care
5139 provider that is a part of the hospital's business entity is
5140 exempt from the disclosure requirements of this subsection.
5141 (7) A blood establishment is liable for a civil penalty for
5142 failing to make the disclosures required under subsection (6).
5143 The Department of Legal Affairs may assess a civil penalty
5144 against the blood establishment for each day that it fails to
5145 make such required disclosures, but the penalty may not exceed
5146 $10,000 per year. If multiple blood establishments operated by a
5147 single business entity fail to meet such disclosure
5148 requirements, the civil penalty may be assessed against only one
5149 of the business entity's blood establishments. The Department of
5150 Legal Affairs may terminate an action if the blood establishment
5151 agrees to pay a stipulated civil penalty. A civil penalty so
5152 collected accrues to the state and shall be deposited as
5153 received into the General Revenue Fund unallocated. The
5154 Department of Legal Affairs may terminate the action and waive
5155 the civil penalty upon a showing of good cause by the blood
5156 establishment as to why the required disclosures were not made.
5157 Section 62. Subsection (9) of section 393.063, Florida
5158 Statutes, is amended, present subsections (13) through (40) of
5159 that section are redesignated as subsections (14) through (41),
5160 respectively, and a new subsection (13) is added to that
5161 section, to read:
5162 393.063 Definitions.—For the purposes of this chapter, the

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5163 term:
5164 (9) “Developmental disability” means a disorder or syndrome
5165 that is attributable to retardation, cerebral palsy, autism,
5166 spina bifida, Down syndrome, or Prader-Willi syndrome; that
5167 manifests before the age of 18; and that constitutes a
5168 substantial handicap that can reasonably be expected to continue
5169 indefinitely.
5170 (13) “Down syndrome” means a disorder that is caused by the
5171 presence of an extra chromosome 21.
5172 Section 63. Section 400.023, Florida Statutes, is reordered
5173 and amended to read:
5174 400.023 Civil enforcement.—
5175 (1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a
5176 violation of rights as specified in this part has ~~are violated~~
5177 ~~shall have~~ a cause of action against the licensee or its
5178 management company, as identified in the state application for
5179 nursing home licensure. However, the cause of action may not be
5180 asserted individually against an officer, director, owner,
5181 including an owner designated as having a controlling interest
5182 on the state application for nursing home licensure, or agent of
5183 a licensee or management company unless, following an
5184 evidentiary hearing, the court determines there is sufficient
5185 evidence in the record or proffered by the claimant which
5186 establishes a reasonable basis for finding that the person or
5187 entity breached, failed to perform, or acted outside the scope
5188 of duties as an officer, director, owner, or agent, and that the
5189 breach, failure to perform, or action outside the scope of
5190 duties is a legal cause of actual loss, injury, death, or damage
5191 to the resident.

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5192 (2) The action may be brought by the resident or his or her
5193 guardian, by a person or organization acting on behalf of a
5194 resident with the consent of the resident or his or her
5195 guardian, or by the personal representative of the estate of a
5196 deceased resident regardless of the cause of death.
5197 (5) If the action alleges a claim for the resident's rights
5198 or for negligence that:
5199 (a) Caused the death of the resident, the claimant must
5200 ~~shall be required to~~ elect ~~either~~ survival damages pursuant to
5201 s. 46.021 or wrongful death damages pursuant to s. 768.21. If
5202 the claimant elects wrongful death damages, total noneconomic
5203 damages may not exceed $250,000, regardless of the number of
5204 claimants.
5205 (b) ~~If the action alleges a claim for the resident's rights~~
5206 ~~or for negligence that~~ Did not cause the death of the resident,
5207 the personal representative of the estate may recover damages
5208 for the negligence that caused injury to the resident.
5209 (3) The action may be brought in any court of competent
5210 jurisdiction to enforce such rights and to recover actual and
5211 punitive damages for any violation of the rights of a resident
5212 or for negligence.
5213 (10) Any resident who prevails in seeking injunctive relief
5214 or a claim for an administrative remedy may ~~is entitled to~~
5215 recover the costs of the action, and a reasonable attorney's fee
5216 assessed against the defendant not to exceed $25,000. Fees shall
5217 be awarded solely for the injunctive or administrative relief
5218 and not for any claim or action for damages whether such claim
5219 or action is brought together with a request for an injunction
5220 or administrative relief or as a separate action, except as

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5221 provided under s. 768.79 or the Florida Rules of Civil
5222 Procedure. Sections 400.023-400.0238 provide the exclusive
5223 remedy for a cause of action for recovery of damages for the
5224 personal injury or death of a nursing home resident arising out
5225 of negligence or a violation of rights specified in s. 400.022.
5226 This section does not preclude theories of recovery not arising
5227 out of negligence or s. 400.022 which are available to a
5228 resident or to the agency. The provisions of chapter 766 do not
5229 apply to any cause of action brought under ss. 400.023-400.0238.
5230 (6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part
5231 alleges ~~alleging~~ a violation of resident's rights or negligence
5232 causing injury to or the death of a resident, the claimant shall
5233 have the burden of proving, by a preponderance of the evidence,
5234 that:
5235 (a) The defendant owed a duty to the resident;
5236 (b) The defendant breached the duty to the resident;
5237 (c) The breach of the duty is a legal cause of loss,
5238 injury, death, or damage to the resident; and
5239 (d) The resident sustained loss, injury, death, or damage
5240 as a result of the breach.
5241 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~
5242 create strict liability. A violation of the rights set forth in
5243 s. 400.022 or in any other standard or guidelines specified in
5244 this part or in any applicable administrative standard or
5245 guidelines of this state or a federal regulatory agency is ~~shall~~
5246 ~~be~~ evidence of negligence but may ~~shall~~ not be considered
5247 negligence per se.
5248 (7) ~~(3)~~ In any claim brought pursuant to this section, a
5249 licensee, person, or entity has ~~shall have~~ a duty to exercise

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5250 reasonable care. Reasonable care is that degree of care which a
5251 reasonably careful licensee, person, or entity would use under
5252 like circumstances.
5253 (9) ~~(4)~~ In any claim for resident's rights violation or
5254 negligence by a nurse licensed under part I of chapter 464, such
5255 nurse has a ~~shall have the~~ duty to exercise care consistent with
5256 the prevailing professional standard of care for a nurse. The
5257 prevailing professional standard of care for a nurse is ~~shall be~~
5258 that level of care, skill, and treatment which, in light of all
5259 relevant surrounding circumstances, is recognized as acceptable
5260 and appropriate by reasonably prudent similar nurses.
5261 (8) ~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical
5262 negligence of any physician rendering care or treatment to the
5263 resident except for the administrative services of a medical
5264 director as required in this part. ~~Nothing in~~ This subsection
5265 does not ~~shall be construed to~~ protect a licensee, person, or
5266 entity from liability for failure to provide a resident with
5267 appropriate observation, assessment, nursing diagnosis,
5268 planning, intervention, and evaluation of care by nursing staff.
5269 (4) ~~(6)~~ The resident or the resident's legal representative
5270 shall serve a copy of any complaint alleging in whole or in part
5271 a violation of any rights specified in this part to the agency
5272 ~~for Health Care Administration~~ at the time of filing the initial
5273 complaint with the clerk of the court for the county in which
5274 the action is pursued. ~~The requirement of~~ Providing a copy of
5275 the complaint to the agency does not impair the resident's legal
5276 rights or ability to seek relief for his or her claim.
5277 (11) ~~(7)~~ An action under this part for a violation of rights
5278 or negligence ~~recognized herein~~ is not a claim for medical

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5279 malpractice, and the provisions of s. 768.21(8) do not apply to
5280 a claim alleging death of the resident.
5281 Section 64. Subsections (1), (2), and (3) of section
5282 400.0237, Florida Statutes, are amended to read:
5283 400.0237 Punitive damages; pleading; burden of proof.—
5284 (1) In any action ~~for damages~~ brought under this part, a ~~no~~
5285 claim for punitive damages is not ~~shall be~~ permitted unless,
5286 based on admissible ~~there is a reasonable showing by~~ evidence ~~in~~
5287 ~~the record or~~ proffered by the claimant, ~~which would provide~~ a
5288 reasonable basis for recovery of such damages is demonstrated
5289 upon applying the criteria set forth in this section. The
5290 defendant may proffer admissible evidence to refute the
5291 claimant's proffer of evidence to recover punitive damages. The
5292 trial judge shall conduct an evidentiary hearing and weigh the
5293 admissible evidence proffered by the claimant and the defendant
5294 to ensure that there is a reasonable basis to believe that the
5295 claimant, at trial, will be able to demonstrate by clear and
5296 convincing evidence that the recovery of such damages is
5297 warranted. The claimant may move to amend her or his complaint
5298 to assert a claim for punitive damages as allowed by the rules
5299 of civil procedure. ~~The rules of civil procedure shall be~~
5300 ~~liberally construed so as to allow the claimant discovery of~~
5301 ~~evidence which appears reasonably calculated to lead to~~
5302 ~~admissible evidence on the issue of punitive damages.~~ ~~No~~
5303 Discovery of financial worth may not ~~shall~~ proceed until after
5304 the trial judge approves the pleading on ~~concerning~~ punitive
5305 damages ~~is permitted~~.
5306 (2) A defendant, including the licensee or management
5307 company, against whom punitive damages is sought may be held

