By the Committees on Budget; Budget Subcommittee on Health and Human Services Appropriations; and Health Regulation; and Senators Negron, Gaetz, Garcia, and Hays

576-04635-11 20111972c3

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.; providing for alternatives to the statewide
106 inpatient psychiatric program; requiring Medicaid-
107 eligible children who have open child welfare cases
108 and who reside in AHCA area 10 to be enrolled in
109 specified capitated managed care plans; expanding the
110 number of children eligible to receive behavioral
111 health care services through a specialty prepaid plan;
112 repealing provisions relating to a provider lock-in
113 program; eliminating obsolete provisions and updating
114 provisions; conforming cross-references; amending s.
115 409.915, F.S.; conforming provisions to changes made
116 by the act; transferring, renumbering, and amending s.

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117 409.9301, F.S.; conforming provisions to changes made
118 by the act; amending s. 409.9126, F.S.; conforming a
119 cross-reference; providing a directive to the Division
120 of Statutory Revision; creating s. 409.961, F.S.;
121 providing for statutory construction of provisions
122 relating to Medicaid managed care; creating s.
123 409.962, F.S.; providing definitions; creating s.
124 409.963, F.S.; establishing the Medicaid managed care
125 program as the statewide, integrated managed care
126 program for medical assistance and long-term care
127 services; directing the agency to apply for and
128 implement waivers; providing for public notice and
129 comment; providing for a limited managed care program
130 if waivers are not approved; creating s. 409.964,
131 F.S.; requiring all Medicaid recipients to be enrolled
132 in Medicaid managed care; providing exemptions;
133 prohibiting a recipient who has access to employer-
134 sponsored health care from enrolling in Medicaid
135 managed care; requiring the agency to develop a
136 process to allow the Medicaid premium that would have
137 been received to be used to pay employer premiums;
138 requiring that the agency allow opt-out opportunities
139 for certain recipients; providing for voluntary
140 enrollment; creating s. 409.965, F.S.; providing
141 requirements for qualified plans that provide services
142 in the Medicaid managed care program; requiring the
143 agency to issue an invitation to negotiate; requiring
144 the agency to compile and publish certain information;
145 establishing regions for separate procurement of

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

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

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204 to ensure the availability of certain types of
205 payments to specified providers; requiring the
206 development of rate cells; requiring that the amount
207 paid to the plans for supplemental payments or
208 enhanced rates be reconciled to the amount required to
209 pay providers; requiring that plans make certain
210 payments to providers within a certain time; requiring
211 the agency to develop a methodology and request a
212 state plan amendment to ensure the availability of
213 certified public expenditures in the Medicaid managed
214 care program to support certain noninstitutional
215 teaching faculty providers; creating s. 409.969, F.S.;
216 authorizing Medicaid recipients to select any plan
217 within a region; providing for automatic enrollment of
218 recipients by the agency in specified circumstances;
219 providing criteria for automatic enrollment;
220 authorizing disenrollment under certain circumstances;
221 providing for a grievance process; defining the term
222 “good cause” for purposes of disenrollment; requiring
223 recipients to stay in plans for a specified time;
224 providing for reenrollment of recipients who move out
225 of a region; creating s. 409.970, F.S.; requiring the
226 agency to maintain an encounter data system; providing
227 requirements for prepaid plans to submit data in a
228 certain format; requiring the agency to analyze the
229 data; requiring the agency to test the data for
230 certain purposes by a certain date; creating s.
231 409.971, F.S.; providing for managed care medical
232 assistance; providing deadlines for beginning and

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233 finalizing implementation; creating s. 409.972, F.S.;
234 establishing minimum services for the managed medical
235 assistance; providing for optional services;
236 authorizing plans to customize benefit packages;
237 requiring the agency to provide certain services to
238 hemophiliacs; creating s. 409.973, F.S.; providing for
239 managed long-term care; providing deadlines for
240 beginning and finalizing implementation; providing
241 duties for the Department of Elderly Affairs relating
242 to the program; creating s. 409.974, F.S.; providing
243 recipient eligibility requirements for managed long-
244 term care; listing programs for which certain
245 recipients are eligible; specifying that an
246 entitlement to home and community-based services is
247 not created; creating s. 409.975, F.S.; establishing
248 minimum services for managed long-term care; creating
249 s. 409.976, F.S.; providing criteria for the selection
250 of plans to provide managed long-term care; creating
251 s. 409.977, F.S.; providing for managed long-term care
252 plan accountability; requiring the agency to establish
253 standards for specified providers; creating s.
254 409.978, F.S.; requiring that the agency operate the
255 Comprehensive Assessment and Review for Long-Term Care
256 Services program through an interagency agreement with
257 the Department of Elderly Affairs; providing duties of
258 the program; requiring the program to assign plan
259 enrollees to a level of care; providing for the
260 evaluation of dually eligible nursing home residents;
261 creating s. 409.980, F.S.; providing minimum

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262 requirements for prescription drug benefits provided
263 by a qualified plan; transferring, renumbering, and
264 amending ss. 409.91207, 409.91211, and 409.9122, F.S.;
265 conforming provisions to changes made by the act;
266 updating provisions and deleting obsolete provisions;
267 transferring and renumbering ss. 409.9123 and
268 409.9124, F.S.; amending s. 430.04, F.S.; eliminating
269 outdated provisions; requiring the Department of
270 Elderly Affairs to develop a transition plan for
271 specified elders and disabled adults receiving long-
272 term care Medicaid services if qualified plans become
273 available; amending s. 430.2053, F.S.; eliminating
274 outdated provisions; providing additional duties of
275 aging resource centers; providing an additional
276 exception to direct services that may not be provided
277 by an aging resource center; providing for the
278 cessation of specified payments by the department as
279 qualified plans become available; eliminating
280 provisions requiring reports; amending s. 641.316,
281 F.S.; redefining the term “fiscal intermediary
282 services organization” to include certain qualified
283 plans that contract with health care professionals for
284 fiscal intermediary services; amending s. 39.407,
285 F.S.; requiring a motion by the Department of Children
286 and Family Services to provide psychotropic medication
287 to a child 10 years of age or younger to include a
288 review by a child psychiatrist; providing that a court
289 may not authorize the administration of such
290 medication absent a finding of compelling state

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291 interest based on the review; amending s. 216.262,
292 F.S.; providing that limitations on an agency's total
293 number of positions does not apply to certain
294 positions in the Department of Health; amending s.
295 381.06014, F.S.; redefining the term "blood
296 establishment" and defining the term "volunteer
297 donor"; requiring that blood establishments disclose
298 specified information on their Internet website;
299 providing an exception for certain hospitals;
300 authorizing the Department of Legal Affairs to assess
301 a civil penalty against a blood establishment that
302 fails to disclose the information; providing that the
303 civil penalty accrues to the state and requiring that
304 it be deposited into the General Revenue Fund;
305 prohibiting local governments from restricting access
306 to public facilities or infrastructure for certain
307 activities based on whether a blood establishment is
308 operating as a for-profit or not-for-profit
309 organization; prohibiting a blood establishment from
310 considering whether certain customers are operating as
311 for-profit or not-for-profit organizations when
312 determining service fees for blood or blood
313 components; amending s. 395.4025, F.S.; providing
314 additional time extensions to hospital applicants
315 seeking to become trauma centers under certain
316 circumstances; amending s. 400.023, F.S.; requiring
317 the trial judge to conduct an evidentiary hearing to
318 determine the sufficiency of evidence for claims
319 against certain persons relating to a nursing home;

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320 limiting noneconomic damages in a wrongful death
321 action against the nursing home; amending s. 400.0237,
322 F.S.; revising provisions relating to punitive damages
323 against a nursing home; authorizing a defendant to
324 proffer admissible evidence to refute a claimant's
325 proffer of evidence for punitive damages; requiring
326 the trial judge to conduct an evidentiary hearing and
327 the plaintiff to demonstrate that a reasonable basis
328 exists for the recovery of punitive damages;
329 prohibiting discovery of the defendant's financial
330 worth until the judge approves the pleading on
331 punitive damages; revising definitions; amending s.
332 408.7057, F.S.; requiring that the dispute resolution
333 program include a hearing in specified circumstances;
334 providing that the dispute resolution program
335 established to resolve claims disputes between
336 providers and health plans does not provide an
337 independent right of recovery; requiring that the
338 conclusions of law in the written recommendation of
339 the resolution organization identify certain
340 information; amending s. 465.014, F.S.; providing that
341 certain practitioners or anyone under the direct
342 supervision of such practitioner may dispense drugs
343 without being licensed as a medical technician;
344 amending s. 456.0635, F.S.; revising the grounds under
345 which the Department of Health or corresponding board
346 is required to refuse to admit a candidate to an
347 examination and to refuse to issue or renew a license,
348 certificate, or registration of a health care

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349 practitioner; providing an exception; amending s.
350 456.036, F.S.; requiring a delinquent licensee whose
351 license becomes delinquent before the final resolution
352 of a case regarding Medicaid fraud to affirmatively
353 apply by submitting a complete application for active
354 or inactive status during the licensure cycle in which
355 the case achieves final resolution by order of the
356 court; providing that failure by a delinquent licensee
357 to become active or inactive before the expiration of
358 that licensure cycle renders the license null;
359 requiring that any subsequent licensure be as a result
360 of applying for and meeting all requirements imposed
361 on an applicant for new licensure; creating ss.
362 458.3167 and 459.0078, F.S.; providing for an expert
363 witness certificate for allopathic and osteopathic
364 physicians licensed in other states or Canada which
365 authorizes such physicians to provide expert medical
366 opinions in this state; providing application
367 requirements and timeframes for approval or denial by
368 the Board of Medicine and Board of Osteopathic
369 Medicine, respectively; requiring the boards to adopt
370 rules and set fees; providing for expiration of a
371 certificate; amending ss. 458.331 and 459.015, F.S.;
372 providing grounds for disciplinary action for
373 providing misleading, deceptive, or fraudulent expert
374 witness testimony relating to the practice of medicine
375 and of osteopathic medicine, respectively; providing
376 for construction with respect to the doctrine of
377 incorporation by reference; amending s. 499.003, F.S.;

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378 redefining the term “health care entity” to clarify
379 that a blood establishment is a health care entity
380 that may engage in certain activities; amending s.
381 499.005, F.S.; clarifying provisions that prohibit the
382 unauthorized wholesale distribution of a prescription
383 drug that was purchased by a hospital or other health
384 care entity or donated or supplied at a reduced price
385 to a charitable organization, to conform to changes
386 made by the act; amending s. 499.01, F.S.; exempting
387 certain blood establishments from the requirements to
388 be permitted as a prescription drug manufacturer and
389 register products; requiring that certain blood
390 establishments obtain a restricted prescription drug
391 distributor permit under specified conditions;
392 limiting the prescription drugs that a blood
393 establishment may distribute under a restricted
394 prescription drug distributor permit; authorizing the
395 Department of Health to adopt rules regarding the
396 distribution of prescription drugs by blood
397 establishments; amending s. 626.9541, F.S.;
398 authorizing insurers to offer rewards or incentives to
399 health benefit plan members to encourage or reward
400 participation in wellness or health improvement
401 programs; authorizing insurers to require plan members
402 not participating in programs to provide verification
403 that their medical condition warrants
404 nonparticipation; providing application; amending s.
405 627.4147, F.S.; deleting a requirement that a medical
406 malpractice insurance contract include a clause

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407 authorizing an insurer to admit liability and make a
408 settlement offer if the offer is within policy limits
409 without the insured's permission; amending s. 641.19,
410 F.S.; defining the term "provider service network";
411 creating s. 641.2019, F.S.; providing that a provider
412 service network that meets the requirements of ch.
413 641, F.S., may obtain a certificate of authority under
414 that chapter; amending s. 641.47, F.S.; redefining the
415 term "organization" to include a provider service
416 network; amending s. 641.49, F.S.; providing that a
417 provider service network may apply for a health care
418 provider certificate; amending s. 430.705, F.S.;
419 conforming a cross-reference; amending s. 766.102,
420 F.S.; providing that a physician who is an expert
421 witness in a medical malpractice presuit action must
422 meet certain requirements; amending s. 766.104, F.S.;
423 requiring a good faith demonstration in a medical
424 malpractice case that there has been a breach of the
425 standard of care; amending s. 766.106, F.S.;
426 clarifying that a physician acting as an expert
427 witness is subject to disciplinary actions; amending
428 s. 766.1115, F.S.; conforming provisions to changes
429 made by the act; creating s. 766.1183, F.S.; defining
430 terms; providing for the recovery of civil damages by
431 Medicaid recipients according to a modified standard
432 of care; providing for recovery of certain excess
433 judgments by act of the Legislature; requiring the
434 Department of Children and Family Services to provide
435 notice to program applicants; creating s. 766.1184,

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436 F.S.; defining terms; providing for the recovery of
437 civil damages by certain recipients of primary care
438 services at primary care clinics receiving specified
439 low-income pool funds according to a modified standard
440 of care; providing for recovery of certain excess
441 judgments by act of the Legislature; providing
442 requirements of health care providers receiving such
443 funds in order for the liability provisions to apply;
444 requiring notice to low-income pool recipients;
445 amending s. 766.202, F.S.; redefining the term "health
446 care provider" to include persons licensed to provide
447 orthotics, prosthetics, and pedorthics; amending s.
448 766.203, F.S.; requiring the presuit investigations
449 conducted by the claimant and the prospective
450 defendant in a medical malpractice action to provide
451 grounds for a breach of the standard of care; amending
452 s. 768.28, F.S.; revising a definition; providing that
453 certain colleges and universities that own or operate
454 an accredited medical school and their employees and
455 agents providing patient services in a teaching
456 hospital pursuant to an affiliation agreement or
457 contract with the teaching hospital are considered
458 agents of the hospital for the purposes of sovereign
459 immunity; providing definitions; requiring patients of
460 such hospitals to be provided with notice of their
461 remedies under sovereign immunity; providing an
462 exception; providing that providers and vendors
463 providing services to certain persons with
464 disabilities on behalf of the state are agents of the

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465 state for the purposes of sovereign immunity;
466 providing legislative findings and intent with respect
467 to including certain colleges and universities and
468 their employees and agents under sovereign immunity;
469 providing a statement of public necessity; amending s.
470 1004.41, F.S.; correcting the name of one of the
471 health center's colleges; specifying that the
472 University of Florida Board of Trustees shall lease
473 Shands Teaching Hospital and Clinics on the
474 Gainesville campus to Shands Teaching Hospital and
475 Clinics, Inc.; specifying the primary purpose of
476 Shands Teaching Hospital and Clinics, Inc.; providing
477 requirements for the lease, contract, or agreement
478 between the University of Florida Board of Trustees
479 and Shands Teaching Hospital and Clinics, Inc.;
480 authorizing the creation of corporate subsidiaries and
481 affiliates; providing the right of control; providing
482 for sovereign immunity; providing that Shands
483 Jacksonville Medical Center, Inc., and its parent,
484 Shands Jacksonville HealthCare, Inc., are private not-
485 for-profit corporations organized primarily to support
486 the health affairs mission of the University of
487 Florida Board of Trustees; authorizing the creation of
488 corporate subsidiaries and affiliates; providing
489 requirements for the lease, contract, or agreement
490 between the University of Florida Board of Trustees
491 and the corporations; providing the right of control;
492 providing for sovereign immunity; repealing s.
493 409.9121, F.S., relating to legislative intent

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494 concerning managed care; repealing s. 409.919, F.S.,
495 relating to rule authority; repealing s. 624.915,
496 F.S., relating to the Florida Healthy Kids Corporation
497 operating fund; renumbering and transferring ss.
498 409.942, 409.944, 409.945, 409.946, 409.953, and
499 409.9531, F.S., as ss. 414.29, 163.464, 163.465,
500 163.466, 402.81, and 402.82, F.S., respectively;
501 amending s. 443.111, F.S.; conforming a cross-
502 reference; directing the Agency for Health Care
503 Administration to submit a reorganization plan to the
504 Legislature; providing for the state's withdrawal from
505 the Medicaid program under certain circumstances;
506 providing for severability; providing an effective
507 date.
508
509 Be It Enacted by the Legislature of the State of Florida:
510
511 Section 1. Paragraph (c) of subsection (2) of section
512 163.387, Florida Statutes, is amended to read:
513 163.387 Redevelopment trust fund.—
514 (2)
515 (c) The following public bodies or taxing authorities are
516 exempt from paragraph (a):
517 1. A special district that levies ad valorem taxes on
518 taxable real property in more than one county.
519 2. A special district for which the sole available source
520 of revenue the district has the authority to levy is ad valorem
521 taxes at the time an ordinance is adopted under this section.
522 However, revenues or aid that may be dispensed or appropriated

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523 to a district as defined in s. 388.011 at the discretion of an
524 entity other than such district shall not be deemed available.
525 3. A library district, except a library district in a
526 jurisdiction where the community redevelopment agency had
527 validated bonds as of April 30, 1984.
528 4. A neighborhood improvement district created under the
529 Safe Neighborhoods Act.
530 5. A metropolitan transportation authority.
531 6. A water management district created under s. 373.069.
532 7. A hospital district that is a special district as
533 defined in s. 189.403, a county hospital that has taxing
534 authority under chapter 155, or a public health trust
535 established pursuant to s. 154.07.
536 Section 2. Section 200.186, Florida Statutes, is created to
537 read:
538 200.186 Hospital districts.—Notwithstanding any special act
539 or other law governing the expenditure of ad valorem revenues,
540 ad valorem revenues raised pursuant to a special act
541 establishing a hospital district, by a county hospital pursuant
542 to chapter 155, or a public health trust established pursuant to
543 s. 154.07, and disbursed by the district, county hospital, or
544 trust to municipalities or other organizations, may be used only
545 to pay for health care services.
546 Section 3. Present subsections (7) and (8) of section
547 393.0661, Florida Statutes, are redesignated as subsections (8)
548 and (9), respectively, a new subsection (7) is added to that
549 section, and present subsection (7) of that section is amended,
550 to read:
551 393.0661 Home and community-based services delivery system;

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552 comprehensive redesign.—The Legislature finds that the home and
553 community-based services delivery system for persons with
554 developmental disabilities and the availability of appropriated
555 funds are two of the critical elements in making services
556 available. Therefore, it is the intent of the Legislature that
557 the Agency for Persons with Disabilities shall develop and
558 implement a comprehensive redesign of the system.
559 (7) The agency shall impose and collect the fee authorized
560 by s. 409.906(13)(d) upon approval by the Centers for Medicare
561 and Medicaid Services.
562 (8) ~~(7)~~ ~~Nothing in~~ This section or related ~~in any~~
563 ~~administrative~~ rule does not ~~shall be construed to~~ prevent or
564 limit the Agency for Health Care Administration, in consultation
565 with the Agency for Persons with Disabilities, from adjusting
566 fees, reimbursement rates, lengths of stay, number of visits, or
567 number of services, or from limiting enrollment, or making any
568 other adjustment necessary to comply with the availability of
569 moneys and any limitations or directions provided ~~for~~ in the
570 General Appropriations Act or pursuant to s. 409.9022.
571 Section 4. The Division of Statutory Revision is requested
572 to designate ss. 409.016-409.803, Florida Statutes, as part I of
573 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC
574 ASSISTANCE."
575 Section 5. Section 409.016, Florida Statutes, is amended to
576 read:
577 409.016 Definitions.—As used in this part, the term
578 ~~chapter~~:
579 (1) "Department~~,~~" ~~unless otherwise specified,~~ means the
580 Department of Children and Family Services.

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581 (2) "Secretary" means the Secretary of ~~the Department of~~
582 Children and Family Services.
583 (3) "Social and economic services~~,~~" ~~within the meaning of~~
584 ~~this chapter,~~ means the providing of financial assistance as
585 well as preventive and rehabilitative social services for
586 children, adults, and families.
587 Section 6. Section 409.16713, Florida Statutes, is created
588 to read:
589 409.16713 Medical assistance for children in out-of-home
590 care and adopted children.—
591 (1) A child who is eligible under Title IV-E of the Social
592 Security Act, as amended, for subsidized board payments, foster
593 care, or adoption subsidies, and a child for whom the state has
594 assumed temporary or permanent responsibility and who does not
595 qualify for Title IV-E assistance but is in foster care, shelter
596 or emergency shelter care, or subsidized adoption is eligible
597 for medical assistance as provided in s. 409.903(4). This
598 includes a young adult who is eligible to receive services under
599 s. 409.1451(5) until the young adult reaches 21 years of age,
600 and a person who was eligible, as a child, under Title IV-E for
601 foster care or the state-provided foster care and who is a
602 participant in the Road-to-Independence Program.
603 (2) If medical assistance under Title XIX of the Social
604 Security Act, as amended, is not available due to the refusal of
605 the federal Department of Health and Human Services to provide
606 federal funds, a child or young adult described in subsection
607 (1) is eligible for medical services under the Medicaid managed
608 care program established in s. 409.963. Such medical assistance
609 shall be obtained by the community-based care lead agencies

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610 established under s. 409.1671 and is subject to the availability
611 of funds appropriated for such purpose in the General
612 Appropriations Act.
613 (3) It is the intent of the Legislature that the provision
614 of medical assistance meet the requirements of s. 471(a)(21) of
615 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),
616 related to eligibility for Title IV-E of the Social Security
617 Act, and that compliance with such provisions meet the
618 requirements of s. 402(a)(3) of the Social Security Act, as
619 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary
620 Assistance for Needy Families Block Grant Program.
621 Section 7. The Division of Statutory Revision is requested
622 to designate ss. 409.810-409.821, Florida Statutes, as part II
623 of chapter 409, Florida Statutes, entitled "KIDCARE."
624 Section 8. Section 624.91, Florida Statutes, is
625 transferred, renumbered as section 409.8115, Florida Statutes,
626 paragraph (b) of subsection (5) of that section is amended, and
627 subsection (8) is added to that section, to read:
628 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.—
629 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
630 (b) The Florida Healthy Kids Corporation shall:
631 1. Arrange for the collection of any family, local
632 contributions, or employer payment or premium, in an amount to
633 be determined by the board of directors, to provide for payment
634 of premiums for comprehensive insurance coverage and for the
635 actual or estimated administrative expenses.
636 2. Arrange for the collection of any voluntary
637 contributions ~~to provide~~ for payment of ~~Florida~~ Kidcare program
638 premiums for children who are not eligible for medical

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639 assistance under Title XIX or Title XXI of the Social Security
640 Act.
641 3. Subject to ~~the provisions of~~ s. 409.8134, accept
642 voluntary supplemental local match contributions that comply
643 with ~~the requirements of~~ Title XXI of the Social Security Act
644 for the purpose of providing additional ~~Florida~~ Kidcare coverage
645 in contributing counties under Title XXI.
646 4. Establish the administrative and accounting procedures
647 for the operation of the corporation.
648 5. Establish, with consultation from appropriate
649 professional organizations, standards for preventive health
650 services and providers and comprehensive insurance benefits
651 appropriate to children if~~, provided that~~ such standards for
652 rural areas do ~~shall~~ not limit primary care providers to board-
653 certified pediatricians.
654 6. Determine eligibility for children seeking to
655 participate in the Title XXI-funded components of the ~~Florida~~
656 Kidcare program consistent with the requirements specified in s.
657 409.814, as well as the non-Title-XXI-eligible children as
658 provided in subsection (3).
659 7. Establish procedures under which providers of local
660 match to, applicants to, and participants in the program may
661 have grievances reviewed by an impartial body and reported to
662 the board of directors of the corporation.
663 8. Establish participation criteria and, if appropriate,
664 contract with an authorized insurer, health maintenance
665 organization, or third-party administrator to provide
666 administrative services to the corporation.
667 9. Establish enrollment criteria that include penalties or

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668 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage
669 upon voluntary cancellation for nonpayment of family premiums.
670 10. Contract with authorized insurers or providers ~~any~~
671 ~~provider~~ of health care services, who meet ~~meeting~~ standards
672 established by the corporation, for the provision of
673 comprehensive insurance coverage to participants. Such standards
674 must ~~shall~~ include criteria under which the corporation may
675 contract with more than one provider of health care services in
676 program sites. Health plans shall be selected through a
677 competitive bid process. The Florida Healthy Kids Corporation
678 shall purchase goods and services in the most cost-effective
679 manner consistent with the delivery of quality medical care. The
680 maximum administrative cost for a Florida Healthy Kids
681 Corporation contract shall be 10 ~~15~~ percent. For health care
682 contracts, the minimum medical loss ratio for a Florida Healthy
683 Kids Corporation contract shall be 90 ~~85~~ percent. For dental
684 contracts, the remaining compensation to be paid to the
685 authorized insurer or provider must be at least 90 ~~under a~~
686 ~~Florida Healthy Kids Corporation contract shall be no less than~~
687 ~~an amount which is 85~~ percent of the premium, and~~;~~ to the extent
688 any contract provision does not provide for this minimum
689 compensation, this section prevails ~~shall prevail~~. The health
690 plan selection criteria and scoring system, and the scoring
691 results, shall be available upon request for inspection after
692 the bids have been awarded.
693 11. Establish disenrollment criteria if ~~in the event~~ local
694 matching funds are insufficient to cover enrollments.
695 12. Develop and implement a plan to publicize the Florida
696 Kidcare program, the eligibility requirements of the program,

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697 and the procedures for enrollment in the program and to maintain
698 public awareness of the corporation and the program. Such plan
699 must include using the application form for the school lunch and
700 breakfast programs as provided under s. 1006.06(7).
701 13. Secure staff necessary to properly administer the
702 corporation. Staff costs shall be funded from state and local
703 matching funds and such other private or public funds as become
704 available. The board of directors shall determine the number of
705 staff members necessary to administer the corporation.
706 14. In consultation with the partner agencies, provide an
707 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the
708 Governor, the Chief Financial Officer, the Commissioner of
709 Education, the President of the Senate, the Speaker of the House
710 of Representatives, and the Minority Leaders of the Senate and
711 the House of Representatives.
712 15. Provide information on a quarterly basis to the
713 Legislature and the Governor which compares the costs and
714 utilization of the full-pay enrolled population and the Title
715 XXI-subsidized enrolled population in the Florida Kidcare
716 program. ~~The information,~~ At a minimum, the information must
717 include:
718 a. The monthly enrollment and expenditure for full-pay
719 enrollees in the Medikids and Florida Healthy Kids programs
720 compared to the Title XXI-subsidized enrolled population; and
721 b. The costs and utilization by service of the full-pay
722 enrollees in the Medikids and Florida Healthy Kids programs and
723 the Title XXI-subsidized enrolled population.
724
725 By February 1, 2010, the Florida Healthy Kids Corporation shall

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726 provide a study to the Legislature and the Governor on premium
727 impacts to the subsidized portion of the program from the
728 inclusion of the full-pay program, which must ~~shall~~ include
729 recommendations on how to eliminate or mitigate possible impacts
730 to the subsidized premiums.
731 16. Establish benefit packages that conform to ~~the~~
732 ~~provisions of~~ the Florida Kidcare program, as created under this
733 part ~~in ss. 409.810-409.821~~.
734 (8) OPERATING FUND.—The Florida Healthy Kids Corporation
735 may establish and manage an operating fund for the purposes of
736 addressing the corporation's unique cash-flow needs and
737 facilitating the fiscal management of the corporation. At any
738 given time, the corporation may accumulate and maintain in the
739 operating fund a cash balance reserve equal to no more than 25
740 percent of its annualized operating expenses. Upon dissolution
741 of the corporation, any remaining cash balances of state funds
742 shall revert to the General Revenue Fund, or such other state
743 funds consistent with the appropriated funding, as provided by
744 law.
745 Section 9. Subsection (1) of section 409.813, Florida
746 Statutes, is amended to read:
747 409.813 Health benefits coverage; program components;
748 entitlement and nonentitlement.—
749 (1) The Florida Kidcare program includes health benefits
750 coverage provided to children through the following program
751 components, which shall be marketed as the Florida Kidcare
752 program:
753 (a) Medicaid.~~;~~
754 (b) Medikids as created in s. 409.8132.~~;~~

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755 (c) The Florida Healthy Kids Corporation as created in s.
756 409.8115. ~~624.91;~~
757 (d) Employer-sponsored group health insurance plans
758 approved under this part. ~~ss. 409.810-409.821; and~~
759 (e) The Children's Medical Services network ~~established in~~
760 ~~chapter 391~~.
761 Section 10. Subsection (4) of section 409.8132, Florida
762 Statutes, is amended to read:
763 409.8132 Medikids program component.—
764 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
765 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
766 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,
767 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,
768 409.987, 409.988, and 409.989 apply to the administration of the
769 Medikids program component of the Florida Kidcare program,
770 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified
771 by ~~the provisions of~~ subsection (7).
772 Section 11. Subsection (1) of section 409.815, Florida
773 Statutes, is amended to read:
774 409.815 Health benefits coverage; limitations.—
775 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare
776 program, benefits available under Medicaid and Medikids include
777 those goods and services provided under the medical assistance
778 program authorized by Title XIX of the Social Security Act, and
779 regulations thereunder, as administered in this state by the
780 agency. This includes those mandatory Medicaid services
781 authorized under s. 409.905 and optional Medicaid services
782 authorized under s. 409.906, rendered on behalf of eligible
783 individuals by qualified providers, in accordance with federal

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784 requirements ~~for Title XIX~~, subject to any limitations or
785 directions provided ~~for~~ in the General Appropriations Act, ~~or~~
786 chapter 216, or s. 409.9022, and according to methodologies and
787 limitations set forth in agency rules and policy manuals and
788 handbooks incorporated by reference ~~thereto~~.
789 Section 12. Subsection (5) of section 409.818, Florida
790 Statutes, is amended to read:
791 409.818 Administration.—In order to implement ss. 409.810-
792 409.821, the following agencies shall have the following duties:
793 (5) The Florida Healthy Kids Corporation shall retain its
794 functions as authorized in s. 409.8115 ~~624.91~~, including
795 eligibility determination for participation in the Healthy Kids
796 program.
797 Section 13. Paragraph (e) of subsection (2) of section
798 154.503, Florida Statutes, is amended to read:
799 154.503 Primary Care for Children and Families Challenge
800 Grant Program; creation; administration.—
801 (2) The department shall:
802 (e) Coordinate with the primary care program developed
803 pursuant to s. 154.011, the Florida Healthy Kids Corporation
804 program created in s. 409.8115 ~~624.91~~, the school health
805 services program created in ss. 381.0056 and 381.0057, the
806 Healthy Communities, Healthy People Program created in s.
807 381.734, and the volunteer health care provider program
808 established ~~developed~~ pursuant to s. 766.1115.
809 Section 14. Paragraph (c) of subsection (4) of section
810 408.915, Florida Statutes, is amended to read:
811 408.915 Eligibility pilot project.—The Agency for Health
812 Care Administration, in consultation with the steering committee

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813 established in s. 408.916, shall develop and implement a pilot
814 project to integrate the determination of eligibility for health
815 care services with information and referral services.
816 (4) The pilot project shall include eligibility
817 determinations for the following programs:
818 (c) Florida Healthy Kids as described in s. 409.8115 ~~624.91~~
819 and within eligibility guidelines provided in s. 409.814.
820 Section 15. Subsection (7) is added to section 1006.06,
821 Florida Statutes, to read:
822 1006.06 School food service programs.—
823 (7) Each school district shall collaborate with the Florida
824 Kidcare program created pursuant to ss. 409.810-409.821 to:
825 (a) At a minimum:
826 1. Provide application information about the Kidcare
827 program or an application for Kidcare to students at the
828 beginning of each school year.
829 2. Modify the school district's application form for the
830 lunch program under subsection (4) and the breakfast program
831 under subsection (5) to incorporate a provision that permits the
832 school district to share data from the application form with the
833 state agencies and the Florida Healthy Kids Corporation and its
834 agents that administer the Kidcare program unless the child's
835 parent or guardian opts out of the provision.
836 (b) At the option of the school district, share income and
837 other demographic data through an electronic interchange with
838 the Florida Healthy Kids Corporation and other state agencies in
839 order to determine eligibility for the Kidcare program on a
840 regular and periodic basis.
841 (c) Establish interagency agreements ensuring that data

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842 exchanged under this subsection is used only to enroll eligible
843 children in the Florida Kidcare program and is protected from
844 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).
845 Section 16. The Division of Statutory Revision is requested
846 to designate ss. 409.901 through 409.9205, Florida Statutes, as
847 part III of chapter 409, Florida Statutes, entitled "MEDICAID."
848 Section 17. Section 409.901, Florida Statutes, is amended
849 to read:
850 409.901 Definitions~~; ss. 409.901-409.920~~.—As used in this
851 part and part IV ~~ss. 409.901-409.920, except as otherwise~~
852 ~~specifically provided~~, the term:
853 (1) "Affiliate" or "affiliated person" means any person who
854 directly or indirectly manages, controls, or oversees the
855 operation of a corporation or other business entity that is a
856 Medicaid provider, regardless of whether such person is a
857 partner, shareholder, owner, officer, director, agent, or
858 employee of the entity.
859 (2) "Agency" means the Agency for Health Care
860 Administration. ~~The agency is the Medicaid agency for the state,~~
861 ~~as provided under federal law.~~
862 (3) "Applicant" means an individual whose written
863 application for medical assistance provided by Medicaid ~~under~~
864 ~~ss. 409.903-409.906~~ has been submitted to the Department of
865 Children and Family Services, or to the Social Security
866 Administration if the application is for Supplemental Security
867 Income, but has not received final action. The ~~This~~ term
868 includes an individual, who need not be alive at the time of
869 application, and whose application is submitted through a
870 representative or a person acting for the individual.

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871 (4) “Benefit” means any benefit, assistance, aid,
872 obligation, promise, debt, liability, or the like, related to
873 any covered injury, illness, or necessary medical care, goods,
874 or services.
875 (5) “Capitation” means a prospective per-member, per-month
876 payment designed to represent, in the aggregate, an actuarially
877 sound estimate of expenditures required for the management and
878 provision of a specified set of medical services or long-term
879 care services needed by members enrolled in a prepaid health
880 plan.
881 (6) ~~(5)~~ “Change of ownership” has the same meaning as in s.
882 408.803 and includes ~~means:~~
883 ~~(a) An event in which the provider ownership changes to a~~
884 ~~different individual entity as evidenced by a change in federal~~
885 ~~employer identification number or taxpayer identification~~
886 ~~number;~~
887 ~~(b) An event in which 51 percent or more of the ownership,~~
888 ~~shares, membership, or controlling interest of a provider is in~~
889 ~~any manner transferred or otherwise assigned. This paragraph~~
890 ~~does not apply to a licensee that is publicly traded on a~~
891 ~~recognized stock exchange; or~~
892 ~~(c) When the provider is licensed or registered by the~~
893 ~~agency,~~ an event considered a change of ownership under part II
894 of chapter 408 ~~for licensure as defined in s. 408.803~~.
895
896 ~~A change solely in the management company or board of directors~~
897 ~~is not a change of ownership.~~
898 (7) ~~(6)~~ “Claim” means any communication, whether written or
899 electronic (electronic impulse or magnetic), which is used by

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900 any person to apply for payment from the Medicaid program, ~~or~~
901 its fiscal agent, or a qualified plan under part IV of this
902 chapter for each item or service purported ~~by any person~~ to have
903 been provided ~~by a person~~ to a ~~any~~ Medicaid recipient.
904 (8) ~~(7)~~ “Collateral” means:
905 (a) Any and all causes of action, suits, claims,
906 counterclaims, and demands that accrue to a ~~the~~ recipient or to
907 a ~~the~~ recipient’s legal representative, related to any covered
908 injury, illness, or necessary medical care, goods, or services
909 that resulted in ~~necessitated that~~ Medicaid providing ~~provide~~
910 medical assistance.
911 (b) All judgments, settlements, and settlement agreements
912 rendered or entered into and related to ~~such~~ causes of action,
913 suits, claims, counterclaims, demands, or judgments.
914 (c) Proceeds, as defined in this section.
915 (9) ~~(8)~~ “Convicted” or “conviction” means a finding of
916 guilt, with or without an adjudication of guilt, in any federal
917 or state trial court ~~of record relating to charges brought by~~
918 ~~indictment or information,~~ as a result of a jury verdict,
919 nonjury trial, or entry of a plea of guilty or nolo contendere,
920 regardless of whether an appeal from judgment is pending.
921 (10) ~~(9)~~ “Covered injury or illness” means any sickness,
922 injury, disease, disability, deformity, abnormality disease,
923 necessary medical care, pregnancy, or death for which a third
924 party is, may be, could be, should be, or has been liable, and
925 for which Medicaid is, or may be, obligated to provide, or has
926 provided, medical assistance.
927 (11) ~~(10)~~ “Emergency medical condition” has the same meaning
928 as in s. 395.002. ~~means:~~

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929 ~~(a) A medical condition manifesting itself by acute~~
930 ~~symptoms of sufficient severity, which may include severe pain~~
931 ~~or other acute symptoms, such that the absence of immediate~~
932 ~~medical attention could reasonably be expected to result in any~~
933 ~~of the following:~~
934 ~~1. Serious jeopardy to the health of a patient, including a~~
935 ~~pregnant woman or a fetus.~~
936 ~~2. Serious impairment to bodily functions.~~
937 ~~3. Serious dysfunction of any bodily organ or part.~~
938 ~~(b) With respect to a pregnant woman:~~
939 ~~1. That there is inadequate time to effect safe transfer to~~
940 ~~another hospital prior to delivery.~~
941 ~~2. That a transfer may pose a threat to the health and~~
942 ~~safety of the patient or fetus.~~
943 ~~3. That there is evidence of the onset and persistence of~~
944 ~~uterine contractions or rupture of the membranes.~~
945 (12) ~~(11)~~ "Emergency services and care" has the same meaning
946 as in s. 395.002 ~~means medical screening, examination, and~~
947 ~~evaluation by a physician, or, to the extent permitted by~~
948 ~~applicable laws, by other appropriate personnel under the~~
949 ~~supervision of a physician, to determine whether an emergency~~
950 ~~medical condition exists and, if it does, the care, treatment,~~
951 ~~or surgery for a covered service by a physician which is~~
952 ~~necessary to relieve or eliminate the emergency medical~~
953 ~~condition, within the service capability of a hospital~~.
954 (13) ~~(12)~~ "Legal representative" means a guardian,
955 conservator, survivor, or personal representative of a recipient
956 or applicant, or of the property or estate of a recipient or
957 applicant.

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958 (14)~~(13)~~ “Managed care plan” means a health insurer
959 authorized under chapter 624, an exclusive provider organization
960 authorized under chapter 627, a health maintenance organization
961 authorized under chapter 641, a provider service network
962 authorized under s. 409.912(4)(d), or an accountable care
963 organization authorized under federal law ~~health maintenance~~
964 ~~organization authorized pursuant to chapter 641 or a prepaid~~
965 ~~health plan authorized pursuant to s. 409.912~~.
966 (15)~~(14)~~ “Medicaid” or Medicaid program means the medical
967 assistance program authorized by Title XIX of the Social
968 Security Act, 42 U.S.C. s. 1396 et seq., and regulations
969 thereunder, as administered in this state by the agency.
970 ~~(15) “Medicaid agency” or “agency” means the single state~~
971 ~~agency that administers or supervises the administration of the~~
972 ~~state Medicaid plan under federal law.~~
973 ~~(16) “Medicaid program” means the program authorized under~~
974 ~~Title XIX of the federal Social Security Act which provides for~~
975 ~~payments for medical items or services, or both, on behalf of~~
976 ~~any person who is determined by the Department of Children and~~
977 ~~Family Services, or, for Supplemental Security Income, by the~~
978 ~~Social Security Administration, to be eligible on the date of~~
979 ~~service for Medicaid assistance.~~
980 (16)~~(17)~~ “Medicaid provider” or “provider” means a person
981 or entity that has a Medicaid provider agreement in effect with
982 the agency and is in good standing with the agency. The term
983 also includes a person or entity that provides medical services
984 to a Medicaid recipient under the Medicaid managed care program
985 in part IV of this chapter.
986 (17)~~(18)~~ “Medicaid provider agreement” or “provider

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987 agreement” means a contract between the agency and a provider
988 for the provision of services or goods, or both, to Medicaid
989 recipients pursuant to Medicaid.
990 (18) ~~(19)~~ “Medicaid recipient” or “recipient” means an
991 individual whom the Department of Children and Family Services,
992 or, for Supplemental Security Income, ~~by~~ the Social Security
993 Administration, determines is eligible, pursuant to federal and
994 state law, to receive medical assistance and related services
995 for which the agency may make payments under the Medicaid
996 program. For the purposes of determining third-party liability,
997 the term includes an individual formerly determined to be
998 eligible for Medicaid, an individual who has received medical
999 assistance under ~~the~~ Medicaid ~~program~~, or an individual on whose
1000 behalf Medicaid has become obligated.
1001 (19) ~~(20)~~ “Medicaid-related records” means records that
1002 relate to the provider’s business or profession and to a
1003 Medicaid recipient. The term includes ~~Medicaid-related records~~
1004 ~~include~~ records related to non-Medicaid customers, clients, or
1005 patients but only to the extent that the documentation is shown
1006 by the agency to be necessary for determining ~~to determine~~ a
1007 provider’s entitlement to payments under the Medicaid program.
1008 (20) ~~(21)~~ “Medical assistance” means any provision of,
1009 payment for, or liability for medical services or care by
1010 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.
1011 (21) ~~(22)~~ “Medical services” or “medical care” means medical
1012 or medically related institutional or noninstitutional care,
1013 goods, or services covered by the Medicaid program. The term
1014 includes any services authorized and funded in the General
1015 Appropriations Act.