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5308 liable for punitive damages only if the trier of fact, based on
5309 clear and convincing evidence, finds that a specific individual
5310 or corporate defendant actively and knowingly participated in
5311 intentional misconduct, or engaged in conduct that constituted
5312 gross negligence, and that conduct contributed to the loss,
5313 damages, or injury suffered by the claimant ~~the defendant was~~
5314 ~~personally guilty of intentional misconduct or gross negligence~~.
5315 As used in this section, the term:
5316 (a) "Intentional misconduct" means that the defendant
5317 against whom a claim for punitive damages is sought had actual
5318 knowledge of the wrongfulness of the conduct and the high
5319 probability that injury or damage to the claimant would result
5320 and, despite that knowledge, intentionally pursued that course
5321 of conduct, resulting in injury or damage.
5322 (b) "Gross negligence" means that the defendant's conduct
5323 was so reckless or wanting in care that it constituted a
5324 conscious disregard or indifference to the life, safety, or
5325 rights of persons exposed to such conduct.
5326 (3) In the case of vicarious liability of an employer,
5327 principal, corporation, or other legal entity, punitive damages
5328 may not be imposed for the conduct of an identified employee or
5329 agent unless ~~only if~~ the conduct of the employee or agent meets
5330 the criteria specified in subsection (2) and officers,
5331 directors, or managers of the actual employer corporation or
5332 legal entity condoned, ratified, or consented to the specific
5333 conduct as alleged by the claimant in subsection (2).~~:~~
5334 ~~(a) The employer, principal, corporation, or other legal~~
5335 ~~entity actively and knowingly participated in such conduct;~~
5336 ~~(b) The officers, directors, or managers of the employer,~~

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5337 ~~principal, corporation, or other legal entity condoned,~~
5338 ~~ratified, or consented to such conduct; or~~
5339 ~~(c) The employer, principal, corporation, or other legal~~
5340 ~~entity engaged in conduct that constituted gross negligence and~~
5341 ~~that contributed to the loss, damages, or injury suffered by the~~
5342 ~~claimant.~~
5343 Section 65. Subsections (3) and (4) of section 408.7057,
5344 Florida Statutes, are amended, subsection (7) of that section is
5345 redesignated as subsection (8), and a new subsection (7) is
5346 added to that section, to read:
5347 408.7057 Statewide provider and health plan claim dispute
5348 resolution program.—
5349 (3) The agency shall adopt rules to establish a process to
5350 be used by the resolution organization in considering claim
5351 disputes submitted by a provider or health plan which must
5352 include a hearing, if requested by the respondent, and the
5353 issuance by the resolution organization of a written
5354 recommendation, supported by findings of fact and conclusions of
5355 law, to the agency within 60 days after the requested
5356 information is received by the resolution organization within
5357 the timeframes specified by the resolution organization. ~~In no~~
5358 ~~event shall~~ The review time may not exceed 90 days following
5359 receipt of the initial claim dispute submission by the
5360 resolution organization.
5361 (4) Within 30 days after receipt of the recommendation of
5362 the resolution organization, the agency shall adopt the
5363 recommendation as a final order subject to chapter 120.
5364 (7) This section creates a procedure for dispute resolution
5365 and not an independent right of recovery. The conclusions of law

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5366 contained in the written recommendation of the resolution
5367 organization must identify the provisions of law or contract
5368 which, under the particular facts and circumstances of the case,
5369 entitle the provider or health plan to the amount awarded, if
5370 any.
5371 Section 66. Paragraphs (f), (h), (j), and (l) of subsection
5372 (1) and subsection (2) of section 409.1671, Florida Statutes,
5373 are amended to read:
5374 409.1671 Foster care and related services; outsourcing.—
5375 (1)
5376 (f)~~1.~~ The Legislature finds that the state has
5377 traditionally provided foster care services to children who are
5378 ~~have been~~ the responsibility of the state. As such, foster
5379 children have not had the right to recover for injuries beyond
5380 the limitations specified in s. 768.28. The Legislature has also
5381 determined that foster care and related services need to be
5382 outsourced ~~pursuant to this section~~ and that the provision of
5383 such services is of paramount importance to the state. The
5384 purpose for such outsourcing is to increase the level of safety,
5385 security, and stability of children who are or become the
5386 responsibility of the state.
5387 1. One of the components necessary to secure a safe and
5388 stable environment for such children is for ~~that~~ private
5389 providers to maintain adequate liability insurance. ~~As~~ Such~~,~~
5390 insurance needs to be available and remain available to
5391 nongovernmental foster care and related services providers
5392 without the resources of such providers being significantly
5393 reduced by the cost of maintaining such insurance. To ensure
5394 that these resources are not significantly reduced, specified

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5395 limits of liability are necessary for eligible lead community-
5396 based providers and subcontractors engaged in the provision of
5397 services previously performed by the department.
5398 2. The Legislature further finds that, by requiring the
5399 following minimum levels of insurance, children in outsourced
5400 foster care and related services will gain increased protection
5401 ~~and rights of recovery in the event of injury than provided for~~
5402 ~~in s. 768.28~~.
5403 (h) Other than an entity to which s. 768.28 applies, an ~~any~~
5404 eligible lead community-based provider~~, as defined in paragraph~~
5405 ~~(e),~~ or its employees or officers, except as otherwise provided
5406 in paragraph (i), must, as a part of its contract, obtain
5407 general liability coverage for a minimum of $200,000 per claim
5408 or $300,000 per incident ~~a minimum of $1 million per claim/$3~~
5409 ~~million per incident in general liability insurance coverage~~.
5410 1. The eligible lead community-based provider must also
5411 require ~~that~~ staff who transport client children and families in
5412 their personal automobiles in order to carry out their job
5413 responsibilities to obtain minimum bodily injury liability
5414 insurance on their personal automobiles in the amount of
5415 $100,000 per claim or~~,~~ $300,000 per incident~~, on their personal~~
5416 ~~automobiles~~. In lieu of personal motor vehicle insurance, the
5417 lead community-based provider’s casualty, liability, or motor
5418 vehicle insurance carrier may provide nonowned automobile
5419 liability coverage~~. This insurance provides liability insurance~~
5420 for automobiles that the provider uses in connection with the
5421 provider’s business but does not own, lease, rent, or borrow.
5422 This coverage includes automobiles owned by the employees of the
5423 provider or a member of the employee’s household ~~but only~~ while

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5424 the automobiles are used in connection with the provider's
5425 business. The nonowned automobile coverage ~~for the provider~~
5426 applies as excess coverage over any other collectible insurance.
5427 The personal automobile policy for the employee of the provider
5428 shall be primary insurance, and the nonowned automobile coverage
5429 of the provider acts as excess insurance to the primary
5430 insurance. The provider shall provide a minimum limit of $1
5431 million in nonowned automobile coverage.
5432 2. In any tort action brought against ~~such~~ an eligible lead
5433 community-based provider or employee, net economic damages are
5434 ~~shall be~~ limited to $200,000 ~~$1 million~~ per liability claim,
5435 $300,000 per liability incident, and $100,000 per automobile
5436 claim, including, but not limited to, past and future medical
5437 expenses, wage loss, and loss of earning capacity, offset by any
5438 collateral source payment paid or payable. In any tort action
5439 brought against an eligible lead community-based provider, the
5440 total economic damages recoverable by all claimants is limited
5441 to $500,000 in the aggregate. In any tort action brought against
5442 such an eligible lead community-based provider, noneconomic
5443 damages are ~~shall be~~ limited to $200,000 per claim and $300,000
5444 per incident. In any tort action brought against an eligible
5445 lead community-based provider, the total noneconomic damages
5446 recoverable by all claimants are limited to $500,000 in the
5447 aggregate.
5448 3. A claims bill may be brought on behalf of a claimant
5449 pursuant to s. 768.28 for any amount exceeding the limits
5450 specified in this paragraph. Any offset of collateral source
5451 payments made as of the date of the settlement or judgment shall
5452 be in accordance with s. 768.76. The lead community-based