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1016 (22)~~(23)~~ “MediPass” means a primary care case management
1017 program operated by the agency.
1018 (23)~~(24)~~ “Minority physician network” means a network of
1019 primary care physicians with experience in managing Medicaid or
1020 Medicare recipients which ~~that~~ is predominantly owned by
1021 minorities, as defined in s. 288.703, and which may have a
1022 collaborative partnership with a public college or university
1023 and a tax-exempt charitable corporation.
1024 (24)~~(25)~~ “Payment,” as it relates to third-party benefits,
1025 means performance of a duty, promise, or obligation, or
1026 discharge of a debt or liability, by the delivery, provision, or
1027 transfer of third-party benefits for medical services. To “pay”
1028 means to do any of the acts set forth in this subsection.
1029 (25)~~(26)~~ “Proceeds” means whatever is received upon the
1030 sale, exchange, collection, or other disposition of the
1031 collateral or proceeds thereon and includes insurance payable by
1032 reason of loss or damage to the collateral or proceeds. Money,
1033 checks, deposit accounts, and the like are “cash proceeds.” All
1034 other proceeds are “noncash proceeds.”
1035 (26)~~(27)~~ “Third party” means an individual, entity, or
1036 program, excluding Medicaid, that is, may be, could be, should
1037 be, or has been liable for all or part of the cost of medical
1038 services related to any medical assistance covered by Medicaid.
1039 A third party includes a third-party administrator or a pharmacy
1040 benefits manager.
1041 (27)~~(28)~~ “Third-party benefit” means any benefit that is or
1042 may be available at any time through contract, court award,
1043 judgment, settlement, agreement, or any arrangement between a
1044 third party and any person or entity, including, without

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1045 limitation, a Medicaid recipient, a provider, another third
1046 party, an insurer, or the agency, for any Medicaid-covered
1047 injury, illness, goods, or services, including costs of medical
1048 services related thereto, for personal injury or for death of
1049 the recipient, but specifically excluding policies of life
1050 insurance on the recipient, unless available under terms of the
1051 policy to pay medical expenses prior to death. The term
1052 includes, without limitation, collateral, as defined in this
1053 section, health insurance, any benefit under a health
1054 maintenance organization, a preferred provider arrangement, a
1055 prepaid health clinic, liability insurance, uninsured motorist
1056 insurance or personal injury protection coverage, medical
1057 benefits under workers' compensation, and any obligation under
1058 law or equity to provide medical support.
1059 Section 18. Section 409.902, Florida Statutes, is amended
1060 to read:
1061 409.902 Designated single state agency; eligibility
1062 determinations; rules ~~payment requirements; program title;~~
1063 ~~release of medical records~~.~~—~~
1064 (1) The agency ~~for Health Care Administration~~ is designated
1065 as the single state agency authorized to administer the Medicaid
1066 state plan and to make payments for medical assistance and
1067 related services under Title XIX of the Social Security Act.
1068 These payments shall be made, subject to any limitations or
1069 directions provided for in the General Appropriations Act, only
1070 for services included in the Medicaid program, ~~shall be made~~
1071 only on behalf of eligible individuals, and ~~shall be made~~ only
1072 to qualified providers in accordance with federal requirements
1073 under ~~for~~ Title XIX of the Social Security Act and ~~the~~

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1074 ~~provisions of~~ state law.
1075 (a) The agency must notify the Legislature before seeking
1076 an amendment to the state plan for purposes of implementing
1077 provisions authorized by the Deficit Reduction Act of 2005.
1078 (b) The agency shall adopt any rules necessary to carry out
1079 its statutory duties under this subsection and any other
1080 statutory provisions related to its responsibility for the
1081 Medicaid program and state compliance with federal Medicaid
1082 requirements, including the Medicaid managed care program. ~~This~~
1083 ~~program of medical assistance is designated the "Medicaid~~
1084 ~~program."~~
1085 (2) The Department of Children and Family Services is
1086 responsible for determining Medicaid eligibility ~~determinations~~,
1087 including, but not limited to, policy, rules, and the agreement
1088 with the Social Security Administration for Medicaid eligibility
1089 ~~determinations~~ for Supplemental Security Income recipients, as
1090 well as the actual determination of eligibility. ~~As a condition~~
1091 ~~of Medicaid eligibility, subject to federal approval, the agency~~
1092 ~~for Health Care Administration and the Department of Children~~
1093 ~~and Family Services shall ensure that each recipient of Medicaid~~
1094 ~~consents to the release of her or his medical records to the~~
1095 ~~agency for Health Care Administration and the Medicaid Fraud~~
1096 ~~Control Unit of the Department of Legal Affairs.~~
1097 (a) Eligibility is restricted to United States citizens and
1098 to lawfully admitted noncitizens who meet the criteria provided
1099 in s. 414.095(3).
1100 1. Citizenship or immigration status must be verified. For
1101 noncitizens, this includes verification of the validity of
1102 documents with the United States Citizenship and Immigration

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1103 Services using the federal SAVE verification process.
1104 2. State funds may not be used to provide medical services
1105 to individuals who do not meet the requirements of this
1106 paragraph unless the services are necessary to treat an
1107 emergency medical condition or are for pregnant women. Such
1108 services are authorized only to the extent provided under
1109 federal law and in accordance with federal regulations as
1110 provided in 42 C.F.R. s. 440.255.
1111 (b) When adopting rules relating to eligibility for
1112 institutional care services, hospice services, and home and
1113 community-based waiver programs, and regardless of whether a
1114 penalty will be applied due to the unlawful transfer of assets,
1115 the payment of fair compensation by an applicant for a personal
1116 care services contract entered into on or after October 1, 2011,
1117 shall be evaluated using the following criteria:
1118 1. The contracted services do not duplicate services
1119 available through other sources or providers, such as Medicaid,
1120 Medicare, private insurance, or another legally obligated third
1121 party;
1122 2. The contracted services directly benefit the individual
1123 and are not services normally provided out of love and
1124 consideration for the individual;
1125 3. The actual cost to deliver services is computed in a
1126 manner that clearly reflects the actual number of hours to be
1127 expended, and the contract clearly identifies each specific
1128 service and the average number of hours of each service to be
1129 delivered each month;
1130 4. The hourly rate for each contracted service is equal to
1131 or less than the amount normally charged by a professional who

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1132 traditionally provides the same or similar services;
1133 5. The contracted services are provided on a prospective
1134 basis only and not for services provided in the past; and
1135 6. The contract provides fair compensation to the
1136 individual in his or her lifetime as set forth in life
1137 expectancy tables adopted in rule 65A-1.716, Florida
1138 Administrative Code.
1139 (c) The department shall adopt any rules necessary to carry
1140 out its statutory duties under this subsection for receiving and
1141 processing Medicaid applications and determining Medicaid
1142 eligibility, and any other statutory provisions related to
1143 responsibility for the determination of Medicaid eligibility.
1144 Section 19. Section 409.9021, Florida Statutes, is amended
1145 to read:
1146 409.9021 Conditions for Medicaid ~~Forfeiture of~~ eligibility
1147 ~~agreement~~.—As a condition of Medicaid eligibility, subject to
1148 federal regulation and approval:~~,~~
1149 (1) A Medicaid applicant must consent ~~shall agree~~ in
1150 writing to:
1151 (a) Have her or his medical records released to the agency
1152 and the Medicaid Fraud Control Unit of the Department of Legal
1153 Affairs.
1154 (b) Forfeit all entitlements to any goods or services
1155 provided through the Medicaid program for the next 10 years if
1156 he or she has been found to have committed Medicaid fraud~~,~~
1157 through judicial or administrative determination~~, two times in a~~
1158 ~~period of 5 years~~. This provision applies only to the Medicaid
1159 recipient found to have committed or participated in Medicaid
1160 ~~the~~ fraud and does not apply to any family member of the

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1161 recipient who was not involved in the fraud.
1162 (2) A Medicaid applicant must pay a $10 monthly premium
1163 that covers all Medicaid-eligible recipients in the applicant's
1164 family. However, an individual who is eligible for the
1165 Supplemental Security Income related Medicaid and is receiving
1166 institutional care payments is exempt from this requirement. The
1167 agency shall seek a federal waiver to authorize the imposition
1168 and collection of this premium effective December 31, 2011. Upon
1169 approval, the agency shall establish by rule procedures for
1170 collecting premiums from recipients, advance notice of
1171 cancellation, and waiting periods for reinstatement of coverage
1172 upon voluntary cancellation for nonpayment of premiums.
1173 (3) A Medicaid applicant must participate, in good faith,
1174 in:
1175 (a) A medically approved smoking cessation program if the
1176 applicant smokes.
1177 (b) A medically directed weight loss program if the
1178 applicant is or becomes morbidly obese.
1179 (c) A medically approved alcohol or substance abuse
1180 recovery program if the applicant is or becomes diagnosed as a
1181 substance abuser.
1182
1183 The agency shall seek a federal waiver to authorize the
1184 implementation of this subsection in order to assist the
1185 recipient in mitigating lifestyle choices and avoiding behaviors
1186 associated with the use of high-cost medical services.
1187 (4) A person who is eligible for Medicaid services and who
1188 has access to health care coverage through an employer-sponsored
1189 health plan may not receive Medicaid services reimbursed under

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1190 s. 409.908, s. 409.912,or s. 409.986, but may use Medicaid
1191 financial assistance to pay the cost of premiums for the
1192 employer-sponsored health plan for the eligible person and his
1193 or her Medicaid-eligible family members.
1194 (5) A Medicaid recipient who has access to other insurance
1195 or coverage created pursuant to state or federal law may opt out
1196 of the Medicaid services provided under s. 409.908, s. 409.912,
1197 or s. 409.986 and use Medicaid financial assistance to pay the
1198 cost of premiums for the recipient and the recipient's Medicaid
1199 eligible family members.
1200 (6) Subsections (4) and (5) shall be administered by the
1201 agency in accordance with s. 409.964(1)(j). The maximum amount
1202 available for the Medicaid financial assistance shall be
1203 calculated based on the Medicaid capitated rate as if the
1204 Medicaid recipient and the recipient's eligible family members
1205 participated in a qualified plan for Medicaid managed care under
1206 part IV of this chapter.
1207 Section 20. Section 409.9022, Florida Statutes, is created
1208 to read:
1209 409.9022 Limitations on Medicaid expenditures.—
1210 (1) Except as specifically authorized in this section, a
1211 state agency may not obligate or expend funds for the Medicaid
1212 program in excess of the amount appropriated in the General
1213 Appropriations Act.
1214 (2) If, at any time during the fiscal year, a state agency
1215 determines that Medicaid expenditures may exceed the amount
1216 appropriated during the fiscal year, the state agency shall
1217 notify the Social Services Estimating Conference, which shall
1218 meet to estimate Medicaid expenditures for the remainder of the

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1219 fiscal year. If, pursuant to this paragraph or for any other
1220 purpose, the conference determines that Medicaid expenditures
1221 will exceed appropriations for the fiscal year, the state agency
1222 shall develop and submit a plan for revising Medicaid
1223 expenditures in order to remain within the annual appropriation.
1224 The plan must include cost-mitigating strategies to negate the
1225 projected deficit for the remainder of the fiscal year and shall
1226 be submitted in the form of a budget amendment to the
1227 Legislative Budget Commission. The conference shall also
1228 estimate the amount of savings which will result from such cost-
1229 mitigating strategies proposed by the state agency as well as
1230 any other strategies the conference may consider and recommend.
1231 (3) In preparing the budget amendment to revise Medicaid
1232 expenditures in order to remain within appropriations, a state
1233 agency shall include the following revisions to the Medicaid
1234 state plan, in the priority order listed below:
1235 (a) Reduction in administrative costs.
1236 (b) Elimination of optional benefits.
1237 (c) Elimination of optional eligibility groups.
1238 (d) Reduction to institutional and provider reimbursement
1239 rates.
1240 (e) Reduction in the amount, duration, and scope of
1241 mandatory benefits.
1242
1243 The state agency may not implement any of these cost-containment
1244 measures until the amendment is approved by the Legislative
1245 Budget Commission.
1246 (4) In order to remedy a projected expenditure in excess of
1247 the amount appropriated in a specific appropriation within the

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1248 Medicaid budget, a state agency may, consistent with chapter
1249 216:
1250 (a) Submit a budget amendment to transfer budget authority
1251 between appropriation categories;
1252 (b) Submit a budget amendment to increase federal trust
1253 authority or grants and donations trust authority if additional
1254 federal or local funds are available; or
1255 (c) Submit any other budget amendment consistent with
1256 chapter 216.
1257 (5) The agency shall amend the Medicaid state plan to
1258 incorporate the provisions of this section.
1259 (6) Chapter 216 does not permit the transfer of funds from
1260 any other program into the Medicaid program or the transfer of
1261 funds out of the Medicaid program into any other program.
1262 Section 21. Section 409.903, Florida Statutes, is amended
1263 to read:
1264 409.903 Mandatory payments for eligible persons.—The agency
1265 shall make payments for medical assistance and related services
1266 on behalf of the following categories of persons who the
1267 Department of Children and Family Services, or the Social
1268 Security Administration by contract with the department ~~of~~
1269 ~~Children and Family Services~~, determines to be eligible for
1270 Medicaid, subject to the income, assets, and categorical
1271 eligibility tests set forth in federal and state law. Payment on
1272 behalf of these recipients ~~Medicaid eligible persons~~ is subject
1273 to the availability of moneys and any limitations established by
1274 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1275 (1) Low-income families with children if ~~are eligible for~~
1276 ~~Medicaid provided~~ they meet the following requirements:

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1277 (a) The family includes a dependent child who is living
1278 with a caretaker relative.
1279 (b) The family's income does not exceed the gross income
1280 test limit.
1281 (c) The family's countable income and resources do not
1282 exceed the applicable Aid to Families with Dependent Children
1283 (AFDC) income and resource standards under the AFDC state plan
1284 in effect on ~~in~~ July 1996, except as amended in the Medicaid
1285 state plan to conform as closely as possible to the requirements
1286 of the welfare transition program, to the extent permitted by
1287 federal law.
1288 (2) A person who receives payments from, who is determined
1289 eligible for, or who was eligible for but lost cash benefits
1290 from the federal program known as the Supplemental Security
1291 Income program (SSI). This ~~category~~ includes a low-income person
1292 age 65 or over and a low-income person under age 65 considered
1293 to be permanently and totally disabled.
1294 (3) A child under age 21 living in a low-income, two-parent
1295 family, and a child under age 7 living with a nonrelative~~,~~ if
1296 the income and assets of the family or child, as applicable, do
1297 not exceed the resource limits under the Temporary Cash
1298 Assistance Program.
1299 (4) A child who is eligible under Title IV-E of the Social
1300 Security Act for subsidized board payments, foster care, or
1301 adoption subsidies, and a child for whom the state has assumed
1302 temporary or permanent responsibility and who does not qualify
1303 for Title IV-E assistance but is in foster care, shelter or
1304 emergency shelter care, or subsidized adoption. This ~~category~~
1305 includes a young adult who is eligible to receive services under

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1306 s. 409.1451(5), until the young adult reaches 21 years of age~~,~~
1307 without regard to any income, resource, or categorical
1308 eligibility test that is otherwise required. This ~~category~~ also
1309 includes a person who as a child was eligible under Title IV-E
1310 of the Social Security Act for foster care or the state-provided
1311 foster care and who is a participant in the Road-to-Independence
1312 Program.
1313 (5) A pregnant woman for the duration of her pregnancy and
1314 for the postpartum period as defined in federal law and rule, or
1315 a child under age 1, if either is living in a family that has an
1316 income which is at or below ~~150 percent of the most current~~
1317 ~~federal poverty level, or, effective January 1, 1992, that has~~
1318 ~~an income which is at or below~~ 185 percent of the most current
1319 federal poverty level. Such a person is not subject to an assets
1320 test. ~~Further,~~ A pregnant woman who applies for eligibility for
1321 the Medicaid program through a qualified Medicaid provider must
1322 be offered the opportunity, subject to federal rules, to be made
1323 presumptively eligible for the Medicaid program.
1324 (6) A child ~~born after September 30, 1983,~~ living in a
1325 family that has an income which is at or below 100 percent of
1326 the current federal poverty level, who has attained the age of
1327 6, but has not attained the age of 19. In determining the
1328 eligibility of such a child, an assets test is not required. A
1329 child who is eligible ~~for Medicaid~~ under this subsection must be
1330 offered the opportunity, subject to federal rules, to be made
1331 presumptively eligible. A child who has been deemed
1332 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in
1333 a managed care plan until the child's full eligibility
1334 ~~determination~~ for Medicaid has been determined ~~completed~~.

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1335 (7) A child living in a family that has an income that
1336 ~~which~~ is at or below 133 percent of the current federal poverty
1337 level, who has attained the age of 1, but has not attained the
1338 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an
1339 assets test is not required. A child who is eligible ~~for~~
1340 ~~Medicaid~~ under this subsection must be offered the opportunity,
1341 subject to federal rules, to be made presumptively eligible. A
1342 child who has been deemed presumptively eligible may ~~for~~
1343 ~~Medicaid shall~~ not be enrolled in a managed care plan until the
1344 child's full eligibility ~~determination~~ for Medicaid has been
1345 determined ~~completed~~.
1346 (8) A person who is age 65 or over or is determined by the
1347 agency to be disabled, whose income is at or below 100 percent
1348 of the most current federal poverty level and whose assets do
1349 not exceed limitations established by the agency. However, the
1350 agency may only pay for premiums, coinsurance, and deductibles,
1351 as required by federal law, unless additional coverage is
1352 provided for any or all members of this group under ~~by~~ s.
1353 409.904(1).
1354 Section 22. Section 409.904, Florida Statutes, is amended
1355 to read:
1356 409.904 Optional payments for eligible persons.—The agency
1357 may make payments for medical assistance and related services on
1358 behalf of the following categories of persons who are determined
1359 to be eligible for Medicaid, subject to the income, assets, and
1360 categorical eligibility tests set forth in federal and state
1361 law. Payment on behalf of these ~~Medicaid eligible~~ persons is
1362 subject to the availability of moneys and any limitations
1363 established by the General Appropriations Act, ~~or~~ chapter 216,

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1364 or s. 409.9022.
1365 (1) ~~Effective January 1, 2006, and~~ Subject to federal
1366 waiver approval, a person who is age 65 or older or is
1367 determined to be disabled, whose income is at or below 88
1368 percent of the federal poverty level, whose assets do not exceed
1369 established limitations, and who is not eligible for Medicare
1370 or, if eligible for Medicare, is also eligible for and receiving
1371 Medicaid-covered institutional care services, hospice services,
1372 or home and community-based services. The agency shall seek
1373 federal authorization through a waiver to provide this coverage.
1374 This subsection expires June 30, 2011.
1375 (2) The following persons who are eligible for the Medicaid
1376 nonpoverty medical subsidy, which includes the same services as
1377 those provided to other Medicaid recipients, with the exception
1378 of services in skilled nursing facilities and intermediate care
1379 facilities for the developmentally disabled:
1380 (a) A family, a pregnant woman, a child under age 21, a
1381 person age 65 or over, or a blind or disabled person, who would
1382 be eligible under any group listed in s. 409.903(1), (2), or
1383 (3), except that the income or assets of such family or person
1384 exceed established limitations. For a family or person in one of
1385 these coverage groups, medical expenses are deductible from
1386 income in accordance with federal requirements in order to make
1387 a determination of eligibility. ~~A family or person eligible~~
1388 ~~under the coverage known as the "medically needy," is eligible~~
1389 ~~to receive the same services as other Medicaid recipients, with~~
1390 ~~the exception of services in skilled nursing facilities and~~
1391 ~~intermediate care facilities for the developmentally disabled.~~
1392 This paragraph expires June 30, 2011.

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1393 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a
1394 child younger than 21 years of age who would be eligible under
1395 any group listed in s. 409.903, except that the income or assets
1396 of such group exceed established limitations. For a person in
1397 one of these coverage groups, medical expenses are deductible
1398 from income in accordance with federal requirements in order to
1399 make a determination of eligibility. ~~A person eligible under the~~
1400 ~~coverage known as the "medically needy" is eligible to receive~~
1401 ~~the same services as other Medicaid recipients, with the~~
1402 ~~exception of services in skilled nursing facilities and~~
1403 ~~intermediate care facilities for the developmentally disabled.~~
1404 (c) A family, a person age 65 or older, or a blind or
1405 disabled person, who would be eligible under any group listed in
1406 s. 409.903(1), (2), or (3), except that the income or assets of
1407 such family or person exceed established limitations. For a
1408 family or person in one of these coverage groups, medical
1409 expenses are deductible from income in accordance with federal
1410 requirements in order to make a determination of eligibility. A
1411 family, a person age 65 or older, or a blind or disabled person,
1412 covered under the Medicaid nonpoverty medical subsidy, is
1413 eligible to receive physician services only.
1414 (3) A person who is in need of the services of a licensed
1415 nursing facility, a licensed intermediate care facility for the
1416 developmentally disabled, or a state mental hospital, whose
1417 income does not exceed 300 percent of the SSI income standard,
1418 and who meets the assets standards established under federal and
1419 state law. In determining the person's responsibility for the
1420 cost of care, the following amounts must be deducted from the
1421 person's income:

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1422 (a) The monthly personal allowance for residents as set
1423 based on appropriations.
1424 (b) The reasonable costs of medically necessary services
1425 and supplies that are not reimbursable by the Medicaid program.
1426 (c) The cost of premiums, copayments, coinsurance, and
1427 deductibles for supplemental health insurance.
1428 (4) A low-income person who meets all other requirements
1429 for Medicaid eligibility except citizenship and who is in need
1430 of emergency medical services. The eligibility of such a
1431 recipient is limited to the period of the emergency, in
1432 accordance with federal regulations.
1433 (5) Subject to specific federal authorization, a woman
1434 living in a family that has an income that is at or below 185
1435 percent of the most current federal poverty level. Coverage is
1436 limited to ~~is eligible for~~ family planning services as specified
1437 in s. 409.905(3) for a period of up to 24 months following a
1438 loss of Medicaid benefits.
1439 (6) A child who has not attained the age of 19 who has been
1440 determined eligible for the Medicaid program is deemed to be
1441 eligible for a total of 6 months, regardless of changes in
1442 circumstances other than attainment of the maximum age.
1443 ~~Effective January 1, 1999,~~ A child who has not attained the age
1444 of 5 and who has been determined eligible for the Medicaid
1445 program is deemed to be eligible for a total of 12 months
1446 regardless of changes in circumstances other than attainment of
1447 the maximum age.
1448 (7) A child under 1 year of age who lives in a family that
1449 has an income above 185 percent of the most recently published
1450 federal poverty level, but which is at or below 200 percent of

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1451 such poverty level. In determining the eligibility ~~of such~~
1452 ~~child~~, an assets test is not required. A child who is eligible
1453 ~~for Medicaid~~ under this subsection must be offered the
1454 opportunity, subject to federal rules, to be made presumptively
1455 eligible.
1456 (8) An eligible person ~~A Medicaid-eligible individual~~ for
1457 the individual's health insurance premiums, if the agency
1458 determines that such payments are cost-effective.
1459 (9) Eligible women with incomes at or below 200 percent of
1460 the federal poverty level and under age 65, for cancer treatment
1461 pursuant to the federal Breast and Cervical Cancer Prevention
1462 and Treatment Act of 2000, screened through the Mary Brogan
1463 Breast and Cervical Cancer Early Detection Program established
1464 under s. 381.93.
1465 Section 23. Section 409.905, Florida Statutes, is amended
1466 to read:
1467 409.905 Mandatory Medicaid services.—The agency shall ~~may~~
1468 make payments for the following services, which are required ~~of~~
1469 ~~the state~~ by Title XIX of the Social Security Act, furnished by
1470 Medicaid providers to recipients who are ~~determined to be~~
1471 eligible on the dates on which the services were provided. Any
1472 service under this section shall be provided only when medically
1473 necessary and in accordance with state and federal law.
1474 Mandatory services rendered by providers in mobile units to
1475 Medicaid recipients may be restricted by the agency. This
1476 section does not ~~Nothing in this section shall be construed to~~
1477 prevent or limit the agency from adjusting fees, reimbursement
1478 rates, lengths of stay, number of visits, number of services, or
1479 any other adjustments necessary to comply with the availability

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1480 of moneys and any limitations or directions provided ~~for~~ in the
1481 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1482 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The
1483 agency shall pay for services provided to a recipient by a
1484 licensed advanced registered nurse practitioner who has a valid
1485 collaboration agreement with a licensed physician on file with
1486 the Department of Health or who provides anesthesia services in
1487 accordance with established protocol required by state law and
1488 approved by the medical staff of the facility in which the
1489 ~~anesthetic~~ service is performed. Reimbursement for such services
1490 must be provided in an amount that equals at least ~~not less than~~
1491 80 percent of the reimbursement to a physician who provides the
1492 same services, unless otherwise provided ~~for~~ in the General
1493 Appropriations Act.
1494 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
1495 SERVICES.—The agency shall pay for early and periodic screening
1496 and diagnosis of a recipient under age 21 to ascertain physical
1497 and mental problems and conditions and ~~provide treatment to~~
1498 ~~correct or ameliorate these problems and conditions. These~~
1499 ~~services include~~ all services determined by the agency to be
1500 medically necessary for the treatment, correction, or
1501 amelioration of these problems and conditions, including
1502 personal care, private duty nursing, durable medical equipment,
1503 physical therapy, occupational therapy, speech therapy,
1504 respiratory therapy, and immunizations.
1505 (3) FAMILY PLANNING SERVICES.—The agency shall pay for
1506 services necessary to enable a recipient voluntarily to plan
1507 family size or to space children. These services include
1508 information; education; counseling regarding the availability,

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1509 benefits, and risks of each method of pregnancy prevention;
1510 drugs and supplies; and necessary medical care and followup.
1511 Each recipient participating in ~~the~~ family planning ~~portion of~~
1512 ~~the Medicaid program~~ must be provided the choice of ~~freedom to~~
1513 ~~choose~~ any alternative method of family planning, as required by
1514 federal law.
1515 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
1516 nursing and home health aide services, supplies, appliances, and
1517 durable medical equipment, necessary to assist a recipient
1518 living at home. An entity that provides such services must
1519 ~~pursuant to this subsection shall~~ be licensed under part III of
1520 chapter 400. These services, equipment, and supplies, or
1521 reimbursement therefor, may be limited as provided in the
1522 General Appropriations Act and do not include services,
1523 equipment, or supplies provided to a person residing in a
1524 hospital or nursing facility.
1525 (a) ~~In providing home health care services,~~ The agency
1526 shall ~~may~~ require prior authorization of home health services
1527 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing
1528 rates. ~~The agency shall require prior authorization for visits~~
1529 ~~for home health services that are not associated with a skilled~~
1530 ~~nursing visit when the home health agency billing rates exceed~~
1531 ~~the state average by 50 percent or more.~~ The home health agency
1532 must submit the recipient’s plan of care and documentation that
1533 supports the recipient’s diagnosis to the agency when requesting
1534 prior authorization.
1535 (b) The agency shall implement a comprehensive utilization
1536 management program ~~that requires prior authorization~~ of all
1537 private duty nursing services, an individualized treatment plan

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1538 that includes information about medication and treatment orders,
1539 treatment goals, methods of care to be used, and plans for care
1540 coordination by nurses and other health professionals. The
1541 utilization management program must ~~shall~~ also include a process
1542 for periodically reviewing the ongoing use of private duty
1543 nursing services. The assessment of need shall be based on a
1544 child's condition;~~,~~ family support and care supplements;~~,~~ a
1545 family's ability to provide care;~~, and~~ a family's and child's
1546 schedule regarding work, school, sleep, and care for other
1547 family dependents; and a determination of the medical necessity
1548 for private duty nursing instead of other more cost-effective
1549 in-home services. When implemented, the private duty nursing
1550 utilization management program shall replace the current
1551 authorization program used by the agency ~~for Health Care~~
1552 ~~Administration~~ and the Children's Medical Services program of
1553 the Department of Health. The agency may competitively bid ~~on~~ a
1554 contract to select a qualified organization to provide
1555 utilization management of private duty nursing services. The
1556 agency may ~~is authorized to~~ seek federal waivers to implement
1557 this initiative.
1558 (c) The agency may not pay for home health services unless
1559 the services are medically necessary and:
1560 1. The services are ordered by a physician.
1561 2. The written prescription for the services is signed and
1562 dated by the recipient's physician before the development of a
1563 plan of care and before any request requiring prior
1564 authorization.
1565 3. The physician ordering the services is not employed,
1566 under contract with, or otherwise affiliated with the home

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1567 health agency rendering the services. However, this subparagraph
1568 does not apply to a home health agency affiliated with a
1569 retirement community, of which the parent corporation or a
1570 related legal entity owns a rural health clinic certified under
1571 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
1572 under part II of chapter 400, or an apartment or single-family
1573 home for independent living. For purposes of this subparagraph,
1574 the agency may, on a case-by-case basis, provide an exception
1575 for medically fragile children who are younger than 21 years of
1576 age.
1577 4. The physician ordering the services has examined the
1578 recipient within the 30 days preceding the initial request for
1579 the services and biannually thereafter.
1580 5. The written prescription for the services includes the
1581 recipient's acute or chronic medical condition or diagnosis, the
1582 home health service required, and, for skilled nursing services,
1583 the frequency and duration of the services.
1584 6. The national provider identifier, Medicaid
1585 identification number, or medical practitioner license number of
1586 the physician ordering the services is listed on the written
1587 prescription for the services, the claim for home health
1588 reimbursement, and the prior authorization request.
1589 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1590 all covered services provided for the medical care and treatment
1591 of a recipient who is admitted as an inpatient by a licensed
1592 physician or dentist to a hospital licensed under part I of
1593 chapter 395. However, the agency shall limit the payment for
1594 inpatient hospital services for a Medicaid recipient 21 years of
1595 age or older to 45 days or the number of days necessary to

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1596 comply with the General Appropriations Act.
1597 (a) The agency may ~~is authorized to~~ implement reimbursement
1598 and utilization management reforms in order to comply with any
1599 limitations or directions in the General Appropriations Act,
1600 which may include, but are not limited to~~:~~ prior authorization
1601 for inpatient psychiatric days; prior authorization for
1602 nonemergency hospital inpatient admissions for individuals 21
1603 years of age and older; authorization of emergency and urgent-
1604 care admissions within 24 hours after admission; enhanced
1605 utilization and concurrent review programs for highly utilized
1606 services; reduction or elimination of covered days of service;
1607 adjusting reimbursement ceilings for variable costs; adjusting
1608 reimbursement ceilings for fixed and property costs; and
1609 implementing target rates of increase. The agency may limit
1610 prior authorization for hospital inpatient services to selected
1611 diagnosis-related groups, based on an analysis of the cost and
1612 potential for unnecessary hospitalizations represented by
1613 certain diagnoses. Admissions for normal delivery and newborns
1614 are exempt from requirements for prior authorization. In
1615 implementing the provisions of this section related to prior
1616 authorization, the agency must ~~shall~~ ensure that the process for
1617 authorization is accessible 24 hours per day, 7 days per week
1618 and that authorization is automatically granted if ~~when~~ not
1619 denied within 4 hours after the request. Authorization
1620 procedures must include steps for reviewing ~~review of~~ denials.
1621 Upon implementing the prior authorization program for hospital
1622 inpatient services, the agency shall discontinue its hospital
1623 retrospective review program.
1624 (b) A licensed hospital maintained primarily for the care

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1625 and treatment of patients having mental disorders or mental
1626 diseases may ~~is~~ not ~~eligible to~~ participate in the hospital
1627 inpatient portion of the Medicaid program except as provided in
1628 federal law. However, the Department of Children and Family
1629 Services shall apply for a waiver~~, within 9 months after June 5,~~
1630 ~~1991,~~ designed to provide hospitalization services for mental
1631 health reasons to children and adults in the most cost-effective
1632 and lowest cost setting possible. Such waiver shall include a
1633 request for the opportunity to pay for care in hospitals known
1634 under federal law as "institutions for mental disease" or
1635 "IMD's." The waiver proposal shall propose no additional
1636 aggregate cost to the state or Federal Government, and shall be
1637 conducted in Hillsborough County, Highlands County, Hardee
1638 County, Manatee County, and Polk County. The waiver proposal may
1639 incorporate competitive bidding for hospital services,
1640 comprehensive brokering, prepaid capitated arrangements, or
1641 other mechanisms deemed by the department to show promise in
1642 reducing the cost of acute care and increasing the effectiveness
1643 of preventive care. When developing the waiver proposal, the
1644 department shall take into account price, quality,
1645 accessibility, linkages of the hospital to community services
1646 and family support programs, plans of the hospital to ensure the
1647 earliest discharge possible, and the comprehensiveness of the
1648 mental health and other health care services offered by
1649 participating providers.
1650 (c) The agency shall adjust a hospital's current inpatient
1651 per diem rate to reflect the cost of serving the Medicaid
1652 population at that institution if:
1653 1. The hospital experiences an increase in Medicaid

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1654 caseload by more than 25 percent in any year, primarily
1655 resulting from the closure of a hospital in the same service
1656 area occurring after July 1, 1995;
1657 2. The hospital's Medicaid per diem rate is at least 25
1658 percent below the Medicaid per patient cost for that year; or
1659 3. The hospital is located in a county that has six or
1660 fewer general acute care hospitals, began offering obstetrical
1661 services on or after September 1999, and has submitted a request
1662 in writing to the agency for a rate adjustment after July 1,
1663 2000, but before September 30, 2000, in which case such
1664 hospital's Medicaid inpatient per diem rate shall be adjusted to
1665 cost, effective July 1, 2002. By October 1 of each year, the
1666 agency must provide estimated costs for any adjustment in a
1667 hospital inpatient per diem rate to the Executive Office of the
1668 Governor, the House of Representatives General Appropriations
1669 Committee, and the Senate Appropriations Committee. Before the
1670 agency implements a change in a hospital's inpatient per diem
1671 rate pursuant to this paragraph, the Legislature must have
1672 specifically appropriated sufficient funds in the General
1673 Appropriations Act to support the increase in cost as estimated
1674 by the agency.
1675 (d) The agency shall implement a hospitalist program in
1676 nonteaching hospitals, select counties, or statewide. The
1677 program shall require hospitalists to manage Medicaid
1678 recipients' hospital admissions and lengths of stay. Individuals
1679 who are dually eligible for Medicare and Medicaid are exempted
1680 from this requirement. Medicaid participating physicians and
1681 other practitioners with hospital admitting privileges shall
1682 coordinate and review admissions of Medicaid recipients with the

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1683 hospitalist. The agency may competitively bid a contract for
1684 selection of a single qualified organization to provide
1685 hospitalist services. The agency may procure hospitalist
1686 services by individual county or may combine counties in a
1687 single procurement. The qualified organization shall contract
1688 with or employ board-eligible physicians in Miami-Dade, Palm
1689 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency
1690 may ~~is authorized to~~ seek federal waivers to implement this
1691 program.
1692 (e) The agency shall implement a comprehensive utilization
1693 management program for hospital neonatal intensive care stays in
1694 certain high-volume participating hospitals, select counties, or
1695 statewide, and shall replace existing hospital inpatient
1696 utilization management programs for neonatal intensive care
1697 admissions. The program shall be designed to manage the lengths
1698 of stay for children being treated in neonatal intensive care
1699 units and must seek the earliest medically appropriate discharge
1700 to the child’s home or other less costly treatment setting. The
1701 agency may competitively bid a contract for selection of a
1702 qualified organization to provide neonatal intensive care
1703 utilization management services. The agency may ~~is authorized to~~
1704 seek any federal waivers to implement this initiative.
1705 (f) The agency may develop and implement a program to
1706 reduce the number of hospital readmissions among the non-
1707 Medicare population eligible in areas 9, 10, and 11.
1708 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for
1709 preventive, diagnostic, therapeutic, or palliative care and
1710 other services provided to a recipient in the outpatient portion
1711 of a hospital licensed under part I of chapter 395, and provided

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1712 under the direction of a licensed physician or licensed dentist,
1713 except that payment for such care and services is limited to
1714 $1,500 per state fiscal year per recipient, unless an exception
1715 has been made by the agency, and with the exception of a
1716 Medicaid recipient under age 21, in which case the only
1717 limitation is medical necessity.
1718 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay
1719 for medically necessary diagnostic laboratory procedures ordered
1720 by a licensed physician or other licensed health care
1721 practitioner ~~of the healing arts~~ which are provided for a
1722 recipient in a laboratory that meets the requirements for
1723 Medicare participation and is licensed under chapter 483, if
1724 required.
1725 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-
1726 hour-a-day nursing and rehabilitative services for a recipient
1727 in a nursing facility licensed under part II of chapter 400 or
1728 in a rural hospital, as defined in s. 395.602, or in a Medicare
1729 certified skilled nursing facility operated by a general
1730 hospital, as defined in ~~by~~ s. 395.002~~(10)~~, which ~~that~~ is
1731 licensed under part I of chapter 395, and in accordance with
1732 ~~provisions set forth in~~ s. 409.908(2)(a), which services are
1733 ordered by and provided under the direction of a licensed
1734 physician. However, if a nursing facility has been destroyed or
1735 otherwise made uninhabitable by natural disaster or other
1736 emergency and another nursing facility is not available, the
1737 agency must pay for similar services temporarily in a hospital
1738 licensed under part I of chapter 395 provided federal funding is
1739 approved and available. The agency shall pay only for bed-hold
1740 days if the facility has an occupancy rate of 95 percent or

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1741 greater. The agency is authorized to seek any federal waivers to
1742 implement this policy.
1743 (9) PHYSICIAN SERVICES.—The agency shall pay for covered
1744 services and procedures rendered to a Medicaid recipient by, or
1745 under the personal supervision of, a person licensed under state
1746 law to practice medicine or osteopathic medicine. These services
1747 may be furnished in the physician's office, the ~~Medicaid~~
1748 recipient's home, a hospital, a nursing facility, or elsewhere,
1749 but must ~~shall~~ be medically necessary for the treatment of a
1750 covered ~~an~~ injury or~~,~~ illness~~, or disease~~ within the scope of
1751 the practice of medicine or osteopathic medicine as defined by
1752 state law. The agency may ~~shall~~ not pay for services that are
1753 clinically unproven, experimental, or for purely cosmetic
1754 purposes.
1755 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for
1756 professional and technical portable radiological services
1757 ordered by a licensed physician or other licensed health care
1758 practitioner ~~of the healing arts~~ which are provided by a
1759 licensed professional in a setting other than a hospital,
1760 clinic, or office of a physician or practitioner ~~of the healing~~
1761 ~~arts~~, on behalf of a recipient.
1762 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for
1763 outpatient primary ~~health~~ care services for a recipient provided
1764 by a clinic certified by and participating in the Medicare
1765 program which is located in a federally designated, rural,
1766 medically underserved area and has on its staff one or more
1767 licensed primary care nurse practitioners or physician
1768 assistants, and a licensed staff supervising physician or a
1769 consulting supervising physician.

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1770 (12) TRANSPORTATION SERVICES.—The agency shall ensure that
1771 appropriate transportation services are available for a Medicaid
1772 recipient in need of transport to a qualified Medicaid provider
1773 for medically necessary ~~and Medicaid-compensable~~ services, if
1774 the recipient's ~~provided a client's~~ ability to choose a specific
1775 transportation provider is ~~shall be~~ limited to those options
1776 resulting from policies established by the agency to meet the
1777 fiscal limitations of the General Appropriations Act. The agency
1778 may pay for necessary transportation and other related travel
1779 expenses ~~as necessary~~ only if these services are not otherwise
1780 available.
1781 Section 24. Section 409.906, Florida Statutes, is amended
1782 to read:
1783 409.906 Optional Medicaid services.—Subject to specific
1784 appropriations, the agency may make payments for services which
1785 are optional to the state under Title XIX of the Social Security
1786 Act and are furnished by Medicaid providers to recipients who
1787 are determined to be eligible on the dates on which the services
1788 were provided. Any optional service that is provided shall be
1789 provided only when medically necessary and in accordance with
1790 state and federal law. Optional services rendered by providers
1791 in mobile units to Medicaid recipients may be restricted or
1792 prohibited by the agency. ~~Nothing in~~ This section does not ~~shall~~
1793 ~~be construed to~~ prevent or limit the agency from adjusting fees,
1794 reimbursement rates, lengths of stay, number of visits, or
1795 number of services, or making any other adjustments necessary to
1796 comply with the availability of moneys and any limitations or
1797 directions provided for in the General Appropriations Act, ~~or~~
1798 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~

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1799 ~~state's systems of providing services to elderly and disabled~~
1800 ~~persons and subject to the notice and review provisions of s.~~
1801 ~~216.177, the Governor may direct the Agency for Health Care~~
1802 ~~Administration to amend the Medicaid state plan to delete the~~
1803 ~~optional Medicaid service known as "Intermediate Care Facilities~~
1804 ~~for the Developmentally Disabled."~~ Optional services may
1805 include:
1806 (1) ADULT DENTAL SERVICES.—For a recipient who is 21 years
1807 of age or older:
1808 (a) The agency may pay for medically necessary, emergency
1809 dental procedures to alleviate pain or infection. Emergency
1810 dental care is ~~shall be~~ limited to emergency oral examinations,
1811 necessary radiographs, extractions, and incision and drainage of
1812 abscess~~, for a recipient who is 21 years of age or older~~.
1813 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or
1814 partial dentures, the procedures required to seat full or
1815 partial dentures, and the repair and reline of full or partial
1816 dentures, provided by or under the direction of a licensed
1817 dentist~~, for a recipient who is 21 years of age or older~~.
1818 (c) ~~However,~~ Medicaid will not provide reimbursement for
1819 dental services provided in a mobile dental unit, except for a
1820 mobile dental unit:
1821 1. Owned by, operated by, or having a contractual agreement
1822 with the Department of Health and complying with Medicaid's
1823 county health department clinic services program specifications
1824 as a county health department clinic services provider.
1825 2. Owned by, operated by, or having a contractual
1826 arrangement with a federally qualified health center and
1827 complying with Medicaid's federally qualified health center

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1828 specifications as a federally qualified health center provider.
1829 3. Rendering dental services to Medicaid recipients, 21
1830 years of age and older, at nursing facilities.
1831 4. Owned by, operated by, or having a contractual agreement
1832 with a state-approved dental educational institution.
1833 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for
1834 an annual routine physical examination, conducted by or under
1835 the direction of a licensed physician, for a recipient age 21 or
1836 older, without regard to medical necessity, in order to detect
1837 and prevent disease, disability, or other health condition or
1838 its progression.
1839 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay
1840 for services provided to a recipient in an ambulatory surgical
1841 center licensed under part I of chapter 395, by or under the
1842 direction of a licensed physician or dentist.
1843 (4) BIRTH CENTER SERVICES.—The agency may pay for
1844 examinations and delivery, recovery, ~~and~~ newborn assessment, and
1845 related services, provided in a licensed birth center staffed
1846 with licensed physicians, certified nurse midwives, and midwives
1847 licensed in accordance with chapter 467, to a recipient expected
1848 to experience a low-risk pregnancy and delivery.
1849 (5) CASE MANAGEMENT SERVICES.—The agency may pay for
1850 primary care case management services rendered to a recipient
1851 pursuant to a federally approved waiver~~,~~ and targeted case
1852 management services for specific groups of targeted recipients,
1853 for which funding has been provided and which are rendered
1854 pursuant to federal guidelines. The agency may ~~is authorized to~~
1855 limit reimbursement for targeted case management services in
1856 order to comply with any limitations or directions provided for

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1857 in the General Appropriations Act.
1858 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
1859 diagnostic, preventive, or corrective procedures, including
1860 orthodontia in severe cases, provided to a recipient under age
1861 21, by or under the supervision of a licensed dentist. Services
1862 ~~provided under this program~~ include treatment of the teeth and
1863 associated structures of the oral cavity, as well as treatment
1864 of disease, injury, or impairment that may affect the oral or
1865 general health of the individual. However, Medicaid may ~~will~~ not
1866 provide reimbursement for dental services provided in a mobile
1867 dental unit, except for a mobile dental unit:
1868 (a) Owned by, operated by, or having a contractual
1869 agreement with the Department of Health and complying with
1870 Medicaid's county health department clinic services program
1871 specifications as a county health department clinic services
1872 provider.
1873 (b) Owned by, operated by, or having a contractual
1874 arrangement with a federally qualified health center and
1875 complying with Medicaid's federally qualified health center
1876 specifications as a federally qualified health center provider.
1877 (c) Rendering dental services to Medicaid recipients, 21
1878 years of age and older, at nursing facilities.
1879 (d) Owned by, operated by, or having a contractual
1880 agreement with a state-approved dental educational institution.
1881 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
1882 manipulation of the spine and initial services, screening, and X
1883 rays provided to a recipient by a licensed chiropractic
1884 physician.
1885 (8) COMMUNITY MENTAL HEALTH SERVICES.—

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1886 ~~(a)~~ The agency may pay for rehabilitative services provided
1887 to a recipient by a mental health or substance abuse provider
1888 under contract with the agency or the Department of Children and
1889 Family Services to provide such services. ~~Those~~ Services that
1890 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or
1891 recommended by a psychiatrist, and ~~those~~ services that ~~which~~ are
1892 medical in nature must ~~shall~~ be rendered or recommended by a
1893 physician or psychiatrist.
1894 (a) The agency shall ~~must~~ develop a provider enrollment
1895 process for community mental health providers which bases
1896 provider enrollment on an assessment of service need. The
1897 provider enrollment process shall be designed to control costs,
1898 prevent fraud and abuse, consider provider expertise and
1899 capacity, and assess provider success in managing utilization of
1900 care and measuring treatment outcomes. Providers must ~~will~~ be
1901 selected through a competitive procurement or selective
1902 contracting process. In addition ~~to other community mental~~
1903 ~~health providers~~, the agency shall consider enrolling ~~for~~
1904 ~~enrollment~~ mental health programs licensed under chapter 395 and
1905 group practices licensed under chapter 458, chapter 459, chapter
1906 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~
1907 continue the operation of its behavioral health utilization
1908 management program and ~~may~~ develop new services, if ~~these~~
1909 ~~actions are~~ necessary, to ensure savings from the implementation
1910 of the utilization management system. The agency shall
1911 coordinate the implementation of this enrollment process with
1912 the Department of Children and Family Services and the
1913 Department of Juvenile Justice. The agency may use ~~is authorized~~
1914 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,

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1915 ~~to~~ preauthorize certain high-cost or highly utilized services,
1916 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make
1917 any other adjustments necessary to comply with any limitations
1918 or directions provided for in the General Appropriations Act.
1919 (b) The agency may ~~is authorized to~~ implement reimbursement
1920 and use management reforms in order to comply with any
1921 limitations or directions in the General Appropriations Act,
1922 which may include, but are not limited to~~:~~ prior authorization
1923 of treatment and service plans; prior authorization of services;
1924 enhanced use review programs for highly used services; and
1925 limits on services for recipients ~~those~~ determined to be abusing
1926 their benefit coverages.
1927 (9) DIALYSIS FACILITY SERVICES.—Subject to specific
1928 appropriations being provided for this purpose, the agency may
1929 pay a dialysis facility that is approved as a dialysis facility
1930 in accordance with Title XVIII of the Social Security Act, for
1931 dialysis services that are provided to a Medicaid recipient
1932 under the direction of a physician licensed to practice medicine
1933 or osteopathic medicine in this state, including dialysis
1934 services provided in the recipient's home by a hospital-based or
1935 freestanding dialysis facility.
1936 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize
1937 and pay for certain durable medical equipment and supplies
1938 provided to a Medicaid recipient as medically necessary.
1939 (11) HEALTHY START SERVICES.—The agency may pay for a
1940 continuum of risk-appropriate medical and psychosocial services
1941 for the Healthy Start program in accordance with a federal
1942 waiver. The agency may not implement the federal waiver unless
1943 the waiver permits the state to limit enrollment or the amount,

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1944 duration, and scope of services to ensure that expenditures will
1945 not exceed funds appropriated by the Legislature or available
1946 from local sources. If ~~the Health Care Financing Administration~~
1947 ~~does not approve~~ a federal waiver for Healthy Start services is
1948 not approved, the agency, in consultation with the Department of
1949 Health and the Florida Association of Healthy Start Coalitions,
1950 may ~~is authorized to~~ establish a Medicaid certified-match
1951 program for Healthy Start services. Participation in the Healthy
1952 Start certified-match program is ~~shall be~~ voluntary, and
1953 reimbursement is ~~shall be~~ limited to the federal Medicaid share
1954 provided to Medicaid-enrolled Healthy Start coalitions for
1955 services provided to Medicaid recipients. The agency may not
1956 ~~shall~~ take ~~no~~ action to implement a certified-match program
1957 without ensuring that the amendment and review requirements of
1958 ss. 216.177 and 216.181 have been met.
1959 (12) HEARING SERVICES.—The agency may pay for hearing and
1960 related services, including hearing evaluations, hearing aid
1961 devices, dispensing of the hearing aid, and related repairs~~, if~~
1962 provided to a recipient by a licensed hearing aid specialist,
1963 otolaryngologist, otologist, audiologist, or physician.
1964 (13) HOME AND COMMUNITY-BASED SERVICES.—
1965 (a) The agency may pay for home-based or community-based
1966 services that are rendered to a recipient in accordance with a
1967 federally approved waiver program. The agency may limit or
1968 eliminate coverage for certain services, preauthorize high-cost
1969 or highly utilized services, or make any other adjustments
1970 necessary to comply with any limitations or directions provided
1971 ~~for~~ in the General Appropriations Act.
1972 (b) The agency may consolidate types of services offered in

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1973 the Aged and Disabled Waiver, the Channeling Waiver, the Project
1974 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury
1975 Waiver programs in order to group similar services under a
1976 single service, or continue a service upon evidence of the need
1977 for including a particular service type in a particular waiver.
1978 The agency may ~~is authorized to~~ seek a Medicaid state plan
1979 amendment or federal waiver approval to implement this policy.
1980 (c) The agency may implement a utilization management
1981 program designed to prior-authorize home and community-based
1982 service plans which ~~and~~ includes, but is not limited to,
1983 assessing proposed quantity and duration of services and
1984 monitoring ongoing service use by participants in the program.
1985 The agency may ~~is authorized to~~ competitively procure a
1986 qualified organization to provide utilization management of home
1987 and community-based services. The agency may ~~is authorized to~~
1988 seek any federal waivers to implement this initiative.
1989 (d) The agency shall assess a fee against the parents of a
1990 child who is being served by a waiver under this subsection if
1991 the adjusted household income is greater than 100 percent of the
1992 federal poverty level. The amount of the fee shall be calculated
1993 using a sliding scale based on the size of the family, the
1994 amount of the parent’s adjusted gross income, and the federal
1995 poverty guidelines. The agency shall seek a federal waiver to
1996 implement this provision.
1997 (14) HOSPICE CARE SERVICES.—The agency may pay for all
1998 reasonable and necessary services for the palliation or
1999 management of a recipient’s terminal illness, if the services
2000 are provided by a hospice that is licensed under part IV of
2001 chapter 400 and meets Medicare certification requirements.

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2002 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
2003 DISABLED SERVICES.—The agency may pay for health-related care
2004 and services provided on a 24-hour-a-day basis by a facility
2005 licensed and certified as a Medicaid Intermediate Care Facility
2006 for the Developmentally Disabled, for a recipient who needs such
2007 care because of a developmental disability. Payment may ~~shall~~
2008 not include bed-hold days except in facilities with occupancy
2009 rates of 95 percent or greater. The agency may ~~is authorized to~~
2010 seek any federal waiver approvals to implement this policy. If
2011 necessary to safeguard the state's systems of providing services
2012 to elderly and disabled persons and subject to notice and review
2013 under s. 216.177, the Governor may direct the agency to amend
2014 the Medicaid state plan to delete these services.
2015 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-
2016 hour-a-day intermediate care nursing and rehabilitation services
2017 rendered to a recipient in a nursing facility licensed under
2018 part II of chapter 400~~,~~ if the services are ordered by and
2019 provided under the direction of a physician.
2020 (17) OPTOMETRIC SERVICES.—The agency may pay for services
2021 provided to a recipient, including examination, diagnosis,
2022 treatment, and management, related to ocular pathology~~,~~ if the
2023 services are provided by a licensed optometrist or physician.
2024 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for
2025 all services provided to a recipient by a physician assistant
2026 licensed under s. 458.347 or s. 459.022. Reimbursement for such
2027 services must be at least ~~not less than~~ 80 percent of the
2028 reimbursement that would be paid to a physician who provided the
2029 same services.
2030 (19) PODIATRIC SERVICES.—The agency may pay for services,

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2031 including diagnosis and medical, surgical, palliative, and
2032 mechanical treatment, related to ailments of the human foot and
2033 lower leg, if provided to a recipient by a podiatric physician
2034 licensed under state law.
2035 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for
2036 medications that are prescribed for a recipient by a physician
2037 or other licensed health care practitioner ~~of the healing arts~~
2038 authorized to prescribe medications and that are dispensed to
2039 the recipient by a licensed pharmacist or physician in
2040 accordance with applicable state and federal law. However, the
2041 agency may not pay for any psychotropic medication prescribed
2042 for a child younger than the age for which the federal Food and
2043 Drug Administration has approved its use.
2044 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency
2045 may pay for all services provided to a recipient by a registered
2046 nurse first assistant as described in s. 464.027. Reimbursement
2047 for such services must be at least ~~may not be less than~~ 80
2048 percent of the reimbursement that would be paid to a physician
2049 providing the same services.
2050 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-
2051 inclusive psychiatric inpatient hospital care provided to a
2052 recipient age 65 or older in a state mental hospital.
2053 (23) VISUAL SERVICES.—The agency may pay for visual
2054 examinations, eyeglasses, and eyeglass repairs for a recipient
2055 if they are prescribed by a licensed physician specializing in
2056 diseases of the eye or by a licensed optometrist. Eyeglass
2057 frames for adult recipients are ~~shall be~~ limited to one pair per
2058 recipient every 2 years, except a second pair may be provided
2059 ~~during that period~~ after prior authorization. Eyeglass lenses

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2060 for adult recipients are ~~shall be~~ limited to one pair per year
2061 except a second pair may be provided ~~during that period~~ after
2062 prior authorization.
2063 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~
2064 ~~Health Care Administration~~, in consultation with the Department
2065 of Children and Family Services, may establish a targeted case-
2066 management project in those counties identified by the
2067 department ~~of Children and Family Services~~ and for all counties
2068 with a community-based child welfare project, as authorized
2069 under s. 409.1671, which have been specifically approved by the
2070 department. The covered group that is ~~of individuals who are~~
2071 eligible for ~~to receive~~ targeted case management include
2072 children who are eligible for Medicaid; who are between the ages
2073 of birth through 21; and who are under protective supervision or
2074 postplacement supervision, under foster-care supervision, or in
2075 shelter care or foster care. The number of eligible children
2076 ~~individuals who are eligible to receive targeted case management~~
2077 is limited to the number for whom the department ~~of Children and~~
2078 ~~Family Services~~ has matching funds to cover the costs. The
2079 general revenue funds required to match the funds for services
2080 provided by the community-based child welfare projects are
2081 limited to funds available for services described under s.
2082 409.1671. The department ~~of Children and Family Services~~ may
2083 transfer the general revenue matching funds as billed by the
2084 agency ~~for Health Care Administration~~.
2085 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for
2086 assistive-care services provided to recipients with functional
2087 or cognitive impairments residing in assisted living facilities,
2088 adult family-care homes, or residential treatment facilities.

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2089 These services may include health support, assistance with the
2090 activities of daily living and the instrumental acts of daily
2091 living, assistance with medication administration, and
2092 arrangements for health care.
2093 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM
2094 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~
2095 ~~authorized to~~ seek federal approval through a Medicaid waiver or
2096 a state plan amendment for the provision of occupational
2097 therapy, speech therapy, physical therapy, behavior analysis,
2098 and behavior assistant services to individuals who are 5 years
2099 of age and under and have a diagnosed developmental disability
2100 as defined in s. 393.063, or autism spectrum disorder as defined
2101 in s. 627.6686~~, or Down syndrome, a genetic disorder caused by~~
2102 ~~the presence of extra chromosomal material on chromosome 21~~.
2103 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~
2104 ~~Robertsonian Translocation, and other duplications of a portion~~
2105 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited
2106 to $36,000 annually and may not exceed $108,000 in total
2107 lifetime benefits. The agency shall submit an annual report
2108 beginning ~~on~~ January 1, 2009, to the President of the Senate,
2109 the Speaker of the House of Representatives, and the relevant
2110 committees of the Senate and the House of Representatives
2111 regarding progress on obtaining federal approval and
2112 recommendations for the implementation of these home and
2113 community-based services. The agency may not implement this
2114 subsection without prior legislative approval.
2115 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may
2116 pay for all services provided to a recipient by an
2117 anesthesiologist assistant licensed under s. 458.3475 or s.

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2118 459.023. Reimbursement for such services must be at least ~~not~~
2119 ~~less than~~ 80 percent of the reimbursement that would be paid to
2120 a physician who provided the same services.
2121 Section 25. Section 409.9062, Florida Statutes, is amended
2122 to read:
2123 409.9062 Lung transplant services for Medicaid recipients.—
2124 Subject to the availability of funds and ~~subject to~~ any
2125 limitations or directions provided ~~for~~ in the General
2126 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~
2127 ~~for Health Care Administration~~ Medicaid program shall pay for
2128 medically necessary lung transplant services for Medicaid
2129 recipients. These payments must be used to reimburse approved
2130 lung transplant facilities a global fee for providing lung
2131 transplant services to Medicaid recipients.
2132 Section 26. Paragraph (h) of subsection (3) of section
2133 409.907, Florida Statutes, is amended to read:
2134 409.907 Medicaid provider agreements.—The agency may make
2135 payments for medical assistance and related services rendered to
2136 Medicaid recipients only to an individual or entity who has a
2137 provider agreement in effect with the agency, who is performing
2138 services or supplying goods in accordance with federal, state,
2139 and local law, and who agrees that no person shall, on the
2140 grounds of handicap, race, color, or national origin, or for any
2141 other reason, be subjected to discrimination under any program
2142 or activity for which the provider receives payment from the
2143 agency.
2144 (3) The provider agreement developed by the agency, in
2145 addition to the requirements specified in subsections (1) and
2146 (2), shall require the provider to:

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2147 (h) Be liable for and indemnify, defend, and hold the
2148 agency harmless from all claims, suits, judgments, or damages,
2149 including court costs and attorney's fees, arising out of the
2150 negligence or omissions of the provider in the course of
2151 providing services to a recipient or a person believed to be a
2152 recipient, subject to s. 766.1183 or s. 766.1184.
2153 Section 27. Section 409.908, Florida Statutes, is amended
2154 to read:
2155 409.908 Reimbursement of Medicaid providers.—Subject to
2156 specific appropriations, the agency shall reimburse Medicaid
2157 providers, in accordance with state and federal law, according
2158 to methodologies set forth in the rules of the agency and in
2159 policy manuals and handbooks incorporated by reference therein.
2160 These methodologies may include fee schedules, reimbursement
2161 methods based on cost reporting, negotiated fees, competitive
2162 bidding pursuant to s. 287.057, and other mechanisms the agency
2163 considers efficient and effective for purchasing services or
2164 goods on behalf of recipients. ~~If a provider is reimbursed based~~
2165 ~~on cost reporting and submits a cost report late and that cost~~
2166 ~~report would have been used to set a lower reimbursement rate~~
2167 ~~for a rate semester, then the provider's rate for that semester~~
2168 ~~shall be retroactively calculated using the new cost report, and~~
2169 ~~full payment at the recalculated rate shall be effected~~
2170 ~~retroactively. Medicare-granted extensions for filing cost~~
2171 ~~reports, if applicable, shall also apply to Medicaid cost~~
2172 ~~reports.~~ Payment for Medicaid compensable services made on
2173 behalf of Medicaid eligible persons is subject to the
2174 availability of moneys and any limitations or directions
2175 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,

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2176 or s. 409.9022. ~~Further, nothing in~~ This section does not ~~shall~~
2177 ~~be construed to~~ prevent or limit the agency from adjusting fees,
2178 reimbursement rates, lengths of stay, number of visits, or
2179 number of services, or making any other adjustments necessary to
2180 comply with the availability of moneys and any limitations or
2181 directions provided ~~for~~ in the General Appropriations Act if~~,~~
2182 ~~provided~~ the adjustment is consistent with legislative intent.
2183 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed
2184 under part I of chapter 395 must be made prospectively or on the
2185 basis of negotiation.
2186 (a) *Inpatient care.*—
2187 1. Reimbursement for inpatient care is limited as provided
2188 ~~for~~ in s. 409.905(5), except for:
2189 a.~~1.~~ The raising of rate reimbursement caps, excluding
2190 rural hospitals.
2191 b.~~2.~~ Recognition of the costs of graduate medical
2192 education.
2193 c.~~3.~~ Other methodologies recognized in the General
2194 Appropriations Act.
2195 2. If ~~During the years~~ funds are transferred from the
2196 Department of Health, any reimbursement supported by such funds
2197 is ~~shall be~~ subject to certification by the Department of Health
2198 that the hospital has complied with s. 381.0403. The agency may
2199 ~~is authorized to~~ receive funds from state entities, including,
2200 but not limited to, the Department of Health, local governments,
2201 and other local political subdivisions, for the purpose of
2202 making special exception payments, including federal matching
2203 funds, through the Medicaid inpatient reimbursement
2204 methodologies. Funds received from state entities or local

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2205 governments for this purpose shall be separately accounted for
2206 and may ~~shall~~ not be commingled with other state or local funds
2207 in any manner. The agency may certify all local governmental
2208 funds used as state match under Title XIX of the Social Security
2209 Act, to the extent that the identified local health care
2210 provider that is otherwise entitled to and is contracted to
2211 receive such local funds is the benefactor under the state's
2212 Medicaid program as determined under the General Appropriations
2213 Act and pursuant to an agreement between the agency ~~for Health~~
2214 ~~Care Administration~~ and the local governmental entity. The local
2215 governmental entity shall use a certification form prescribed by
2216 the agency. At a minimum, the certification form must ~~shall~~
2217 identify the amount being certified and describe the
2218 relationship between the certifying local governmental entity
2219 and the local health care provider. The agency shall prepare an
2220 annual statement of impact which documents the specific
2221 activities undertaken during the previous fiscal year pursuant
2222 to this paragraph, to be submitted to the Legislature annually
2223 by ~~no later than~~ January 1~~, annually~~.
2224 (b) *Outpatient care.*—
2225 1. Reimbursement for hospital outpatient care is limited to
2226 $1,500 per state fiscal year per recipient, except for:
2227 a.~~1.~~ ~~Such~~ Care provided to a Medicaid recipient under age
2228 21, in which case the only limitation is medical necessity.
2229 b.~~2.~~ Renal dialysis services.
2230 c.~~3.~~ Other exceptions made by the agency.
2231 2. The agency may ~~is authorized to~~ receive funds from state
2232 entities, including, but not limited to, the Department of
2233 Health, the Board of Governors of the State University System,

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2234 local governments, and other local political subdivisions, for
2235 the purpose of making payments, including federal matching
2236 funds, through the Medicaid outpatient reimbursement
2237 methodologies. Funds received ~~from state entities and local~~
2238 ~~governments~~ for this purpose shall be separately accounted for
2239 and may ~~shall~~ not be commingled with other state or local funds
2240 ~~in any manner~~.
2241 3. The agency may limit inflationary increases for
2242 outpatient hospital services as directed by the General
2243 Appropriations Act.
2244 (c) *Disproportionate share.*—Hospitals that provide services
2245 to a disproportionate share of low-income Medicaid recipients,
2246 ~~or~~ that participate in the regional perinatal intensive care
2247 center program under chapter 383, or that participate in the
2248 statutory teaching hospital disproportionate share program may
2249 receive additional reimbursement. The total amount of payment
2250 for disproportionate share hospitals shall be fixed by the
2251 General Appropriations Act. The computation of these payments
2252 must comply ~~be made in compliance~~ with all federal regulations
2253 and the methodologies described in ss. 409.911, 409.9112, and
2254 409.9113.
2255 ~~(d) The agency is authorized to limit inflationary~~
2256 ~~increases for outpatient hospital services as directed by the~~
2257 ~~General Appropriations Act.~~
2258 (2) NURSING HOME CARE.—
2259 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II
2260 of chapter 400 and state-owned-and-operated intermediate care
2261 facilities for the developmentally disabled licensed under part
2262 VIII of chapter 400 must be made prospectively.

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2263 (a)~~2.~~ Unless otherwise limited or directed in the General
2264 Appropriations Act, reimbursement to hospitals licensed under
2265 part I of chapter 395 for ~~the provision of~~ swing-bed nursing
2266 home services must be based ~~made~~ on ~~the basis of~~ the average
2267 statewide nursing home payment, and reimbursement to a hospital
2268 ~~licensed under part I of chapter 395~~ for ~~the provision of~~
2269 skilled nursing services must be based ~~made~~ on ~~the basis of~~ the
2270 average nursing home payment for those services in the county in
2271 which the hospital is located. If ~~When~~ a hospital is located in
2272 a county that does not have any community nursing homes,
2273 reimbursement shall be determined by averaging the nursing home
2274 payments in counties that surround the county in which the
2275 hospital is located. Reimbursement to hospitals, including
2276 Medicaid payment of Medicare copayments, for skilled nursing
2277 services is ~~shall be~~ limited to 30 days, unless a prior
2278 authorization has been obtained from the agency. Medicaid
2279 reimbursement may be extended by the agency beyond 30 days, and
2280 approval must be based upon verification by the patient's
2281 physician that the patient requires short-term rehabilitative
2282 and recuperative services only, in which case an extension of no
2283 more than 15 days may be approved. Reimbursement to a hospital
2284 ~~licensed under part I of chapter 395~~ for the temporary provision
2285 of skilled nursing services to nursing home residents who have
2286 been displaced as the result of a natural disaster or other
2287 emergency may not exceed the average county nursing home payment
2288 for those services in the county in which the hospital is
2289 located and is limited to the period of time which the agency
2290 considers necessary for continued placement of the nursing home
2291 residents in the hospital.

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2292 (b) Subject to any limitations or directions provided ~~for~~
2293 in the General Appropriations Act, the agency shall establish
2294 and implement a Florida Title XIX Long-Term Care Reimbursement
2295 Plan (Medicaid) for nursing home care in order to provide care
2296 and services that conform to ~~in conformance with the~~ applicable
2297 state and federal laws, rules, regulations, and quality and
2298 safety standards and to ensure that individuals eligible for
2299 medical assistance have reasonable geographic access to such
2300 care.
2301 1. The agency shall amend the long-term care reimbursement
2302 plan and cost reporting system to create direct care and
2303 indirect care subcomponents of the patient care component of the
2304 per diem rate. These two subcomponents together must ~~shall~~ equal
2305 the patient care component of the per diem rate. Separate cost-
2306 based ceilings shall be calculated for each patient care
2307 subcomponent. The direct care subcomponent of the per diem rate
2308 is ~~shall be~~ limited by the cost-based class ceiling, and the
2309 indirect care subcomponent may be limited by the lower of the
2310 cost-based class ceiling, the target rate class ceiling, or the
2311 individual provider target.
2312 2. The direct care subcomponent includes ~~shall include~~
2313 salaries and benefits of direct care staff providing nursing
2314 services, including registered nurses, licensed practical
2315 nurses, and certified nursing assistants who deliver care
2316 directly to residents in the nursing home facility. This
2317 excludes nursing administration, minimum data set, and care plan
2318 coordinators, staff development, and the staffing coordinator.
2319 The direct care subcomponent also includes medically necessary
2320 dental care, vision care, hearing care, and podiatric care.

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2321 3. All other patient care costs are ~~shall be~~ included in
2322 the indirect care cost subcomponent of the patient care per diem
2323 rate. ~~There shall be no~~ Costs may not be directly or indirectly
2324 allocated to the direct care subcomponent from a home office or
2325 management company.
2326 4. On July 1 of each year, the agency shall report to the
2327 Legislature direct and indirect care costs, including average
2328 direct and indirect care costs per resident per facility and
2329 direct care and indirect care salaries and benefits per category
2330 of staff member per facility.
2331 5. In order to offset the cost of general and professional
2332 liability insurance, the agency shall amend the plan to allow
2333 for interim rate adjustments to reflect increases in the cost of
2334 general or professional liability insurance for nursing homes.
2335 This provision shall be implemented to the extent existing
2336 appropriations are available.
2337
2338 It is the intent of the Legislature that the reimbursement plan
2339 achieve the goal of providing access to health care for nursing
2340 home residents who require large amounts of care while
2341 encouraging diversion services as an alternative to nursing home
2342 care for residents who can be served within the community. The
2343 agency shall base the establishment of any maximum rate of
2344 payment, whether overall or component, on the available moneys
2345 ~~as~~ provided ~~for~~ in the General Appropriations Act. The agency
2346 may base the maximum rate of payment on the results of
2347 scientifically valid analysis and conclusions derived from
2348 objective statistical data pertinent to the particular maximum
2349 rate of payment.

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2350 (c) The agency shall request and implement Medicaid waivers
2351 approved by the federal Centers for Medicare and Medicaid
2352 Services to advance and treat a portion of the Medicaid nursing
2353 home per diem as capital for creating and operating a risk-
2354 retention group for self-insurance purposes, consistent with
2355 federal and state laws and rules.
2356 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any
2357 limitations or directions provided ~~for~~ in the General
2358 Appropriations Act, the following Medicaid services and goods
2359 may be reimbursed on a fee-for-service basis. For each allowable
2360 service or goods furnished in accordance with Medicaid rules,
2361 policy manuals, handbooks, and state and federal law, the
2362 payment shall be the amount billed by the provider, the
2363 provider's usual and customary charge, or the maximum allowable
2364 fee established by the agency, whichever amount is less, with
2365 the exception of those services or goods for which the agency
2366 makes payment using a methodology based on capitation rates,
2367 average costs, or negotiated fees.
2368 (a) Advanced registered nurse practitioner services.
2369 (b) Birth center services.
2370 (c) Chiropractic services.
2371 (d) Community mental health services.
2372 (e) Dental services, including oral and maxillofacial
2373 surgery.
2374 (f) Durable medical equipment.
2375 (g) Hearing services.
2376 (h) Occupational therapy for Medicaid recipients under age
2377 21.
2378 (i) Optometric services.

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2379 (j) Orthodontic services.
2380 (k) Personal care for Medicaid recipients under age 21.
2381 (l) Physical therapy for Medicaid recipients under age 21.
2382 (m) Physician assistant services.
2383 (n) Podiatric services.
2384 (o) Portable X-ray services.
2385 (p) Private-duty nursing for Medicaid recipients under age
2386 21.
2387 (q) Registered nurse first assistant services.
2388 (r) Respiratory therapy for Medicaid recipients under age
2389 21.
2390 (s) Speech therapy for Medicaid recipients under age 21.
2391 (t) Visual services.
2392 (4) MANAGED CARE SERVICES.—Subject to any limitations or
2393 directions provided ~~for~~ in the General Appropriations Act,
2394 alternative health plans, health maintenance organizations, and
2395 prepaid health plans shall be reimbursed a fixed, prepaid amount
2396 negotiated, or competitively bid pursuant to s. 287.057, by the
2397 agency and prospectively paid to the provider monthly for each
2398 Medicaid recipient enrolled. The amount may not exceed the
2399 average amount the agency determines it would have paid, based
2400 on claims experience, for recipients in the same or similar
2401 category of eligibility. The agency shall calculate capitation
2402 rates on a regional basis and~~, beginning September 1, 1995,~~
2403 ~~shall~~ include age-band differentials in such calculations.
2404 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical
2405 center shall be reimbursed the lesser of the amount billed by
2406 the provider or the Medicare-established allowable amount for
2407 the facility.

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2408 (6) EPSDT SERVICES.—A provider of early and periodic
2409 screening, diagnosis, and treatment services to Medicaid
2410 recipients who are ~~children~~ under age 21 shall be reimbursed
2411 using an all-inclusive rate stipulated in a fee schedule
2412 established by the agency. A provider of the visual, dental, and
2413 hearing components of such services shall be reimbursed the
2414 lesser of the amount billed by the provider or the Medicaid
2415 maximum allowable fee established by the agency.
2416 (7) FAMILY PLANNING SERVICES.—A provider of family planning
2417 services shall be reimbursed the lesser of the amount billed by
2418 the provider or an all-inclusive amount per type of visit for
2419 physicians and advanced registered nurse practitioners, as
2420 established by the agency in a fee schedule.
2421 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-
2422 based or community-based services rendered pursuant to a
2423 federally approved waiver shall be reimbursed based on an
2424 established or negotiated rate for each service. These rates
2425 shall be established according to an analysis of the expenditure
2426 history and prospective budget developed by each contract
2427 provider participating in the waiver program, or under any other
2428 methodology adopted by the agency and approved by the Federal
2429 Government in accordance with the waiver. Privately owned and
2430 operated community-based residential facilities that ~~which~~ meet
2431 agency requirements and ~~which~~ formerly received Medicaid
2432 reimbursement for the optional intermediate care facility for
2433 the mentally retarded service may participate in the
2434 developmental services waiver as part of a home-and-community-
2435 based continuum of care for Medicaid recipients who receive
2436 waiver services.

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2437 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider
2438 of home health care services or of medical supplies and
2439 appliances shall be reimbursed on the basis of competitive
2440 bidding or for the lesser of the amount billed by the provider
2441 or the agency's established maximum allowable amount, except
2442 that~~, in the case of the rental of durable medical equipment,~~
2443 the total rental payments for durable medical equipment may not
2444 exceed the purchase price of the equipment over its expected
2445 useful life or the agency's established maximum allowable
2446 amount, whichever amount is less.
2447 (10) HOSPICE.—A hospice shall be reimbursed through a
2448 prospective system for each Medicaid hospice patient at Medicaid
2449 rates using the methodology established for hospice
2450 reimbursement pursuant to Title XVIII of the federal Social
2451 Security Act.
2452 (11) LABORATORY SERVICES.—A provider of independent
2453 laboratory services shall be reimbursed on the basis of
2454 competitive bidding or for the least of the amount billed by the
2455 provider, the provider's usual and customary charge, or the
2456 Medicaid maximum allowable fee established by the agency.
2457 (12) PHYSICIAN SERVICES.—
2458 (a) A physician shall be reimbursed the lesser of the
2459 amount billed by the provider or the Medicaid maximum allowable
2460 fee established by the agency.
2461 (b) The agency shall adopt a fee schedule, subject to any
2462 limitations or directions provided ~~for~~ in the General
2463 Appropriations Act, based on a resource-based relative value
2464 scale for pricing Medicaid physician services. Under the ~~this~~
2465 fee schedule, physicians shall be paid a dollar amount for each

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2466 service based on the average resources required to provide the
2467 service, including, but not limited to, estimates of average
2468 physician time and effort, practice expense, and the costs of
2469 professional liability insurance. The fee schedule must ~~shall~~
2470 provide increased reimbursement for preventive and primary care
2471 services and lowered reimbursement for specialty services by
2472 using at least two conversion factors, one for cognitive
2473 services and another for procedural services. The fee schedule
2474 may ~~shall~~ not increase total Medicaid physician expenditures
2475 unless moneys are available. The agency ~~for Health Care~~
2476 ~~Administration~~ shall seek the advice of a 16-member advisory
2477 panel in formulating and adopting the fee schedule. The panel
2478 shall consist of Medicaid physicians licensed under chapters 458
2479 and 459 and ~~shall~~ be composed of 50 percent primary care
2480 physicians and 50 percent specialty care physicians.
2481 (c) Notwithstanding paragraph (b), reimbursement fees to
2482 physicians for providing total obstetrical services to Medicaid
2483 recipients, which include prenatal, delivery, and postpartum
2484 care, must ~~shall~~ be at least $1,500 per delivery for a pregnant
2485 woman with low medical risk and at least $2,000 per delivery for
2486 a pregnant woman with high medical risk. However, reimbursement
2487 to physicians working in regional perinatal intensive care
2488 centers designated pursuant to chapter 383, for services to
2489 ~~certain~~ pregnant Medicaid recipients with a high medical risk,
2490 may be made according to obstetrical care and neonatal care
2491 groupings and rates established by the agency. Nurse midwives
2492 licensed under part I of chapter 464 or midwives licensed under
2493 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent
2494 of the low medical risk fee. The agency shall by rule determine,

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2495 for the purpose of this paragraph, what constitutes a high or
2496 low medical risk pregnant woman and may ~~shall~~ not pay more based
2497 solely on the fact that a caesarean section was performed,
2498 rather than a vaginal delivery. The agency shall by rule
2499 determine a prorated payment for obstetrical services ~~in cases~~
2500 where only part of the total prenatal, delivery, or postpartum
2501 care was performed. The Department of Health shall adopt rules
2502 for appropriate insurance coverage for midwives licensed under
2503 chapter 467. Before issuing and renewing ~~Prior to the issuance~~
2504 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~
2505 ~~of~~ an inactive license for midwives licensed under chapter 467,
2506 such licensees must ~~shall~~ submit proof of coverage with each
2507 application.
2508 (d) Effective January 1, 2013, Medicaid fee-for-service
2509 payments to primary care physicians for primary care services
2510 must be at least 100 percent of the Medicare payment rate for
2511 such services.
2512 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for
2513 persons eligible for both Medicare and Medicaid coverage shall
2514 be paid at the rates established by Title XVIII of the Social
2515 Security Act. For Medicare services rendered to Medicaid-
2516 eligible persons, Medicaid shall pay Medicare deductibles and
2517 coinsurance as follows:
2518 (a) Medicaid’s financial obligation for deductibles and
2519 coinsurance payments shall be based on Medicare allowable fees,
2520 not on a provider’s billed charges.
2521 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare
2522 deductibles and coinsurance if ~~when~~ payment that Medicare has
2523 made for the service equals or exceeds what Medicaid would have

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2524 paid if it had been the sole payor. The combined payment of
2525 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid
2526 would have paid had it been the sole payor. The Legislature
2527 finds that there has been confusion regarding the reimbursement
2528 for services rendered to dually eligible Medicare beneficiaries.
2529 Accordingly, the Legislature clarifies that it has always been
2530 the intent of the Legislature before and after 1991 that, in
2531 reimbursing in accordance with fees established by Title XVIII
2532 for premiums, deductibles, and coinsurance for Medicare services
2533 rendered by physicians to Medicaid eligible persons, physicians
2534 be reimbursed at the lesser of the amount billed by the
2535 physician or the Medicaid maximum allowable fee established by
2536 the agency ~~for Health Care Administration~~, as is permitted by
2537 federal law. It has never been the intent of the Legislature
2538 ~~with regard to such services rendered by physicians~~ that
2539 Medicaid be required to provide any payment for deductibles,
2540 coinsurance, or copayments for Medicare cost sharing, or any
2541 expenses incurred relating thereto, in excess of the payment
2542 amount provided for under the State Medicaid plan for physician
2543 services ~~such service~~. This payment methodology is applicable
2544 even in those situations in which the payment for Medicare cost
2545 sharing for a qualified Medicare beneficiary with respect to an
2546 item or service is reduced or eliminated. This expression of the
2547 Legislature clarifies ~~is in clarification of~~ existing law and
2548 applies ~~shall apply~~ to payment for, and with respect to provider
2549 agreements with respect to, items or services furnished on or
2550 after July 1, 2000 ~~the effective date of this act~~. This
2551 paragraph applies to payment by Medicaid for items and services
2552 furnished before July 1, 2000, ~~the effective date of this act~~ if

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2553 such payment is the subject of a lawsuit that is based on ~~the~~
2554 ~~provisions of~~ this section, and that is pending as of, or is
2555 initiated after that date~~, the effective date of this act~~.
2556 (c) Notwithstanding paragraphs (a) and (b):
2557 1. Medicaid payments for Nursing Home Medicare part A
2558 coinsurance are limited to the Medicaid nursing home per diem
2559 rate less any amounts paid by Medicare, but only up to the
2560 amount of Medicare coinsurance. The Medicaid per diem rate is
2561 ~~shall be~~ the rate in effect for the dates of service of the
2562 crossover claims and may not be subsequently adjusted due to
2563 subsequent per diem rate adjustments.
2564 2. Medicaid shall pay all deductibles and coinsurance for
2565 Medicare-eligible recipients receiving freestanding end stage
2566 renal dialysis center services.
2567 3. Medicaid payments for general and specialty hospital
2568 inpatient services are limited to the Medicare deductible and
2569 coinsurance per spell of illness. Medicaid payments for hospital
2570 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid
2571 hospital per diem rate less any amounts paid by Medicare, but
2572 only up to the amount of Medicare coinsurance. Medicaid payments
2573 for coinsurance are ~~shall be~~ limited to the Medicaid per diem
2574 rate in effect for the dates of service of the crossover claims
2575 and may not be subsequently adjusted due to subsequent per diem
2576 adjustments.
2577 4. Medicaid shall pay all deductibles and coinsurance for
2578 Medicare emergency transportation services provided by
2579 ambulances licensed pursuant to chapter 401.
2580 5. Medicaid shall pay all deductibles and coinsurance for
2581 portable X-ray Medicare Part B services provided in a nursing