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5453 provider is ~~shall~~ not ~~be~~ liable in tort for the acts or
5454 omissions of its subcontractors or the officers, agents, or
5455 employees of its subcontractors.
5456 (j) Any subcontractor of an eligible lead community-based
5457 provider~~, as defined in paragraph (c),~~ which is a direct
5458 provider of foster care and related services to children and
5459 families, and its employees or officers, except as otherwise
5460 provided in paragraph (i), must, as a part of its contract,
5461 obtain general liability insurance coverage for a minimum of
5462 $200,000 per claim or $300,000 ~~$1 million per claim/$3 million~~
5463 per incident ~~in general liability insurance coverage~~.
5464 1. The subcontractor of an eligible lead community-based
5465 provider must also require that staff who transport client
5466 children and families in their personal automobiles in order to
5467 carry out their job responsibilities obtain minimum bodily
5468 injury liability insurance in the amount of $100,000 per claim,
5469 $300,000 per incident, on their personal automobiles. In lieu of
5470 personal motor vehicle insurance, the subcontractor’s casualty,
5471 liability, or motor vehicle insurance carrier may provide
5472 nonowned automobile liability coverage. This insurance provides
5473 liability insurance for automobiles that the subcontractor uses
5474 in connection with the subcontractor’s business but does not
5475 own, lease, rent, or borrow. This coverage includes automobiles
5476 owned by the employees of the subcontractor or a member of the
5477 employee’s household but only while the automobiles are used in
5478 connection with the subcontractor’s business. The nonowned
5479 automobile coverage for the subcontractor applies as excess
5480 coverage over any other collectible insurance. The personal
5481 automobile policy for the employee of the subcontractor is ~~shall~~

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5482 ~~be~~ primary insurance, and the nonowned automobile coverage of
5483 the subcontractor acts as excess insurance to the primary
5484 insurance. The subcontractor shall provide a minimum limit of $1
5485 million in nonowned automobile coverage.
5486 2. In any tort action brought against such subcontractor or
5487 employee, net economic damages shall be limited to $200,000 ~~$1~~
5488 ~~million~~ per liability claim, $300,000 per liability incident,
5489 and $100,000 per automobile claim, including, but not limited
5490 to, past and future medical expenses, wage loss, and loss of
5491 earning capacity, offset by any collateral source payment paid
5492 or payable. In any tort action brought against such
5493 subcontractor or employee, the total economic damages
5494 recoverable by all claimants is limited to $500,000 in the
5495 aggregate. In any tort action brought against such
5496 subcontractor, noneconomic damages shall be limited to $200,000
5497 per claim and $300,000 per incident. In any tort action brought
5498 against such subcontractor or employee, the total noneconomic
5499 damages recoverable by all claimants is limited to $500,000 in
5500 the aggregate.
5501 3. A claims bill may be brought on behalf of a claimant
5502 pursuant to s. 768.28 for any amount exceeding the limits
5503 specified in this paragraph. Any offset of collateral source
5504 payments made as of the date of the settlement or judgment shall
5505 be in accordance with s. 768.76.
5506 ~~(l) The Legislature is cognizant of the increasing costs of~~
5507 ~~goods and services each year and recognizes that fixing a set~~
5508 ~~amount of compensation actually has the effect of a reduction in~~
5509 ~~compensation each year. Accordingly, the conditional limitations~~
5510 ~~on damages in this section shall be increased at the rate of 5~~

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5511 ~~percent each year, prorated from the effective date of this~~
5512 ~~paragraph to the date at which damages subject to such~~
5513 ~~limitations are awarded by final judgment or settlement.~~
5514 (2)~~(a)~~ The department may contract for the delivery,
5515 administration, or management of protective services, the
5516 services specified in subsection (1) relating to foster care,
5517 and other related services or programs, as appropriate.
5518 (a) The department shall use diligent efforts to ensure
5519 that r~~etain responsibility for the quality of~~ contracted
5520 services and programs ~~and shall ensure that services~~ are of high
5521 quality and delivered in accordance with applicable federal and
5522 state statutes and regulations. However, the department is not
5523 liable in tort for the acts or omissions of eligible lead
5524 community-based providers or their officers, agents, or
5525 employees, or liable in tort for the acts or omissions of the
5526 subcontractors of eligible lead community-based care providers
5527 or their officers, agents, or employees. Further, the department
5528 may not require eligible lead community-based providers or their
5529 subcontractors to indemnify the department for the department's
5530 acts or omissions or require eligible lead-based community
5531 providers or their subcontractors to include the department as
5532 an additional insured on an insurance policy.
5533 (b) The department shall ~~must~~ adopt written policies and
5534 procedures for monitoring the contract for the delivery of
5535 services by lead community-based providers. These policies and
5536 procedures must, at a minimum, address the evaluation of fiscal
5537 accountability and program operations, including provider
5538 achievement of performance standards, provider monitoring of
5539 subcontractors, and timely followup of corrective actions for

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5540 significant monitoring findings related to providers and
5541 subcontractors. The ~~These~~ policies and procedures must also
5542 include provisions for reducing the duplication of the
5543 department's program monitoring activities both internally and
5544 with other agencies, to the extent possible. The department's
5545 written procedures must ensure that the written findings,
5546 conclusions, and recommendations from monitoring the contract
5547 ~~for services of lead community-based providers~~ are communicated
5548 to the director of the provider agency as expeditiously as
5549 possible.
5550 (c) ~~(b)~~ Persons employed by the department in the provision
5551 of foster care and related services whose positions are being
5552 outsourced under this statute shall be given hiring preference
5553 by the provider, if provider qualifications are met.
5554 Section 67. Section 458.3167, Florida Statutes, is created
5555 to read:
5556 458.3167 Expert witness certificate.—
5557 (1) A physician who holds an active and valid license to
5558 practice allopathic medicine in any other state or in Canada,
5559 who submits an application form prescribed by the board to
5560 obtain a certificate to provide expert testimony and pays the
5561 application fee, and who has not had a previous expert witness
5562 certificate revoked by the board shall be issued a certificate
5563 to provide expert testimony.
5564 (2) A physician possessing an expert witness certificate
5565 may use the certificate only to give a verified written medical
5566 expert opinion as provided in s. 766.203 and to provide expert
5567 testimony concerning the prevailing professional standard of
5568 care for medical negligence litigation pending in this state

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5569 against a physician licensed under this chapter or chapter 459.
5570 (3) An application for an expert witness certificate must
5571 be approved or denied within 5 business days after receipt of a
5572 completed application. An application that is not approved or
5573 denied within the required time period is deemed approved. An
5574 applicant seeking to claim certification by default shall notify
5575 the board, in writing, of the intent to rely on the default
5576 certification provision of this subsection. In such case, s.
5577 458.327 does not apply, and the applicant may provide expert
5578 testimony as provided in subsection (2).
5579 (4) All licensure fees, other than the initial certificate
5580 application fee, including the neurological injury compensation
5581 assessment, are waived for those persons obtaining an expert
5582 witness certificate. The possession of an expert witness
5583 certificate alone does not entitle the physician to engage in
5584 the practice of medicine as defined in s. 458.305.
5585 (5) The board shall adopt rules to administer this section,
5586 including rules setting the amount of the expert witness
5587 certificate application fee, which may not exceed $50. An expert
5588 witness certificate expires 2 years after the date of issuance.
5589 Section 68. Subsection (11) is added to section 458.331,
5590 Florida Statutes, present paragraphs (oo) through (qq) of
5591 subsection (1) of that section are redesignated as paragraphs
5592 (pp) through (rr), respectively, and a new paragraph (oo) is
5593 added to that subsection, to read:
5594 458.331 Grounds for disciplinary action; action by the
5595 board and department.—
5596 (1) The following acts constitute grounds for denial of a
5597 license or disciplinary action, as specified in s. 456.072(2):

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5598 (oo) Providing misleading, deceptive, or fraudulent expert
5599 witness testimony related to the practice of medicine.
5600 (11) The purpose of this section is to facilitate uniform
5601 discipline for those acts made punishable under this section
5602 and, to this end, a reference to this section constitutes a
5603 general reference under the doctrine of incorporation by
5604 reference.
5605 Section 69. Section 459.0078, Florida Statutes, is created
5606 to read:
5607 459.0078 Expert witness certificate.—
5608 (1) A physician who holds an active and valid license to
5609 practice osteopathic medicine in any other state or in Canada,
5610 who submits an application form prescribed by the board to
5611 obtain a certificate to provide expert testimony and pays the
5612 application fee, and who has not had a previous expert witness
5613 certificate revoked by the board shall be issued a certificate
5614 to provide expert testimony.
5615 (2) A physician possessing an expert witness certificate
5616 may use the certificate only to give a verified written medical
5617 expert opinion as provided in s. 766.203 and to provide expert
5618 testimony concerning the prevailing professional standard of
5619 care for medical negligence litigation pending in this state
5620 against a physician licensed under this chapter or chapter 458.
5621 (3) An application for an expert witness certificate must
5622 be approved or denied within 5 business days after receipt of a
5623 completed application. An application that is not approved or
5624 denied within the required time period is deemed approved. An
5625 applicant seeking to claim certification by default shall notify
5626 the board, in writing, of the intent to rely on the default