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2582 home.
2583 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall
2584 be reimbursed the least of the amount billed by the provider,
2585 the provider's usual and customary charge, or the Medicaid
2586 maximum allowable fee established by the agency, plus a
2587 dispensing fee. The Medicaid maximum allowable fee for
2588 ingredient cost must ~~will~~ be based on the lower of the~~:~~ average
2589 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition
2590 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the
2591 state maximum allowable cost (SMAC), or the usual and customary
2592 (UAC) charge billed by the provider.
2593 (a) Medicaid providers must ~~are required to~~ dispense
2594 generic drugs if available at lower cost and the agency has not
2595 determined that the branded product is more cost-effective,
2596 unless the prescriber has requested and received approval to
2597 require the branded product.
2598 (b) The agency shall ~~is directed to~~ implement a variable
2599 dispensing fee for ~~payments for~~ prescribed medicines while
2600 ensuring continued access for Medicaid recipients. The variable
2601 dispensing fee may be based upon, but not limited to, either or
2602 both the volume of prescriptions dispensed by a specific
2603 pharmacy provider, the volume of prescriptions dispensed to an
2604 individual recipient, and dispensing of preferred-drug-list
2605 products.
2606 (c) The agency may increase the pharmacy dispensing fee
2607 authorized by statute and in the ~~annual~~ General Appropriations
2608 Act by $0.50 for the dispensing of a Medicaid preferred-drug-
2609 list product and reduce the pharmacy dispensing fee by $0.50 for
2610 the dispensing of a Medicaid product that is not included on the

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2611 preferred drug list.
2612 (d) The agency may establish a supplemental pharmaceutical
2613 dispensing fee to be paid to providers returning unused unit-
2614 dose packaged medications to stock and crediting the Medicaid
2615 program for the ingredient cost of those medications if the
2616 ingredient costs to be credited exceed the value of the
2617 supplemental dispensing fee.
2618 (e) The agency may ~~is authorized to~~ limit reimbursement for
2619 prescribed medicine in order to comply with any limitations or
2620 directions provided ~~for~~ in the General Appropriations Act, which
2621 may include implementing a prospective or concurrent utilization
2622 review program.
2623 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary
2624 care case management services rendered pursuant to a federally
2625 approved waiver shall be reimbursed by payment of a fixed,
2626 prepaid monthly sum for each Medicaid recipient enrolled with
2627 the provider.
2628 (16) RURAL HEALTH CLINICS.—A provider of rural health
2629 clinic services and federally qualified health center services
2630 shall be reimbursed a rate per visit based on total reasonable
2631 costs of the clinic, as determined by the agency in accordance
2632 with federal regulations.
2633 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case
2634 management services shall be reimbursed pursuant to an
2635 established fee, except where the Federal Government requires a
2636 public provider be reimbursed on the basis of average actual
2637 costs.
2638 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the
2639 General Appropriations Act, a provider of transportation

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2640 services shall be reimbursed the lesser of the amount billed by
2641 the provider or the Medicaid maximum allowable fee established
2642 by the agency, except if ~~when~~ the agency has entered into a
2643 direct contract with the provider, or with a community
2644 transportation coordinator, for the provision of an all-
2645 inclusive service, or if ~~when~~ services are provided pursuant to
2646 an agreement negotiated between the agency and the provider. ~~The~~
2647 ~~agency, as provided for in s. 427.0135, shall purchase~~
2648 ~~transportation services through the community coordinated~~
2649 ~~transportation system, if available, unless the agency, after~~
2650 ~~consultation with the commission, determines that it cannot~~
2651 ~~reach mutually acceptable contract terms with the commission.~~
2652 ~~The agency may then contract for the same transportation~~
2653 ~~services provided in a more cost-effective manner and of~~
2654 ~~comparable or higher quality and standards. Nothing in~~
2655 (a) This subsection does not ~~shall be construed to~~ limit or
2656 preclude the agency from contracting for services using a
2657 prepaid capitation rate or from establishing maximum fee
2658 schedules, individualized reimbursement policies by provider
2659 type, negotiated fees, prior authorization, competitive bidding,
2660 increased use of mass transit, or any other mechanism that the
2661 agency considers efficient and effective for the purchase of
2662 services on behalf of Medicaid clients, including implementing a
2663 transportation eligibility process.
2664 (b) The agency may ~~shall~~ not ~~be required to~~ contract with
2665 any community transportation coordinator or transportation
2666 operator that has been determined by the agency, the Department
2667 of Legal Affairs Medicaid Fraud Control Unit, or any other state
2668 or federal agency to have engaged in any abusive or fraudulent

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2669 billing activities.
2670 (c) The agency shall ~~is authorized to~~ competitively procure
2671 transportation services or make other changes necessary to
2672 secure approval of federal waivers needed to permit federal
2673 financing of Medicaid transportation services at the service
2674 matching rate rather than the administrative matching rate.
2675 ~~Notwithstanding chapter 427, the agency is authorized to~~
2676 ~~continue contracting for Medicaid nonemergency transportation~~
2677 ~~services in agency service area 11 with managed care plans that~~
2678 ~~were under contract for those services before July 1, 2004.~~
2679 (d) Transportation to access covered services provided by a
2680 qualified plan pursuant to part IV of this chapter shall be
2681 contracted for by the plan. A qualified plan is not required to
2682 purchase such services through a coordinated transportation
2683 system established pursuant to part I of chapter 427.
2684 (19) COUNTY HEALTH DEPARTMENTS.—County health department
2685 services shall be reimbursed a rate per visit based on total
2686 reasonable costs of the clinic, as determined by the agency in
2687 accordance with federal regulations under the authority of 42
2688 C.F.R. s. 431.615.
2689 (20) DIALYSIS.—A renal dialysis facility that provides
2690 dialysis services under s. 409.906(9) must be reimbursed the
2691 lesser of the amount billed by the provider, the provider's
2692 usual and customary charge, or the maximum allowable fee
2693 established by the agency, whichever ~~amount~~ is less.
2694 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse
2695 school districts that ~~which~~ certify the state match pursuant to
2696 ss. 409.9071 and 1011.70 for the federal portion of the school
2697 district's allowable costs to deliver the services, based on the

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2698 reimbursement schedule. The school district shall determine the
2699 costs for delivering services as authorized in ss. 409.9071 and
2700 1011.70 for which the state match will be certified.
2701 Reimbursement of school-based providers is contingent on such
2702 providers being enrolled as Medicaid providers and meeting the
2703 qualifications contained in 42 C.F.R. s. 440.110, unless
2704 otherwise waived by the federal Centers for Medicare and
2705 Medicaid Services ~~Health Care Financing Administration~~. Speech
2706 therapy providers who are certified through the Department of
2707 Education pursuant to rule 6A-4.0176, Florida Administrative
2708 Code, are eligible for reimbursement for services that are
2709 provided on school premises. Any employee of the school district
2710 who has been fingerprinted and has received a criminal
2711 background check in accordance with Department of Education
2712 rules and guidelines is ~~shall be~~ exempt from any agency
2713 requirements relating to criminal background checks.
2714 ~~(22) The agency shall request and implement Medicaid~~
2715 ~~waivers from the federal Health Care Financing Administration to~~
2716 ~~advance and treat a portion of the Medicaid nursing home per~~
2717 ~~diem as capital for creating and operating a risk-retention~~
2718 ~~group for self-insurance purposes, consistent with federal and~~
2719 ~~state laws and rules.~~
2720 (22)~~(23)(a)~~ LIMITATION ON REIMBURSEMENT RATES.—The agency
2721 shall establish rates at a level that ensures no increase in
2722 statewide expenditures resulting from a change in unit costs for
2723 2 fiscal years effective July 1, 2009. Reimbursement rates for
2724 the 2 fiscal years shall be as provided in the General
2725 Appropriations Act.
2726 (a)~~(b)~~ This subsection applies to the following provider

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2727 types:
2728 1. Inpatient hospitals.
2729 2. Outpatient hospitals.
2730 3. Nursing homes.
2731 4. County health departments.
2732 5. Community intermediate care facilities for the
2733 developmentally disabled.
2734 6. Prepaid health plans.
2735 (b) The agency shall apply ~~the effect of~~ this subsection to
2736 the reimbursement rates for nursing home diversion programs.
2737 ~~(c) The agency shall create a workgroup on hospital~~
2738 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
2739 ~~and a workgroup on managed care plan payment. The workgroups~~
2740 ~~shall evaluate alternative reimbursement and payment~~
2741 ~~methodologies for hospitals, nursing facilities, and managed~~
2742 ~~care plans, including prospective payment methodologies for~~
2743 ~~hospitals and nursing facilities. The nursing facility workgroup~~
2744 ~~shall also consider price-based methodologies for indirect care~~
2745 ~~and acuity adjustments for direct care. The agency shall submit~~
2746 ~~a report on the evaluated alternative reimbursement~~
2747 ~~methodologies to the relevant committees of the Senate and the~~
2748 ~~House of Representatives by November 1, 2009.~~
2749 (c) ~~(d)~~ This subsection expires June 30, 2011.
2750 (23) PAYMENT METHODOLOGIES.—If a provider is reimbursed
2751 based on cost reporting and submits a cost report late and that
2752 cost report would have been used to set a lower reimbursement
2753 rate for a rate semester, the provider's rate for that semester
2754 shall be retroactively calculated using the new cost report, and
2755 full payment at the recalculated rate shall be applied

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2756 retroactively. Medicare-granted extensions for filing cost
2757 reports, if applicable, also apply to Medicaid cost reports.
2758 (24) RETURN OF PAYMENTS.—If a provider fails to notify the
2759 agency within 5 business days after suspension or disenrollment
2760 from Medicare, sanctions may be imposed pursuant to this
2761 chapter, and the provider may be required to return funds paid
2762 to the provider during the period of time that the provider was
2763 suspended or disenrolled ~~as a Medicare provider~~.
2764 Section 28. Subsection (1) of section 409.9081, Florida
2765 Statutes, is amended to read:
2766 409.9081 Copayments.—
2767 (1) ~~The agency shall require,~~ Subject to federal
2768 regulations and limitations, each Medicaid recipient must ~~to~~ pay
2769 at the time of service a nominal copayment for the following
2770 Medicaid services:
2771 (a) Hospital outpatient services: up to $3 for each
2772 hospital outpatient visit.
2773 (b) Physician services: up to $2 copayment for each visit
2774 with a primary care physician and up to $3 copayment for each
2775 visit with a specialty care physician ~~licensed under chapter~~
2776 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463~~.
2777 (c) Hospital emergency department visits for nonemergency
2778 care: 5 percent of up to the first $300 of the Medicaid payment
2779 for emergency room services, not to exceed $15. The agency shall
2780 seek a federal waiver of the requirement that cost-sharing
2781 amounts for nonemergency services and care furnished in a
2782 hospital emergency department be nominal. Upon waiver approval,
2783 a Medicaid recipient who requests such services and care, must
2784 pay a $100 copayment to the hospital for the nonemergency

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2785 services and care provided in the hospital emergency department.
2786 (d) Prescription drugs: a coinsurance equal to 2.5 percent
2787 of the Medicaid cost of the prescription drug at the time of
2788 purchase. The maximum coinsurance is ~~shall be~~ $7.50 per
2789 prescription drug purchased.
2790 Section 29. Paragraphs (b) and (d) of subsection (4) and
2791 subsections (8), (34), (44), (47), and (53) of section 409.912,
2792 Florida Statutes, are amended, and subsections (48) through (52)
2793 of that section are renumbered as subsections (47) through (51)
2794 respectively, to read:
2795 409.912 Cost-effective purchasing of health care.—The
2796 agency shall purchase goods and services for Medicaid recipients
2797 in the most cost-effective manner consistent with the delivery
2798 of quality medical care. To ensure that medical services are
2799 effectively utilized, the agency may, in any case, require a
2800 confirmation or second physician's opinion of the correct
2801 diagnosis for purposes of authorizing future services under the
2802 Medicaid program. This section does not restrict access to
2803 emergency services or poststabilization care services as defined
2804 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2805 shall be rendered in a manner approved by the agency. The agency
2806 shall maximize the use of prepaid per capita and prepaid
2807 aggregate fixed-sum basis services when appropriate and other
2808 alternative service delivery and reimbursement methodologies,
2809 including competitive bidding pursuant to s. 287.057, designed
2810 to facilitate the cost-effective purchase of a case-managed
2811 continuum of care. The agency shall also require providers to
2812 minimize the exposure of recipients to the need for acute
2813 inpatient, custodial, and other institutional care and the

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2814 inappropriate or unnecessary use of high-cost services. The
2815 agency shall contract with a vendor to monitor and evaluate the
2816 clinical practice patterns of providers in order to identify
2817 trends that are outside the normal practice patterns of a
2818 provider’s professional peers or the national guidelines of a
2819 provider’s professional association. The vendor must be able to
2820 provide information and counseling to a provider whose practice
2821 patterns are outside the norms, in consultation with the agency,
2822 to improve patient care and reduce inappropriate utilization.
2823 The agency may mandate prior authorization, drug therapy
2824 management, or disease management participation for certain
2825 populations of Medicaid beneficiaries, certain drug classes, or
2826 particular drugs to prevent fraud, abuse, overuse, and possible
2827 dangerous drug interactions. The Pharmaceutical and Therapeutics
2828 Committee shall make recommendations to the agency on drugs for
2829 which prior authorization is required. The agency shall inform
2830 the Pharmaceutical and Therapeutics Committee of its decisions
2831 regarding drugs subject to prior authorization. The agency is
2832 authorized to limit the entities it contracts with or enrolls as
2833 Medicaid providers by developing a provider network through
2834 provider credentialing. The agency may competitively bid single-
2835 source-provider contracts if procurement of goods or services
2836 results in demonstrated cost savings to the state without
2837 limiting access to care. The agency may limit its network based
2838 on the assessment of beneficiary access to care, provider
2839 availability, provider quality standards, time and distance
2840 standards for access to care, the cultural competence of the
2841 provider network, demographic characteristics of Medicaid
2842 beneficiaries, practice and provider-to-beneficiary standards,

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2843 appointment wait times, beneficiary use of services, provider
2844 turnover, provider profiling, provider licensure history,
2845 previous program integrity investigations and findings, peer
2846 review, provider Medicaid policy and billing compliance records,
2847 clinical and medical record audits, and other factors. Providers
2848 shall not be entitled to enrollment in the Medicaid provider
2849 network. The agency shall determine instances in which allowing
2850 Medicaid beneficiaries to purchase durable medical equipment and
2851 other goods is less expensive to the Medicaid program than long-
2852 term rental of the equipment or goods. The agency may establish
2853 rules to facilitate purchases in lieu of long-term rentals in
2854 order to protect against fraud and abuse in the Medicaid program
2855 as defined in s. 409.913. The agency may seek federal waivers
2856 necessary to administer these policies.
2857 (4) The agency may contract with:
2858 (b) An entity that is providing comprehensive behavioral
2859 health care services to ~~certain~~ Medicaid recipients through a
2860 capitated, prepaid arrangement pursuant to the federal waiver
2861 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.
2862 Such entity must be licensed under chapter 624, chapter 636, or
2863 chapter 641, or authorized under paragraph (c) or paragraph (d),
2864 and must possess the clinical systems and operational competence
2865 to manage risk and provide comprehensive behavioral health care
2866 to Medicaid recipients. As used in this paragraph, the term
2867 “comprehensive behavioral health care services” means covered
2868 mental health and substance abuse treatment services that are
2869 available to Medicaid recipients. The Secretary ~~of the~~
2870 ~~Department~~ of Children and Family Services must ~~shall~~ approve
2871 ~~provisions of~~ procurements related to children in the

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2872 department's care or custody before enrolling such children in a
2873 prepaid behavioral health plan. Any contract awarded under this
2874 paragraph must be competitively procured. ~~In developing~~ The
2875 behavioral health care prepaid plan procurement document must
2876 require~~, the agency shall ensure that the procurement document~~
2877 ~~requires~~ the contractor to develop and implement a plan to
2878 ensure compliance with s. 394.4574 related to services provided
2879 to residents of licensed assisted living facilities that hold a
2880 limited mental health license. Except as provided in
2881 subparagraph 5. ~~8.~~, and except in counties where the Medicaid
2882 managed care pilot program is authorized pursuant to s. 409.986
2883 ~~409.91211~~, the agency shall seek federal approval to contract
2884 with a single entity ~~meeting these requirements~~ to provide
2885 comprehensive behavioral health care services to all Medicaid
2886 recipients not enrolled in a Medicaid managed care plan
2887 authorized under s. 409.986 ~~409.91211~~, a provider service
2888 network authorized under paragraph (d), or a Medicaid health
2889 maintenance organization in an AHCA area. In an AHCA area where
2890 the Medicaid managed care pilot program is authorized pursuant
2891 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may
2892 procure a contract with a single entity to serve the remaining
2893 counties as an AHCA area or the remaining counties may be
2894 included with an adjacent AHCA area and are subject to this
2895 paragraph. Each entity must offer a ~~sufficient~~ choice of
2896 providers in its network to ensure recipient access to care and
2897 the opportunity to select a provider with whom they are
2898 satisfied. The network shall include all public mental health
2899 hospitals. To ensure unimpaired access to behavioral health care
2900 services by Medicaid recipients, all contracts issued pursuant

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2901 to this paragraph must require that 90 ~~80~~ percent of the
2902 capitation paid to the managed care plan, including health
2903 maintenance organizations and capitated provider service
2904 networks, ~~to~~ be expended for the provision of behavioral health
2905 care services. If the managed care plan expends less than 90 ~~80~~
2906 percent ~~of the capitation paid~~ for the provision of behavioral
2907 health care services, the difference shall be returned to the
2908 agency. The agency shall provide the plan with a certification
2909 letter indicating the amount of capitation paid during each
2910 calendar year for behavioral health care services pursuant to
2911 this section. The agency may reimburse ~~for~~ substance abuse
2912 treatment services on a fee-for-service basis until the agency
2913 finds that adequate funds are available for capitated, prepaid
2914 arrangements.
2915 1. ~~By January 1, 2001,~~ The agency shall modify the
2916 contracts with the entities providing comprehensive inpatient
2917 and outpatient mental health care services to Medicaid
2918 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
2919 Counties, to include substance abuse treatment services.
2920 ~~2. By July 1, 2003, the agency and the Department of~~
2921 ~~Children and Family Services shall execute a written agreement~~
2922 ~~that requires collaboration and joint development of all policy,~~
2923 ~~budgets, procurement documents, contracts, and monitoring plans~~
2924 ~~that have an impact on the state and Medicaid community mental~~
2925 ~~health and targeted case management programs.~~
2926 2.~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~
2927 ~~2006,~~ the agency and the Department of Children and Family
2928 Services shall contract with managed care entities in each AHCA
2929 area ~~except area 6~~ or arrange to provide comprehensive inpatient

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2930 and outpatient mental health and substance abuse services
2931 through capitated prepaid arrangements to all Medicaid
2932 recipients who are eligible to participate in such plans under
2933 federal law and regulation. In AHCA areas where there are fewer
2934 than 150,000 eligible individuals ~~number less than 150,000~~, the
2935 agency shall contract with a single managed care plan to provide
2936 comprehensive behavioral health services to all recipients who
2937 are not enrolled in a Medicaid health maintenance organization,
2938 a provider service network authorized under paragraph (d), or a
2939 Medicaid capitated managed care plan authorized under s. 409.986
2940 ~~409.91211~~. The agency may contract with more than one
2941 comprehensive behavioral health provider to provide care to
2942 recipients who are not enrolled in a Medicaid capitated managed
2943 care plan authorized under s. 409.986 ~~409.91211~~, a provider
2944 service network authorized under paragraph (d), or a Medicaid
2945 health maintenance organization in AHCA areas where the eligible
2946 population exceeds 150,000. In an AHCA area where the Medicaid
2947 managed care pilot program is authorized pursuant to s. 409.986
2948 ~~409.91211~~ in one or more counties, the agency may procure a
2949 contract with a single entity to serve the remaining counties as
2950 an AHCA area or the remaining counties may be included with an
2951 adjacent AHCA area and shall be subject to this paragraph.
2952 Contracts for comprehensive behavioral health providers awarded
2953 pursuant to this section must ~~shall~~ be competitively procured.
2954 Both for-profit and not-for-profit corporations are eligible to
2955 compete. Managed care plans contracting with the agency under
2956 subsection (3) or paragraph (d), shall provide and receive
2957 payment for the same comprehensive behavioral health benefits as
2958 provided in AHCA rules, including handbooks incorporated by

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2959 reference. In AHCA area 11, the agency shall contract with at
2960 least two comprehensive behavioral health care providers to
2961 provide behavioral health care to recipients ~~in that area~~ who
2962 are enrolled in, or assigned to, the MediPass program. One of
2963 the ~~behavioral health care~~ contracts must be with the existing
2964 provider service network pilot project, as described in
2965 paragraph (d), for the purpose of demonstrating the cost-
2966 effectiveness of the provision of quality mental health services
2967 through a public hospital-operated managed care model. Payment
2968 shall be at an agreed-upon capitated rate to ensure cost
2969 savings. Of the recipients in area 11 who are assigned to
2970 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those
2971 MediPass-enrolled recipients shall be assigned to the existing
2972 provider service network in area 11 for their behavioral care.
2973 ~~4. By October 1, 2003, the agency and the department shall~~
2974 ~~submit a plan to the Governor, the President of the Senate, and~~
2975 ~~the Speaker of the House of Representatives which provides for~~
2976 ~~the full implementation of capitated prepaid behavioral health~~
2977 ~~care in all areas of the state.~~
2978 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
2979 ~~of the state where the agency is able to establish sufficient~~
2980 ~~capitation rates.~~
2981 ~~b. If the agency determines that the proposed capitation~~
2982 ~~rate in any area is insufficient to provide appropriate~~
2983 ~~services, the agency may adjust the capitation rate to ensure~~
2984 ~~that care will be available. The agency and the department may~~
2985 ~~use existing general revenue to address any additional required~~
2986 ~~match but may not over-obligate existing funds on an annualized~~
2987 ~~basis.~~

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2988 ~~c. Subject to any limitations provided in the General~~
2989 ~~Appropriations Act, the agency, in compliance with appropriate~~
2990 ~~federal authorization, shall develop policies and procedures~~
2991 ~~that allow for certification of local and state funds.~~
2992 3.~~5.~~ Children residing in a statewide inpatient psychiatric
2993 program, or in a Department of Juvenile Justice or a Department
2994 of Children and Family Services residential program approved as
2995 a Medicaid behavioral health overlay services provider may not
2996 be included in a behavioral health care prepaid health plan or
2997 any other Medicaid managed care plan pursuant to this paragraph.
2998 ~~6. In converting to a prepaid system of delivery, the~~
2999 ~~agency shall in its procurement document require an entity~~
3000 ~~providing only comprehensive behavioral health care services to~~
3001 ~~prevent the displacement of indigent care patients by enrollees~~
3002 ~~in the Medicaid prepaid health plan providing behavioral health~~
3003 ~~care services from facilities receiving state funding to provide~~
3004 ~~indigent behavioral health care, to facilities licensed under~~
3005 ~~chapter 395 which do not receive state funding for indigent~~
3006 ~~behavioral health care, or reimburse the unsubsidized facility~~
3007 ~~for the cost of behavioral health care provided to the displaced~~
3008 ~~indigent care patient.~~
3009 4.~~7.~~ Traditional community mental health providers under
3010 contract with the Department of Children and Family Services
3011 pursuant to part IV of chapter 394, ~~child welfare providers~~
3012 ~~under contract with the Department of Children and Family~~
3013 ~~Services in areas 1 and 6,~~ and inpatient mental health providers
3014 licensed pursuant to chapter 395 must be offered an opportunity
3015 to accept or decline a contract to participate in any provider
3016 network for prepaid behavioral health services.

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3017 5.~~8.~~ All Medicaid-eligible children, except children in
3018 area 1 and children in ~~Highlands County, Hardee County, Polk~~
3019 ~~County, or~~ Manatee County in ~~of~~ area 6, whose cases ~~that~~ are
3020 open for child welfare services in the statewide automated child
3021 welfare information ~~HomeSafeNet~~ system, shall receive their
3022 behavioral health care services through a specialty prepaid plan
3023 operated by community-based lead agencies through a single
3024 agency or formal agreements among several agencies. The agency
3025 shall work with the specialty plan to develop clinically
3026 effective, evidence-based alternatives as a downward
3027 substitution for the statewide inpatient psychiatric program and
3028 similar residential care and institutional services. The
3029 specialty prepaid plan must result in savings to the state
3030 comparable to savings achieved in other Medicaid managed care
3031 and prepaid programs. Such plan must provide mechanisms to
3032 maximize state and local revenues. The specialty prepaid plan
3033 shall be developed by the agency and the Department of Children
3034 and Family Services. The agency may seek federal waivers to
3035 implement this initiative. Medicaid-eligible children whose
3036 cases are open for child welfare services in the statewide
3037 automated child welfare information ~~HomeSafeNet~~ system and who
3038 reside in AHCA area 10 shall be enrolled in a capitated managed
3039 care plan, which includes provider service networks, which, in
3040 coordination with available community-based care providers
3041 specified in s. 409.1671, shall provide sufficient medical,
3042 developmental, behavioral, and emotional services to meet the
3043 needs of these children, subject to funding as provided in the
3044 General Appropriations Act ~~are exempt from the specialty prepaid~~
3045 ~~plan upon the development of a service delivery mechanism for~~

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3046 ~~children who reside in area 10 as specified in s.~~
3047 ~~409.91211(3)(dd)~~.
3048 (d) A provider service network, which may be reimbursed on
3049 a fee-for-service or prepaid basis.
3050 1. A provider service network that ~~which~~ is reimbursed by
3051 the agency on a prepaid basis is ~~shall be~~ exempt from parts I
3052 and III of chapter 641, but must comply with the solvency
3053 requirements in s. 641.2261(2) and meet appropriate financial
3054 reserve, quality assurance, and patient rights requirements ~~as~~
3055 established by the agency.
3056 2. ~~Medicaid recipients assigned to a provider service~~
3057 ~~network shall be chosen equally from those who would otherwise~~
3058 ~~have been assigned to prepaid plans and MediPass.~~ The agency may
3059 ~~is authorized to~~ seek federal Medicaid waivers as necessary to
3060 implement ~~the provisions of~~ this section. ~~Any contract~~
3061 ~~previously awarded to a provider service network operated by a~~
3062 ~~hospital pursuant to this subsection shall remain in effect for~~
3063 ~~a period of 3 years following the current contract expiration~~
3064 ~~date, regardless of any contractual provisions to the contrary.~~
3065 3. A provider service network is a network established or
3066 organized and operated by a health care provider, or group of
3067 affiliated health care providers, including minority physician
3068 networks and emergency room diversion programs that meet the
3069 requirements of s. 409.986 ~~409.91211~~, which provides a
3070 substantial proportion of the health care items and services
3071 under a contract directly through the provider or affiliated
3072 group of providers and may make arrangements with physicians or
3073 other health care professionals, health care institutions, or
3074 any combination of such individuals or institutions to assume

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3075 all or part of the financial risk on a prospective basis for the
3076 provision of basic health services by the physicians, by other
3077 health professionals, or through the institutions. The health
3078 care providers must have a controlling interest in the governing
3079 body of the provider service network organization.
3080 (8)~~(a)~~ The agency may contract on a prepaid or fixed-sum
3081 basis with an exclusive provider organization to provide health
3082 care services to Medicaid recipients if ~~provided that~~ the
3083 exclusive provider organization meets applicable managed care
3084 plan requirements in this section, ss. 409.987, 409.988
3085 ~~409.9122, 409.9123~~, 409.9128, and 627.6472, and other applicable
3086 provisions of law.
3087 ~~(b) For a period of no longer than 24 months after the~~
3088 ~~effective date of this paragraph, when a member of an exclusive~~
3089 ~~provider organization that is contracted by the agency to~~
3090 ~~provide health care services to Medicaid recipients in rural~~
3091 ~~areas without a health maintenance organization obtains services~~
3092 ~~from a provider that participates in the Medicaid program in~~
3093 ~~this state, the provider shall be paid in accordance with the~~
3094 ~~appropriate fee schedule for services provided to eligible~~
3095 ~~Medicaid recipients. The agency may seek waiver authority to~~
3096 ~~implement this paragraph.~~
3097 (34) The agency and entities that contract with the agency
3098 to provide health care services to Medicaid recipients under
3099 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~
3100 must comply with the provisions of s. 641.513 in providing
3101 emergency services and care to Medicaid recipients and MediPass
3102 recipients. Where feasible, safe, and cost-effective, the agency
3103 shall encourage hospitals, emergency medical services providers,

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3104 and other public and private health care providers to work
3105 together in their local communities to enter into agreements or
3106 arrangements to ensure access to alternatives to emergency
3107 services and care for those Medicaid recipients who need
3108 nonemergent care. The agency shall coordinate with hospitals,
3109 emergency medical services providers, private health plans,
3110 capitated managed care networks as established in s. 409.986
3111 ~~409.91211~~, and other public and private health care providers to
3112 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),
3113 627.6405, and 641.31097 to develop and implement emergency
3114 department diversion programs for Medicaid recipients.
3115 (44) The agency ~~for Health Care Administration~~ shall ensure
3116 that any Medicaid managed care plan as defined in s.
3117 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis
3118 or a shared savings basis, is cost-effective. For purposes of
3119 this subsection, the term “cost-effective” means that a
3120 network’s per-member, per-month costs to the state, including,
3121 but not limited to, fee-for-service costs, administrative costs,
3122 and case-management fees, if any, must be no greater than the
3123 state’s costs associated with contracts for Medicaid services
3124 established under subsection (3), which may be adjusted for
3125 health status. The agency shall conduct actuarially sound
3126 adjustments for health status in order to ensure such cost-
3127 effectiveness and shall annually publish the results on its
3128 Internet website. Contracts established pursuant to this
3129 subsection which are not cost-effective may not be renewed.
3130 ~~(47) The agency shall conduct a study of available~~
3131 ~~electronic systems for the purpose of verifying the identity and~~
3132 ~~eligibility of a Medicaid recipient. The agency shall recommend~~

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3133 ~~to the Legislature a plan to implement an electronic~~
3134 ~~verification system for Medicaid recipients by January 31, 2005.~~
3135 ~~(53) Before seeking an amendment to the state plan for~~
3136 ~~purposes of implementing programs authorized by the Deficit~~
3137 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~
3138 Section 30. Paragraph (a) of subsection (1) of section
3139 409.915, Florida Statutes, is amended to read:
3140 409.915 County contributions to Medicaid.—Although the
3141 state is responsible for the full portion of the state share of
3142 the matching funds required for the Medicaid program, in order
3143 to acquire a certain portion of these funds, the state shall
3144 charge the counties for certain items of care and service as
3145 provided in this section.
3146 (1) Each county shall participate in the following items of
3147 care and service:
3148 (a) For both health maintenance members and fee-for-service
3149 beneficiaries, payments for inpatient hospitalization in excess
3150 of 10 days, but not in excess of 45 days, with the exception of
3151 pregnant women and children whose income is greater than ~~in~~
3152 ~~excess of~~ the federal poverty level and who do not receive a
3153 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~
3154 ~~medically needy Program~~, and for adult lung transplant services.
3155 Section 31. Section 409.9301, Florida Statutes, is
3156 transferred, renumbered as section 409.9067, Florida Statutes,
3157 and subsections (1) and (2) of that section are amended, to
3158 read:
3159 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—
3160 (1) PROGRAM ESTABLISHED.—A program is established in the
3161 agency ~~for Health Care Administration~~ to provide pharmaceutical

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3162 expense assistance to individuals diagnosed with cancer or
3163 individuals who have obtained ~~received~~ organ transplants who
3164 received a Medicaid nonpoverty medical subsidy before ~~were~~
3165 ~~medically needy recipients prior to~~ January 1, 2006.
3166 (2) ELIGIBILITY.—Eligibility for the program is limited to
3167 an individual who:
3168 (a) Is a resident of this state;
3169 (b) Was a Medicaid recipient who received a nonpoverty
3170 medical subsidy before ~~under the Florida Medicaid medically~~
3171 ~~needy program prior to~~ January 1, 2006;
3172 (c) Is eligible for Medicare;
3173 (d) Is a cancer patient or an organ transplant recipient;
3174 and
3175 (e) Requests to be enrolled in the program.
3176 Section 32. Subsection (1) of section 409.9126, Florida
3177 Statutes, is amended to read:
3178 409.9126 Children with special health care needs.—
3179 (1) Except as provided in subsection (4), children eligible
3180 for Children's Medical Services who receive Medicaid benefits,
3181 and other Medicaid-eligible children with special health care
3182 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987
3183 ~~409.9122~~ and shall be served through the Children's Medical
3184 Services network established in chapter 391.
3185 Section 33. The Division of Statutory Revision is requested
3186 to create part IV of chapter 409, Florida Statutes, consisting
3187 of sections 409.961-409.978, Florida Statutes, entitled
3188 "MEDICAID MANAGED CARE."
3189 Section 34. Section 409.961, Florida Statutes, is created
3190 to read:

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3191 409.961 Construction; applicability.—It is the intent of
3192 the Legislature that if any conflict exists between ss. 409.961-
3193 409.978 and other parts or sections of this chapter, the
3194 provisions in ss. 409.961-409.978 control. Sections 409.961-
3195 409.978 apply only to the Medicaid managed care program, as
3196 provided in this part.
3197 Section 35. Section 409.962, Florida Statutes, is created
3198 to read:
3199 409.962 Definitions.—As used in this part, and including
3200 the terms defined in s. 409.901, the term:
3201 (1) "Direct care management" means care management
3202 activities that involve direct interaction between providers and
3203 patients.
3204 (2) "Home and community-based services" means a specific
3205 set of services designed to assist recipients qualifying under
3206 s. 409.974 in avoiding institutionalization.
3207 (3) "Medicaid managed care program" means the integrated,
3208 statewide Medicaid program created in this part, which includes
3209 the provision of managed care medical assistance services
3210 described in ss. 409.971 and 409.972 and managed long-term care
3211 services described in ss. 409.973-409.978.
3212 (4) "Provider service network" means an entity of which a
3213 controlling interest is owned by, or a controlling interest in
3214 the governing body of the entity is composed of, a health care
3215 provider, a group of affiliated providers, or a public agency or
3216 entity that delivers health services. For purposes of this
3217 chapter, health care providers include Florida-licensed health
3218 care professionals, Florida-licensed health care facilities,
3219 federally qualified health centers, and home health care

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3220 agencies.
3221 (5) "Qualified plan" means a managed care plan that is
3222 determined eligible to participate in the Medicaid managed care
3223 program pursuant to s. 409.965.
3224 (6) "Specialty plan" means a qualified plan that serves
3225 Medicaid recipients who meet specified criteria based on age,
3226 medical condition, or diagnosis.
3227 Section 36. Section 409.963, Florida Statutes, is created
3228 to read:
3229 409.963 Medicaid managed care program.—The Medicaid managed
3230 care program is established as a statewide, integrated managed
3231 care program for all covered medical assistance services and
3232 long-term care services as provided under this part. Pursuant to
3233 s. 409.902, the program shall be administered by the agency, and
3234 eligibility for the program shall be determined by the
3235 Department of Children and Family Services.
3236 (1) The agency shall submit amendments to the Medicaid
3237 state plan or to existing waivers, or submit new waiver requests
3238 under section 1115 or other applicable sections of the Social
3239 Security Act, by August 1, 2011, as needed to implement the
3240 managed care program. At a minimum, the waiver requests must
3241 include a waiver that allows home and community-based services
3242 to be preferred over nursing home services for persons who can
3243 be safely managed in the home and community, and a waiver that
3244 requires dually eligible recipients to participate in the
3245 Medicaid managed care program. The waiver requests must also
3246 include provisions authorizing the state to limit enrollment in
3247 managed long-term care, establish waiting lists, and limit the
3248 amount, duration, and scope of home and community-based services

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3249 to ensure that expenditures for persons eligible for managed
3250 long-term care services do not exceed funds provided in the
3251 General Appropriations Act.
3252 (a) The agency shall initiate any necessary procurements
3253 required to implement the managed care program as soon as
3254 practicable, but no later than July 1, 2011, in anticipation of
3255 prompt approval of the waivers needed for the managed care
3256 program by the United States Department of Health and Human
3257 Services.
3258 (b) In submitting waivers, the agency shall work with the
3259 federal Centers for Medicare and Medicaid Services to accomplish
3260 approval of all waivers by December 1, 2011, in order to begin
3261 implementation of the managed care program by December 31, 2011.
3262 (c) Before seeking a waiver, the agency shall provide
3263 public notice and the opportunity for public comment and include
3264 public feedback in the waiver application.
3265 (2) The agency shall begin implementation of the Medicaid
3266 managed care program on December 31, 2011. If waiver approval is
3267 obtained, the program shall be implemented in accordance with
3268 the terms and conditions of the waiver. If necessary waivers
3269 have not been timely received, the agency shall notify the
3270 Centers for Medicare and Medicaid Services of the state's
3271 implementation of the managed care program and request the
3272 federal agency to continue providing federal funds equivalent to
3273 the funding level provided under the Federal Medical Assistance
3274 Percentage in order to implement the managed care program.
3275 (a) If the Centers for Medicare and Medicaid Services
3276 refuses to continue providing federal funds, the managed care
3277 program shall be implemented as a state-only funded program to

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3278 the extent state funds are available.
3279 (b) If implemented as a state-only funded program, priority
3280 shall be given to providing:
3281 1. Nursing home services to persons eligible for nursing
3282 home care.
3283 2. Medical services to persons served by the Agency for
3284 Persons with Disabilities.
3285 3. Medical services to pregnant women.
3286 4. Physician and hospital services to persons who are
3287 determined to be eligible for Medicaid subject to the income,
3288 assets, and categorical eligibility tests set forth in federal
3289 and state law.
3290 5. Services provided under the Healthy Start waiver.
3291 6. Medical services provided to persons in the Nursing Home
3292 Diversion waiver.
3293 7. Medical services provided to persons in intermediate
3294 care facilities for the developmentally disabled.
3295 8. Services to children in the child welfare system whose
3296 medical care is provided in accordance with s. 409.16713, as
3297 authorized by the General Appropriations Act.
3298 (c) If implemented as a state-only funded program pursuant
3299 to paragraph (b), provisions related to the eligibility
3300 standards of the state and federally funded Medicaid program
3301 remain in effect, except as otherwise provided under the managed
3302 care program.
3303 (d) If implemented as a state-only funded program pursuant
3304 to paragraph (a), provider agreements and other contracts that
3305 provide for Medicaid services to recipients identified in
3306 paragraph (b) continue in effect.

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3307 Section 37. Section 409.964, Florida Statutes, is created
3308 to read:
3309 409.964 Enrollment.—All Medicaid recipients shall receive
3310 medical services through the Medicaid managed care program
3311 established under this part unless excluded under this section.
3312 (1) The following recipients are excluded from
3313 participation in the Medicaid managed care program:
3314 (a) Women who are eligible only for family planning
3315 services.
3316 (b) Women who are eligible only for breast and cervical
3317 cancer services.
3318 (c) Persons who have a developmental disability as defined
3319 in s. 393.063.
3320 (d) Persons who are eligible for a Medicaid nonpoverty
3321 medical subsidy.
3322 (e) Persons who receive eligible services under emergency
3323 Medicaid for aliens.
3324 (f) Persons who are residing in a nursing home facility or
3325 are considered residents under the nursing home's bed-hold
3326 policy on or before July 1, 2011.
3327 (g) Persons who are eligible for and receiving prescribed
3328 pediatric extended care.
3329 (h) Persons who are dependent on a respirator by medical
3330 necessity and who meet the definition of a medically dependent
3331 or technologically dependent child under s. 400.902.
3332 (i) Persons who select the Medicaid hospice benefit and are
3333 receiving hospice services from a hospice licensed under part IV
3334 of chapter 400.
3335 (j) Children residing in a statewide inpatient psychiatric

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3336 program.
3337 (k) A person who is eligible for services under the
3338 Medicaid program who has access to health care coverage through
3339 an employer-sponsored health plan. Such person may not receive
3340 Medicaid services under the fee-for-service program but may use
3341 Medicaid financial assistance to pay the cost of premiums for
3342 the employer-sponsored health plan. For purposes of this
3343 paragraph, access to health care coverage through an employer-
3344 sponsored health plan means that the Medicaid financial
3345 assistance available to the person is sufficient to pay the
3346 premium for the employer-sponsored health plan for the eligible
3347 person and his or her Medicaid eligible family members.
3348 1. The agency shall develop a process that allows a
3349 recipient who has access to employer-sponsored health coverage
3350 to use Medicaid financial assistance to pay the cost of the
3351 premium for the recipient and the recipient’s Medicaid-eligible
3352 family members for such coverage. The amount of financial
3353 assistance may not exceed the Medicaid capitated rate that would
3354 have been paid to a qualified plan for that recipient and the
3355 recipient’s family members.
3356 2. Contingent upon federal approval, the agency shall also
3357 allow recipients who have access to other insurance or coverage
3358 created pursuant to state or federal law to opt out of Medicaid
3359 managed care and apply the Medicaid capitated rate that would
3360 have been paid to a qualified plan for that recipient and the
3361 recipient’s family to pay for the other insurance product.
3362 (2) The following Medicaid recipients are exempt from
3363 mandatory enrollment in the managed care program but may
3364 volunteer to participate in the program:

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3365 (a) Recipients residing in residential commitment
3366 facilities operated through the Department of Juvenile Justice,
3367 group care facilities operated by the Department of Children and
3368 Family Services, or treatment facilities funded through the
3369 substance abuse and mental health program of the Department of
3370 Children and Family Services.
3371 (b) Persons eligible for refugee assistance.
3372 (3) Medicaid recipients who are exempt from mandatory
3373 participation under this section and who do not choose to enroll
3374 in the Medicaid managed care program shall be served though the
3375 Medicaid fee-for-service program as provided under part III of
3376 this chapter.
3377 Section 38. Section 409.965, Florida Statutes, is created
3378 to read:
3379 409.965 Qualified plans; regions; selection criteria.—
3380 Services in the Medicaid managed care program shall be provided
3381 by qualified plans.
3382 (1) The agency shall select qualified plans to participate
3383 in the Medicaid managed care program using an invitation to
3384 negotiate issued pursuant to s. 287.057.
3385 (a) The agency shall notice separate invitations to
3386 negotiate for the managed medical assistance component and the
3387 managed long-term care component of the managed care program.
3388 (b) At least 30 days before noticing the invitation to
3389 negotiate and annually thereafter, the agency shall compile and
3390 publish a databook consisting of a comprehensive set of
3391 utilization and spending data for the 3 most recent contract
3392 years, consistent with the rate-setting periods for all Medicaid
3393 recipients by region and county. Pursuant to s. 409.970, the

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3394 source of the data must include both historic fee-for-service
3395 claims and validated data from the Medicaid Encounter Data
3396 System. The report shall be made available electronically and
3397 must delineate utilization by age, gender, eligibility group,
3398 geographic area, and acuity level.
3399 (2) Separate and simultaneous procurements shall be
3400 conducted in each of the following regions:
3401 (a) Region 1, which consists of Escambia, Okaloosa, Santa
3402 Rosa, and Walton counties.
3403 (b) Region 2, which consists of Franklin, Gadsden,
3404 Jefferson, Leon, Liberty, and Wakulla counties.
3405 (c) Region 3, which consists of Columbia, Dixie, Hamilton,
3406 Lafayette, Madison, Suwannee, and Taylor counties.
3407 (d) Region 4, which consists of Baker, Clay, Duval, and
3408 Nassau counties.
3409 (e) Region 5, which consists of Citrus, Hernando, Lake,
3410 Marion, and Sumter counties.
3411 (f) Region 6, which consists of Pasco and Pinellas
3412 counties.
3413 (g) Region 7, which consists of Flagler, Putnam, St. Johns,
3414 and Volusia counties.
3415 (h) Region 8, which consists of Alachua, Bradford,
3416 Gilchrist, Levy, and Union counties.
3417 (i) Region 9, which consists of Orange and Osceola
3418 counties.
3419 (j) Region 10, which consists of Hardee, Highlands, and
3420 Polk counties.
3421 (k) Region 11, which consists of Miami-Dade and Monroe
3422 counties.