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5627 certification provision of this subsection. In such case, s.
5628 459.013 does not apply, and the applicant may provide expert
5629 testimony as provided in subsection (2).
5630 (4) All licensure fees, other than the initial certificate
5631 application fee, including the neurological injury compensation
5632 assessment, are waived for those persons obtaining an expert
5633 witness certificate. The possession of an expert witness
5634 certificate alone does not entitle the physician to engage in
5635 the practice of osteopathic medicine as defined in s. 459.003.
5636 (5) The board shall adopt rules to administer this section,
5637 including rules setting the amount of the expert witness
5638 certificate application fee, which may not exceed $50. An expert
5639 witness certificate expires 2 years after the date of issuance.
5640 Section 70. Subsection (11) is added to section 459.015,
5641 Florida Statutes, present paragraphs (qq) through (ss) of
5642 subsection (1) of that section are redesignated as paragraphs
5643 (rr) through (tt), respectively, and a new paragraph (qq) is
5644 added to that subsection, to read:
5645 459.015 Grounds for disciplinary action; action by the
5646 board and department.—
5647 (1) The following acts constitute grounds for denial of a
5648 license or disciplinary action, as specified in s. 456.072(2):
5649 (qq) Providing misleading, deceptive, or fraudulent expert
5650 witness testimony related to the practice of osteopathic
5651 medicine.
5652 (11) The purpose of this section is to facilitate uniform
5653 discipline for those acts made punishable under this section
5654 and, to this end, a reference to this section constitutes a
5655 general reference under the doctrine of incorporation by

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5656 reference.
5657 Section 71. Subsection (23) of section 499.003, Florida
5658 Statutes, is amended to read:
5659 499.003 Definitions of terms used in this part.—As used in
5660 this part, the term:
5661 (23) "Health care entity" means a closed pharmacy or any
5662 person, organization, or business entity that provides
5663 diagnostic, medical, surgical, or dental treatment or care, or
5664 chronic or rehabilitative care, but does not include any
5665 wholesale distributor or retail pharmacy licensed under state
5666 law to deal in prescription drugs. However, a blood
5667 establishment is a health care entity that may engage in the
5668 wholesale distribution of prescription drugs under s.
5669 499.01(2)(g)1.c.
5670 Section 72. Subsection (21) of section 499.005, Florida
5671 Statutes, is amended to read:
5672 499.005 Prohibited acts.—It is unlawful for a person to
5673 perform or cause the performance of any of the following acts in
5674 this state:
5675 (21) The wholesale distribution of any prescription drug
5676 that was:
5677 (a) Purchased by a public or private hospital or other
5678 health care entity; or
5679 (b) Donated or supplied at a reduced price to a charitable
5680 organization,
5681
5682 unless the wholesale distribution of the prescription drug is
5683 authorized in s. 499.01(2)(g)1.c.
5684 Section 73. Paragraphs (a) and (g) of subsection (2) of

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5685 section 499.01, Florida Statutes, are amended to read:
5686 499.01 Permits.—
5687 (2) The following permits are established:
5688 (a) *Prescription drug manufacturer permit.*—A prescription
5689 drug manufacturer permit is required for any person that is a
5690 manufacturer of a prescription drug and that manufactures or
5691 distributes such prescription drugs in this state.
5692 1. A person that operates an establishment permitted as a
5693 prescription drug manufacturer may engage in wholesale
5694 distribution of prescription drugs manufactured at that
5695 establishment and must comply with all of the provisions of this
5696 part, except s. 499.01212, and the rules adopted under this
5697 part, except s. 499.01212, which ~~that~~ apply to a wholesale
5698 distributor.
5699 2. A prescription drug manufacturer must comply with all
5700 appropriate state and federal good manufacturing practices.
5701 3. A blood establishment, as defined in s. 381.06014,
5702 operating in a manner consistent with the provisions of Title 21
5703 C.F.R. parts 211 and 600-640 and manufacturing only the
5704 prescription drugs described in s. 499.003(54)(d) is not
5705 required to be permitted as a prescription drug manufacturer
5706 under this paragraph or to register its products under s.
5707 499.015.
5708 (g) *Restricted prescription drug distributor permit.*—
5709 1. A restricted prescription drug distributor permit is
5710 required for:
5711 a. Any person located in this state that engages in the
5712 distribution of a prescription drug, which distribution is not
5713 considered “wholesale distribution” under s. 499.003(54)(a).

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5714 b.~~1.~~ Any ~~A~~ person located in this state who engages in the
5715 receipt or distribution of a prescription drug in this state for
5716 the purpose of processing its return or its destruction ~~must~~
5717 ~~obtain a permit as a restricted prescription drug distributor~~ if
5718 such person is not the person initiating the return, the
5719 prescription drug wholesale supplier of the person initiating
5720 the return, or the manufacturer of the drug.
5721 c. A blood establishment located in this state which
5722 collects blood and blood components only from volunteer donors
5723 as defined in s. 381.06014 or pursuant to an authorized
5724 practitioner's order for medical treatment or therapy and
5725 engages in the wholesale distribution of a prescription drug not
5726 described in s. 499.003(54)(d) to a health care entity. The
5727 health care entity receiving a prescription drug distributed
5728 under this sub-subparagraph must be licensed as a closed
5729 pharmacy or provide health care services at that establishment.
5730 The blood establishment must operate in accordance with s.
5731 381.06014 and may distribute only:
5732 (I) Prescription drugs indicated for a bleeding or clotting
5733 disorder or anemia;
5734 (II) Blood-collection containers approved under s. 505 of
5735 the federal act;
5736 (III) Drugs that are blood derivatives, or a recombinant or
5737 synthetic form of a blood derivative;
5738 (IV) Prescription drugs that are identified in rules
5739 adopted by the department and that are essential to services
5740 performed or provided by blood establishments and authorized for
5741 distribution by blood establishments under federal law; or
5742 (V) To the extent authorized by federal law, drugs

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5743 necessary to collect blood or blood components from volunteer
5744 blood donors; for blood establishment personnel to perform
5745 therapeutic procedures under the direction and supervision of a
5746 licensed physician; and to diagnose, treat, manage, and prevent
5747 any reaction of either a volunteer blood donor or a patient
5748 undergoing a therapeutic procedure performed under the direction
5749 and supervision of a licensed physician,
5750
5751 as long as all of the health care services provided by the blood
5752 establishment are related to its activities as a registered
5753 blood establishment or the health care services consist of
5754 collecting, processing, storing, or administering human
5755 hematopoietic stem cells or progenitor cells or performing
5756 diagnostic testing of specimens if such specimens are tested
5757 together with specimens undergoing routine donor testing.
5758 2. Storage, handling, and recordkeeping of these
5759 distributions by a person required to be permitted as a
5760 restricted prescription drug distributor must comply with the
5761 requirements for wholesale distributors under s. 499.0121, but
5762 not those set forth in s. 499.01212 if the distribution occurs
5763 pursuant to sub-subparagraph 1.a. or sub-subparagraph 1.b.
5764 3. A person who applies for a permit as a restricted
5765 prescription drug distributor, or for the renewal of such a
5766 permit, must provide to the department the information required
5767 under s. 499.012.
5768 4. The department may adopt rules regarding the
5769 distribution of prescription drugs by hospitals, health care
5770 entities, charitable organizations, ~~or~~ other persons not
5771 involved in wholesale distribution, and blood establishments,

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5772 which rules are necessary for the protection of the public
5773 health, safety, and welfare.
5774 Section 74. Subsection (4) is added to section 626.9541,
5775 Florida Statutes, to read:
5776 626.9541 Unfair methods of competition and unfair or
5777 deceptive acts or practices defined.—
5778 (4) WELLNESS OR HEALTH IMPROVEMENT PROGRAMS.—
5779 (a) An insurer issuing a group or individual health benefit
5780 plan may offer a voluntary wellness or health improvement
5781 program and may encourage or reward participation in the program
5782 by authorizing rewards or incentives, including, but not limited
5783 to, merchandise, gift cards, debit cards, premium discounts or
5784 rebates, contributions to a member's health savings account, or
5785 modifications to copayment, deductible, or coinsurance amounts.
5786 (b) An insurer may require a health benefit plan member to
5787 provide verification, such as an affirming statement from the
5788 member's physician, that the member's medical condition makes it
5789 unreasonably difficult or inadvisable to participate in the
5790 wellness or health improvement program.
5791 (c) A reward or incentive offered under this subsection is
5792 not an insurance benefit or violation of this section if it is
5793 disclosed in the policy or certificate. This subsection does not
5794 prohibit insurers from offering other incentives or rewards for
5795 adherence to a wellness or health improvement program if
5796 otherwise authorized by state or federal law.
5797 Section 75. Paragraph (b) of subsection (1) of section
5798 627.4147, Florida Statutes, is amended to read:
5799 627.4147 Medical malpractice insurance contracts.—
5800 (1) In addition to any other requirements imposed by law,