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3423 (l) Region 12, which consists of DeSoto, Manatee, and
3424 Sarasota counties.
3425 (m) Region 13, which consists of Hillsborough County.
3426 (n) Region 14, which consists of Bay, Calhoun, Gulf,
3427 Holmes, Jackson, and Washington counties.
3428 (o) Region 15, which consists of Palm Beach County.
3429 (p) Region 16, which consists of Broward County.
3430 (q) Region 17, which consists of Brevard and Seminole
3431 counties.
3432 (r) Region 18, which consists of Indian River, Martin,
3433 Okeechobee, and St. Lucie counties.
3434 (s) Region 19, which consists of Charlotte, Collier,
3435 Glades, Hendry, and Lee counties.
3436 (3) The invitation to negotiate must specify the criteria
3437 and the relative weight of the criteria to be used for
3438 determining the acceptability of a reply and guiding the
3439 selection of qualified plans with which the agency shall
3440 contract. In addition to other criteria developed by the agency,
3441 the agency shall give preference to the following factors in
3442 selecting qualified plans:
3443 (a) Accreditation by the National Committee for Quality
3444 Assurance or another nationally recognized accrediting body.
3445 (b) Experience serving similar populations, including the
3446 organization’s record in achieving specific quality standards
3447 for similar populations.
3448 (c) Availability and accessibility of primary care and
3449 specialty physicians in the provider network.
3450 (d) Establishment of partnerships with community providers
3451 that provide community-based services.

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3452 (e) The organization's commitment to quality improvement
3453 and documentation of achievements in specific quality-
3454 improvement projects, including active involvement by the
3455 organization's leadership.
3456 (f) Provision of additional benefits, particularly dental
3457 care for all recipients, disease management, and other programs
3458 offering additional benefits.
3459 (g) Establishment of incentive programs that reward
3460 specific behaviors with health-related benefits not otherwise
3461 covered by the organizations' benefit plan. Such behaviors may
3462 include participation in smoking-cessation programs, weight-loss
3463 programs, or other activities designed to mitigate lifestyle
3464 choices and avoid behaviors associated with the use of high-cost
3465 medical services.
3466 (h) Organizations without a history of voluntary or
3467 involuntary withdrawal from any state Medicaid program or
3468 program area.
3469 (i) Evidence that an organization has written agreements or
3470 signed contracts or has made substantial progress in
3471 establishing relationships with providers before the
3472 organization submits a reply. The agency shall evaluate such
3473 evidence based on the following factors:
3474 1. Contracts with primary care and specialty physicians in
3475 sufficient numbers to meet the specific performance standards
3476 established pursuant to s. 409.966(2)(b).
3477 2. Specific arrangements that provide evidence that the
3478 compensation offered by the plan is sufficient to retain primary
3479 care and specialty physicians in sufficient numbers to comply
3480 with the performance standards established pursuant to s.

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3481 409.966(2) throughout the 5-year contract term. The agency shall
3482 give preference to plans that provide evidence that primary care
3483 physicians within the plan's provider network will be
3484 compensated for primary care services with payments equivalent
3485 to or greater than payments for such services under the Medicare
3486 program, whether compensation is made on a fee-for-service basis
3487 or by sub-capitation.
3488 3. Contracts with community pharmacies located in rural
3489 areas; contracts with community pharmacies serving specialty
3490 disease populations, including, but not limited to, HIV/AIDS
3491 patients, hemophiliacs, patients suffering from end-stage renal
3492 disease, diabetes, or cancer; community pharmacies located
3493 within distinct cultural communities that reflect the unique
3494 cultural dynamics of such communities, including, but not
3495 limited to, languages spoken, ethnicities served, unique disease
3496 states serviced, and geographic location within the
3497 neighborhoods of culturally distinct populations; and community
3498 pharmacies providing value-added services to patients, such as
3499 free delivery, immunizations, disease management, diabetes
3500 education, and medication utilization review.
3501 4. Contracts with cancer disease management programs that
3502 have a proven record of clinical efficiencies and cost savings.
3503 5. Contracts with diabetes disease management programs that
3504 have a proven record of clinical efficiencies and cost savings.
3505 (j) The capitated rates provided in the reply to the
3506 invitation to negotiate.
3507 (k) Establishment of a claims payment process to ensure
3508 that claims that are not contested or denied will be paid within
3509 20 days after receipt.

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3510 (l) Utilizing a tiered approach, organizations that are
3511 based in Florida and have operational functions performed in
3512 Florida, either performed in-house or through contractual
3513 arrangements, by Florida-employed staff. The highest number of
3514 points shall be awarded to any plan with all or substantially
3515 all of its operational functions performed in the state. The
3516 second highest number of points shall be awarded to any plan
3517 with a majority of its operational functions performed in the
3518 state. The agency may establish a third tier; however, no
3519 preference points shall be awarded to plans that perform only
3520 community outreach, medical director functions, and state
3521 administrative functions in the state. For purposes of this
3522 paragraph, operational functions include claims processing,
3523 member services, provider relations, utilization and prior
3524 authorization, case management, disease and quality functions,
3525 and finance and administration. For purposes of this paragraph,
3526 "based in Florida" means that the entity's principal office is
3527 in Florida and the plan is not a subsidiary, directly or
3528 indirectly through one or more subsidiaries of, or a joint
3529 venture with, any other entity whose principal office is not
3530 located in the state.
3531 (m) For long-term care plans, additional criteria as
3532 specified in s. 409.976(3).
3533 (4) Acceptable replies to the invitation to negotiate for
3534 each region shall be ranked, and the agency shall select the
3535 number of qualified plans with which to contract in each region.
3536 (a) The agency may not select more than one plan per 20,000
3537 Medicaid recipients residing in the region who are subject to
3538 mandatory managed care enrollment, except that, in addition to

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3539 the Children's Medical Services Network, a region may not have
3540 fewer than three or more than 10 qualified plans for the managed
3541 medical assistance or the managed long-term care components of
3542 the program.
3543 (b) If the funding available in the General Appropriations
3544 Act is not adequate to meet the proposed statewide requirement
3545 under the Medicaid managed care program, the agency shall enter
3546 into negotiations with qualified plans that responded to the
3547 invitation to negotiate. The negotiation process may alter the
3548 rank of a qualified plan. If negotiations are conducted, the
3549 agency shall select qualified plans that are responsive and
3550 provide the best value to the state.
3551 (5) The agency may issue a new invitation to negotiate in
3552 any region:
3553 (a) At any time if:
3554 1. Data becomes available to the agency indicating that the
3555 population of recipients residing in the region who are subject
3556 to mandatory managed care enrollment cannot be served by the
3557 plans under contract with the agency in that region or has
3558 increased by more than 20,000 since the most recent invitation
3559 to negotiate was issued in that region; and
3560 2. The agency has not contracted with the maximum number of
3561 plans authorized for that region.
3562 (b) At any time during the first 2 years after the initial
3563 contract period and upon the request of a qualified plan under
3564 contract in one or more regions if:
3565 1. Data becomes available to the agency indicating that the
3566 population of Medicaid recipients residing in the region who are
3567 subject to mandatory managed care enrollment has increased by

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3568 more than 20,000 since the initial invitation to negotiate was
3569 issued for the contract period; and
3570 2. The agency has not contracted with the maximum number of
3571 plans authorized for that region.
3572
3573 The term of a contract executed under this subsection shall be
3574 for the remainder of the 5-year contract cycle.
3575 (6) The Children's Medical Services Network authorized
3576 under chapter 391 is a qualified plan for purposes of the
3577 managed care medical assistance component of the Medicaid
3578 managed care program. Participation by the network shall be
3579 pursuant to a single statewide contract with the agency which is
3580 not subject to the procurement requirements of this section. The
3581 network must meet all other plan requirements for the managed
3582 care medical assistance component of the program.
3583 (7) In order to allow a provider service network in rural
3584 areas sufficient time to develop an adequate provider network to
3585 participate in the Medicaid managed care program on a capitated
3586 basis, the network may submit an application or invitation to
3587 negotiate after July 1, 2011, as required by the agency, for a
3588 region where there was no Medicaid-contracted health maintenance
3589 organization or provider service network on July 1, 2011. For
3590 the first 12 months that the network operates in the region, the
3591 agency shall assign existing Medicaid provider agreements to the
3592 provider service network for purposes of administering managed
3593 care services and building an adequate provider network to meet
3594 the access standards established by the agency.
3595 Section 39. Section 409.966, Florida Statutes, is created
3596 to read:

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3597 409.966 Plan contracts.—
3598 (1) The agency shall execute a 5-year contract with each
3599 qualified plan selected through the procurement process
3600 described in s. 409.965. A contract between the agency and the
3601 qualified plan may be amended annually, or as needed, to reflect
3602 capitated rate adjustments due to funding availability pursuant
3603 to the General Appropriations Act and ss. 409.9022, 409.972, and
3604 409.975(2).
3605 (a) A plan contract may not be renewed; however, the agency
3606 may extend the term of a contract, keeping intact all
3607 operational provisions in the contract, including capitation
3608 rates, to cover any delays in transitioning to a new plan.
3609 (b) If a plan applies for a rate increase that is not the
3610 result of a solicitation from the agency and the application for
3611 rate increase is not timely withdrawn, the plan will be deemed
3612 to have submitted a notice of intent to leave the region before
3613 the end of the contract term.
3614 (2) The agency shall establish such contract requirements
3615 as are necessary for the operation of the Medicaid managed care
3616 program. In addition to any other provisions the agency may deem
3617 necessary, the contract must require:
3618 (a) *Access.*—The agency shall establish specific standards
3619 for the number, type, and regional distribution of providers in
3620 plan networks in order to ensure access to care. Each qualified
3621 plan shall:
3622 1. Maintain a network of providers in sufficient numbers to
3623 meet the access standards for specified services for all
3624 recipients enrolled in the plan.
3625 2. Establish and maintain an accurate and complete

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3626 electronic database of contracted providers, including
3627 information about licensure or registration, locations and hours
3628 of operation, specialty credentials and other certifications,
3629 specific performance indicators, and such other information as
3630 the agency deems necessary. The provider database must be
3631 available online to both the agency and the public and allow
3632 comparison of the availability of providers to network adequacy
3633 standards, and accept and display feedback from each provider's
3634 patients.
3635 3. Provide for reasonable and adequate hours of operation,
3636 including 24-hour availability of information, referral, and
3637 treatment for emergency medical conditions.
3638 4. Assign each new enrollee to a primary care provider and
3639 ensure that an appointment with that provider has been scheduled
3640 within 30 days after the enrollment in the plan.
3641 5. Submit quarterly reports to the agency identifying the
3642 number of enrollees assigned to each primary care provider.
3643 (b) *Performance standards.*—The agency shall establish
3644 specific performance standards and expected milestones or
3645 timelines for improving plan performance over the term of the
3646 contract.
3647 1. Each plan shall establish an internal health care
3648 quality improvement system that includes enrollee satisfaction
3649 and disenrollment surveys and incentives and disincentives for
3650 network providers.
3651 2. Each plan must collect and report the Health Plan
3652 Employer Data and Information Set (HEDIS) measures, as specified
3653 by the agency. These measures must be published on the plan's
3654 website in a manner that allows recipients to reliably compare

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3655 the performance of plans. The agency shall use the HEDIS
3656 measures as a tool to monitor plan performance.
3657 3. A qualified plan that is not accredited when the
3658 contract is executed with the agency must become accredited or
3659 have initiated the accreditation process within 1 year after the
3660 contract is executed. If the plan is not accredited within 18
3661 months after executing the contract, the plan shall be suspended
3662 from automated enrollments pursuant to s. 409.969(2).
3663 4. In addition to agency standards, a qualified plan must
3664 ensure that the agency is notified of the impending birth of a
3665 child to an enrollee or as soon as practicable after the child's
3666 birth. Upon the birth, the child is deemed enrolled with the
3667 qualified plan, regardless of the administrative enrollment
3668 procedures, and the qualified plan is responsible for providing
3669 Medicaid services to the child on a capitated basis.
3670 (c) *Program integrity.*—Each plan shall establish program
3671 integrity functions and activities in order to reduce the
3672 incidence of fraud and abuse, including, at a minimum:
3673 1. A provider credentialing system and ongoing provider
3674 monitoring. Each plan must maintain written provider
3675 credentialing policies and procedures that are compliant with
3676 federal and agency guidelines. Each plan must verify at least
3677 annually that all providers have a valid and unencumbered
3678 license or permit to provide services to Medicaid recipients,
3679 and shall establish a procedure for providers to notify the plan
3680 when the provider has been notified by a licensing or regulatory
3681 agency that the provider's license or permit is to be revoked or
3682 suspended, or when an event has occurred which would prevent the
3683 provider from renewing its license or permit. The provider must

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3684 also notify the plan if the license or permit is revoked or
3685 suspended, if renewal of the license or permit is denied or
3686 expires by operation of law, or if the provider requests that
3687 the license or permit be inactivated. The plan must immediately
3688 exclude a provider from the plan's provider network if the
3689 provider's license is suspended or invalid. However, this
3690 section does not preclude a plan from contracting with a
3691 provider that is approved via a final order, has commenced
3692 construction, and will be licensed and operational within 18
3693 months after the effective date of this act;
3694 2. An effective prepayment and postpayment review process
3695 that includes, at a minimum, data analysis, system editing, and
3696 auditing of network providers;
3697 3. Procedures for reporting instances of fraud and abuse
3698 pursuant to s. 409.91212;
3699 4. The establishment of an anti-fraud plan pursuant to s.
3700 409.91212; and
3701 5. Designation of a program integrity compliance officer.
3702 (d) *Encounter data.*—Each plan must comply with the agency's
3703 reporting requirements for the Medicaid Encounter Data System
3704 under s. 409.970. The agency shall assess a fine of $5,000 per
3705 day against a qualified plan for failing to comply with this
3706 requirement. If a plan fails to comply for more than 30 days,
3707 the agency shall assess a fine of $10,000 per day beginning on
3708 the 31st day. If a plan is fined $300,000 or more for failing to
3709 comply, in addition to paying the fine, the plan shall be
3710 disqualified from the Medicaid managed care program for 3 years.
3711 If the plan is disqualified, the plan shall be deemed to have
3712 terminated its contract before the scheduled end date and shall

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3713 also be subject to applicable penalties under paragraph (l).
3714 However, the agency may waive or reduce the fine upon a showing
3715 of good cause for the failure to comply.
3716 (e) *Electronic claims and prior authorization requests.*—
3717 Plans shall accept electronic claims that are in compliance with
3718 federal standards and accept electronic prior authorization
3719 requests from prescribers and pharmacists for medication
3720 exceptions to the preferred drug list or formulary. The criteria
3721 for the approval and the reasons for denial of prior
3722 authorization requests shall be made readily available to
3723 prescribers and pharmacists submitting the request. Plans shall
3724 require any vendor or subcontractor providing fiscal
3725 intermediary services to the plan pursuant to s. 641.316, which
3726 involve the acceptance of provider claims, to accept electronic
3727 claims in compliance with federal standards.
3728 (f) *Prompt payment.*—All qualified plans must comply with
3729 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay
3730 nursing homes by the 10th day of the month for enrollees who are
3731 residing in the nursing home on the 1st day of the month.
3732 Payment for the month in which an enrollee initiates residency
3733 in a nursing home shall be in accordance with s. 641.3155. On an
3734 annual basis, qualified plans shall submit a report certifying
3735 compliance with the prompt payment requirements for the plan
3736 year.
3737 (g) *Emergency services.*—Qualified plans must pay for
3738 emergency services and care required under ss. 395.1041 and
3739 401.45 and rendered by a noncontracted provider in accordance
3740 with the prompt payment standards established in s. 641.3155.
3741 The payment rate shall be the fee-for-service rate the agency

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3742 would pay the noncontracted provider for such services, unless
3743 the agency has developed an average rate for the noncontracted
3744 provider for such services under s. 409.967(3)(c). If the agency
3745 has developed an average rate for the noncontracted provider for
3746 such services under s. 409.967(3)(c), the payment rate for such
3747 services under this paragraph shall be the average rate
3748 developed by the agency for the noncontracted provider for such
3749 services under s. 409.967(3)(c).
3750 (h) *Surety bond.*—A qualified plan shall post and maintain a
3751 surety bond with the agency, payable to the agency, or in lieu
3752 of a surety bond, establish and maintain an irrevocable letter
3753 of credit or a deposit in a trust account in a financial
3754 institution, payable to the agency.
3755 1. The amount of the surety bond, letter of credit, or
3756 trust account shall be 125 percent of the estimated annual
3757 guaranteed savings for each qualified plan, and at least $2
3758 million but no more than $15 million for each qualified plan.
3759 The estimated guaranteed savings shall be calculated before the
3760 execution of the contract as follows:
3761 a. The agreed-upon monthly contractual capitated rate for
3762 each level of acuity multiplied by the estimated population in
3763 the region for the plan for each level of acuity, multiplied by
3764 12 months, multiplied by 7 percent, multiplied by 125 percent.
3765 b. The estimated population in the region for the plan
3766 under sub-subparagraph a. shall be based on the maximum enrollee
3767 level that the agency initially authorizes. The factors that the
3768 agency may consider in determining the maximum enrollee level
3769 include, but are not limited to, requested capacity, projected
3770 enrollment, network adequacy, and the available budget in the

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3771 General Appropriations Act.
3772 2. The purpose of the surety bond, letter of credit, or
3773 trust account is to protect the agency if the entity terminates
3774 its contract with the agency before the scheduled end date for
3775 the contract, if the plan fails to comply with the terms of the
3776 contract, including, but not limited to, the timely submission
3777 of encounter data, if the agency imposes fines or penalties for
3778 noncompliance, or if the plan fails to achieve the guaranteed
3779 savings. If any of those events occurs, the agency shall first
3780 request payment from the qualified plan. If the qualified plan
3781 does not pay all costs, fines, penalties, or the differential in
3782 the guaranteed savings in full within 30 days, the agency shall
3783 pursue a claim against the surety bond, letter of credit, or
3784 trust account for all applicable moneys and the legal and
3785 administrative costs associated with pursuing such claim.
3786 (i) *Grievance resolution.*—Each plan shall establish and the
3787 agency shall approve an internal process for reviewing and
3788 responding to grievances from enrollees consistent with s.
3789 641.511. Each plan shall submit quarterly reports to the agency
3790 on the number, description, and outcome of grievances filed by
3791 enrollees.
3792 (j) *Solvency.*—A qualified plan must meet and maintain the
3793 surplus and solvency requirements under s. 409.912(17) and (18).
3794 A provider service network may satisfy the surplus and solvency
3795 requirements if the network's performance and financial
3796 obligations are guaranteed in writing by an entity licensed by
3797 the Office of Insurance Regulation which meets the surplus and
3798 solvency requirements of s. 624.408 or s. 641.225.
3799 (k) *Guaranteed savings.*—During the first contract period, a

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3800 qualified plan must agree to provide a guaranteed minimum
3801 savings of 7 percent to the state. The agency shall conduct a
3802 cost reconciliation to determine the amount of cost savings
3803 achieved by the qualified plan compared with the reimbursements
3804 the agency would have incurred under fee-for-service provisions.
3805 (l) *Costs and penalties.*—Plans that reduce enrollment
3806 levels or leave a region before the end of the contract term
3807 must reimburse the agency for the cost of enrollment changes and
3808 other transition activities. If more than one plan leaves a
3809 region at the same time, costs shall be shared by the departing
3810 plans proportionate to their enrollment. In addition to the
3811 payment of costs, departing plans must pay a penalty of 1
3812 month's payment calculated as an average of the past 12 months
3813 of payments, or since inception if the plan has not contracted
3814 with the agency for 12 months, plus the differential of the
3815 guaranteed savings based on the original contract term and the
3816 corresponding termination date. Plans must provide the agency
3817 with at least 180 days' notice before withdrawing from a region.
3818 (m) *Formulary.*—Upon recommendation of the Medicaid
3819 Pharmaceutical and Therapeutics Committee as defined in s.
3820 409.91195, all qualified plans must adopt a standard minimum
3821 preferred drug list as described in s. 409.912(39). A plan may
3822 offer additional products on its formulary. Each plan must
3823 publish an up-to-date listing of its formulary on a publicly
3824 available website.
3825 (n) *Fiscal intermediary services.*—If a qualified plan
3826 contracts for fiscal intermediary services as defined in s.
3827 641.316(1), the plan shall contract only with a fiscal
3828 intermediary services organization registered with the Office of

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3829 Insurance Regulation as required under s. 641.316(6). All
3830 noncapitated payments to a health care provider by a fiscal
3831 intermediary services organization under contract with a
3832 qualified plan must include an explanation of benefits for which
3833 payment is being made and include, at a minimum, the enrollee's
3834 name, the date of service, the procedure code, the amount of
3835 reimbursement, and the identification of the qualified plan on
3836 whose behalf the payment is being made.
3837 (3) If the agency terminates more than one regional
3838 contract with a qualified plan due to the plan's noncompliance
3839 with one or more requirements of this section, the agency shall
3840 terminate all regional contracts with the plan under the
3841 Medicaid managed care program, as well as any other contracts or
3842 agreements for other programs or services, and the plan may not
3843 be awarded new contracts for 3 years.
3844 Section 40. Section 409.967, Florida Statutes, is created
3845 to read:
3846 409.967 Plan accountability.—In addition to the contract
3847 requirements of s. 409.966, plans and providers participating in
3848 the Medicaid managed care program must comply with this section.
3849 (1) The agency shall require qualified plans to use a
3850 uniform method of reporting and accounting for medical, direct
3851 care management, and nonmedical costs and shall evaluate plan-
3852 spending patterns after the plan completes 2 full years of
3853 operation and at least annually thereafter.
3854 (2) The agency shall implement the following thresholds and
3855 consequences of various spending patterns for qualified plans
3856 under the managed medical assistance component of the Medicaid
3857 managed care program:

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3858 (a) The minimum medical loss ratio shall be 90 percent.
3859 (b) A plan and its subcontractors that spend less than 90
3860 percent of the plan's Medicaid capitation revenue on medical
3861 services and direct care management, as determined by the
3862 agency, must pay back to the agency a share of the dollar
3863 difference between the plan's actual medical loss ratio and the
3864 minimum medical loss ratio, as follows:
3865 1. If the plan's actual medical loss ratio is not lower
3866 than 87 percent, the plan must pay back 50 percent of the dollar
3867 difference between the actual medical loss ratio and the minimum
3868 medical loss ratio of 90 percent.
3869 2. If the plan's actual medical loss ratio is lower than 87
3870 percent, the plan must pay back 50 percent of the dollar
3871 difference between a medical loss ratio of 87 percent and the
3872 minimum medical loss ratio of 90 percent, plus 100 percent of
3873 the dollar difference between the actual medical loss ratio and
3874 a medical loss ratio of 87 percent.
3875 (c) To administer this subsection, the agency shall adopt
3876 rules that specify a methodology for calculating medical loss
3877 ratios and the requirements for plans to annually report
3878 information related to medical loss ratios. Repayments required
3879 by this subsection must be made annually.
3880 (3) Plans may limit the providers in their networks.
3881 (a) However, during the first year in which a qualified
3882 plan is operating in a region after the initial plan procurement
3883 for that region, the plan must offer a network contract to the
3884 following providers in the region:
3885 1. Federally qualified health centers.
3886 2. Nursing homes if the plan is providing managed long-term

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3887 care services.
3888 3. Aging network service providers that have previously
3889 participated in home and community-based waivers serving elders,
3890 or community-service programs administered by the Department of
3891 Elderly Affairs if the plan is providing managed long-term care
3892 services.
3893 (b) After 12 months of active participation in a plan's
3894 network, the plan may exclude any of the providers listed in
3895 paragraph (a) from the network while maintaining the network
3896 performance standards required under s. 409.966(2)(b). If the
3897 plan excludes a nursing home that meets the standards for
3898 ongoing Medicaid certification, the plan must provide an
3899 alternative residence in that community for Medicaid recipients
3900 residing in that nursing home. If a Medicaid recipient residing
3901 in an excluded nursing home does not choose to change residence,
3902 the plan must continue to pay for the recipient's care in that
3903 nursing home. If the plan excludes a provider, the plan must
3904 provide written notice to all enrollees who have chosen that
3905 provider for care. Notice to excluded providers must be
3906 delivered at least 30 days before the effective date of the
3907 exclusion.
3908 (c) Notwithstanding the limitation provided in this
3909 subsection, qualified plans must include the following essential
3910 providers in their networks:
3911 1. Faculty plans of state medical schools, unless the
3912 medical school and an affiliated teaching hospital owns or
3913 collaboratively operates a provider service network in the
3914 region; and
3915 2. Hospitals licensed as a children's specialty hospital as

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3916 defined in s. 395.002.
3917
3918 Qualified plans that have not contracted with all statewide
3919 essential providers as of the first date of recipient enrollment
3920 must continue to negotiate in good faith. Payments to a
3921 nonparticipating essential provider must be equal to the highest
3922 rate established by contract between that provider and any other
3923 Medicaid managed care plan.
3924 (d) Qualified plans and providers shall engage in good
3925 faith negotiations to reach contract terms.
3926 1. If a qualified plan seeks to develop a provider network
3927 in a county or region that, as of June 30, 2011, does not have a
3928 capitated managed care plan providing comprehensive acute care
3929 for Medicaid recipients, and the qualified plan has made at
3930 least three documented, unsuccessful, good faith attempts to
3931 contract with a specific provider, the plan may request the
3932 agency to examine the negotiation process. During the
3933 examination, the agency shall consider similar counties or
3934 regions in which qualified plans have contracted with providers
3935 under similar circumstances, as well as the contracted rates
3936 between qualified plans and that provider and similar providers
3937 in the same region. If the agency determines that the plan has
3938 made three good faith attempts to contract with the provider,
3939 the agency shall consider that provider to be part of the
3940 qualified plan’s provider network for the purpose of determining
3941 network adequacy, and the plan shall pay the provider for
3942 services to Medicaid recipients on a noncontracted basis at a
3943 rate or rates determined by the agency to be the average of
3944 rates for corresponding services paid by the qualified plan and

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3945 other qualified plans in the region and in similar counties or
3946 regions under similar circumstances.
3947 2. The agency may continue to calculate Medicaid hospital
3948 inpatient per diem rates and outpatient rates. However, these
3949 rates may not be the basis for contract negotiations between a
3950 managed care plan and a hospital.
3951 (4) Each qualified plan shall monitor the quality and
3952 performance of each provider within its network based on metrics
3953 established by the agency for evaluating and documenting
3954 provider performance and determining continued participation in
3955 the network. However, qualified plans are not required to
3956 conduct surveys of health care facilities that the agency
3957 surveys periodically for licensure or certification purposes and
3958 shall accept the results of such surveys. The agency shall
3959 establish requirements for qualified plans to report, at least
3960 annually, provider performance data compiled under this
3961 subsection. If a plan uses additional metrics to evaluate the
3962 provider's performance and to determine continued participation
3963 in the network, the plan must notify the network providers of
3964 these metrics at the beginning of the contract period.
3965 (a) At a minimum, a qualified plan shall hold primary care
3966 physicians responsible for the following activities:
3967 1. Supervision, coordination, and provision of care to each
3968 assigned enrollee.
3969 2. Initiation of referrals for medically necessary
3970 specialty care and other services.
3971 3. Maintaining continuity of care for each assigned
3972 enrollee.
3973 4. Maintaining the enrollee's medical record, including

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3974 documentation of all medical services provided to the enrollee
3975 by the primary care physician, as well as any specialty or
3976 referral services.
3977 (b) Qualified plans shall establish and implement policies
3978 and procedures to monitor primary care physician activities and
3979 ensure that primary care physicians are adequately notified and
3980 receive documentation of specialty and referral services
3981 provided to enrollees by specialty physicians and other health
3982 care providers within the plan's provider network.
3983 (5) Each qualified plan shall establish specific programs
3984 and procedures to improve pregnancy outcomes and infant health,
3985 including, but not limited to, coordination with the Healthy
3986 Start program, immunization programs, and referral to the
3987 Special Supplemental Nutrition Program for Women, Infants, and
3988 Children, and the Children's Medical Services Program for
3989 children with special health care needs.
3990 (a) Qualified plans must ensure that primary care
3991 physicians who provide obstetrical care are available to
3992 pregnant recipients and that an obstetrical care provider is
3993 assigned to each pregnant recipient for the duration of her
3994 pregnancy and postpartum care, by referral of the recipient's
3995 primary care physician if necessary.
3996 (b) Qualified plans within the managed long-term care
3997 component are exempt from this subsection.
3998 (6) Each qualified plan shall achieve an annual screening
3999 rate for early and periodic screening, diagnosis, and treatment
4000 services of at least 80 percent of those recipients continuously
4001 enrolled for at least 8 months. Qualified plans within the
4002 managed long-term care component are exempt from this

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4003 requirement.
4004 (7) Effective January 1, 2013, qualified plans must
4005 compensate primary care physicians for primary care services at
4006 payment rates that are equivalent to or greater than payments
4007 under the federal Medicare program, whether compensation is made
4008 on a fee-for-service basis or by sub-capitation.
4009 (8) In order to protect the continued operation of the
4010 Medicaid managed care program, unresolved disputes, including
4011 claim and other types of disputes, between a qualified plan and
4012 a provider shall proceed in accordance with s. 408.7057. This
4013 process may not be used to review or reverse a decision by a
4014 qualified plan to exclude a provider from its network if the
4015 decision does not conflict with s. 409.967(3).
4016 Section 41. Section 409.968, Florida Statutes, is created
4017 to read:
4018 409.968 Plan payment.—Payments for managed medical
4019 assistance and managed long-term care services under this part
4020 shall be made in accordance with a capitated managed care model.
4021 Qualified plans shall receive per-member, per-month payments
4022 pursuant to the procurements described in s. 409.965 and annual
4023 adjustments as described in s. 409.966(1). Payment rates must be
4024 based on the acuity level for each member pursuant to ss.
4025 409.972 and 409.978, and must encourage plans to use the most
4026 cost-effective modalities for the treatment of chronic disease,
4027 such as peritoneal dialysis over hemodialysis if the patient and
4028 physician choose this form of treatment. Payment rates for
4029 managed long-term care plans shall be combined with rates for
4030 managed medical assistance plans.
4031 (1) The agency shall develop a methodology and request a

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4032 waiver that ensures the availability of intergovernmental
4033 transfers in the Medicaid managed care program to support
4034 providers that have historically served Medicaid recipients.
4035 Such providers include, but are not limited to, safety net
4036 providers, trauma hospitals, children's hospitals, and statutory
4037 teaching hospitals. The agency may develop a supplemental
4038 capitation rate, risk pool, or incentive payment for plans that
4039 contract with these providers. A plan is eligible for a
4040 supplemental payment only if there are sufficient
4041 intergovernmental transfers available from allowable sources.
4042 (2) The agency shall evaluate the development of the rate
4043 cell to accurately reflect the underlying utilization to the
4044 maximum extent possible. This methodology may include interim
4045 rate adjustments as permitted under federal regulations. Any
4046 such methodology must preserve federal funding to these entities
4047 and be actuarially sound. In the absence of federal approval of
4048 the methodology, the agency may set an enhanced rate and require
4049 that plans pay the rate if the agency determines the enhanced
4050 rate is necessary to ensure access to care by the providers
4051 described in this subsection.
4052 (3) The amount paid to the plans to make supplemental
4053 payments or to enhance provider rates pursuant to this
4054 subsection must be reconciled to the exact amounts the plans are
4055 required to pay providers. The plans shall make the designated
4056 payments to providers within 15 business days after notification
4057 by the agency regarding provider-specific distributions.
4058 (4) The agency shall develop a methodology and request a
4059 state plan amendment or waiver that ensures the availability of
4060 certified public expenditures in the Medicaid managed care

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4061 program to support noninstitutional teaching faculty providers
4062 that have historically served Medicaid recipients. Such
4063 providers include allopathic and osteopathic physicians employed
4064 by or under contract with a medical school in this state. The
4065 agency shall directly make supplemental payments to teaching
4066 faculty providers or to a statewide entity acting on behalf of
4067 state medical schools and teaching faculty providers that
4068 contract with qualified plans and provide care to Medicaid
4069 recipients in recognition of the costs associated with graduate
4070 medical education and training, educating medical school
4071 students, and access to primary and specialty care provided to
4072 Medicaid recipients. Physicians employed by or under contract
4073 with a medical school in this state are eligible for a
4074 supplemental payment only if there are sufficient certified
4075 public expenditures available from allowable sources. The agency
4076 shall evaluate the development of teaching faculty provider
4077 payments for managed care to accurately reflect the historical
4078 and underlying as well as current and prospective utilization to
4079 the maximum extent possible. Any such methodology must preserve
4080 federal funding to these entities.
4081 Section 42. Section 409.969, Florida Statutes, is created
4082 to read:
4083 409.969 Enrollment; disenrollment; grievance procedure.—
4084 (1) Each Medicaid recipient may choose any available plan
4085 within the region in which the recipient resides unless that
4086 plan is a specialty plan for which the recipient does not
4087 qualify. The agency may not provide or contract for choice
4088 counseling services for persons enrolling in the Medicaid
4089 managed care program.

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4090 (2) If a recipient has not made a choice of plans within 30
4091 days after having been notified to choose a plan, the agency
4092 shall assign the recipient to a plan in accordance with the
4093 following:
4094 (a) A recipient who was previously enrolled in a plan
4095 within the preceding 90 days shall automatically be enrolled in
4096 the same plan, if available.
4097 (b) Newborns of eligible mothers enrolled in a plan at the
4098 time of the child's birth shall be enrolled in the mother's
4099 plan; however, the mother may choose another plan for the
4100 newborn within 90 days after the child's birth.
4101 (c) If the recipient is diagnosed with HIV/AIDS and resides
4102 in region 11, region 15, or region 16, the agency shall assign
4103 the recipient to a plan that:
4104 1. Is a specialty plan under contract with the agency
4105 pursuant to s. 409.965; and
4106 2. Offers a delivery system through a teaching- and
4107 research-oriented organization that specializes in providing
4108 health care services and treatment for individuals diagnosed
4109 with HIV/AIDS.
4110
4111 The agency shall assign recipients under this paragraph on an
4112 even basis among all such plans within a region under contract
4113 with the agency.
4114 (d) A recipient who is currently receiving Medicare
4115 services from an entity qualified under 42 C.F.R. part 422 as a
4116 Medicare Advantage health maintenance organization, Medicare
4117 Advantage coordinated care plan, Medicare Advantage preferred
4118 provider organization, Medicare Advantage provider-sponsored

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4119 organization, or Medicare Advantage special needs plan that is
4120 under contract with the agency shall be assigned to that plan
4121 for the Medicaid services not covered by Medicare for which the
4122 recipient is eligible.
4123 (e) Other recipients shall be enrolled into a qualified
4124 plan in accordance with an auto-assignment enrollment algorithm
4125 that the agency develops by rule. The algorithm must heavily
4126 weigh family continuity.
4127 1. Automatic enrollment of recipients in plans must be
4128 based on the following criteria:
4129 a. Whether the plan has sufficient network capacity to meet
4130 the needs of recipients.
4131 b. Whether the recipient has previously received services
4132 from one of the plan's primary care providers.
4133 c. Whether primary care providers in one plan are more
4134 geographically accessible to the recipient's residence than
4135 providers in other plans.
4136 d. If a recipient is eligible for long-term care services,
4137 whether the recipient has previously received services from one
4138 of the plan's home and community-based service providers.
4139 e. If a recipient is eligible for long-term care services,
4140 whether the home and community-based providers in one plan are
4141 more geographically accessible to the recipient's residence than
4142 providers in other plans.
4143 2. The agency shall automatically enroll recipients in
4144 plans that meet or exceed the performance or quality standards
4145 established pursuant to s. 409.967, and may not automatically
4146 enroll recipients in a plan that is not meeting those standards.
4147 Except as provided by law or rule, the agency may not engage in

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4148 practices that favor one qualified plan over another.
4149 (3) After a recipient has enrolled in a qualified plan, the
4150 enrollee shall have 90 days to voluntarily disenroll and select
4151 another plan. After 90 days, no further changes may be made
4152 except for good cause. Good cause includes, but is not limited
4153 to, poor quality of care, lack of access to necessary specialty
4154 services, an unreasonable delay or denial of service, or
4155 fraudulent enrollment. The agency shall determine whether good
4156 cause exists. The agency may require an enrollee to use the
4157 plan's grievance process before the agency makes a determination
4158 of good cause, unless an immediate risk of permanent damage to
4159 the enrollee's health is alleged.
4160 (a) If used, the qualified plan's internal grievance
4161 process must be completed in time to allow the enrollee to
4162 disenroll by the first day of the second month after the month
4163 the disenrollment request was made. If the grievance process
4164 approves an enrollee's request to disenroll, the agency is not
4165 required to make a determination of good cause.
4166 (b) The agency must make a determination of good cause and
4167 take final action on an enrollee's request so that disenrollment
4168 occurs by the first day of the second month after the month the
4169 request was made. If the agency fails to act within this
4170 timeframe, the enrollee's request to disenroll is deemed
4171 approved as of the date agency action was required. Enrollees
4172 who disagree with the agency's finding that good cause for
4173 disenrollment does not exist shall be advised of their right to
4174 pursue a Medicaid fair hearing to dispute the agency's finding.
4175 (c) Medicaid recipients enrolled in a qualified plan after
4176 the 90-day period must remain in the plan for the remainder of

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4177 the 12-month period. After 12 months, the enrollee may select
4178 another plan. However, a recipient who is referred for nursing
4179 home or assisted living facility services may change plans
4180 within 30 days after such referral. An enrollee may change
4181 primary care providers within the plan at any time.
4182 (d) On the first day of the next month after receiving
4183 notice from a recipient that the recipient has moved to another
4184 region, the agency shall automatically disenroll the recipient
4185 from the plan the recipient is currently enrolled in and treat
4186 the recipient as if the recipient is a new enrollee. At that
4187 time, the recipient may choose another plan pursuant to the
4188 enrollment process established in this section.
4189 Section 43. Section 409.970, Florida Statutes, is created
4190 to read:
4191 409.970 Medicaid Encounter Data System.—The agency shall
4192 maintain and operate the Medicaid Encounter Data System to
4193 collect, process, and report on covered services provided to all
4194 Medicaid recipients enrolled in qualified plans.
4195 (1) Qualified plans shall submit encounter data
4196 electronically in a format that complies with provisions of the
4197 federal Health Insurance Portability and Accountability Act for
4198 electronic claims and in accordance with deadlines established
4199 by the agency. Plans must certify that the data reported is
4200 accurate and complete. The agency is responsible for validating
4201 the data submitted by the plans.
4202 (2) The agency shall develop methods and protocols for
4203 ongoing analysis of the encounter data, which must adjust for
4204 differences in the characteristics of enrollees in order to
4205 allow for the comparison of service utilization among plans. The

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4206 analysis shall be used to identify possible cases of systemic
4207 overutilization, underutilization, inappropriate denials of
4208 claims, and inappropriate utilization of covered services, such
4209 as higher than expected emergency department and pharmacy
4210 encounters. One of the primary focus areas for the analysis
4211 shall be the use of prescription drugs.
4212 (3) The agency shall provide periodic feedback to the plans
4213 based on the analysis and establish corrective action plans if
4214 necessary.
4215 (4) The agency shall make encounter data available to plans
4216 accepting enrollees who are reassigned to them from other plans
4217 leaving a region.
4218 (5) Beginning July 1, 2011, the agency shall conduct
4219 appropriate tests and establish specific criteria for
4220 determining whether the Medicaid Encounter Data System has
4221 valid, complete, and sound data for a sufficient period of time
4222 to provide qualified plans with a reliable basis for determining
4223 and proposing actuarially sound payment rates.
4224 Section 44. Section 409.971, Florida Statutes, is created
4225 to read:
4226 409.971 Managed care medical assistance.—Pursuant to s.
4227 409.902, the agency shall administer the managed care medical
4228 assistance component of the Medicaid managed care program
4229 described in this section and s. 409.972. Unless otherwise
4230 specified, the provisions of ss. 409.961-409.970 apply to the
4231 provision of managed care medical assistance. By December 31,
4232 2011, the agency shall begin implementation of managed care
4233 medical assistance, and full implementation in all regions must
4234 be completed by December 31, 2012.