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5801 each self-insurance policy ~~as~~ authorized under s. 627.357 or s.
5802 624.462 or insurance policy providing coverage for claims
5803 arising out of the rendering of, or the failure to render,
5804 medical care or services, including those of the Florida Medical
5805 Malpractice Joint Underwriting Association, must ~~shall~~ include:
5806 (b)~~1. Except as provided in subparagraph 2., a clause~~
5807 ~~authorizing the insurer or self-insurer to determine, to make,~~
5808 ~~and to conclude, without the permission of the insured, any~~
5809 ~~offer of admission of liability and for arbitration pursuant to~~
5810 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~
5811 ~~is within the policy limits. It is against public policy for any~~
5812 ~~insurance or self-insurance policy to contain a clause giving~~
5813 ~~the insured the exclusive right to veto any offer for admission~~
5814 ~~of liability and for arbitration made pursuant to s. 766.106,~~
5815 ~~settlement offer, or offer of judgment, when such offer is~~
5816 ~~within the policy limits. However, any offer of admission of~~
5817 ~~liability, settlement offer, or offer of judgment made by an~~
5818 ~~insurer or self-insurer shall be made in good faith and in the~~
5819 ~~best interests of the insured.~~
5820 1.~~2.a.~~ With respect to dentists licensed under chapter 466,
5821 a clause clearly stating whether or not the insured has the
5822 exclusive right to veto any offer of admission of liability and
5823 for arbitration pursuant to s. 766.106, settlement offer, or
5824 offer of judgment if the offer is within policy limits. An
5825 insurer or self-insurer may ~~shall~~ not make or conclude, without
5826 the permission of the insured, any offer of admission of
5827 liability and for arbitration pursuant to s. 766.106, settlement
5828 offer, or offer of judgment, if such offer is outside the policy
5829 limits. However, any offer for admission of liability and for

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5830 arbitration made under s. 766.106, settlement offer, or offer of
5831 judgment made by an insurer or self-insurer must ~~shall~~ be made
5832 in good faith and in the best interest of the insured.
5833 2.~~b.~~ If the policy contains a clause stating the insured
5834 does not have the exclusive right to veto any offer or admission
5835 of liability and for arbitration made pursuant to s. 766.106,
5836 settlement offer or offer of judgment, the insurer or self-
5837 insurer shall provide to the insured or the insured's legal
5838 representative by certified mail, return receipt requested, a
5839 copy of the final offer of admission of liability and for
5840 arbitration made pursuant to s. 766.106, settlement offer or
5841 offer of judgment and at the same time such offer is provided to
5842 the claimant. A copy of any final agreement reached between the
5843 insurer and claimant shall also be provided to the insurer or
5844 his or her legal representative by certified mail, return
5845 receipt requested within ~~not more than~~ 10 days after affecting
5846 such agreement.
5847 Section 76. Present subsection (12) of section 766.102,
5848 Florida Statutes, is redesignated as subsection (13), and a new
5849 subsection (12) is added to that section, to read:
5850 766.102 Medical negligence; standards of recovery; expert
5851 witness.—
5852 (12) If a physician licensed under chapter 458 or chapter
5853 459 is a party against whom, or on whose behalf, expert
5854 testimony about the prevailing professional standard of care is
5855 offered, the expert witness must otherwise meet the requirements
5856 of this section and be licensed as a physician under chapter 458
5857 or chapter 459, or must possess a valid expert witness
5858 certificate issued under s. 458.3167 or s. 459.0078.

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5859 Section 77. Subsection (1) of section 766.104, Florida
5860 Statutes, is amended to read:
5861 766.104 Pleading in medical negligence cases; claim for
5862 punitive damages; authorization for release of records for
5863 investigation.—
5864 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or
5865 wrongful death arising out of medical negligence, whether in
5866 tort or in contract, may not be filed unless the attorney filing
5867 the action has made a reasonable investigation, as permitted by
5868 the circumstances, to determine that there are grounds for a
5869 good faith belief that there has been negligence in the care or
5870 treatment of the claimant.
5871 (a) The complaint or initial pleading must ~~shall~~ contain a
5872 certificate of counsel that such reasonable investigation gave
5873 rise to a good faith belief that grounds exist for an action
5874 against each named defendant. For purposes of this section, good
5875 faith may be shown ~~to exist~~ if the claimant or his or her
5876 counsel has received a written opinion, ~~which shall~~ not ~~be~~
5877 subject to discovery by an opposing party, of an expert as
5878 defined in s. 766.102 that there appears to be evidence of
5879 medical negligence. If the court determines that the ~~such~~
5880 certificate of counsel was not made in good faith and that no
5881 justiciable issue was presented against a health care provider
5882 that fully cooperated in providing informal discovery, the court
5883 shall award attorney's fees and taxable costs against claimant's
5884 counsel~~,~~ and ~~shall~~ submit the matter to The Florida Bar for
5885 disciplinary review of the attorney.
5886 (b) If the cause of action requires the plaintiff to
5887 establish the breach of a standard of care other than negligence

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5888 in order to impose liability or secure specified damages arising
5889 out of the rendering of, or the failure to render, medical care
5890 or services, and the plaintiff intends to pursue such liability
5891 or damages, the investigation and certification required by this
5892 subsection must demonstrate grounds for a good faith belief that
5893 the requirement is satisfied.
5894 Section 78. Subsection (5) of section 766.106, Florida
5895 Statutes, is amended to read:
5896 766.106 Notice before filing action for medical negligence;
5897 presuit screening period; offers for admission of liability and
5898 for arbitration; informal discovery; review.—
5899 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,
5900 written document, report, or other work product generated by the
5901 presuit screening process is discoverable or admissible in any
5902 civil action for any purpose by the opposing party. All
5903 participants, including, but not limited to, physicians,
5904 investigators, witnesses, and employees or associates of the
5905 defendant, are immune from civil liability arising from
5906 participation in the presuit screening process. This subsection
5907 does not prohibit a physician licensed under chapter 458 or
5908 chapter 459, or a physician who holds a certificate to provide
5909 expert testimony under s. 458.3167 or s. 459.0078, who submits a
5910 verified written expert medical opinion from being subject to
5911 disciplinary action pursuant to s. 456.073.
5912 Section 79. Subsection (11) of section 766.1115, Florida
5913 Statutes, is amended to read:
5914 766.1115 Health care providers; creation of agency
5915 relationship with governmental contractors.—
5916 (11) APPLICABILITY.—

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5917 (a) This section applies to incidents occurring on or after
5918 April 17, 1992.
5919 (b) This section does not apply to any health care contract
5920 entered into by the Department of Corrections which is subject
5921 to s. 768.28(10)(a).
5922 (c) This section does not apply to any affiliation
5923 agreement or other contract subject to s. 768.28(10)(f).
5924 (d) ~~Nothing in~~ This section does not reduce or limit ~~in any~~
5925 ~~way reduces or limits~~ the rights of the state or any of its
5926 agencies or subdivisions to any benefit currently provided under
5927 s. 768.28.
5928 Section 80. Section 766.1183, Florida Statutes, is created
5929 to read:
5930 766.1183 Standard of care for Medicaid providers.—
5931 (1) As used in this section:
5932 (a) The terms "applicant," "medical assistance," "medical
5933 services," and "Medicaid recipient" have the same meaning as in
5934 s. 409.901.
5935 (b) The term "provider" means a health care provider as
5936 defined in s. 766.202 or an entity that qualifies for an
5937 exemption under s. 400.9905(4)(e). The term includes:
5938 1. Any person or entity for whom a provider is vicariously
5939 liable; and
5940 2. Any person or entity whose liability is based solely on
5941 such person or entity being vicariously liable for the actions
5942 of a provider.
5943 (c) The term "wrongful manner" means in bad faith or with
5944 malicious purpose or in a manner exhibiting wanton and willful
5945 disregard of human rights, safety, or property, and shall be

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5946 construed in conformity with the standard set forth in s.
5947 768.28(9)(a).
5948 (2) A provider is not liable in excess of $200,000 per
5949 claimant or $300,000 per occurrence for any cause of action
5950 arising out of the rendering of, or the failure to render,
5951 medical services to a Medicaid recipient, except as provided
5952 under subsection (3). However, a judgment may be claimed and
5953 rendered in excess of the amounts set forth in this subsection.
5954 That portion of the judgment that exceeds these amounts may be
5955 reported to the Legislature, but may be paid in part or in whole
5956 by the state only by further act of the Legislature.
5957 (3) A provider may be liable for an amount in excess of
5958 $200,000 per claimant or $300,000 per occurrence only if the
5959 claimant pleads and proves, by clear and convincing evidence,
5960 that the provider acted in a wrongful manner. If the claimant so
5961 pleads, the court, after a reasonable opportunity for discovery,
5962 shall conduct a hearing before trial to determine if there is a
5963 reasonable basis in evidence to conclude that the provider acted
5964 in a wrongful manner. A claim for wrongful conduct is not
5965 permitted, to the extent it exceeds the amounts set forth in
5966 subsection (2), unless the claimant makes the showing required
5967 by this subsection.
5968 (4) At the time an application for medical assistance is
5969 submitted, the Department of Children and Family Services shall
5970 furnish the applicant with written notice of the provisions of
5971 this section.
5972 (5) This section does not limit or exclude the application
5973 of any law, including s. 766.118, which places limitations upon
5974 the recovery of civil damages.

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5975 (6) This section does not apply to any claim for damages to
5976 which s. 768.28 applies.
5977 Section 81. Section 766.1184, Florida Statutes, is created
5978 to read:
5979 766.1184 Standard of care; low-income pool recipient.—
5980 (1) As used in this section, the term:
5981 (a) "Low-income pool recipient" means a low-income
5982 individual who is uninsured or underinsured and who receives
5983 primary care services from a provider which are delivered
5984 exclusively using funding received by that provider under
5985 proviso language accompanying specific appropriation 191 of the
5986 2010-2011 fiscal year General Appropriations Act to establish
5987 new or expand existing primary care clinics for low-income
5988 persons who are uninsured or underinsured.
5989 (b) "Provider" means a health care provider, as defined in
5990 s. 766.202, which received funding under proviso language
5991 accompanying specific appropriation 191 of the fiscal year 2010-
5992 11 General Appropriations Act to establish new or expand
5993 existing primary care clinics for low-income persons who are
5994 uninsured or underinsured. The term includes:
5995 1. Any person or entity for whom a provider is vicariously
5996 liable; and
5997 2. Any person or entity whose liability is based solely on
5998 such person or entity being vicariously liable for the actions
5999 of a provider.
6000 (c) "Wrongful manner" means in bad faith or with malicious
6001 purpose or in a manner exhibiting wanton and willful disregard
6002 of human rights, safety, or property, and shall be construed in
6003 conformity with the standard set forth in s. 768.28(9)(a).

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6004

6005 The funding of the provider's primary care clinic must have been
6006 awarded pursuant to a plan approved by the Legislative Budget
6007 Commission, and must be the subject of an agreement between the
6008 provider and the Agency for Health Care Administration,
6009 following the competitive solicitation of proposals to use low-
6010 income pool grant funds to provide primary care services in
6011 general acute hospitals, county health departments, faith-based
6012 and community clinics, and federally qualified health centers to
6013 uninsured or underinsured persons.
6014 (2) A provider is not liable in excess of $200,000 per
6015 claimant or $300,000 per occurrence for any cause of action
6016 arising out of the rendering of, or the failure to render,
6017 primary care services to a low-income pool recipient, except as
6018 provided under subsection (3). However, a judgment may be
6019 claimed and rendered in excess of the amounts set forth in this
6020 subsection. That portion of the judgment that exceeds these
6021 amounts may be reported to the Legislature, but may be paid in
6022 part or in whole by the state only by further act of the
6023 Legislature.
6024 (3) A provider may be liable for an amount in excess of
6025 $200,000 per claimant or $300,000 per occurrence only if the
6026 claimant pleads and proves, by clear and convincing evidence,
6027 that the provider acted in a wrongful manner. If the claimant so
6028 pleads, the court, after a reasonable opportunity for discovery,
6029 shall conduct a hearing before trial to determine if there is a
6030 reasonable basis in evidence to conclude that the provider acted
6031 in a wrongful manner. A claim for wrongful conduct is not
6032 permitted, to the extent it exceeds the amounts set forth in

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6033 subsection (2), unless the claimant makes the showing required
6034 by this subsection.
6035 (4) In order for this section to apply, the provider must:
6036 (a) Develop, implement, and maintain policies and
6037 procedures to:
6038 1. Ensure that funds described in subsection (1) are used
6039 exclusively to serve low-income persons who are uninsured or
6040 underinsured;
6041 2. Determine whether funds described in subsection (1) are
6042 being used to provide primary care services to a particular
6043 person; and
6044 3. Identify whether an individual receiving primary care
6045 services is a low-income pool recipient to whom the provisions
6046 of this section apply.
6047 (b) Furnish a low-income pool recipient with written notice
6048 of the provisions of this section before providing primary care
6049 services to the recipient.
6050 (c) Be in compliance with the terms of any agreement
6051 between the provider and the Agency for Health Care
6052 Administration governing the receipt of the funds described in
6053 subsection (1).
6054 (5) This section does not limit or exclude the application
6055 of any law, including s. 766.118, which places limitations upon
6056 the recovery of civil damages.
6057 (6) This section does not apply to any claim for damages to
6058 which s. 768.28 applies.
6059 Section 82. Subsection (5) is added to section 766.203,
6060 Florida Statutes, to read:
6061 766.203 Presuit investigation of medical negligence claims

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6062 and defenses by prospective parties.—
6063 (5) STANDARDS OF CARE.—If the cause of action that is the
6064 basis for the litigation requires the plaintiff to establish the
6065 breach of a standard of care other than negligence in order to
6066 impose liability or secure specified damages arising out of the
6067 rendering of, or the failure to render, medical care or
6068 services, and the plaintiff intends to pursue such liability or
6069 damages, the presuit investigations required of the claimant and
6070 the prospective defendant by this section must ascertain that
6071 there are reasonable grounds to believe that the requirement is
6072 satisfied.
6073 Section 83. Paragraph (b) of subsection (9) of section
6074 768.28, Florida Statutes, is amended, and paragraphs (f) and (g)
6075 are added to subsection (10) of that section, to read:
6076 768.28 Waiver of sovereign immunity in tort actions;
6077 recovery limits; limitation on attorney fees; statute of
6078 limitations; exclusions; indemnification; risk management
6079 programs.—
6080 (9)
6081 (b) As used in this subsection, the term:
6082 1. “Employee” includes any volunteer firefighter.
6083 2. “Officer, employee, or agent” includes, but is not
6084 limited to, any health care provider when providing services
6085 pursuant to s. 766.1115;~~,~~ any member of the Florida Health
6086 Services Corps, as defined in s. 381.0302, who provides
6087 uncompensated care to medically indigent persons referred by the
6088 Department of Health; any nonprofit independent college or
6089 university located and chartered in this state which owns or
6090 operates an accredited medical school, and its employees or

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6091 agents, when providing patient services pursuant to paragraph
6092 (10)(f);~~,~~ and any public defender or her or his employee or
6093 agent, including, among others, an assistant public defender and
6094 an investigator.
6095 (10)
6096 (f) For purposes of this section, any nonprofit independent
6097 college or university located and chartered in this state which
6098 owns or operates an accredited medical school, or any of its
6099 employees or agents, and which has agreed in an affiliation
6100 agreement or other contract to provide, or to permit its
6101 employees or agents to provide, patient services as agents of a
6102 teaching hospital, is considered an agent of the teaching
6103 hospital while acting within the scope of and pursuant to
6104 guidelines established in the contract. To the extent allowed by
6105 law, the contract must provide for the indemnification of the
6106 state, up to the limits set out in this chapter, by the agent
6107 for any liability incurred which was caused by the negligence of
6108 the college or university or its employees or agents.
6109 1. For purposes of this paragraph, the term:
6110 a. "Employee or agent" means an officer, employee, agent,
6111 or servant of a nonprofit independent college or university
6112 located and chartered in this state which owns or operates an
6113 accredited medical school, including, but not limited to, the
6114 faculty of the medical school, any health care practitioner or
6115 licensee as defined in s. 456.001 for which the college or
6116 university is vicariously liable, and the staff or administrator
6117 of the medical school.
6118 b. "Patient services" mean:
6119 (I) Comprehensive health care services as defined in s.