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4235 Section 45. Section 409.972, Florida Statutes, is created
4236 to read:
4237 409.972 Managed care medical assistance services.—
4238 (1) Qualified plans providing managed care medical
4239 assistance must, at a minimum, cover the following services:
4240 (a) Ambulatory patient services.
4241 (b) Dental services for a recipient who is under age 21.
4242 (c) Dental services as provided in s. 627.419(7) for a
4243 recipient who is 21 years of age or older.
4244 (d) Dialysis services.
4245 (e) Durable medical equipment and supplies.
4246 (f) Early periodic screening diagnosis and treatment
4247 services, hearing services and hearing aids, and vision services
4248 and eyeglasses for enrollees under age 21.
4249 (g) Emergency services.
4250 (h) Family planning services. Pursuant to 42 C.F.R. s.
4251 438.102, plans may elect to not provide this service due to an
4252 objection on moral or religious grounds, and must notify the
4253 agency of that election when submitting a reply to the
4254 invitation to negotiate pursuant to s. 409.963.
4255 (i) Hearing services for a recipient who is under age 21.
4256 (j) Hearing services that are medically indicated for a
4257 recipient who is 21 years of age or older.
4258 (k) Home health services.
4259 (l) Hospital inpatient services.
4260 (m) Hospital outpatient services.
4261 (n) Laboratory and imaging services.
4262 (o) Maternity and newborn care and birth center services.
4263 (p) Mental health services, substance abuse disorder

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4264 services, and behavioral health treatment.
4265 (q) Prescription drugs.
4266 (r) Primary care service, referred specialty care services,
4267 preventive services, and wellness services.
4268 (s) Skilled nursing facility or inpatient rehabilitation
4269 facility services.
4270 (t) Transplant services.
4271 (u) Transportation to access covered services.
4272 (v) Vision services for a recipient who is under age 21.
4273 (w) Vision services that are medically indicated for a
4274 recipient who is 21 years of age or older.
4275 (2) Subject to specific appropriations, the agency may make
4276 payments for services that are optional.
4277 (3) Qualified plans may customize benefit packages for
4278 nonpregnant adults, vary cost-sharing provisions, and provide
4279 coverage for additional services. The agency shall evaluate the
4280 proposed benefit packages to ensure that services are sufficient
4281 to meet the needs of the plans' enrollees and to verify
4282 actuarial equivalence.
4283 (4) For Medicaid recipients diagnosed with hemophilia who
4284 have been prescribed anti-hemophilic-factor replacement
4285 products, the agency shall provide for those products and
4286 hemophilia overlay services through the agency's hemophilia
4287 disease management program authorized under s. 409.912.
4288 (5) Managed care medical assistance services provided under
4289 this section must be medically necessary and provided in
4290 accordance with state and federal law. This section does not
4291 prevent the agency from adjusting fees, reimbursement rates,
4292 lengths of stay, number of visits, or number of services, or

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4293 from making any other adjustments necessary to comply with the
4294 availability of funding and any limitations or directions
4295 provided in the General Appropriations Act, chapter 216, or s.
4296 409.9022.
4297 Section 46. Section 409.973, Florida Statutes, is created
4298 to read:
4299 409.973 Managed long-term care.—
4300 (1) Qualified plans providing managed care medical
4301 assistance may also participate in the managed long-term care
4302 component of the Medicaid managed care program. Unless otherwise
4303 specified, the provisions of ss. 409.961-409.970 apply to the
4304 managed long-term care component of the managed care program.
4305 (2) Pursuant to s. 409.902, the agency shall administer the
4306 managed long-term care component described in this section and
4307 ss. 409.974-409.978, but may delegate specific duties and
4308 responsibilities to the Department of Elderly Affairs and other
4309 state agencies. By March 31, 2012, the agency shall begin
4310 implementation of the managed long-term care component, with
4311 full implementation in all regions by March 31, 2013.
4312 (3) The Department of Elderly Affairs shall assist the
4313 agency in developing specifications for use in the invitation to
4314 negotiate and the model contract, determining clinical
4315 eligibility for enrollment in managed long-term care plans,
4316 monitoring plan performance and measuring quality of service
4317 delivery, assisting clients and families in order to address
4318 complaints with the plans, facilitating working relationships
4319 between plans and providers serving elders and disabled adults,
4320 and performing other functions specified in a memorandum of
4321 agreement.

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4322 Section 47. Section 409.974, Florida Statutes, is created
4323 to read:
4324 409.974 Recipient eligibility for managed long-term care.—
4325 (1) Medicaid recipients shall receive covered long-term
4326 care services through the managed long-term care component of
4327 the Medicaid managed care program unless excluded pursuant to s.
4328 409.964. In order to participate in the managed long-term care
4329 component, the recipient must be:
4330 (a) Sixty-five years of age or older or eligible for
4331 Medicaid by reason of a disability; and
4332 (b) Determined by the Comprehensive Assessment and Review
4333 for Long-Term Care Services (CARES) Program to meet the criteria
4334 for nursing facility care.
4335 (2) Medicaid recipients who are enrolled in one of the
4336 following Medicaid long-term care waiver programs on the date
4337 that a managed long-term care plan becomes available in the
4338 recipient's region may remain in that program if it is
4339 operational on that date:
4340 (a) The Assisted Living for the Frail Elderly Waiver.
4341 (b) The Aged and Disabled Adult Waiver.
4342 (c) The Adult Day Health Care Waiver.
4343 (d) The Consumer-Directed Care Program as described in s.
4344 409.221.
4345 (e) The Program of All-inclusive Care for the Elderly.
4346 (f) The Long-Term Care Community Diversion Pilot Project as
4347 described in s. 430.705.
4348 (g) The Channeling Services Waiver for Frail Elders.
4349 (3) If a long-term care waiver program in which the
4350 recipient is enrolled ceases to operate, the Medicaid recipient

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4351 may transfer to another long-term care waiver program or to the
4352 Medicaid managed long-term care component of the Medicaid
4353 managed care program. If no waivers are operational in the
4354 recipient's region and the recipient continues to participate in
4355 Medicaid, the recipient must transfer to the managed long-term
4356 care component of the Medicaid managed care program.
4357 (4) New enrollment in a waiver program ends on the date
4358 that a managed long-term care plan becomes available in a
4359 region.
4360 (5) Medicaid recipients who are residing in a nursing home
4361 facility on the date that a managed long-term care plan becomes
4362 available in the recipient's region are eligible for the long-
4363 term care Medicaid waiver programs.
4364 (6) This section does not create an entitlement to any home
4365 and community-based services provided under the managed long-
4366 term care component.
4367 Section 48. Section 409.975, Florida Statutes, is created
4368 to read:
4369 409.975 Managed long-term care services.—
4370 (1) Qualified plans participating in the managed long-term
4371 care component of the Medicaid managed care program, at a
4372 minimum, shall cover the following services:
4373 (a) The services listed in s. 409.972.
4374 (b) Nursing facility services.
4375 (c) Home and community-based services, including, but not
4376 limited to, assisted living facility services.
4377 (2) Services provided under this section must be medically
4378 necessary and provided in accordance with state and federal law.
4379 This section does not prevent the agency from adjusting fees,

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4380 reimbursement rates, lengths of stay, number of visits, or
4381 number of services, or from making any other adjustments
4382 necessary to comply with the availability of funding and any
4383 limitations or directions provided in the General Appropriations
4384 Act, chapter 216, or s. 409.9022.
4385 Section 49. Section 409.976, Florida Statutes, is created
4386 to read:
4387 409.976 Qualified managed long-term care plans.—
4388 (1) For purposes of managed long-term care, qualified plans
4389 also include:
4390 (a) Entities who are qualified under 42 C.F.R. part 422 as
4391 Medicare Advantage Preferred Provider Organizations, Medicare
4392 Advantage Provider-sponsored Organizations, and Medicare
4393 Advantage Special Needs Plans. Such plans may participate in the
4394 managed long-term care component. A plan submitting a response
4395 to the invitation to negotiate for the managed long-term care
4396 component may reference one or more of these entities as part of
4397 its demonstration of network adequacy for the provision of
4398 services required under s. 409.972 for dually eligible
4399 enrollees.
4400 (b) The Program of All-inclusive Care for the Elderly
4401 (PACE). Participation by PACE shall be pursuant to a contract
4402 with the agency and is not subject to the procurement
4403 requirements of this section. PACE plans may continue to provide
4404 services to recipients at such levels and enrollment caps as
4405 authorized by the General Appropriations Act.
4406 (c) Provider service networks formed by community care for
4407 the elderly lead agencies. Participation by such networks must
4408 be pursuant to a contract with the agency and is not subject to

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4409 the procurement requirements of this section.
4410 (2) The agency shall select qualified plans through the
4411 procurement described in s. 409.965. The agency shall notice the
4412 invitation to negotiate by November 14, 2011.
4413 (3) In addition to the criteria established in s. 409.965,
4414 the agency shall give preference to the following factors in
4415 selecting qualified plans:
4416 (a) The plan's employment of executive managers having
4417 expertise and experience in serving aged and disabled persons
4418 who require long-term care.
4419 (b) The plan's establishment of a network of service
4420 providers dispersed throughout the region and in sufficient
4421 numbers to meet specific service standards established by the
4422 agency for a continuum of care, beginning from the provision of
4423 assistance with the activities of daily living at a recipient's
4424 home and the provision of other home and community-based care
4425 through the provision of nursing home care. These providers
4426 include:
4427 1. Adult day centers.
4428 2. Adult family care homes.
4429 3. Assisted living facilities.
4430 4. Health care services pools.
4431 5. Home health agencies.
4432 6. Homemaker and companion services.
4433 7. Community Care for the Elderly lead agencies.
4434 8. Nurse registries.
4435 9. Nursing homes.
4436
4437 All providers are not required to be located within the region;

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4438 however, the provider network must be sufficient to ensure that
4439 services are available throughout the region.
4440 (c) Whether a plan offers consumer-directed care services
4441 to enrollees pursuant to s. 409.221 or includes attendant care
4442 or paid family caregivers in the benefit package. Consumer-
4443 directed care services must provide a flexible budget, which is
4444 managed by enrollees and their families or representatives, and
4445 allows them to choose service providers, determine provider
4446 rates of payment, and direct the delivery of services to best
4447 meet their special long-term care needs. If all other factors
4448 are equal among competing qualified plans, the agency shall give
4449 preference to such plans.
4450 (d) Evidence that a qualified plan has written agreements
4451 or signed contracts or has made substantial progress in
4452 establishing relationships with providers before the plan
4453 submits a response.
4454 (e) The availability and accessibility of case managers in
4455 the plan and provider network.
4456 Section 50. Section 409.977, Florida Statutes, is created
4457 to read:
4458 409.977 Managed long-term plan and provider
4459 accountability.—In addition to the requirements of ss. 409.966
4460 and 409.967, plans and providers participating in managed long-
4461 term care must comply with s. 641.31(25) and with the specific
4462 standards established by the agency for the number, type, and
4463 regional distribution of the following providers in the plan's
4464 network, which must include:
4465 (1) Adult day centers.
4466 (2) Adult family care homes.

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4467 (3) Assisted living facilities.
4468 (4) Health care services pools.
4469 (5) Home health agencies.
4470 (6) Homemaker and companion services.
4471 (7) Community Care for the Elderly lead agencies.
4472 (8) Nurse registries.
4473 (9) Nursing homes.
4474 Section 51. Section 409.978, Florida Statutes, is created
4475 to read:
4476 409.978 CARES program screening; levels of care.—
4477 (1) The agency shall operate the Comprehensive Assessment
4478 and Review for Long-Term Care Services (CARES) preadmission
4479 screening program to ensure that only recipients whose
4480 conditions require long-term care services are enrolled in
4481 managed long-term care plans.
4482 (2) The agency shall operate the CARES program through an
4483 interagency agreement with the Department of Elderly Affairs.
4484 The agency, in consultation with the department, may contract
4485 for any function or activity of the CARES program, including any
4486 function or activity required by 42 C.F.R. part 483.20, relating
4487 to preadmission screening and review.
4488 (3) The CARES program shall determine if a recipient
4489 requires nursing facility care and, if so, assign the recipient
4490 to one of the following levels of care:
4491 (a) Level of care 1 consists of enrollees who require the
4492 constant availability of routine medical and nursing treatment
4493 and care, have a limited need for health-related care and
4494 services, are mildly medically or physically incapacitated, and
4495 cannot be managed at home due to inadequacy of home-based

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4496 services.
4497 (b) Level of care 2 consists of enrollees who require the
4498 constant availability of routine medical and nursing treatment
4499 and care, and require extensive health-related care and services
4500 because of mental or physical incapacitation. Current enrollees
4501 in home and community-based waiver programs for persons who are
4502 elderly or adults with physical disability, or both, who remain
4503 financially eligible for Medicaid are not required to meet new
4504 level-of-care criteria except for immediate placement in a
4505 nursing home.
4506 (c) Level of care 3 consists of enrollees residing in
4507 nursing homes, or needing immediate placement in a nursing home,
4508 and who have a priority score of 5 or above as determined by
4509 CARES.
4510 (4) For recipients whose nursing home stay is initially
4511 funded by Medicare and Medicare coverage is being terminated for
4512 lack of progress towards rehabilitation, CARES staff shall
4513 consult with the person determining the recipient's progress
4514 toward rehabilitation in order to ensure that the recipient is
4515 not being inappropriately disqualified from Medicare coverage.
4516 If, in their professional judgment, CARES staff believes that a
4517 Medicare beneficiary is still making progress, they may assist
4518 the Medicare beneficiary with appealing the disqualification
4519 from Medicare coverage. The CARES teams may review Medicare
4520 denials for coverage under this section only if it is determined
4521 that such reviews qualify for federal matching funds through
4522 Medicaid. The agency shall seek or amend federal waivers as
4523 necessary to implement this section.
4524 Section 52. Section 409.980, Florida Statutes, is created

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4525 to read:
4526 409.980 Prescribed drug services for qualified plans.—The
4527 agency shall ensure that a qualified plan has transparency and
4528 patient protections in its prescription drug benefit. The
4529 qualified plan must, at a minimum:
4530 (1) Include at least two products, when available, in each
4531 therapeutic class.
4532 (2) Make available those drugs and dosage forms listed in
4533 its preferred drug list.
4534 (3) Ensure that the prior-authorization process is readily
4535 available to health care providers, including posting
4536 appropriate contact information on its website and providing
4537 timely responses to providers.
4538 (4) Not arbitrarily deny or reduce the amount, duration, or
4539 scope of prescriptions based solely on the enrollee's diagnosis,
4540 type of illness, or condition. The qualified plan may place
4541 appropriate limits on prescriptions based on criteria such as
4542 medical necessity, or for the purpose of utilization control, if
4543 the plan reasonably expects such limits to achieve the purpose
4544 of the prescribed drug services set forth in the Medicaid state
4545 plan.
4546 (5) Make available those drugs not on its preferred drug
4547 list, when requested and approved, if drugs on the list have
4548 been used in a step therapy sequence or if other medical
4549 documentation is provided.
4550 (6) Cover the cost of a brand name drug if the prescriber
4551 writes in his or her own handwriting on the prescription that
4552 the brand name drug is medically necessary and submits a
4553 completed multisource drug and miscellaneous prior authorization

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4554 form to the qualified plan indicating that the enrollee has had
4555 an adverse reaction to a generic drug or has had, in the
4556 prescriber's medical opinion, better results when taking the
4557 brand name drug.
4558 (7) Ensure that antiretroviral agents are not subject to
4559 the preferred drug list.
4560 Section 53. Section 409.91207, Florida Statutes, is
4561 transferred, renumbered as section 409.985, Florida Statutes,
4562 and subsection (1) of that section is amended to read:
4563 409.985 ~~409.91207~~ Medical home pilot project.—
4564 (1) The agency shall develop a plan to implement a medical
4565 home pilot project that uses ~~utilizes~~ primary care case
4566 management enhanced by medical home networks to provide
4567 coordinated and cost-effective care that is reimbursed on a fee-
4568 for-service basis and to compare the performance of the medical
4569 home networks with other existing Medicaid managed care models.
4570 The agency may ~~is authorized to~~ seek a federal Medicaid waiver
4571 or an amendment to any existing Medicaid waiver, except for the
4572 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,
4573 as needed, to develop the pilot project created in this section
4574 but must obtain approval of the Legislature before ~~prior to~~
4575 implementing the pilot project.
4576 Section 54. Section 409.91211, Florida Statutes, is
4577 transferred, renumbered as section 409.986, Florida Statutes,
4578 and paragraph (aa) of subsection (3) and paragraph (a) of
4579 subsection (4) of that section are amended, to read:
4580 409.986 ~~409.91211~~ Medicaid managed care pilot program.—
4581 (3) The agency shall have the following powers, duties, and
4582 responsibilities with respect to the pilot program:

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4583 (aa) To implement a mechanism whereby Medicaid recipients
4584 who are already enrolled in a managed care plan or the MediPass
4585 program in the pilot areas are ~~shall be~~ offered the opportunity
4586 to change to capitated managed care plans on a staggered basis,
4587 as defined by the agency. All Medicaid recipients shall have 30
4588 days in which to make a choice of capitated managed care plans.
4589 Those Medicaid recipients who do not make a choice shall be
4590 assigned to a capitated managed care plan in accordance with
4591 paragraph (4)(a) and shall be exempt from s. 409.987 ~~409.9122~~.
4592 To facilitate continuity of care for a Medicaid recipient who is
4593 also a recipient of Supplemental Security Income (SSI), prior to
4594 assigning the SSI recipient to a capitated managed care plan,
4595 the agency shall determine whether the SSI recipient has an
4596 ongoing relationship with a provider or capitated managed care
4597 plan, and, if so, the agency shall assign the SSI recipient to
4598 that provider or capitated managed care plan where feasible.
4599 Those SSI recipients who do not have such a provider
4600 relationship shall be assigned to a capitated managed care plan
4601 provider in accordance with paragraph (4)(a) and shall be exempt
4602 from s. 409.987 ~~409.9122~~.
4603 (4)(a) A Medicaid recipient in the pilot area who is not
4604 currently enrolled in a capitated managed care plan upon
4605 implementation is not eligible for services as specified in ss.
4606 409.905 and 409.906, for the amount of time that the recipient
4607 does not enroll in a capitated managed care network. If a
4608 Medicaid recipient has not enrolled in a capitated managed care
4609 plan within 30 days after eligibility, the agency shall assign
4610 the Medicaid recipient to a capitated managed care plan based on
4611 the assessed needs of the recipient as determined by the agency

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4612 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When
4613 making assignments, the agency shall take into account the
4614 following criteria:
4615 1. A capitated managed care network has sufficient network
4616 capacity to meet the needs of members.
4617 2. The capitated managed care network has previously
4618 enrolled the recipient as a member, or one of the capitated
4619 managed care network's primary care providers has previously
4620 provided health care to the recipient.
4621 3. The agency has knowledge that the member has previously
4622 expressed a preference for a particular capitated managed care
4623 network as indicated by Medicaid fee-for-service claims data,
4624 but has failed to make a choice.
4625 4. The capitated managed care network's primary care
4626 providers are geographically accessible to the recipient's
4627 residence.
4628 Section 55. Section 409.9122, Florida Statutes, is
4629 transferred, renumbered as section 409.987, and paragraph (a) of
4630 subsection (2) of that section is amended to read:
4631 409.987 ~~409.9122~~ Mandatory Medicaid managed care
4632 enrollment; programs and procedures.—
4633 (2)(a) The agency shall enroll all Medicaid recipients in a
4634 managed care plan or MediPass ~~all Medicaid recipients~~, except
4635 ~~those Medicaid~~ recipients who are~~:~~ in an institution, receiving
4636 a Medicaid nonpoverty medical subsidy,~~; enrolled in the Medicaid~~
4637 ~~medically needy Program;~~ or eligible for both Medicaid and
4638 Medicare. Upon enrollment, recipients may ~~individuals will be~~
4639 ~~able to~~ change their managed care option during the 90-day opt
4640 out period required by federal Medicaid regulations. The agency

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4641 may ~~is authorized to~~ seek the necessary Medicaid state plan
4642 amendment to implement this policy. ~~However, to the extent~~
4643 1. If permitted by federal law, the agency may enroll ~~in a~~
4644 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
4645 from mandatory managed care enrollment in a managed care plan or
4646 MediPass if~~, provided that~~:
4647 a.~~1.~~ The recipient's decision to enroll in a managed care
4648 plan or MediPass is voluntary;
4649 b.~~2.~~ ~~If~~ The recipient chooses to enroll in a managed care
4650 plan, the agency has determined that the ~~managed care~~ plan
4651 provides specific programs and services that ~~which~~ address the
4652 special health needs of the recipient; and
4653 c.~~3.~~ The agency receives the ~~any~~ necessary waivers from the
4654 federal Centers for Medicare and Medicaid Services.
4655 2. The agency shall develop rules to establish policies by
4656 which exceptions to the mandatory managed care enrollment
4657 requirement may be made on a case-by-case basis. The rules must
4658 ~~shall~~ include the specific criteria to be applied when
4659 determining ~~making a determination as to~~ whether to exempt a
4660 recipient from mandatory enrollment ~~in a managed care plan or~~
4661 ~~MediPass~~.
4662 3. School districts participating in the certified school
4663 match program pursuant to ss. 409.908(21) and 1011.70 shall be
4664 reimbursed by Medicaid, subject to the limitations of s.
4665 1011.70(1), for a Medicaid-eligible child participating in the
4666 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
4667 409.9071, regardless of whether the child is enrolled in
4668 MediPass or a managed care plan. Managed care plans must ~~shall~~
4669 make a good faith effort to execute agreements with school

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4670 districts regarding the coordinated provision of services
4671 authorized under s. 1011.70.
4672 4. County health departments delivering school-based
4673 services pursuant to ss. 381.0056 and 381.0057 shall be
4674 reimbursed by Medicaid for the federal share for a Medicaid-
4675 eligible child who receives Medicaid-covered services in a
4676 school setting, regardless of whether the child is enrolled in
4677 MediPass or a managed care plan. Managed care plans shall make a
4678 good faith effort to execute agreements with county health
4679 departments that coordinate the ~~regarding the coordinated~~
4680 provision of services to a Medicaid-eligible child. To ensure
4681 continuity of care for Medicaid patients, the agency, the
4682 Department of Health, and the Department of Education shall
4683 develop procedures for ensuring that a student's managed care
4684 plan or MediPass provider receives information relating to
4685 services provided in accordance with ss. 381.0056, 381.0057,
4686 409.9071, and 1011.70.
4687 Section 56. Section 409.9123, Florida Statutes, is
4688 transferred and renumbered as section 409.988, Florida Statutes.
4689 Section 57. Section 409.9124, Florida Statutes, is
4690 transferred and renumbered as section 409.989.
4691 Section 58. Subsection (15) of section 430.04, Florida
4692 Statutes, is amended to read:
4693 430.04 Duties and responsibilities of the Department of
4694 Elderly Affairs.—The Department of Elderly Affairs shall:
4695 (15) Administer all Medicaid waivers and programs relating
4696 to elders and their appropriations. The waivers include, but are
4697 not limited to:
4698 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~

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4699 ~~established in s. 430.502(7), (8), and (9).~~
4700 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.
4701 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.
4702 (c) ~~(d)~~ The Adult Day Health Care Waiver.
4703 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined
4704 in s. 409.221.
4705 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.
4706 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
4707 Project as described in s. 430.705.
4708 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
4709
4710 The department shall develop a transition plan for recipients
4711 receiving services under long-term care Medicaid waivers for
4712 elders or disabled adults on the date qualified plans become
4713 available in each recipient's region pursuant to s. 409.973(2)
4714 in order to enroll those recipients in qualified plans.
4715 Section 59. Section 430.2053, Florida Statutes, is amended
4716 to read:
4717 430.2053 Aging resource centers.—
4718 (1) The department, in consultation with the Agency for
4719 Health Care Administration and the Department of Children and
4720 Family Services, shall develop pilot projects for aging resource
4721 centers. ~~By October 31, 2004, the department, in consultation~~
4722 ~~with the agency and the Department of Children and Family~~
4723 ~~Services, shall develop an implementation plan for aging~~
4724 ~~resource centers and submit the plan to the Governor, the~~
4725 ~~President of the Senate, and the Speaker of the House of~~
4726 ~~Representatives. The plan must include qualifications for~~
4727 ~~designation as a center, the functions to be performed by each~~

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4728 ~~center, and a process for determining that a current area agency~~
4729 ~~on aging is ready to assume the functions of an aging resource~~
4730 ~~center.~~
4731 ~~(2) Each area agency on aging shall develop, in~~
4732 ~~consultation with the existing community care for the elderly~~
4733 ~~lead agencies within their planning and service areas, a~~
4734 ~~proposal that describes the process the area agency on aging~~
4735 ~~intends to undertake to transition to an aging resource center~~
4736 ~~prior to July 1, 2005, and that describes the area agency's~~
4737 ~~compliance with the requirements of this section. The proposals~~
4738 ~~must be submitted to the department prior to December 31, 2004.~~
4739 ~~The department shall evaluate all proposals for readiness and,~~
4740 ~~prior to March 1, 2005, shall select three area agencies on~~
4741 ~~aging which meet the requirements of this section to begin the~~
4742 ~~transition to aging resource centers. Those area agencies on~~
4743 ~~aging which are not selected to begin the transition to aging~~
4744 ~~resource centers shall, in consultation with the department and~~
4745 ~~the existing community care for the elderly lead agencies within~~
4746 ~~their planning and service areas, amend their proposals as~~
4747 ~~necessary and resubmit them to the department prior to July 1,~~
4748 ~~2005. The department may transition additional area agencies to~~
4749 ~~aging resource centers as it determines that area agencies are~~
4750 ~~in compliance with the requirements of this section.~~
4751 ~~(3) The Auditor General and the Office of Program Policy~~
4752 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
4753 ~~review and assess the department's process for determining an~~
4754 ~~area agency's readiness to transition to an aging resource~~
4755 ~~center.~~
4756 ~~(a) The review must, at a minimum, address the~~

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4757 ~~appropriateness of the department's criteria for selection of an~~
4758 ~~area agency to transition to an aging resource center, the~~
4759 ~~instruments applied, the degree to which the department~~
4760 ~~accurately determined each area agency's compliance with the~~
4761 ~~readiness criteria, the quality of the technical assistance~~
4762 ~~provided by the department to an area agency in correcting any~~
4763 ~~weaknesses identified in the readiness assessment, and the~~
4764 ~~degree to which each area agency overcame any identified~~
4765 ~~weaknesses.~~
4766 ~~(b) Reports of these reviews must be submitted to the~~
4767 ~~appropriate substantive and appropriations committees in the~~
4768 ~~Senate and the House of Representatives on March 1 and September~~
4769 ~~1 of each year until full transition to aging resource centers~~
4770 ~~has been accomplished statewide, except that the first report~~
4771 ~~must be submitted by February 1, 2005, and must address all~~
4772 ~~readiness activities undertaken through December 31, 2004. The~~
4773 ~~perspectives of all participants in this review process must be~~
4774 ~~included in each report.~~
4775 (2) ~~(4)~~ The purposes of an aging resource center are ~~shall~~
4776 ~~be~~:
4777 (a) To provide Florida's elders and their families with a
4778 locally focused, coordinated approach to integrating information
4779 and referral for all available services for elders with the
4780 eligibility determination entities for state and federally
4781 funded long-term-care services.
4782 (b) To provide for easier access to long-term-care services
4783 by Florida's elders and their families by creating multiple
4784 access points to the long-term-care network that flow through
4785 one established entity with wide community recognition.

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4786 (3) ~~(5)~~ The duties of an aging resource center are to:
4787 (a) Develop referral agreements with local community
4788 service organizations, such as senior centers, existing elder
4789 service providers, volunteer associations, and other similar
4790 organizations, to better assist clients who do not need or do
4791 not wish to enroll in programs funded by the department or the
4792 agency. The referral agreements must also include a protocol,
4793 developed and approved by the department, which provides
4794 specific actions that an aging resource center and local
4795 community service organizations must take when an elder or an
4796 elder's representative seeking information on long-term-care
4797 services contacts a local community service organization prior
4798 to contacting the aging resource center. The protocol shall be
4799 designed to ensure that elders and their families are able to
4800 access information and services in the most efficient and least
4801 cumbersome manner possible.
4802 (b) Provide an initial screening of all clients who request
4803 long-term-care services to determine whether the person would be
4804 most appropriately served through any combination of federally
4805 funded programs, state-funded programs, locally funded or
4806 community volunteer programs, or private funding for services.
4807 (c) Determine eligibility for the programs and services
4808 listed in subsection (9) ~~(11)~~ for persons residing within the
4809 geographic area served by the aging resource center and
4810 determine a priority ranking for services which is based upon
4811 the potential recipient's frailty level and likelihood of
4812 institutional placement without such services.
4813 (d) Manage the availability of financial resources for the
4814 programs and services listed in subsection (9) ~~(11)~~ for persons

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4815 residing within the geographic area served by the aging resource
4816 center.
4817 (e) If ~~When~~ financial resources become available, refer a
4818 client to the most appropriate entity to begin receiving
4819 services. The aging resource center shall make referrals to lead
4820 agencies for service provision that ensure that individuals who
4821 are vulnerable adults in need of services pursuant to s.
4822 415.104(3)(b), or who are victims of abuse, neglect, or
4823 exploitation in need of immediate services to prevent further
4824 harm and are referred by the adult protective services program,
4825 are given primary consideration for receiving community-care-
4826 for-the-elderly services in compliance with the requirements of
4827 s. 430.205(5)(a) and that other referrals for services are in
4828 compliance with s. 430.205(5)(b).
4829 (f) Convene a work group to advise in the planning,
4830 implementation, and evaluation of the aging resource center. The
4831 work group shall be composed ~~comprised~~ of representatives of
4832 local service providers, Alzheimer's Association chapters,
4833 housing authorities, social service organizations, advocacy
4834 groups, representatives of clients receiving services through
4835 the aging resource center, and ~~any~~ other persons or groups as
4836 determined by the department. The aging resource center, in
4837 consultation with the work group, must develop annual program
4838 improvement plans that shall be submitted to the department for
4839 consideration. The department shall review each annual
4840 improvement plan and make recommendations on how to implement
4841 the components of the plan.
4842 (g) Enhance the existing area agency on aging in each
4843 planning and service area by integrating, ~~either~~ physically or

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4844 virtually, the staff and services of the area agency on aging
4845 with the staff of the department's local CARES Medicaid ~~nursing~~
4846 ~~home~~ preadmission screening unit and a sufficient number of
4847 staff from the Department of Children and Family Services'
4848 Economic Self-Sufficiency Unit necessary to determine the
4849 financial eligibility for all persons age 60 and older residing
4850 within the area served by the aging resource center who ~~that~~ are
4851 seeking Medicaid services, Supplemental Security Income, and
4852 food assistance.
4853 (h) Assist clients who request long-term care services in
4854 being evaluated for eligibility for the long-term care managed
4855 care component of the Medicaid managed care program as qualified
4856 plans become available in each of the regions pursuant to s.
4857 409.973(2).
4858 (i) Provide enrollment and coverage information to Medicaid
4859 managed long-term care enrollees as qualified plans become
4860 available in each of the regions pursuant to s. 409.973(2).
4861 (j) Assist enrollees in the Medicaid long-term care managed
4862 care program with informally resolving grievances with a managed
4863 care network and in accessing the managed care network's formal
4864 grievance process as qualified plans become available in each of
4865 the regions pursuant to s. 409.973(2).
4866 (4) ~~(6)~~ The department shall select the entities to become
4867 aging resource centers based on each entity's readiness and
4868 ability to perform the duties listed in subsection (3) ~~(5)~~ and
4869 the entity's:
4870 (a) Expertise in the needs of each target population the
4871 center proposes to serve and a thorough knowledge of the
4872 providers that serve these populations.

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4873 (b) Strong connections to service providers, volunteer
4874 agencies, and community institutions.
4875 (c) Expertise in information and referral activities.
4876 (d) Knowledge of long-term-care resources, including
4877 resources designed to provide services in the least restrictive
4878 setting.
4879 (e) Financial solvency and stability.
4880 (f) Ability to collect, monitor, and analyze data in a
4881 timely and accurate manner, along with systems that meet the
4882 department's standards.
4883 (g) Commitment to adequate staffing by qualified personnel
4884 to effectively perform all functions.
4885 (h) Ability to meet all performance standards established
4886 by the department.
4887 (5) ~~(7)~~ The aging resource center shall have a governing
4888 body which shall be the same entity described in s. 20.41(7),
4889 and an executive director who may be the same person as
4890 described in s. 20.41(7). The governing body shall annually
4891 evaluate the performance of the executive director.
4892 (6) ~~(8)~~ The aging resource center may not be a provider of
4893 direct services other than information and referral services,
4894 and screening.
4895 (7) ~~(9)~~ The aging resource center must agree to allow the
4896 department to review any financial information the department
4897 determines is necessary for monitoring or reporting purposes,
4898 including financial relationships.
4899 (8) ~~(10)~~ The duties and responsibilities of the community
4900 care for the elderly lead agencies within each area served by an
4901 aging resource center shall be to:

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4902 (a) Develop strong community partnerships to maximize the
4903 use of community resources for the purpose of assisting elders
4904 to remain in their community settings for as long as it is
4905 safely possible.
4906 (b) Conduct comprehensive assessments of clients that have
4907 been determined eligible and develop a care plan consistent with
4908 established protocols that ensures that the unique needs of each
4909 client are met.
4910 (9) ~~(11)~~ The services to be administered through the aging
4911 resource center shall include those funded by the following
4912 programs:
4913 (a) Community care for the elderly.
4914 (b) Home care for the elderly.
4915 (c) Contracted services.
4916 (d) Alzheimer's disease initiative.
4917 (e) Aged and disabled adult Medicaid waiver.
4918 (f) Assisted living for the frail elderly Medicaid waiver.
4919 (g) Older Americans Act.
4920 (10) ~~(12)~~ The department shall, prior to designation of an
4921 aging resource center, develop by rule operational and quality
4922 assurance standards and outcome measures to ensure that clients
4923 receiving services through all long-term-care programs
4924 administered through an aging resource center are receiving the
4925 appropriate care they require and that contractors and
4926 subcontractors are adhering to the terms of their contracts and
4927 are acting in the best interests of the clients they are
4928 serving, consistent with the intent of the Legislature to reduce
4929 the use of and cost of nursing home care. The department shall
4930 by rule provide operating procedures for aging resource centers,

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4931 which shall include:
4932 (a) Minimum standards for financial operation, including
4933 audit procedures.
4934 (b) Procedures for monitoring and sanctioning of service
4935 providers.
4936 (c) Minimum standards for technology utilized by the aging
4937 resource center.
4938 (d) Minimum staff requirements which shall ensure that the
4939 aging resource center employs sufficient quality and quantity of
4940 staff to adequately meet the needs of the elders residing within
4941 the area served by the aging resource center.
4942 (e) Minimum accessibility standards, including hours of
4943 operation.
4944 (f) Minimum oversight standards for the governing body of
4945 the aging resource center to ensure its continuous involvement
4946 in, and accountability for, all matters related to the
4947 development, implementation, staffing, administration, and
4948 operations of the aging resource center.
4949 (g) Minimum education and experience requirements for
4950 executive directors and other executive staff positions of aging
4951 resource centers.
4952 (h) Minimum requirements regarding any executive staff
4953 positions that the aging resource center must employ and minimum
4954 requirements that a candidate must meet in order to be eligible
4955 for appointment to such positions.
4956 (11) ~~(13)~~ In an area in which the department has designated
4957 an area agency on aging as an aging resource center, the
4958 department and the agency may ~~shall~~ not make payments for the
4959 services listed in subsection (9) ~~(11)~~ and the Long-Term Care

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4960 Community Diversion Project for ~~such~~ persons who were not
4961 screened and enrolled through the aging resource center. The
4962 department shall cease making these payments for enrollees in
4963 qualified plans as qualified plans become available in each of
4964 the regions pursuant to s. 409.973(2).
4965 (12) ~~(14)~~ Each aging resource center shall enter into a
4966 memorandum of understanding with the department for
4967 collaboration with the CARES unit staff. The memorandum of
4968 understanding must ~~shall~~ outline the staff person responsible
4969 for each function and ~~shall~~ provide the staffing levels
4970 necessary to carry out the functions of the aging resource
4971 center.
4972 (13) ~~(15)~~ Each aging resource center shall enter into a
4973 memorandum of understanding with the Department of Children and
4974 Family Services for collaboration with the Economic Self-
4975 Sufficiency Unit staff. The memorandum of understanding must
4976 ~~shall~~ outline which staff persons are responsible for which
4977 functions and ~~shall~~ provide the staffing levels necessary to
4978 carry out the functions of the aging resource center.
4979 (14) ~~(16)~~ If any of the state activities described in this
4980 section are outsourced, ~~either~~ in part or in whole, the contract
4981 executing the outsourcing must ~~shall~~ mandate that the contractor
4982 or its subcontractors shall, ~~either~~ physically or virtually,
4983 execute the provisions of the memorandum of understanding
4984 instead of the state entity whose function the contractor or
4985 subcontractor now performs.
4986 (15) ~~(17)~~ In order to be eligible to begin transitioning to
4987 an aging resource center, an area agency on aging board must
4988 ensure that the area agency on aging which it oversees meets all

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4989 of the minimum requirements set by law and in rule.
4990 ~~(18) The department shall monitor the three initial~~
4991 ~~projects for aging resource centers and report on the progress~~
4992 ~~of those projects to the Governor, the President of the Senate,~~
4993 ~~and the Speaker of the House of Representatives by June 30,~~
4994 ~~2005. The report must include an evaluation of the~~
4995 ~~implementation process.~~
4996 (16) ~~(19)~~(a) Once an aging resource center is operational,
4997 the department, in consultation with the agency, may develop
4998 capitation rates for any of the programs administered through
4999 the aging resource center. Capitation rates for programs must
5000 ~~shall~~ be based on the historical cost experience of the state in
5001 providing those same services to the population age 60 or older
5002 residing within each area served by an aging resource center.
5003 Each capitated rate may vary by geographic area as determined by
5004 the department.
5005 (b) The department and the agency may determine for each
5006 area served by an aging resource center whether it is
5007 appropriate, consistent with federal and state laws and
5008 regulations, to develop and pay separate capitated rates for
5009 each program administered through the aging resource center or
5010 to develop and pay capitated rates for service packages which
5011 include more than one program or service administered through
5012 the aging resource center.
5013 (c) Once capitation rates have been developed and certified
5014 as actuarially sound, the department and the agency may pay
5015 service providers the capitated rates for services if ~~when~~
5016 appropriate.
5017 (d) The department, in consultation with the agency, shall