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6120 641.19, including any related administrative service, provided
6121 to patients in a teaching hospital or in a health care facility
6122 that is a part of a nonprofit independent college or university
6123 located and chartered in this state which owns or operates an
6124 accredited medical school, pursuant to an affiliation agreement
6125 or other contract with a teaching hospital;
6126 (II) Training and supervision of interns, residents, and
6127 fellows providing patient services in a teaching hospital or in
6128 a health care facility that is a part of a nonprofit independent
6129 college or university located and chartered in this state which
6130 owns or operates an accredited medical school, pursuant to an
6131 affiliation agreement or other contract with a teaching
6132 hospital;
6133 (III) Participation in medical research protocols; or
6134 (IV) Training and supervision of medical students in a
6135 teaching hospital or in a health care facility owned by a not-
6136 for-profit college or university that owns or operates an
6137 accredited medical school, pursuant to an affiliation agreement
6138 or other contract with a teaching hospital.
6139 c. “Teaching hospital” means a teaching hospital as defined
6140 in s. 408.07 which is owned or operated by the state, a county
6141 or municipality, a public health trust, a special taxing
6142 district, a governmental entity having health care
6143 responsibilities, or a not-for-profit entity that operates such
6144 facilities as an agent of the state or a political subdivision
6145 of the state under a lease or other contract.
6146 2. The teaching hospital or the medical school, or its
6147 employees or agents, must provide written notice to each
6148 patient, or the patient’s legal representative, receipt of which

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6149 must be acknowledged in writing, that the college or university
6150 that owns or operates the medical school and the employees or
6151 agents of that college or university are acting as agents of the
6152 teaching hospital and that the exclusive remedy for injury or
6153 damage suffered as the result of any act or omission of the
6154 teaching hospital, the college or university that owns or
6155 operates the medical school, or the employees or agents of the
6156 college or university while acting within the scope of duties
6157 pursuant to the affiliation agreement or other contract with a
6158 teaching hospital, is by commencement of an action pursuant to
6159 the provisions of this section.
6160 3. This paragraph does not designate any employee providing
6161 contracted patient services in a teaching hospital as an
6162 employee or agent of the state for purposes of chapter 440.
6163 (g) Providers or vendors, 75 percent of whose client
6164 population consists of individuals with a developmental
6165 disability as defined in ss. 393.063 and 400.960, individuals
6166 who are blind or severely handicapped individuals as defined in
6167 s. 413.033, individuals who have a mental illness as defined
6168 under s. 394.455, or individuals who have any combination of
6169 these conditions, which have contractually agreed to act on
6170 behalf of the Agency for Persons with Disabilities, the Agency
6171 for Health Care Administration, the Division of Blind Services
6172 in the Department of Education, or the Mental Health Program
6173 Office of the Department of Children and Family Services to
6174 provide services to such individuals, and their employees or
6175 agents, are considered agents of the state, solely with respect
6176 to the provision of such services while acting within the scope
6177 of and pursuant to guidelines established by contract, a

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6178 Medicaid waiver agreement, or rule. The contracts for such
6179 services must provide for the indemnification of the state by
6180 the agent for any liabilities incurred up to the limits
6181 specified in this section.
6182 Section 84. Legislative findings and intent.—
6183 (1) The Legislature finds that:
6184 (a) Access to high-quality, comprehensive, and affordable
6185 health care for all persons in this state is a necessary state
6186 goal and that teaching hospitals play an intrinsic and essential
6187 role in providing that access.
6188 (b) Graduate medical education, provided by nonprofit
6189 independent colleges and universities located and chartered in
6190 this state which own or operate medical schools, helps provide
6191 the comprehensive specialty training needed by medical school
6192 graduates to develop and refine the skills essential to the
6193 provision of high-quality health care for our state residents.
6194 Much of that education and training is provided in teaching
6195 hospitals under the direct supervision of medical faculty who
6196 provide guidance, training, and oversight, and serve as role
6197 models to their students.
6198 (c) A large proportion of medical care is provided in
6199 teaching hospitals that serve as safety nets for many indigent
6200 and underserved patients who otherwise might not receive the
6201 medical help they need. Resident physician training that takes
6202 place in such hospitals provides much of the care provided to
6203 this population. Medical faculty, supervising such training and
6204 care, are a vital link between educating and training resident
6205 physicians and ensuring the provision of quality care for
6206 indigent and underserved residents. Physicians that assume this

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6207 role are often called upon to juggle the demands of patient
6208 care, teaching, research, health policy, and budgetary issues
6209 related to the programs they administer.
6210 (d) While teaching hospitals are afforded sovereign
6211 immunity protections under s. 768.28, Florida Statutes, the
6212 nonprofit independent colleges and universities located and
6213 chartered in this state which own or operate medical schools and
6214 which enter into affiliation agreements or contracts with the
6215 teaching hospitals to provide patient services are not afforded
6216 such sovereign immunity protections.
6217 (e) The employees or agents of nonprofit independent
6218 colleges and universities located and chartered in this state
6219 which enter into affiliation agreements or contracts with
6220 teaching hospitals to provide patient services do not have the
6221 same level of protection against liability claims as teaching
6222 hospitals and their employees and agents that provide the same
6223 patient services to the same patients. Thus, these colleges and
6224 universities and their employees and agents are
6225 disproportionately affected by claims arising out of alleged
6226 medical malpractice and other allegedly negligent acts. Given
6227 the recent growth in medical schools and medical education
6228 programs and ongoing efforts to support, strengthen, and
6229 increase physician residency training positions and medical
6230 faculty in both existing and newly designated teaching
6231 hospitals, this exposure and the consequent disparity in
6232 liability exposure will continue to increase. The vulnerability
6233 of these colleges and universities to claims of medical
6234 malpractice will only add to the current physician workforce
6235 crisis in Florida and can be alleviated only through legislative

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6236 action.
6237 (f) Ensuring that the employees and agents of nonprofit
6238 independent colleges and universities located and chartered in
6239 this state which own or operated medical schools are able to
6240 continue to treat patients, provide graduate medical education,
6241 supervise medical students, engage in research, and provide
6242 administrative support and services in teaching hospitals is an
6243 overwhelming public necessity.
6244 (2) The Legislature intends that:
6245 (a) Employees and agents of nonprofit independent colleges
6246 and universities located and chartered in this state which own
6247 or operate medical schools, who provide patient services as
6248 agents of a teaching hospital be immune from lawsuits in the
6249 same manner and to the same extent as employees and agents of
6250 teaching hospitals in this state under existing law, and that
6251 such colleges and universities and their employees and agents
6252 not be held personally liable in tort or named as a party
6253 defendant in an action while providing patient services in a
6254 teaching hospital, unless such services are provided in bad
6255 faith, with malicious purpose, or in a manner exhibiting wanton
6256 and willful disregard of human rights, safety, or property.
6257 (b) Nonprofit independent private colleges and universities
6258 located and chartered in this state which own or operate medical
6259 schools and which permit their employees or agents to provide
6260 patient services in teaching hospitals pursuant to an
6261 affiliation agreement or other contract, be afforded sovereign
6262 immunity protections under s. 768.28, Florida Statutes.
6263 (3) The Legislature declares that there is an overwhelming
6264 public necessity for extending the state’s sovereign immunity to

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6265 nonprofit independent colleges and universities located and
6266 chartered in this state which own or operate medical schools and
6267 provide patient services in teaching hospitals, and to their
6268 employees and agents, and that there is no alternative method of
6269 meeting such public necessity.
6270 (4) The terms "employee or agent," "patient services," and
6271 "teaching hospital" used in this section have the same meaning
6272 as the terms defined in s. 768.28, Florida Statutes, as amended
6273 by this act.
6274 Section 85. Section 1004.41, Florida Statutes, is amended
6275 to read:
6276 1004.41 University of Florida; J. Hillis Miller Health
6277 Center.—
6278 (1) There is established the J. Hillis Miller Health Center
6279 at the University of Florida, including campuses at Gainesville
6280 and Jacksonville and affiliated teaching hospitals, which shall
6281 include the following colleges:
6282 (a) College of Dentistry.
6283 (b) College of Public Health and Health Professions.
6284 (c) College of Medicine.
6285 (d) College of Nursing.
6286 (e) College of Pharmacy.
6287 (f) College of Veterinary Medicine and related teaching
6288 hospitals.
6289 (2) Each college of the health center shall be ~~so~~
6290 maintained and operated so as to comply with the standards
6291 approved by a nationally recognized association for
6292 accreditation.
6293 (3)(a) The University of Florida Health Center Operations

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6294 and Maintenance Trust Fund shall be administered by the
6295 University of Florida Board of Trustees. Funds shall be credited
6296 to the trust fund from the sale of goods and services performed
6297 by the University of Florida Veterinary Medicine Teaching
6298 Hospital. The purpose of the trust fund is to support the
6299 instruction, research, and service missions of the University of
6300 Florida College of Veterinary Medicine.
6301 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and
6302 pursuant to s. 216.351, any balance in the trust fund at the end
6303 of any fiscal year shall remain in the trust fund and ~~shall~~ be
6304 available for carrying out the purposes of the trust fund.
6305 (4)(a) The University of Florida Board of Trustees shall
6306 lease the hospital facilities of the health center known as the
6307 Shands Teaching Hospital and Clinics on the Gainesville campus
6308 of the University of Florida and all furnishings, equipment, and
6309 other chattels or choses in action used in the operation of the
6310 hospital, to Shands Teaching Hospital and Clinics, Inc., a
6311 private not-for-profit corporation organized ~~solely~~ for the
6312 primary purpose of supporting ~~operating~~ the University of
6313 Florida Board of Trustees' health affairs mission of community
6314 service and patient care, education and training of health
6315 professionals, and clinical research. In furtherance of that
6316 purpose, Shands Teaching Hospital and Clinics, Inc., shall
6317 operate the hospital and ancillary health care facilities as
6318 deemed ~~of the health center and other health care facilities and~~
6319 ~~programs determined to be~~ necessary by the board of Shands
6320 Teaching Hospital and Clinics, Inc. ~~the nonprofit corporation.~~
6321 The rental for the hospital facilities shall be an amount equal
6322 to the debt service on bonds or revenue certificates issued

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6323 solely for capital improvements to the hospital facilities or as
6324 otherwise provided by law.
6325 (b) The University of Florida Board of Trustees shall
6326 provide in the lease or by separate contract or agreement with
6327 Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6328 ~~corporation~~ for the following:
6329 1. Approval of the articles of incorporation of Shands
6330 Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6331 ~~corporation~~ by the University of Florida Board of Trustees and
6332 the governance of that ~~the~~ not-for-profit corporation by a board
6333 of directors appointed, subject to removal, and chaired by the
6334 President of the University of Florida, or his or her designee,
6335 and vice chaired by the Vice President for Health Affairs of the
6336 University of Florida, or his or her designee.
6337 2. The use of hospital facilities and personnel in support
6338 of community service and patient care, ~~the~~ research programs,
6339 and ~~of the~~ teaching roles ~~role~~ of the health center.
6340 3. The continued recognition of the collective bargaining
6341 units and collective bargaining agreements as currently composed
6342 and recognition of the certified labor organizations
6343 representing those units and agreements.
6344 4. The use of hospital facilities and personnel in
6345 connection with research programs conducted by the health
6346 center.
6347 5. Reimbursement to the hospital for indigent patients,
6348 state-mandated programs, underfunded state programs, and costs
6349 to the hospital for support of the teaching and research
6350 programs of the health center. Such reimbursement shall be
6351 appropriated to either the health center or the hospital each

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6352 year by the Legislature after review and approval of the request
6353 for funds.
6354 (c) The University of Florida Board of Trustees may, with
6355 the approval of the Legislature, increase the hospital
6356 facilities or remodel or renovate them, provided that the rental
6357 paid by the hospital for such new, remodeled, or renovated
6358 facilities is sufficient to amortize the costs thereof over a
6359 reasonable period of time or fund the debt service for any bonds
6360 or revenue certificates issued to finance such improvements.
6361 (d) The University of Florida Board of Trustees is
6362 authorized to provide to Shands Teaching Hospital and Clinics,
6363 Inc., ~~the not-for-profit corporation leasing the hospital~~
6364 ~~facilities~~ and its not-for-profit subsidiaries and affiliates
6365 comprehensive general liability insurance including professional
6366 liability from a self-insurance trust program established
6367 pursuant to s. 1004.24.
6368 (e) Shands Teaching Hospital and Clinics, Inc., may, in
6369 support of the health affairs mission of the University of
6370 Florida Board of Trustees and with its prior approval, create
6371 for-profit or not-for-profit corporate subsidiaries and
6372 affiliates, or both. The University of Florida Board of
6373 Trustees, which may act through the President of the University
6374 of Florida or his or her designee, has the right to control
6375 Shands Teaching Hospital and Clinics, Inc. Shands Teaching
6376 Hospital and Clinics, Inc., and any not-for-profit subsidiaries
6377 are conclusively deemed corporations primarily acting as
6378 instrumentalities of the state, pursuant to s. 768.28(2), for
6379 purposes of sovereign immunity.
6380 (f) ~~(e)~~ If ~~In the event that~~ the lease of the hospital

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6381 facilities to Shands Teaching Hospital and Clinics, Inc., ~~the~~
6382 ~~not-for-profit corporation~~ is terminated for any reason, the
6383 University of Florida Board of Trustees shall resume management
6384 and operation of the hospital facilities. In such event, the
6385 University of Florida Board of Trustees is authorized to utilize
6386 revenues generated from the operation of the hospital facilities
6387 to pay the costs and expenses of operating the hospital facility
6388 for the remainder of the fiscal year in which such termination
6389 occurs.
6390 (5) ~~(f)~~ Shands Jacksonville Medical Center, Inc., and its
6391 parent Shands Jacksonville Healthcare, Inc., are private not-
6392 for-profit corporations organized primarily to support the
6393 health affairs mission of the University of Florida Board of
6394 Trustees in community service and patient care, education and
6395 training of health affairs professionals, and clinical research.
6396 Shands Jacksonville Medical Center, Inc., is a teaching hospital
6397 affiliated with the University of Florida Board of Trustees,
6398 located on the Jacksonville Campus of the University of Florida.
6399 Shands Jacksonville Medical Center, Inc., and Shands
6400 Jacksonville Healthcare, Inc., may, in support of the health
6401 affairs mission of the University of Florida Board of Trustees
6402 and with its prior approval, create for-profit or not-for-profit
6403 corporate subsidiaries and affiliates, or both.
6404 (a) The University of Florida Board of Trustees, which may
6405 act through the President of the University of Florida or his or
6406 her designee, has the right to control Shands Jacksonville
6407 Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.
6408 Shands Jacksonville Medical Center, Inc., Shands Jacksonville
6409 Healthcare, Inc., and any not-for-profit subsidiary of Shands

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6410 Jacksonville Medical Center, Inc., are conclusively deemed
6411 corporations primarily acting as instrumentalities of the state,
6412 pursuant to s. 768.28(2), for purposes of sovereign immunity.
6413 (b) The University of Florida Board of Trustees is
6414 authorized to provide to Shands Jacksonville Healthcare, Inc.,
6415 and its not-for-profit subsidiaries and affiliates and any
6416 successor corporation that acts in support of the board of
6417 trustees, comprehensive general liability coverage, including
6418 professional liability, from the self-insurance programs
6419 established pursuant to s. 1004.24.
6420 Section 86. Sections 409.9121, 409.919, and 624.915,
6421 Florida Statutes, are repealed.
6422 Section 87. Section 409.942, Florida Statutes, is
6423 transferred and renumbered as section 414.29, Florida Statutes.
6424 Section 88. Paragraph (a) of subsection (1) of section
6425 443.111, Florida Statutes, is amended to read:
6426 443.111 Payment of benefits.—
6427 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
6428 in accordance with rules adopted by the Agency for Workforce
6429 Innovation, subject to the following requirements:
6430 (a) Benefits are payable by mail or electronically.
6431 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a
6432 system for the payment of benefits by electronic funds transfer,
6433 including, but not limited to, debit cards, electronic payment
6434 cards, or any other means of electronic payment that the agency
6435 deems to be commercially viable or cost-effective. Commodities
6436 or services related to the development of such a system shall be
6437 procured by competitive solicitation, unless they are purchased
6438 from a state term contract pursuant to s. 287.056. The agency

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6439 shall adopt rules necessary to administer the system.
6440 Section 89. Sections 409.944, 409.945, and 409.946, Florida
6441 Statutes, are transferred and renumbered as sections 163.464,
6442 163.465, and 163.466, Florida Statutes, respectively.
6443 Section 90. Sections 409.953 and 409.9531, Florida
6444 Statutes, are transferred and renumbered as sections 402.81 and
6445 402.82, Florida Statutes, respectively.
6446 Section 91. The Agency for Health Care Administration shall
6447 submit a reorganizational plan to the Governor, the Speaker of
6448 the House of Representatives, and the President of the Senate by
6449 January 1, 2012, which converts the agency from a check-writing
6450 and fraud-chasing agency into a contract compliance and
6451 monitoring agency.
6452 Section 92. Effective December 1, 2011, if the Legislature
6453 has not received a letter from the Governor stating that the
6454 federal Centers for Medicare and Medicaid has approved the
6455 waivers necessary to implement the Medicaid managed care reforms
6456 contained in this act, the State of Florida shall withdraw from
6457 the Medicaid program effective December 31, 2011.
6458 Section 93. If any provision of this act or its application
6459 to any person or circumstance is held invalid, the invalidity
6460 does not affect other provisions or applications of the act
6461 which can be given effect without the invalid provision or
6462 application, and to this end the provisions of this act are
6463 severable.
6464 Section 94. This act shall take effect upon becoming a law.

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