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5018 annually reevaluate and recertify the capitation rates,
5019 adjusting forward to account for inflation, programmatic
5020 changes.
5021 ~~(20) The department, in consultation with the agency, shall~~
5022 ~~submit to the Governor, the President of the Senate, and the~~
5023 ~~Speaker of the House of Representatives, by December 1, 2006, a~~
5024 ~~report addressing the feasibility of administering the following~~
5025 ~~services through aging resource centers beginning July 1, 2007:~~
5026 ~~(a) Medicaid nursing home services.~~
5027 ~~(b) Medicaid transportation services.~~
5028 ~~(c) Medicaid hospice care services.~~
5029 ~~(d) Medicaid intermediate care services.~~
5030 ~~(e) Medicaid prescribed drug services.~~
5031 ~~(f) Medicaid assistive care services.~~
5032 ~~(g) Any other long-term-care program or Medicaid service.~~
5033 (17) ~~(21)~~ This section does ~~shall~~ not ~~be construed to~~ allow
5034 an aging resource center to restrict, manage, or impede the
5035 local fundraising activities of service providers.
5036 Section 60. Paragraph (b) of subsection (2) of section
5037 641.316, Florida Statutes, is amended to read:
5038 641.316 Fiscal intermediary services.—
5039 (2)
5040 (b) The term “fiscal intermediary services organization”
5041 means a person or entity that performs fiduciary or fiscal
5042 intermediary services to health care professionals who contract
5043 with health maintenance organizations other than a hospital
5044 licensed under chapter 395, an insurer licensed under chapter
5045 624, a third-party administrator licensed under chapter 626, a
5046 prepaid limited health service organization licensed under

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5047 chapter 636, a health maintenance organization licensed under
5048 this chapter, a qualified plan authorized under part IV of
5049 chapter 409, or a physician group practice as defined in s.
5050 456.053(3)~~(h)~~ which provides services under the scope of
5051 licenses of the members of the group practice.
5052 Section 61. Paragraphs (c) and (d) of subsection (3) of
5053 section 39.407, Florida Statutes, are amended to read:
5054 39.407 Medical, psychiatric, and psychological examination
5055 and treatment of child; physical, mental, or substance abuse
5056 examination of person with or requesting child custody.—
5057 (3)
5058 (c) Except as provided in paragraphs (b) and (e), the
5059 department must file a motion seeking the court's authorization
5060 to initially provide or continue to provide psychotropic
5061 medication to a child in its legal custody. The motion must be
5062 supported by a written report prepared by the department which
5063 describes the efforts made to enable the prescribing physician
5064 to obtain express and informed consent to provide ~~for providing~~
5065 the medication to the child and other treatments considered or
5066 recommended for the child. ~~In addition,~~ The motion must also be
5067 supported by the prescribing physician's signed medical report
5068 providing:
5069 1. The name of the child, the name and range of the dosage
5070 of the psychotropic medication, and the ~~that there is a~~ need to
5071 prescribe psychotropic medication to the child based upon a
5072 diagnosed condition for which such medication is being
5073 prescribed.
5074 2. A statement indicating that the physician has reviewed
5075 all medical information concerning the child which has been

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5076 provided.
5077 3. A statement indicating that the psychotropic medication,
5078 at its prescribed dosage, is appropriate for treating the
5079 child's diagnosed medical condition, as well as the behaviors
5080 and symptoms the medication, at its prescribed dosage, is
5081 expected to address.
5082 4. An explanation of the nature and purpose of the
5083 treatment; the recognized side effects, risks, and
5084 contraindications of the medication; drug-interaction
5085 precautions; the possible effects of stopping the medication;
5086 and how the treatment will be monitored, followed by a statement
5087 indicating that this explanation was provided to the child if
5088 age appropriate and to the child's caregiver.
5089 5. Documentation addressing whether the psychotropic
5090 medication will replace or supplement any other currently
5091 prescribed medications or treatments; the length of time the
5092 child is expected to be taking the medication; and any
5093 additional medical, mental health, behavioral, counseling, or
5094 other services that the prescribing physician recommends.
5095 6. For a child 10 years of age or younger who is in an out-
5096 of-home placement, the results of a review of the administration
5097 of the medication by a child psychiatrist who is licensed under
5098 chapter 458 or chapter 459. The review must be provided to the
5099 child and the parent or legal guardian before final express and
5100 informed consent is given. The review must include a
5101 determination of the following:
5102 a. The presence of a genetic psychiatric disorder or a
5103 family history of a psychiatric disorder;
5104 b. Whether the cause of a psychiatric disorder is physical

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5105 or environmental; and
5106 c. The likelihood of the child being an imminent danger to
5107 self or others.
5108 (d)~~1.~~ The department must notify all parties of the
5109 proposed action taken under paragraph (c) in writing or by
5110 whatever other method best ensures that all parties receive
5111 notification of the proposed action within 48 hours after the
5112 motion is filed. If any party objects to the department's
5113 motion, that party shall file the objection within 2 working
5114 days after being notified of the department's motion. If any
5115 party files an objection to the authorization of the proposed
5116 psychotropic medication, the court shall hold a hearing as soon
5117 as possible before authorizing the department to initially
5118 provide or to continue providing psychotropic medication to a
5119 child in the legal custody of the department.
5120 1. At such hearing and notwithstanding s. 90.803, the
5121 medical report described in paragraph (c) is admissible in
5122 evidence. The prescribing physician need not attend the hearing
5123 or testify unless the court specifically orders such attendance
5124 or testimony, or a party subpoenas the physician to attend the
5125 hearing or provide testimony.
5126 2. If, after considering any testimony received, the court
5127 finds that the department's motion and the physician's medical
5128 report meet the requirements of this subsection and that it is
5129 in the child's best interests, the court may order that the
5130 department provide or continue to provide the psychotropic
5131 medication to the child without additional testimony or
5132 evidence.
5133 3. At any hearing held under this paragraph, the court

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5134 shall ~~further~~ inquire of the department as to whether additional
5135 medical, mental health, behavioral, counseling, or other
5136 services are being provided to the child by the department which
5137 the prescribing physician considers to be necessary or
5138 beneficial in treating the child's medical condition and which
5139 the physician recommends or expects to provide to the child in
5140 concert with the medication. The court may order additional
5141 medical consultation, including consultation with the MedConsult
5142 line at the University of Florida, if available, or require the
5143 department to obtain a second opinion within a reasonable
5144 timeframe as established by the court, not to exceed 21 calendar
5145 days, ~~after such order~~ based upon consideration of the best
5146 interests of the child. The department must make a referral for
5147 an appointment for a second opinion with a physician within 1
5148 working day.
5149 4. The court may not order the discontinuation of
5150 prescribed psychotropic medication if such order is contrary to
5151 the decision of the prescribing physician unless the court first
5152 obtains an opinion from a licensed psychiatrist, if available,
5153 or, if not available, a physician licensed under chapter 458 or
5154 chapter 459, stating that more likely than not, discontinuing
5155 the medication would not cause significant harm to the child.
5156 If, however, the prescribing psychiatrist specializes in mental
5157 health care for children and adolescents, the court may not
5158 order the discontinuation of prescribed psychotropic medication
5159 unless the required opinion is also from a psychiatrist who
5160 specializes in mental health care for children and adolescents.
5161 The court may also order the discontinuation of prescribed
5162 psychotropic medication if a child's treating physician,

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5163 licensed under chapter 458 or chapter 459, states that
5164 continuing the prescribed psychotropic medication would cause
5165 significant harm to the child due to a diagnosed nonpsychiatric
5166 medical condition.
5167 5. If a child who is in out-of-home placement is 10 years
5168 of age or younger, psychotropic medication may not be authorized
5169 by the court absent a finding of a compelling governmental
5170 interest. In making such finding, the court shall review the
5171 psychiatric review described in subparagraph (c)6.
5172 6.~~2.~~ The burden of proof at any hearing held under this
5173 paragraph shall be by a preponderance of the evidence.
5174 Section 62. Paragraph (a) of subsection (1) of section
5175 216.262, Florida Statutes, is amended to read:
5176 216.262 Authorized positions.—
5177 (1)(a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by
5178 law, the total number of authorized positions may not exceed the
5179 total provided in the appropriations acts. If a ~~In the event any~~
5180 state agency or entity of the judicial branch finds that the
5181 number of positions so provided is not sufficient to administer
5182 its authorized programs, it may file an application with the
5183 Executive Office of the Governor or the Chief Justice~~,~~ and, if
5184 the Executive Office of the Governor or Chief Justice certifies
5185 that there are no authorized positions available for addition,
5186 deletion, or transfer within the agency or entity as provided in
5187 paragraph (c), may recommend ~~and recommends~~ an increase in the
5188 number of positions.~~,~~
5189 1. The Governor or the Chief Justice may recommend an
5190 increase in the number of positions for the following reasons
5191 only:

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5192 a.~~1.~~ To implement or provide for continuing federal grants
5193 or changes in grants not previously anticipated.
5194 b.~~2.~~ To meet emergencies pursuant to s. 252.36.
5195 c.~~3.~~ To satisfy new federal regulations or changes therein.
5196 d.~~4.~~ To take advantage of opportunities to reduce operating
5197 expenditures or to increase the revenues of the state or local
5198 government.
5199 e.~~5.~~ To authorize positions that were not fixed by the
5200 Legislature due to ~~through~~ error in drafting the appropriations
5201 acts.
5202 2. Actions recommended pursuant to this paragraph are
5203 subject to approval by the Legislative Budget Commission. The
5204 certification and the final authorization shall be provided to
5205 the Legislative Budget Commission, the legislative
5206 appropriations committees, and the Auditor General.
5207 3. The provisions of this paragraph do not apply to
5208 positions in the Department of Health which are funded by the
5209 County Health Department Trust Fund.
5210 Section 63. Section 381.06014, Florida Statutes, is amended
5211 to read:
5212 381.06014 Blood establishments.—
5213 (1) As used in this section, the term:
5214 (a) “Blood establishment” means any person, entity, or
5215 organization, operating within the state, which examines an
5216 individual for the purpose of blood donation or which collects,
5217 processes, stores, tests, or distributes blood or blood
5218 components collected from the human body for the purpose of
5219 transfusion, for any other medical purpose, or for the
5220 production of any biological product. A person, entity, or

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5221 organization that uses a mobile unit to conduct such activities
5222 within the state is also a blood establishment.
5223 (b) "Volunteer donor" means a person who does not receive
5224 remuneration, other than an incentive, for a blood donation
5225 intended for transfusion, and the product container of the
5226 donation from the person qualifies for labeling with the
5227 statement "volunteer donor" under 21 C.F.R. s. 606.121.
5228 (2) An entity or organization may not hold itself out and
5229 engage in the activities of a ~~Any~~ blood establishment in this
5230 state ~~operating in the state may not conduct any activity~~
5231 ~~defined in subsection (1)~~ unless it operates in accordance ~~that~~
5232 ~~blood establishment is operated in a manner consistent~~ with ~~the~~
5233 ~~provisions of~~ Title 21 C.F.R. parts 211 and 600-640~~, Code of~~
5234 ~~Federal Regulations~~.
5235 (3) A ~~Any~~ blood establishment determined to be operating in
5236 the state in a manner not consistent with ~~the provisions of~~
5237 Title 21 C.F.R. parts 211 and 600-640, ~~Code of Federal~~
5238 ~~Regulations,~~ and in a manner that constitutes a danger to the
5239 health or well-being of donors or recipients as evidenced by the
5240 federal Food and Drug Administration's inspection reports and
5241 the revocation of the blood establishment's license or
5242 registration is ~~shall be~~ in violation of this chapter, ~~and shall~~
5243 ~~immediately cease all operations in the state.~~
5244 ~~(4) The operation of a blood establishment in a manner not~~
5245 ~~consistent with the provisions of Title 21 parts 211 and 600-~~
5246 ~~640, Code of Federal Regulations, and in a manner that~~
5247 ~~constitutes a danger to the health or well-being of blood donors~~
5248 ~~or recipients as evidenced by the federal Food and Drug~~
5249 ~~Administration's inspection process~~ is declared a nuisance and

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5250 inimical to the public health, welfare, and safety, and must
5251 immediately cease all operations in this state. The Agency for
5252 Health Care Administration or any state attorney may bring an
5253 action for an injunction to restrain such operations or enjoin
5254 the future operation of the blood establishment.
5255 (4) A local government may not restrict access to or the
5256 use of any public facility or infrastructure for the collection
5257 of blood or blood components from volunteer donors based on
5258 whether the blood establishment is operating as a for-profit or
5259 not-for-profit organization.
5260 (5) In determining the service fee of blood or blood
5261 components received from volunteer donors and sold to hospitals
5262 or other health care providers, a blood establishment may not
5263 base the service fee of the blood or blood component solely on
5264 whether the purchasing entity is a for-profit or not-for-profit
5265 organization.
5266 (6) A blood establishment that collects blood or blood
5267 components from volunteer donors must disclose the following
5268 information on its Internet website in order to educate and
5269 inform donors and the public about the blood establishment's
5270 activities, and the information required to be disclosed may be
5271 cumulative for all blood establishments within a business
5272 entity:
5273 (a) A description of the steps involved in collecting,
5274 processing, and distributing volunteer donations.
5275 (b) By March 1 of each year, the number of units of blood
5276 components which were:
5277 1. Produced by the blood establishment during the preceding
5278 calendar year;

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5279 2. Obtained from other sources during the preceding
5280 calendar year;
5281 3. Distributed during the preceding calendar year to health
5282 care providers located outside this state. However, if the blood
5283 establishment collects donations in a county outside this state,
5284 distributions to health care providers in that county are
5285 excluded. Such information shall be reported in the aggregate
5286 for health care providers located within the United States and
5287 its territories or outside the United States and its
5288 territories; and
5289 4. Distributed during the preceding calendar year to
5290 entities that are not health care providers. Such information
5291 shall be reported in the aggregate for purchasers located within
5292 the United States and its territories or outside the United
5293 States and its territories.
5294 (c) The blood establishment's conflict-of-interest policy,
5295 policy concerning related-party transactions, whistleblower
5296 policy, and policy for determining executive compensation. If a
5297 change occurs to any of these documents, the revised document
5298 must be available on the blood establishment's website by the
5299 following March 1.
5300 (d) Except for a hospital that collects blood or blood
5301 components from volunteer donors:
5302 1. The most recent 3 years of the Return of Organization
5303 Exempt from Income Tax, Internal Revenue Service Form 990, if
5304 the business entity for the blood establishment is eligible to
5305 file such return. The Form 990 must be available on the blood
5306 establishment's website within 60 calendar days after it is
5307 filed with the Internal Revenue Service; or

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5308 2. If the business entity for the blood establishment is
5309 not eligible to file the Form 990 return, a balance sheet,
5310 income statement, and statement of changes in cash flow, along
5311 with the expression of an opinion thereon by an independent
5312 certified public accountant who audited or reviewed such
5313 financial statements. Such documents must be available on the
5314 blood establishment's website within 120 days after the end of
5315 the blood establishment's fiscal year and must remain on the
5316 blood establishment's website for at least 36 months.
5317
5318 A hospital that collects blood or blood components to be used
5319 only by that hospital's licensed facilities or by a health care
5320 provider that is a part of the hospital's business entity is
5321 exempt from the disclosure requirements of this subsection.
5322 (7) A blood establishment is liable for a civil penalty for
5323 failing to make the disclosures required under subsection (6).
5324 The Department of Legal Affairs may assess a civil penalty
5325 against the blood establishment for each day that it fails to
5326 make such required disclosures, but the penalty may not exceed
5327 $10,000 per year. If multiple blood establishments operated by a
5328 single business entity fail to meet such disclosure
5329 requirements, the civil penalty may be assessed against only one
5330 of the business entity's blood establishments. The Department of
5331 Legal Affairs may terminate an action if the blood establishment
5332 agrees to pay a stipulated civil penalty. A civil penalty so
5333 collected accrues to the state and shall be deposited as
5334 received into the General Revenue Fund unallocated. The
5335 Department of Legal Affairs may terminate the action and waive
5336 the civil penalty upon a showing of good cause by the blood

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5337 establishment as to why the required disclosures were not made.
5338 Section 64. Subsection (9) of section 393.063, Florida
5339 Statutes, is amended, present subsections (13) through (40) of
5340 that section are redesignated as subsections (14) through (41),
5341 respectively, and a new subsection (13) is added to that
5342 section, to read:
5343 393.063 Definitions.—For the purposes of this chapter, the
5344 term:
5345 (9) "Developmental disability" means a disorder or syndrome
5346 that is attributable to retardation, cerebral palsy, autism,
5347 spina bifida, Down syndrome, or Prader-Willi syndrome; that
5348 manifests before the age of 18; and that constitutes a
5349 substantial handicap that can reasonably be expected to continue
5350 indefinitely.
5351 (13) "Down syndrome" means a disorder that is caused by the
5352 presence of an extra chromosome 21.
5353 Section 65. Paragraph (d) of subsection (2) of section
5354 395.4025, Florida Statutes, is amended to read:
5355 395.4025 Trauma centers; selection; quality assurance;
5356 records.—
5357 (2)
5358 (d)1. Notwithstanding other provisions in this section, the
5359 department may grant up to an additional 18 months to a hospital
5360 applicant that is unable to meet all the requirements under ~~as~~
5361 ~~provided in~~ paragraph (c) at the time of application if the
5362 number of applicants in the service area in which the applicant
5363 is located is equal to or less than the service area allocation,
5364 as provided by rule of the department.
5365 a. An applicant that is granted additional time ~~pursuant to~~

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5366 ~~this paragraph~~ shall submit a plan for departmental approval
5367 which includes timelines and activities that the applicant
5368 proposes to complete in order to meet application requirements.
5369 An ~~Any~~ applicant that demonstrates an ongoing effort to complete
5370 the activities within the timelines outlined in the plan shall
5371 be included in the number of trauma centers when ~~at such time~~
5372 ~~that~~ the department conducts ~~has conducted~~ a provisional review
5373 of the application and determines ~~has determined~~ that the
5374 application is complete and that the hospital has the critical
5375 elements required for a trauma center.
5376 b. If construction related to a critical element is delayed
5377 due to governmental action or inaction with respect to
5378 regulations or permitting and a hospital applicant has
5379 demonstrated that it has made a good faith effort to comply with
5380 the applicable regulations or obtain the required permits, the
5381 department shall grant an applicant that has received an
5382 additional 18 months up to two additional 6-month extensions to
5383 meet all the requirements under paragraph (c).
5384 2. Timeframes provided in subsections (1)-(8) shall be
5385 stayed until the department determines that the application is
5386 complete and that the hospital has the critical elements
5387 required for a trauma center.
5388 Section 66. Section 400.023, Florida Statutes, is reordered
5389 and amended to read:
5390 400.023 Civil enforcement.—
5391 (1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a
5392 violation of rights as specified in this part has ~~are violated~~
5393 ~~shall have~~ a cause of action against the licensee or its
5394 management company, as identified in the state application for

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5395 nursing home licensure. However, the cause of action may not be
5396 asserted individually against an officer, director, owner,
5397 including an owner designated as having a controlling interest
5398 on the state application for nursing home licensure, or agent of
5399 a licensee or management company unless, following an
5400 evidentiary hearing, the court determines there is sufficient
5401 evidence in the record or proffered by the claimant which
5402 establishes a reasonable basis for finding that the person or
5403 entity breached, failed to perform, or acted outside the scope
5404 of duties as an officer, director, owner, or agent, and that the
5405 breach, failure to perform, or action outside the scope of
5406 duties is a legal cause of actual loss, injury, death, or damage
5407 to the resident.
5408 (2) The action may be brought by the resident or his or her
5409 guardian, by a person or organization acting on behalf of a
5410 resident with the consent of the resident or his or her
5411 guardian, or by the personal representative of the estate of a
5412 deceased resident regardless of the cause of death.
5413 (5) If the action alleges a claim for the resident's rights
5414 or for negligence that:
5415 (a) Caused the death of the resident, the claimant must
5416 ~~shall be required to~~ elect ~~either~~ survival damages pursuant to
5417 s. 46.021 or wrongful death damages pursuant to s. 768.21. If
5418 the claimant elects wrongful death damages, total noneconomic
5419 damages may not exceed $250,000, regardless of the number of
5420 claimants.
5421 (b) ~~If the action alleges a claim for the resident's rights~~
5422 ~~or for negligence that~~ Did not cause the death of the resident,
5423 the personal representative of the estate may recover damages

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5424 for the negligence that caused injury to the resident.
5425 (3) The action may be brought in any court of competent
5426 jurisdiction to enforce such rights and to recover actual and
5427 punitive damages for any violation of the rights of a resident
5428 or for negligence.
5429 (10) Any resident who prevails in seeking injunctive relief
5430 or a claim for an administrative remedy may ~~is entitled to~~
5431 recover the costs of the action, and a reasonable attorney's fee
5432 assessed against the defendant not to exceed $25,000. Fees shall
5433 be awarded solely for the injunctive or administrative relief
5434 and not for any claim or action for damages whether such claim
5435 or action is brought together with a request for an injunction
5436 or administrative relief or as a separate action, except as
5437 provided under s. 768.79 or the Florida Rules of Civil
5438 Procedure. Sections 400.023-400.0238 provide the exclusive
5439 remedy for a cause of action for recovery of damages for the
5440 personal injury or death of a nursing home resident arising out
5441 of negligence or a violation of rights specified in s. 400.022.
5442 This section does not preclude theories of recovery not arising
5443 out of negligence or s. 400.022 which are available to a
5444 resident or to the agency. The provisions of chapter 766 do not
5445 apply to any cause of action brought under ss. 400.023-400.0238.
5446 (6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part
5447 alleges ~~alleging~~ a violation of resident's rights or negligence
5448 causing injury to or the death of a resident, the claimant shall
5449 have the burden of proving, by a preponderance of the evidence,
5450 that:
5451 (a) The defendant owed a duty to the resident;
5452 (b) The defendant breached the duty to the resident;

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5453 (c) The breach of the duty is a legal cause of loss,
5454 injury, death, or damage to the resident; and
5455 (d) The resident sustained loss, injury, death, or damage
5456 as a result of the breach.
5457 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~
5458 create strict liability. A violation of the rights set forth in
5459 s. 400.022 or in any other standard or guidelines specified in
5460 this part or in any applicable administrative standard or
5461 guidelines of this state or a federal regulatory agency is ~~shall~~
5462 ~~be~~ evidence of negligence but may ~~shall~~ not be considered
5463 negligence per se.
5464 (7) ~~(3)~~ In any claim brought pursuant to this section, a
5465 licensee, person, or entity has ~~shall have~~ a duty to exercise
5466 reasonable care. Reasonable care is that degree of care which a
5467 reasonably careful licensee, person, or entity would use under
5468 like circumstances.
5469 (9) ~~(4)~~ In any claim for resident's rights violation or
5470 negligence by a nurse licensed under part I of chapter 464, such
5471 nurse has a ~~shall have the~~ duty to exercise care consistent with
5472 the prevailing professional standard of care for a nurse. The
5473 prevailing professional standard of care for a nurse is ~~shall be~~
5474 that level of care, skill, and treatment which, in light of all
5475 relevant surrounding circumstances, is recognized as acceptable
5476 and appropriate by reasonably prudent similar nurses.
5477 (8) ~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical
5478 negligence of any physician rendering care or treatment to the
5479 resident except for the administrative services of a medical
5480 director as required in this part. ~~Nothing in~~ This subsection
5481 does not ~~shall be construed to~~ protect a licensee, person, or

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5482 entity from liability for failure to provide a resident with
5483 appropriate observation, assessment, nursing diagnosis,
5484 planning, intervention, and evaluation of care by nursing staff.
5485 (4) ~~(6)~~ The resident or the resident's legal representative
5486 shall serve a copy of any complaint alleging in whole or in part
5487 a violation of any rights specified in this part to the agency
5488 ~~for Health Care Administration~~ at the time of filing the initial
5489 complaint with the clerk of the court for the county in which
5490 the action is pursued. ~~The requirement of~~ Providing a copy of
5491 the complaint to the agency does not impair the resident's legal
5492 rights or ability to seek relief for his or her claim.
5493 (11) ~~(7)~~ An action under this part for a violation of rights
5494 or negligence ~~recognized herein~~ is not a claim for medical
5495 malpractice, and the provisions of s. 768.21(8) do not apply to
5496 a claim alleging death of the resident.
5497 Section 67. Subsections (1), (2), and (3) of section
5498 400.0237, Florida Statutes, are amended to read:
5499 400.0237 Punitive damages; pleading; burden of proof.—
5500 (1) In any action ~~for damages~~ brought under this part, a ~~no~~
5501 claim for punitive damages is not ~~shall be~~ permitted unless,
5502 based on admissible ~~there is a reasonable showing by~~ evidence ~~in~~
5503 ~~the record or~~ proffered by the claimant, ~~which would provide~~ a
5504 reasonable basis for recovery of such damages is demonstrated
5505 upon applying the criteria set forth in this section. The
5506 defendant may proffer admissible evidence to refute the
5507 claimant's proffer of evidence to recover punitive damages. The
5508 trial judge shall conduct an evidentiary hearing and weigh the
5509 admissible evidence proffered by the claimant and the defendant
5510 to ensure that there is a reasonable basis to believe that the

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5511 claimant, at trial, will be able to demonstrate by clear and
5512 convincing evidence that the recovery of such damages is
5513 warranted. The claimant may move to amend her or his complaint
5514 to assert a claim for punitive damages as allowed by the rules
5515 of civil procedure. ~~The rules of civil procedure shall be~~
5516 ~~liberally construed so as to allow the claimant discovery of~~
5517 ~~evidence which appears reasonably calculated to lead to~~
5518 ~~admissible evidence on the issue of punitive damages.~~ ~~No~~
5519 Discovery of financial worth may not ~~shall~~ proceed until after
5520 the trial judge approves the pleading on ~~concerning~~ punitive
5521 damages ~~is permitted~~.
5522 (2) A defendant, including the licensee or management
5523 company, against whom punitive damages is sought may be held
5524 liable for punitive damages only if the trier of fact, based on
5525 clear and convincing evidence, finds that a specific individual
5526 or corporate defendant actively and knowingly participated in
5527 intentional misconduct, or engaged in conduct that constituted
5528 gross negligence, and that conduct contributed to the loss,
5529 damages, or injury suffered by the claimant ~~the defendant was~~
5530 ~~personally guilty of intentional misconduct or gross negligence~~.
5531 As used in this section, the term:
5532 (a) “Intentional misconduct” means that the defendant
5533 against whom a claim for punitive damages is sought had actual
5534 knowledge of the wrongfulness of the conduct and the high
5535 probability that injury or damage to the claimant would result
5536 and, despite that knowledge, intentionally pursued that course
5537 of conduct, resulting in injury or damage.
5538 (b) “Gross negligence” means that the defendant’s conduct
5539 was so reckless or wanting in care that it constituted a

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5540 conscious disregard or indifference to the life, safety, or
5541 rights of persons exposed to such conduct.
5542 (3) In the case of vicarious liability of an employer,
5543 principal, corporation, or other legal entity, punitive damages
5544 may not be imposed for the conduct of an identified employee or
5545 agent unless ~~only if~~ the conduct of the employee or agent meets
5546 the criteria specified in subsection (2) and officers,
5547 directors, or managers of the actual employer corporation or
5548 legal entity condoned, ratified, or consented to the specific
5549 conduct as alleged by the claimant in subsection (2).~~:~~
5550 ~~(a) The employer, principal, corporation, or other legal~~
5551 ~~entity actively and knowingly participated in such conduct;~~
5552 ~~(b) The officers, directors, or managers of the employer,~~
5553 ~~principal, corporation, or other legal entity condoned,~~
5554 ~~ratified, or consented to such conduct; or~~
5555 ~~(c) The employer, principal, corporation, or other legal~~
5556 ~~entity engaged in conduct that constituted gross negligence and~~
5557 ~~that contributed to the loss, damages, or injury suffered by the~~
5558 ~~claimant.~~
5559 Section 68. Subsections (3) and (4) of section 408.7057,
5560 Florida Statutes, are amended, present subsection (7) of that
5561 section is redesignated as subsection (8), and a new subsection
5562 (7) is added to that section, to read:
5563 408.7057 Statewide provider and health plan claim dispute
5564 resolution program.—
5565 (3) The agency shall adopt rules to establish a process to
5566 be used by the resolution organization in considering claim
5567 disputes submitted by a provider or health plan which must
5568 include a hearing, if requested by the respondent, and the

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5569 issuance by the resolution organization of a written
5570 recommendation, supported by findings of fact and conclusions of
5571 law, to the agency within 60 days after the requested
5572 information is received by the resolution organization within
5573 the timeframes specified by the resolution organization. ~~In no~~
5574 ~~event shall~~ The review time may not exceed 90 days following
5575 receipt of the initial claim dispute submission by the
5576 resolution organization.
5577 (4) Within 30 days after receipt of the recommendation of
5578 the resolution organization, the agency shall adopt the
5579 recommendation as a final order subject to chapter 120.
5580 (7) This section creates a procedure for dispute resolution
5581 and not an independent right of recovery. The conclusions of law
5582 contained in the written recommendation of the resolution
5583 organization must identify the provisions of law or contract
5584 which, under the particular facts and circumstances of the case,
5585 entitle the provider or health plan to the amount awarded, if
5586 any.
5587 Section 69. Subsection (9) is added to section 465.014,
5588 Florida Statutes, to read:
5589 465.014 Pharmacy technician.—
5590 (9) This section does not apply to a practitioner
5591 authorized to dispense drugs under s. 465.0276 or any medical
5592 personnel under the direct supervision of such practitioner if
5593 the practitioner is treating a patient who provides proof of
5594 insurance through a public or private payor source. Medical
5595 personnel under the direct supervision of the practitioner may
5596 perform all activities required by s. 465.0276.
5597 Section 70. Section 456.0635, Florida Statutes, is amended

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5598 to read:
5599 456.0635 Health care ~~Medicaid~~ fraud; disqualification for
5600 license, certificate, or registration.—
5601 (1) ~~Medicaid~~ Fraud in the practice of a health care
5602 profession is prohibited.
5603 (2) Each board within the jurisdiction of the department,
5604 or the department if there is no board, shall refuse to admit a
5605 candidate to any examination and refuse to issue ~~or renew~~ a
5606 license, certificate, or registration to any applicant if the
5607 candidate or applicant or any principal, officer, agent,
5608 managing employee, or affiliated person of the applicant~~, has~~
5609 ~~been~~:
5610 (a) Has been convicted of, or entered a plea of guilty or
5611 nolo contendere to, regardless of adjudication, a felony under
5612 chapter 409, chapter 817, or chapter 893, or a similar felony
5613 offense committed in another state or jurisdiction ~~21 U.S.C. ss.~~
5614 ~~801-970, or 42 U.S.C. ss. 1395-1396~~, unless the sentence and any
5615 subsequent period of probation for such conviction or plea ~~pleas~~
5616 ended: ~~more than 15 years prior to the date of the application;~~
5617 1. For felonies of the first or second degree, more than 15
5618 years before the date of application.
5619 2. For felonies of the third degree, more than 10 years
5620 before the date of application, except for felonies of the third
5621 degree under s. 893.13(6)(a).
5622 3. For felonies of the third degree under s. 893.13(6)(a),
5623 more than 5 years before the date of application.
5624
5625 Notwithstanding s. 120.60, for felonies in which the defendant
5626 entered a plea of guilty or nolo contendere in an agreement with

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5627 the court to enter a pretrial intervention or drug diversion
5628 program, the board, or the department if there is no board, may
5629 not approve or deny the application for a license, certificate,
5630 or registration until final resolution of the case;
5631 (b) Has been convicted of, or entered a plea of guilty or
5632 nolo contendere to, regardless of adjudication, a felony under
5633 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the
5634 sentence and any subsequent period of probation for such
5635 conviction or plea ended more than 15 years before the date of
5636 the application;
5637 (c) ~~(b)~~ Has been terminated for cause from the Florida
5638 Medicaid program pursuant to s. 409.913, unless the applicant
5639 has been in good standing with the Florida Medicaid program for
5640 the most recent 5 years;
5641 (d) ~~(c)~~ Has been terminated for cause, pursuant to the
5642 appeals procedures established by the state ~~or Federal~~
5643 ~~Government~~, from any other state Medicaid program ~~or the federal~~
5644 ~~Medicare program~~, unless the applicant has been in good standing
5645 with a state Medicaid program ~~or the federal Medicare program~~
5646 for the most recent 5 years and the termination occurred at
5647 least 20 years before ~~prior to~~ the date of the application; or~~.~~
5648 (e) Is currently listed on the United States Department of
5649 Health and Human Services Office of Inspector General's List of
5650 Excluded Individuals and Entities.
5651
5652 This subsection does not apply to applicants for initial
5653 licensure or certification who were enrolled in an educational
5654 or training program on or before July 1, 2010, which was
5655 recognized by a board or, if there is no board, recognized by

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5656 the department, and who applied for licensure after July 1,
5657 2010.
5658 (3) The department shall refuse to renew a license,
5659 certificate, or registration of any applicant if the candidate
5660 or applicant or any principal, officer, agent, managing
5661 employee, or affiliated person of the applicant:
5662 (a) Has been convicted of, or entered a plea of guilty or
5663 nolo contendere to, regardless of adjudication, a felony under:
5664 chapter 409, chapter 817, or chapter 893, or a similar felony
5665 offense committed in another state or jurisdiction since July 1,
5666 2010;
5667 (b) Has been convicted of, or entered a plea of guilty or
5668 nolo contendere to, regardless of adjudication, a felony under
5669 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396 since July 1,
5670 2010;
5671 (c) Has been terminated for cause from the Florida Medicaid
5672 program pursuant to s. 409.913, unless the applicant has been in
5673 good standing with the Florida Medicaid program for the most
5674 recent 5 years;
5675 (d) Has been terminated for cause, pursuant to the appeals
5676 procedures established by the state, from any other state
5677 Medicaid program, unless the applicant has been in good standing
5678 with a state Medicaid program for the most recent 5 years and
5679 the termination occurred at least 20 years before the date of
5680 the application; or
5681 (e) Is currently listed on the United States Department of
5682 Health and Human Services Office of Inspector General's List of
5683 Excluded Individuals and Entities.
5684

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5685 For felonies in which the defendant entered a plea of guilty or
5686 nolo contendere in an agreement with the court to enter a
5687 pretrial intervention or drug diversion program, the department
5688 may not approve or deny the application for a renewal of a
5689 license, certificate, or registration until the final resolution
5690 of the case.
5691 (4) ~~(3)~~ Licensed health care practitioners shall report
5692 allegations of health care ~~Medicaid~~ fraud to the department,
5693 regardless of the practice setting in which the alleged Medicaid
5694 fraud occurred.
5695 (5) ~~(4)~~ The acceptance by a licensing authority of a
5696 candidate's relinquishment of a license which is offered in
5697 response to or anticipation of the filing of administrative
5698 charges alleging health care ~~Medicaid~~ fraud or similar charges
5699 constitutes the permanent revocation of the license.
5700 Section 71. Subsection (6) of section 456.036, Florida
5701 Statutes, is amended to read:
5702 456.036 Licenses; active and inactive status; delinquency.—
5703 (6)(a) Except as provided in paragraph (b), a delinquent
5704 licensee must affirmatively apply with a complete application,
5705 as defined by rule of the board, or the department if there is
5706 no board, for active or inactive status during the licensure
5707 cycle in which a licensee becomes delinquent. Failure by a
5708 delinquent licensee to become active or inactive before the
5709 expiration of the current licensure cycle renders the license
5710 null without any further action by the board or the department.
5711 Any subsequent licensure shall be as a result of applying for
5712 and meeting all requirements imposed on an applicant for new
5713 licensure.

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5714 (b) A delinquent licensee whose license becomes delinquent
5715 before the final resolution of a case under s. 456.0635(3) must
5716 affirmatively apply by submitting a complete application, as
5717 defined by rule of the board, or the department if there is no
5718 board, for active or inactive status during the licensure cycle
5719 in which the case achieves final resolution by order of the
5720 court. Failure by a delinquent licensee to become active or
5721 inactive before the expiration of that licensure cycle renders
5722 the license null without any further action by the board or the
5723 department. Any subsequent licensure shall be as a result of
5724 applying for and meeting all requirements imposed on an
5725 applicant for new licensure.
5726 Section 72. Section 458.3167, Florida Statutes, is created
5727 to read:
5728 458.3167 Expert witness certificate.—
5729 (1) A physician who holds an active and valid license to
5730 practice allopathic medicine in any other state or in Canada,
5731 who submits an application form prescribed by the board to
5732 obtain a certificate to provide expert testimony and pays the
5733 application fee, and who has not had a previous expert witness
5734 certificate revoked by the board shall be issued a certificate
5735 to provide expert testimony.
5736 (2) A physician possessing an expert witness certificate
5737 may use the certificate only to give a verified written medical
5738 expert opinion as provided in s. 766.203 and to provide expert
5739 testimony concerning the prevailing professional standard of
5740 care for medical negligence litigation pending in this state
5741 against a physician licensed under this chapter or chapter 459.
5742 (3) An application for an expert witness certificate must

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5743 be approved or denied within 5 business days after receipt of a
5744 completed application. An application that is not approved or
5745 denied within the required time period is deemed approved. An
5746 applicant seeking to claim certification by default shall notify
5747 the board, in writing, of the intent to rely on the default
5748 certification provision of this subsection. In such case, s.
5749 458.327 does not apply, and the applicant may provide expert
5750 testimony as provided in subsection (2).
5751 (4) All licensure fees, other than the initial certificate
5752 application fee, including the neurological injury compensation
5753 assessment, are waived for those persons obtaining an expert
5754 witness certificate. The possession of an expert witness
5755 certificate alone does not entitle the physician to engage in
5756 the practice of medicine as defined in s. 458.305.
5757 (5) The board shall adopt rules to administer this section,
5758 including rules setting the amount of the expert witness
5759 certificate application fee, which may not exceed $50. An expert
5760 witness certificate expires 2 years after the date of issuance.
5761 Section 73. Subsection (11) is added to section 458.331,
5762 Florida Statutes, present paragraphs (oo) through (qq) of
5763 subsection (1) of that section are redesignated as paragraphs
5764 (pp) through (rr), respectively, and a new paragraph (oo) is
5765 added to that subsection, to read:
5766 458.331 Grounds for disciplinary action; action by the
5767 board and department.—
5768 (1) The following acts constitute grounds for denial of a
5769 license or disciplinary action, as specified in s. 456.072(2):
5770 (oo) Providing misleading, deceptive, or fraudulent expert
5771 witness testimony related to the practice of medicine.

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5772 (11) The purpose of this section is to facilitate uniform
5773 discipline for those acts made punishable under this section
5774 and, to this end, a reference to this section constitutes a
5775 general reference under the doctrine of incorporation by
5776 reference.
5777 Section 74. Section 459.0078, Florida Statutes, is created
5778 to read:
5779 459.0078 Expert witness certificate.—
5780 (1) A physician who holds an active and valid license to
5781 practice osteopathic medicine in any other state or in Canada,
5782 who submits an application form prescribed by the board to
5783 obtain a certificate to provide expert testimony and pays the
5784 application fee, and who has not had a previous expert witness
5785 certificate revoked by the board shall be issued a certificate
5786 to provide expert testimony.
5787 (2) A physician possessing an expert witness certificate
5788 may use the certificate only to give a verified written medical
5789 expert opinion as provided in s. 766.203 and to provide expert
5790 testimony concerning the prevailing professional standard of
5791 care for medical negligence litigation pending in this state
5792 against a physician licensed under this chapter or chapter 458.
5793 (3) An application for an expert witness certificate must
5794 be approved or denied within 5 business days after receipt of a
5795 completed application. An application that is not approved or
5796 denied within the required time period is deemed approved. An
5797 applicant seeking to claim certification by default shall notify
5798 the board, in writing, of the intent to rely on the default
5799 certification provision of this subsection. In such case, s.
5800 459.013 does not apply, and the applicant may provide expert

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5801 testimony as provided in subsection (2).
5802 (4) All licensure fees, other than the initial certificate
5803 application fee, including the neurological injury compensation
5804 assessment, are waived for those persons obtaining an expert
5805 witness certificate. The possession of an expert witness
5806 certificate alone does not entitle the physician to engage in
5807 the practice of osteopathic medicine as defined in s. 459.003.
5808 (5) The board shall adopt rules to administer this section,
5809 including rules setting the amount of the expert witness
5810 certificate application fee, which may not exceed $50. An expert
5811 witness certificate expires 2 years after the date of issuance.
5812 Section 75. Subsection (11) is added to section 459.015,
5813 Florida Statutes, present paragraphs (qq) through (ss) of
5814 subsection (1) of that section are redesignated as paragraphs
5815 (rr) through (tt), respectively, and a new paragraph (qq) is
5816 added to that subsection, to read:
5817 459.015 Grounds for disciplinary action; action by the
5818 board and department.—
5819 (1) The following acts constitute grounds for denial of a
5820 license or disciplinary action, as specified in s. 456.072(2):
5821 (qq) Providing misleading, deceptive, or fraudulent expert
5822 witness testimony related to the practice of osteopathic
5823 medicine.
5824 (11) The purpose of this section is to facilitate uniform
5825 discipline for those acts made punishable under this section
5826 and, to this end, a reference to this section constitutes a
5827 general reference under the doctrine of incorporation by
5828 reference.
5829 Section 76. Subsection (23) of section 499.003, Florida

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5830 Statutes, is amended to read:
5831 499.003 Definitions of terms used in this part.—As used in
5832 this part, the term:
5833 (23) "Health care entity" means a closed pharmacy or any
5834 person, organization, or business entity that provides
5835 diagnostic, medical, surgical, or dental treatment or care, or
5836 chronic or rehabilitative care, but does not include any
5837 wholesale distributor or retail pharmacy licensed under state
5838 law to deal in prescription drugs. However, a blood
5839 establishment is a health care entity that may engage in the
5840 wholesale distribution of prescription drugs under s.
5841 499.01(2)(g)1.c.
5842 Section 77. Subsection (21) of section 499.005, Florida
5843 Statutes, is amended to read:
5844 499.005 Prohibited acts.—It is unlawful for a person to
5845 perform or cause the performance of any of the following acts in
5846 this state:
5847 (21) The wholesale distribution of any prescription drug
5848 that was:
5849 (a) Purchased by a public or private hospital or other
5850 health care entity; or
5851 (b) Donated or supplied at a reduced price to a charitable
5852 organization,
5853
5854 unless the wholesale distribution of the prescription drug is
5855 authorized in s. 499.01(2)(g)1.c.
5856 Section 78. Paragraphs (a) and (g) of subsection (2) of
5857 section 499.01, Florida Statutes, are amended to read:
5858 499.01 Permits.—

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5859 (2) The following permits are established:
5860 (a) *Prescription drug manufacturer permit.*—A prescription
5861 drug manufacturer permit is required for any person that is a
5862 manufacturer of a prescription drug and that manufactures or
5863 distributes such prescription drugs in this state.
5864 1. A person that operates an establishment permitted as a
5865 prescription drug manufacturer may engage in wholesale
5866 distribution of prescription drugs manufactured at that
5867 establishment and must comply with all of the provisions of this
5868 part, except s. 499.01212, and the rules adopted under this
5869 part, except s. 499.01212, which ~~that~~ apply to a wholesale
5870 distributor.
5871 2. A prescription drug manufacturer must comply with all
5872 appropriate state and federal good manufacturing practices.
5873 3. A blood establishment, as defined in s. 381.06014,
5874 operating in a manner consistent with the provisions of Title 21
5875 C.F.R. parts 211 and 600-640 and manufacturing only the
5876 prescription drugs described in s. 499.003(54)(d) is not
5877 required to be permitted as a prescription drug manufacturer
5878 under this paragraph or to register its products under s.
5879 499.015.
5880 (g) *Restricted prescription drug distributor permit.*—
5881 1. A restricted prescription drug distributor permit is
5882 required for:
5883 a. Any person located in this state that engages in the
5884 distribution of a prescription drug, which distribution is not
5885 considered "wholesale distribution" under s. 499.003(54)(a).
5886 b.~~1.~~ Any ~~A~~ person located in this state who engages in the
5887 receipt or distribution of a prescription drug in this state for

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5888 the purpose of processing its return or its destruction ~~must~~
5889 ~~obtain a permit as a restricted prescription drug distributor~~ if
5890 such person is not the person initiating the return, the
5891 prescription drug wholesale supplier of the person initiating
5892 the return, or the manufacturer of the drug.
5893 c. A blood establishment located in this state which
5894 collects blood and blood components only from volunteer donors
5895 as defined in s. 381.06014 or pursuant to an authorized
5896 practitioner's order for medical treatment or therapy and
5897 engages in the wholesale distribution of a prescription drug not
5898 described in s. 499.003(54)(d) to a health care entity. The
5899 health care entity receiving a prescription drug distributed
5900 under this sub-subparagraph must be licensed as a closed
5901 pharmacy or provide health care services at that establishment.
5902 The blood establishment must operate in accordance with s.
5903 381.06014 and may distribute only:
5904 (I) Prescription drugs indicated for a bleeding or clotting
5905 disorder or anemia;
5906 (II) Blood-collection containers approved under s. 505 of
5907 the federal act;
5908 (III) Drugs that are blood derivatives, or a recombinant or
5909 synthetic form of a blood derivative;
5910 (IV) Prescription drugs that are identified in rules
5911 adopted by the department and that are essential to services
5912 performed or provided by blood establishments and authorized for
5913 distribution by blood establishments under federal law; or
5914 (V) To the extent authorized by federal law, drugs
5915 necessary to collect blood or blood components from volunteer
5916 blood donors; for blood establishment personnel to perform

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5917 therapeutic procedures under the direction and supervision of a
5918 licensed physician; and to diagnose, treat, manage, and prevent
5919 any reaction of either a volunteer blood donor or a patient
5920 undergoing a therapeutic procedure performed under the direction
5921 and supervision of a licensed physician,
5922
5923 as long as all of the health care services provided by the blood
5924 establishment are related to its activities as a registered
5925 blood establishment or the health care services consist of
5926 collecting, processing, storing, or administering human
5927 hematopoietic stem cells or progenitor cells or performing
5928 diagnostic testing of specimens if such specimens are tested
5929 together with specimens undergoing routine donor testing.
5930 2. Storage, handling, and recordkeeping of these
5931 distributions by a person required to be permitted as a
5932 restricted prescription drug distributor must comply with the
5933 requirements for wholesale distributors under s. 499.0121, but
5934 not those set forth in s. 499.01212 if the distribution occurs
5935 pursuant to sub-subparagraph 1.a. or sub-subparagraph 1.b.
5936 3. A person who applies for a permit as a restricted
5937 prescription drug distributor, or for the renewal of such a
5938 permit, must provide to the department the information required
5939 under s. 499.012.
5940 4. The department may adopt rules regarding the
5941 distribution of prescription drugs by hospitals, health care
5942 entities, charitable organizations, ~~or~~ other persons not
5943 involved in wholesale distribution, and blood establishments,
5944 which rules are necessary for the protection of the public
5945 health, safety, and welfare.

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5946 Section 79. Subsection (4) is added to section 626.9541,
5947 Florida Statutes, to read:
5948 626.9541 Unfair methods of competition and unfair or
5949 deceptive acts or practices defined.—
5950 (4) WELLNESS OR HEALTH IMPROVEMENT PROGRAMS.—
5951 (a) An insurer issuing a group or individual health benefit
5952 plan may offer a voluntary wellness or health improvement
5953 program and may encourage or reward participation in the program
5954 by authorizing rewards or incentives, including, but not limited
5955 to, merchandise, gift cards, debit cards, premium discounts or
5956 rebates, contributions to a member's health savings account, or
5957 modifications to copayment, deductible, or coinsurance amounts.
5958 (b) An insurer may require a health benefit plan member to
5959 provide verification, such as an affirming statement from the
5960 member's physician, that the member's medical condition makes it
5961 unreasonably difficult or inadvisable to participate in the
5962 wellness or health improvement program.
5963 (c) A reward or incentive offered under this subsection is
5964 not an insurance benefit or violation of this section if it is
5965 disclosed in the policy or certificate. This subsection does not
5966 prohibit insurers from offering other incentives or rewards for
5967 adherence to a wellness or health improvement program if
5968 otherwise authorized by state or federal law.
5969 Section 80. Paragraph (b) of subsection (1) of section
5970 627.4147, Florida Statutes, is amended to read:
5971 627.4147 Medical malpractice insurance contracts.—
5972 (1) In addition to any other requirements imposed by law,
5973 each self-insurance policy ~~as~~ authorized under s. 627.357 or s.
5974 624.462 or insurance policy providing coverage for claims

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5975 arising out of the rendering of, or the failure to render,
5976 medical care or services, including those of the Florida Medical
5977 Malpractice Joint Underwriting Association, must ~~shall~~ include:
5978 (b)~~1. Except as provided in subparagraph 2., a clause~~
5979 ~~authorizing the insurer or self-insurer to determine, to make,~~
5980 ~~and to conclude, without the permission of the insured, any~~
5981 ~~offer of admission of liability and for arbitration pursuant to~~
5982 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~
5983 ~~is within the policy limits. It is against public policy for any~~
5984 ~~insurance or self-insurance policy to contain a clause giving~~
5985 ~~the insured the exclusive right to veto any offer for admission~~
5986 ~~of liability and for arbitration made pursuant to s. 766.106,~~
5987 ~~settlement offer, or offer of judgment, when such offer is~~
5988 ~~within the policy limits. However, any offer of admission of~~
5989 ~~liability, settlement offer, or offer of judgment made by an~~
5990 ~~insurer or self-insurer shall be made in good faith and in the~~
5991 ~~best interests of the insured.~~
5992 1.~~2.a.~~ With respect to dentists licensed under chapter 466,
5993 a clause clearly stating whether or not the insured has the
5994 exclusive right to veto any offer of admission of liability and
5995 for arbitration pursuant to s. 766.106, settlement offer, or
5996 offer of judgment if the offer is within policy limits. An
5997 insurer or self-insurer may ~~shall~~ not make or conclude, without
5998 the permission of the insured, any offer of admission of
5999 liability and for arbitration pursuant to s. 766.106, settlement
6000 offer, or offer of judgment, if such offer is outside the policy
6001 limits. However, any offer for admission of liability and for
6002 arbitration made under s. 766.106, settlement offer, or offer of
6003 judgment made by an insurer or self-insurer must ~~shall~~ be made

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6004 in good faith and in the best interest of the insured.
6005 2.~~b.~~ If the policy contains a clause stating the insured
6006 does not have the exclusive right to veto any offer or admission
6007 of liability and for arbitration made pursuant to s. 766.106,
6008 settlement offer or offer of judgment, the insurer or self-
6009 insurer shall provide to the insured or the insured's legal
6010 representative by certified mail, return receipt requested, a
6011 copy of the final offer of admission of liability and for
6012 arbitration made pursuant to s. 766.106, settlement offer or
6013 offer of judgment and at the same time such offer is provided to
6014 the claimant. A copy of any final agreement reached between the
6015 insurer and claimant shall also be provided to the insurer or
6016 his or her legal representative by certified mail, return
6017 receipt requested within ~~not more than~~ 10 days after affecting
6018 such agreement.
6019 Section 81. Present subsections (15) through (21) of
6020 section 641.19, Florida Statutes, are renumbered as subsections
6021 (16) through (22), respectively, and a new subsection (15) is
6022 added to that section, to read:
6023 641.19 Definitions.—As used in this part, the term:
6024 (15) "Provider service network" means a network established
6025 or organized and operated by a health care provider or group of
6026 affiliated health care providers, including minority physician
6027 networks and emergency room diversion programs that meet the
6028 requirements of s. 409.91211, which directly provides a
6029 substantial proportion of the health care items and services
6030 under a contract and may make arrangements with physicians,
6031 other health care practitioners, health care institutions, or
6032 any combination of such practitioners or institutions to assume

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6033 all or part of the financial risk on a prospective basis for the
6034 provision of basic health services by such physicians,
6035 practitioners, or institutions. The health care providers
6036 operating the provider service network must have a controlling
6037 interest in the governing body of the network.
6038 Section 82. Section 641.2019, Florida Statutes, is created
6039 to read:
6040 641.2019 Provider service network certificate of
6041 authority.—Notwithstanding any other provisions of this chapter,
6042 a provider service network, including a prepaid provider service
6043 network described under s. 409.912(4)(d), which meets all of the
6044 applicable requirements of this part may apply for and obtain a
6045 health care provider certificate pursuant to part III of this
6046 chapter and a certificate of authority pursuant to this part
6047 which states that the network is authorized to operate a
6048 certified provider service network under this chapter. A
6049 certified provider service network has the same rights and
6050 responsibilities as a health maintenance organization certified
6051 under this part.
6052 Section 83. Subsection (13) of section 641.47, Florida
6053 Statutes, is amended to read:
6054 641.47 Definitions.—As used in this part, the term:
6055 (13) "Organization" means a ~~any~~ health maintenance
6056 organization as defined in s. 641.19, a ~~and any~~ prepaid health
6057 clinic as defined in s. 641.402, and a provider service network
6058 as defined in s. 641.19.
6059 Section 84. Section 641.49, Florida Statutes, is amended to
6060 read:
6061 641.49 Health care provider certificate ~~certification of~~

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6062 ~~health maintenance organization and prepaid health clinic as~~
6063 ~~health care providers; application procedure~~.—
6064 (1) No person or governmental unit shall establish,
6065 conduct, or maintain a health maintenance organization, ~~or a~~
6066 prepaid health clinic, or provider service network in this state
6067 without first obtaining a health care provider certificate under
6068 this part.
6069 (2) The office may ~~shall~~ not issue a certificate of
6070 authority under part I or part II of this chapter to any
6071 applicant which does not possess a valid health care provider
6072 certificate issued by the agency under this part.
6073 (3) Each application for a health care provider certificate
6074 shall be on a form prescribed by the agency. The following
6075 information and documents shall be submitted by an applicant and
6076 maintained, after certification under this part, by each
6077 organization and shall be available for inspection or
6078 examination by the agency at the offices of an organization at
6079 any time during regular business hours. The agency shall give
6080 reasonable notice to an organization before ~~prior to~~ any onsite
6081 inspection or examination of its records or premises conducted
6082 under this section. The agency may require that the following
6083 information or documents be submitted with the application:
6084 (a) A copy of the articles of incorporation and all
6085 amendments to the articles.
6086 (b) A copy of the bylaws, rules and regulations, or similar
6087 form of document, if any, regulating the conduct of the affairs
6088 of the applicant or organization.
6089 (c) A list of the names, addresses, and official capacities
6090 with the applicant or organization of the persons who are to be

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6091 responsible for the conduct of the affairs of the applicant or
6092 organization, including all officers and directors of the
6093 corporation. Such persons must ~~shall~~ fully disclose to the
6094 agency and the directors of the applicant or organization the
6095 extent and nature of any contracts or arrangements between them
6096 and the applicant or organization, including any possible
6097 conflicts of interest.
6098 (d) The name and address of the applicant and the name by
6099 which the applicant or organization is to be known.
6100 (e) A statement generally describing the applicant or
6101 organization and its operations.
6102 (f) A copy of the form for each group and individual
6103 contract, certificate, subscriber handbook, and any other
6104 similar documents issued to subscribers.
6105 (g) A statement describing the manner in which health care
6106 services shall be regularly available.
6107 (h) A statement that the applicant has an established
6108 network of health care providers which is capable of providing
6109 the health care services that are to be offered by the
6110 organization.
6111 (i) The locations at which health care services shall be
6112 regularly available to subscribers.
6113 (j) The type of health care personnel engaged to provide
6114 the health care services and the quantity of the personnel of
6115 each type.
6116 (k) A statement giving the present and projected number of
6117 subscribers to be enrolled annually ~~yearly~~ for the next 3 years.
6118 (l) A statement indicating the source of emergency services
6119 and care on a 24-hour basis.

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6120 (m) A statement that the physicians employed by the
6121 applicant have been formally organized as a medical staff and
6122 that the applicant's governing body has designated a chief of
6123 medical staff.
6124 (n) A statement describing the manner in which the
6125 applicant or organization assures the maintenance of a medical
6126 records system in accordance with accepted medical records'
6127 standards and practices.
6128 (o) If general anesthesia is to be administered in a
6129 facility not licensed by the agency, a copy of architectural
6130 plans that meet the requirements for institutional occupancy
6131 (NFPA 101 Life Safety Code, current edition as adopted by the
6132 State Fire Marshal).
6133 (p) A description of the applicant's or organization's
6134 internal quality assurance program, including committee
6135 structure, as required under s. 641.51.
6136 (q) A description and supporting documentation concerning
6137 how the applicant or health maintenance organization will comply
6138 with internal risk management program requirements under s.
6139 641.55.
6140 (r) An explanation of how coverage for emergency services
6141 and care is to be effected outside the applicant's or health
6142 maintenance organization's stated geographic area.
6143 (s) A statement and map describing with reasonable accuracy
6144 the specific geographic area to be served.
6145 (t) A nonrefundable application fee of $1,000.
6146 (u) Such additional information as the agency may
6147 reasonably require.
6148 Section 85. Paragraph (b) of subsection (2) of section

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6149 430.705, Florida Statutes, is amended to read:
6150 430.705 Implementation of the long-term care community
6151 diversion pilot projects.—
6152 (2)
6153 (b) The department shall select providers that meet all of
6154 the following criteria. Providers shall:
6155 1. Have a plan administrator who is dedicated to the
6156 diversion pilot project and project staff who perform the
6157 necessary project administrative functions, including data
6158 collection, reporting, and analysis.
6159 2. Demonstrate the ability to provide program enrollees
6160 with a choice of care provider by contracting with multiple
6161 providers that provide the same type of service.
6162 3. Demonstrate through performance or other documented
6163 means the capacity for prompt payment of claims as specified
6164 under s. 641.3155.
6165 4. Maintain an insolvency protection account in a bank or
6166 savings and loan association located in the state with a balance
6167 of at least $100,000 into which monthly deposits equal to at
6168 least 5 percent of premiums received under the project are made
6169 until the balance equals 2 percent of the total contract amount.
6170 The account shall be established with such terms as to ensure
6171 that funds are ~~may only be~~ withdrawn only with the signature
6172 approval of designated department representatives.
6173 5. Maintain a surplus of at least $1.5 million as
6174 determined by the department. Each applicant and each provider
6175 shall furnish to the department initial and annual unqualified
6176 audited financial statements prepared by a certified public
6177 accountant that expressly confirm that the applicant or provider

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6178 satisfies this surplus requirement. The department may approve a
6179 waiver of compliance with the surplus requirement for an
6180 existing diversion provider. The department's approval of the
6181 ~~this~~ waiver is ~~must be~~ contingent on the provider demonstrating
6182 proof to the department that the entity has posted and maintains
6183 a $1.5 million performance bond, which is written by an insurer
6184 licensed to transact insurance in this state, in lieu of meeting
6185 the surplus requirement. The department may not approve a waiver
6186 of compliance with the surplus requirement that extends beyond
6187 June 30, 2006. As used in this subparagraph, the term:
6188 a. "Existing diversion provider" means an entity that is
6189 approved by the department on or before June 30, 2005, to
6190 provide services to consumers through any long-term care
6191 community diversion pilot project authorized under ss. 430.701-
6192 430.709.
6193 b. "Surplus" has the same meaning as in s. 641.19~~(19)~~.
6194 Section 86. Present subsection (12) of section 766.102,
6195 Florida Statutes, is redesignated as subsection (13), and a new
6196 subsection (12) is added to that section, to read:
6197 766.102 Medical negligence; standards of recovery; expert
6198 witness.—
6199 (12) If a physician licensed under chapter 458 or chapter
6200 459 is a party against whom, or on whose behalf, expert
6201 testimony about the prevailing professional standard of care is
6202 offered, the expert witness must otherwise meet the requirements
6203 of this section and be licensed as a physician under chapter 458
6204 or chapter 459, or must possess a valid expert witness
6205 certificate issued under s. 458.3167 or s. 459.0078.
6206 Section 87. Subsection (1) of section 766.104, Florida

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6207 Statutes, is amended to read:
6208 766.104 Pleading in medical negligence cases; claim for
6209 punitive damages; authorization for release of records for
6210 investigation.—
6211 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or
6212 wrongful death arising out of medical negligence, whether in
6213 tort or in contract, may not be filed unless the attorney filing
6214 the action has made a reasonable investigation, as permitted by
6215 the circumstances, to determine that there are grounds for a
6216 good faith belief that there has been negligence in the care or
6217 treatment of the claimant.
6218 (a) The complaint or initial pleading must ~~shall~~ contain a
6219 certificate of counsel that such reasonable investigation gave
6220 rise to a good faith belief that grounds exist for an action
6221 against each named defendant. For purposes of this section, good
6222 faith may be shown ~~to exist~~ if the claimant or his or her
6223 counsel has received a written opinion, ~~which shall~~ not ~~be~~
6224 subject to discovery by an opposing party, of an expert as
6225 defined in s. 766.102 that there appears to be evidence of
6226 medical negligence. If the court determines that the ~~such~~
6227 certificate of counsel was not made in good faith and that no
6228 justiciable issue was presented against a health care provider
6229 that fully cooperated in providing informal discovery, the court
6230 shall award attorney's fees and taxable costs against claimant's
6231 counsel~~,~~ and ~~shall~~ submit the matter to The Florida Bar for
6232 disciplinary review of the attorney.
6233 (b) If the cause of action requires the plaintiff to
6234 establish the breach of a standard of care other than negligence
6235 in order to impose liability or secure specified damages arising

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6236 out of the rendering of, or the failure to render, medical care
6237 or services, and the plaintiff intends to pursue such liability
6238 or damages, the investigation and certification required by this
6239 subsection must demonstrate grounds for a good faith belief that
6240 the requirement is satisfied.
6241 Section 88. Subsection (5) of section 766.106, Florida
6242 Statutes, is amended to read:
6243 766.106 Notice before filing action for medical negligence;
6244 presuit screening period; offers for admission of liability and
6245 for arbitration; informal discovery; review.—
6246 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,
6247 written document, report, or other work product generated by the
6248 presuit screening process is discoverable or admissible in any
6249 civil action for any purpose by the opposing party. All
6250 participants, including, but not limited to, physicians,
6251 investigators, witnesses, and employees or associates of the
6252 defendant, are immune from civil liability arising from
6253 participation in the presuit screening process. This subsection
6254 does not prohibit a physician licensed under chapter 458 or
6255 chapter 459, or a physician who holds a certificate to provide
6256 expert testimony under s. 458.3167 or s. 459.0078, who submits a
6257 verified written expert medical opinion from being subject to
6258 disciplinary action pursuant to s. 456.073.
6259 Section 89. Subsection (11) of section 766.1115, Florida
6260 Statutes, is amended to read:
6261 766.1115 Health care providers; creation of agency
6262 relationship with governmental contractors.—
6263 (11) APPLICABILITY.—
6264 (a) This section applies to incidents occurring on or after

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6265 April 17, 1992.
6266 (b) This section does not apply to any health care contract
6267 entered into by the Department of Corrections which is subject
6268 to s. 768.28(10)(a).
6269 (c) This section does not apply to any affiliation
6270 agreement or other contract subject to s. 768.28(10)(f).
6271 (d) ~~Nothing in~~ This section does not reduce or limit ~~in any~~
6272 ~~way reduces or limits~~ the rights of the state or any of its
6273 agencies or subdivisions to any benefit currently provided under
6274 s. 768.28.
6275 Section 90. Section 766.1183, Florida Statutes, is created
6276 to read:
6277 766.1183 Standard of care for Medicaid providers.—
6278 (1) As used in this section:
6279 (a) The terms "applicant," "medical assistance," "medical
6280 services," and "Medicaid recipient" have the same meaning as in
6281 s. 409.901.
6282 (b) The term "provider" means a health care provider as
6283 defined in s. 766.202, an ambulance provider licensed under
6284 chapter 401, or an entity that qualifies for an exemption under
6285 s. 400.9905(4)(e). The term includes:
6286 1. Any person or entity for whom a provider is vicariously
6287 liable; and
6288 2. Any person or entity whose liability is based solely on
6289 such person or entity being vicariously liable for the actions
6290 of a provider.
6291 (c) The term "wrongful manner" means in bad faith or with
6292 malicious purpose or in a manner exhibiting wanton and willful
6293 disregard of human rights, safety, or property, and shall be

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6294 construed in conformity with the standard set forth in s.
6295 768.28(9)(a).
6296 (2) A provider is not liable in excess of $200,000 per
6297 claimant or $300,000 per occurrence for any cause of action
6298 arising out of the rendering of, or the failure to render,
6299 medical services to a Medicaid recipient, except as provided
6300 under subsection (3). However, a judgment may be claimed and
6301 rendered in excess of the amounts set forth in this subsection.
6302 That portion of the judgment that exceeds these amounts may be
6303 reported to the Legislature, but may be paid in part or in whole
6304 by the state only by further act of the Legislature.
6305 (3) A provider may be liable for an amount in excess of
6306 $200,000 per claimant or $300,000 per occurrence only if the
6307 claimant pleads and proves, by clear and convincing evidence,
6308 that the provider acted in a wrongful manner. If the claimant so
6309 pleads, the court, after a reasonable opportunity for discovery,
6310 shall conduct a hearing before trial to determine if there is a
6311 reasonable basis in evidence to conclude that the provider acted
6312 in a wrongful manner. A claim for wrongful conduct is not
6313 permitted, to the extent it exceeds the amounts set forth in
6314 subsection (2), unless the claimant makes the showing required
6315 by this subsection.
6316 (4) At the time an application for medical assistance is
6317 submitted, the Department of Children and Family Services shall
6318 furnish the applicant with written notice of the provisions of
6319 this section.
6320 (5) This section does not limit or exclude the application
6321 of any law, including s. 766.118, which places limitations upon
6322 the recovery of civil damages.

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6323 (6) This section does not apply to any claim for damages to
6324 which s. 768.28 applies.
6325 Section 91. Section 766.1184, Florida Statutes, is created
6326 to read:
6327 766.1184 Standard of care; low-income pool recipient.—
6328 (1) As used in this section, the term:
6329 (a) "Low-income pool recipient" means a low-income
6330 individual who is uninsured or underinsured and who receives
6331 primary care services from a provider which are delivered
6332 exclusively using funding received by that provider under
6333 proviso language accompanying specific appropriation 191 of the
6334 2010-2011 fiscal year General Appropriations Act to establish
6335 new or expand existing primary care clinics for low-income
6336 persons who are uninsured or underinsured.
6337 (b) "Provider" means a health care provider, as defined in
6338 s. 766.202, which received funding under proviso language
6339 accompanying specific appropriation 191 of the fiscal year 2010-
6340 11 General Appropriations Act to establish new or expand
6341 existing primary care clinics for low-income persons who are
6342 uninsured or underinsured. The term includes:
6343 1. Any person or entity for whom a provider is vicariously
6344 liable; and
6345 2. Any person or entity whose liability is based solely on
6346 such person or entity being vicariously liable for the actions
6347 of a provider.
6348 (c) "Wrongful manner" means in bad faith or with malicious
6349 purpose or in a manner exhibiting wanton and willful disregard
6350 of human rights, safety, or property, and shall be construed in
6351 conformity with the standard set forth in s. 768.28(9)(a).

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6353 The funding of the provider's primary care clinic must have been
6354 awarded pursuant to a plan approved by the Legislative Budget
6355 Commission, and must be the subject of an agreement between the
6356 provider and the Agency for Health Care Administration,
6357 following the competitive solicitation of proposals to use low-
6358 income pool grant funds to provide primary care services in
6359 general acute hospitals, county health departments, faith-based
6360 and community clinics, and federally qualified health centers to
6361 uninsured or underinsured persons.
6362 (2) A provider is not liable in excess of $200,000 per
6363 claimant or $300,000 per occurrence for any cause of action
6364 arising out of the rendering of, or the failure to render,
6365 primary care services to a low-income pool recipient, except as
6366 provided under subsection (3). However, a judgment may be
6367 claimed and rendered in excess of the amounts set forth in this
6368 subsection. That portion of the judgment that exceeds these
6369 amounts may be reported to the Legislature, but may be paid in
6370 part or in whole by the state only by further act of the
6371 Legislature.
6372 (3) A provider may be liable for an amount in excess of
6373 $200,000 per claimant or $300,000 per occurrence only if the
6374 claimant pleads and proves, by clear and convincing evidence,
6375 that the provider acted in a wrongful manner. If the claimant so
6376 pleads, the court, after a reasonable opportunity for discovery,
6377 shall conduct a hearing before trial to determine if there is a
6378 reasonable basis in evidence to conclude that the provider acted
6379 in a wrongful manner. A claim for wrongful conduct is not
6380 permitted, to the extent it exceeds the amounts set forth in

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6381 subsection (2), unless the claimant makes the showing required
6382 by this subsection.
6383 (4) In order for this section to apply, the provider must:
6384 (a) Develop, implement, and maintain policies and
6385 procedures to:
6386 1. Ensure that funds described in subsection (1) are used
6387 exclusively to serve low-income persons who are uninsured or
6388 underinsured;
6389 2. Determine whether funds described in subsection (1) are
6390 being used to provide primary care services to a particular
6391 person; and
6392 3. Identify whether an individual receiving primary care
6393 services is a low-income pool recipient to whom the provisions
6394 of this section apply.
6395 (b) Furnish a low-income pool recipient with written notice
6396 of the provisions of this section before providing primary care
6397 services to the recipient.
6398 (c) Be in compliance with the terms of any agreement
6399 between the provider and the Agency for Health Care
6400 Administration governing the receipt of the funds described in
6401 subsection (1).
6402 (5) This section does not limit or exclude the application
6403 of any law, including s. 766.118, which places limitations upon
6404 the recovery of civil damages.
6405 (6) This section does not apply to any claim for damages to
6406 which s. 768.28 applies.
6407 Section 92. Subsection (4) of section 766.202, Florida
6408 Statutes, is amended to read:
6409 766.202 Definitions; ss. 766.201-766.212.—As used in ss.

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6410 766.201-766.212, the term:
6411 (4) “Health care provider” means any hospital, ambulatory
6412 surgical center, or mobile surgical facility as defined and
6413 licensed under chapter 395; a birth center licensed under
6414 chapter 383; any person licensed under chapter 458, chapter 459,
6415 chapter 460, chapter 461, chapter 462, chapter 463, part I of
6416 chapter 464, chapter 466, chapter 467, part XIV of chapter 468,
6417 or chapter 486; a clinical lab licensed under chapter 483; a
6418 health maintenance organization certificated under part I of
6419 chapter 641; a blood bank; a plasma center; an industrial
6420 clinic; a renal dialysis facility; or a professional association
6421 partnership, corporation, joint venture, or other association
6422 for professional activity by health care providers.
6423 Section 93. Subsection (5) is added to section 766.203,
6424 Florida Statutes, to read:
6425 766.203 Presuit investigation of medical negligence claims
6426 and defenses by prospective parties.—
6427 (5) STANDARDS OF CARE.—If the cause of action that is the
6428 basis for the litigation requires the plaintiff to establish the
6429 breach of a standard of care other than negligence in order to
6430 impose liability or secure specified damages arising out of the
6431 rendering of, or the failure to render, medical care or
6432 services, and the plaintiff intends to pursue such liability or
6433 damages, the presuit investigations required of the claimant and
6434 the prospective defendant by this section must ascertain that
6435 there are reasonable grounds to believe that the requirement is
6436 satisfied.
6437 Section 94. Paragraph (b) of subsection (9) of section
6438 768.28, Florida Statutes, is amended, and paragraphs (f) and (g)

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6439 are added to subsection (10) of that section, to read:
6440 768.28 Waiver of sovereign immunity in tort actions;
6441 recovery limits; limitation on attorney fees; statute of
6442 limitations; exclusions; indemnification; risk management
6443 programs.—
6444 (9)
6445 (b) As used in this subsection, the term:
6446 1. "Employee" includes any volunteer firefighter.
6447 2. "Officer, employee, or agent" includes, but is not
6448 limited to, any health care provider when providing services
6449 pursuant to s. 766.1115;~~,~~ any member of the Florida Health
6450 Services Corps, as defined in s. 381.0302, who provides
6451 uncompensated care to medically indigent persons referred by the
6452 Department of Health; any nonprofit independent college or
6453 university located and chartered in this state which owns or
6454 operates an accredited medical school, and its employees or
6455 agents, when providing patient services pursuant to paragraph
6456 (10)(f);~~,~~ and any public defender or her or his employee or
6457 agent, including, among others, an assistant public defender and
6458 an investigator.
6459 (10)
6460 (f) For purposes of this section, any nonprofit independent
6461 college or university located and chartered in this state which
6462 owns or operates an accredited medical school, or any of its
6463 employees or agents, and which has agreed in an affiliation
6464 agreement or other contract to provide, or to permit its
6465 employees or agents to provide, patient services as agents of a
6466 teaching hospital, is considered an agent of the teaching
6467 hospital while acting within the scope of and pursuant to

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6468 guidelines established in the contract. To the extent allowed by
6469 law, the contract must provide for the indemnification of the
6470 state, up to the limits set out in this chapter, by the agent
6471 for any liability incurred which was caused by the negligence of
6472 the college or university or its employees or agents.
6473 1. For purposes of this paragraph, the term:
6474 a. "Employee or agent" means an officer, employee, agent,
6475 or servant of a nonprofit independent college or university
6476 located and chartered in this state which owns or operates an
6477 accredited medical school, including, but not limited to, the
6478 faculty of the medical school, any health care practitioner or
6479 licensee as defined in s. 456.001 for which the college or
6480 university is vicariously liable, and the staff or administrator
6481 of the medical school.
6482 b. "Patient services" mean:
6483 (I) Comprehensive health care services as defined in s.
6484 641.19, including any related administrative service, provided
6485 to patients in a teaching hospital or in a health care facility
6486 that is a part of a nonprofit independent college or university
6487 located and chartered in this state which owns or operates an
6488 accredited medical school, pursuant to an affiliation agreement
6489 or other contract with a teaching hospital;
6490 (II) Training and supervision of interns, residents, and
6491 fellows providing patient services in a teaching hospital or in
6492 a health care facility that is a part of a nonprofit independent
6493 college or university located and chartered in this state which
6494 owns or operates an accredited medical school, pursuant to an
6495 affiliation agreement or other contract with a teaching
6496 hospital;

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6497 (III) Participation in medical research protocols; or
6498 (IV) Training and supervision of medical students in a
6499 teaching hospital or in a health care facility owned by a not-
6500 for-profit college or university that owns or operates an
6501 accredited medical school, pursuant to an affiliation agreement
6502 or other contract with a teaching hospital.
6503 c. "Teaching hospital" means a teaching hospital as defined
6504 in s. 408.07 which is owned or operated by the state, a county
6505 or municipality, a public health trust, a special taxing
6506 district, a governmental entity having health care
6507 responsibilities, or a not-for-profit entity that operates such
6508 facilities as an agent of the state or a political subdivision
6509 of the state under a lease or other contract.
6510 2. The teaching hospital or the medical school, or its
6511 employees or agents, must provide written notice to each
6512 patient, or the patient's legal representative, receipt of which
6513 must be acknowledged in writing, that the college or university
6514 that owns or operates the medical school and the employees or
6515 agents of that college or university are acting as agents of the
6516 teaching hospital and that the exclusive remedy for injury or
6517 damage suffered as the result of any act or omission of the
6518 teaching hospital, the college or university that owns or
6519 operates the medical school, or the employees or agents of the
6520 college or university while acting within the scope of duties
6521 pursuant to the affiliation agreement or other contract with a
6522 teaching hospital, is by commencement of an action pursuant to
6523 the provisions of this section.
6524 3. This paragraph does not designate any employee providing
6525 contracted patient services in a teaching hospital as an

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6526 employee or agent of the state for purposes of chapter 440.
6527 (g) Providers or vendors, 75 percent of whose client
6528 population consists of individuals with a developmental
6529 disability as defined in ss. 393.063 and 400.960, individuals
6530 who are blind or severely handicapped individuals as defined in
6531 s. 413.033, individuals who have a mental illness as defined
6532 under s. 394.455, or individuals who have any combination of
6533 these conditions, which have contractually agreed to act on
6534 behalf of the Agency for Persons with Disabilities, the Agency
6535 for Health Care Administration, the Division of Blind Services
6536 in the Department of Education, or the Mental Health Program
6537 Office of the Department of Children and Family Services to
6538 provide services to such individuals, and their employees or
6539 agents, are considered agents of the state, solely with respect
6540 to the provision of such services while acting within the scope
6541 of and pursuant to guidelines established by contract, a
6542 Medicaid waiver agreement, or rule. The contracts for such
6543 services must provide for the indemnification of the state by
6544 the agent for any liabilities incurred up to the limits
6545 specified in this section.
6546 Section 95. Legislative findings and intent.—
6547 (1) The Legislature finds that:
6548 (a) Access to high-quality, comprehensive, and affordable
6549 health care for all persons in this state is a necessary state
6550 goal and that teaching hospitals play an intrinsic and essential
6551 role in providing that access.
6552 (b) Graduate medical education, provided by nonprofit
6553 independent colleges and universities located and chartered in
6554 this state which own or operate medical schools, helps provide

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6555 the comprehensive specialty training needed by medical school
6556 graduates to develop and refine the skills essential to the
6557 provision of high-quality health care for our state residents.
6558 Much of that education and training is provided in teaching
6559 hospitals under the direct supervision of medical faculty who
6560 provide guidance, training, and oversight, and serve as role
6561 models to their students.
6562 (c) A large proportion of medical care is provided in
6563 teaching hospitals that serve as safety nets for many indigent
6564 and underserved patients who otherwise might not receive the
6565 medical help they need. Resident physician training that takes
6566 place in such hospitals provides much of the care provided to
6567 this population. Medical faculty, supervising such training and
6568 care, are a vital link between educating and training resident
6569 physicians and ensuring the provision of quality care for
6570 indigent and underserved residents. Physicians that assume this
6571 role are often called upon to juggle the demands of patient
6572 care, teaching, research, health policy, and budgetary issues
6573 related to the programs they administer.
6574 (d) While teaching hospitals are afforded sovereign
6575 immunity protections under s. 768.28, Florida Statutes, the
6576 nonprofit independent colleges and universities located and
6577 chartered in this state which own or operate medical schools and
6578 which enter into affiliation agreements or contracts with the
6579 teaching hospitals to provide patient services are not afforded
6580 such sovereign immunity protections.
6581 (e) The employees or agents of nonprofit independent
6582 colleges and universities located and chartered in this state
6583 which enter into affiliation agreements or contracts with

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6584 teaching hospitals to provide patient services do not have the
6585 same level of protection against liability claims as teaching
6586 hospitals and their employees and agents that provide the same
6587 patient services to the same patients. Thus, these colleges and
6588 universities and their employees and agents are
6589 disproportionately affected by claims arising out of alleged
6590 medical malpractice and other allegedly negligent acts. Given
6591 the recent growth in medical schools and medical education
6592 programs and ongoing efforts to support, strengthen, and
6593 increase physician residency training positions and medical
6594 faculty in both existing and newly designated teaching
6595 hospitals, this exposure and the consequent disparity in
6596 liability exposure will continue to increase. The vulnerability
6597 of these colleges and universities to claims of medical
6598 malpractice will only add to the current physician workforce
6599 crisis in Florida and can be alleviated only through legislative
6600 action.
6601 (f) Ensuring that the employees and agents of nonprofit
6602 independent colleges and universities located and chartered in
6603 this state which own or operated medical schools are able to
6604 continue to treat patients, provide graduate medical education,
6605 supervise medical students, engage in research, and provide
6606 administrative support and services in teaching hospitals is an
6607 overwhelming public necessity.
6608 (2) The Legislature intends that:
6609 (a) Employees and agents of nonprofit independent colleges
6610 and universities located and chartered in this state which own
6611 or operate medical schools, who provide patient services as
6612 agents of a teaching hospital be immune from lawsuits in the

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6613 same manner and to the same extent as employees and agents of
6614 teaching hospitals in this state under existing law, and that
6615 such colleges and universities and their employees and agents
6616 not be held personally liable in tort or named as a party
6617 defendant in an action while providing patient services in a
6618 teaching hospital, unless such services are provided in bad
6619 faith, with malicious purpose, or in a manner exhibiting wanton
6620 and willful disregard of human rights, safety, or property.
6621 (b) Nonprofit independent private colleges and universities
6622 located and chartered in this state which own or operate medical
6623 schools and which permit their employees or agents to provide
6624 patient services in teaching hospitals pursuant to an
6625 affiliation agreement or other contract, be afforded sovereign
6626 immunity protections under s. 768.28, Florida Statutes.
6627 (3) The Legislature declares that there is an overwhelming
6628 public necessity for extending the state's sovereign immunity to
6629 nonprofit independent colleges and universities located and
6630 chartered in this state which own or operate medical schools and
6631 provide patient services in teaching hospitals, and to their
6632 employees and agents, and that there is no alternative method of
6633 meeting such public necessity.
6634 (4) The terms "employee or agent," "patient services," and
6635 "teaching hospital" used in this section have the same meaning
6636 as the terms defined in s. 768.28, Florida Statutes, as amended
6637 by this act.
6638 Section 96. Section 1004.41, Florida Statutes, is amended
6639 to read:
6640 1004.41 University of Florida; J. Hillis Miller Health
6641 Center.—

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6642 (1) There is established the J. Hillis Miller Health Center
6643 at the University of Florida, including campuses at Gainesville
6644 and Jacksonville and affiliated teaching hospitals, which shall
6645 include the following colleges:
6646 (a) College of Dentistry.
6647 (b) College of Public Health and Health Professions.
6648 (c) College of Medicine.
6649 (d) College of Nursing.
6650 (e) College of Pharmacy.
6651 (f) College of Veterinary Medicine and related teaching
6652 hospitals.
6653 (2) Each college of the health center shall be ~~so~~
6654 maintained and operated so as to comply with the standards
6655 approved by a nationally recognized association for
6656 accreditation.
6657 (3)(a) The University of Florida Health Center Operations
6658 and Maintenance Trust Fund shall be administered by the
6659 University of Florida Board of Trustees. Funds shall be credited
6660 to the trust fund from the sale of goods and services performed
6661 by the University of Florida Veterinary Medicine Teaching
6662 Hospital. The purpose of the trust fund is to support the
6663 instruction, research, and service missions of the University of
6664 Florida College of Veterinary Medicine.
6665 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and
6666 pursuant to s. 216.351, any balance in the trust fund at the end
6667 of any fiscal year shall remain in the trust fund and ~~shall~~ be
6668 available for carrying out the purposes of the trust fund.
6669 (4)(a) The University of Florida Board of Trustees shall
6670 lease the hospital facilities of the health center known as ~~the~~

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6671 Shands Teaching Hospital and Clinics on the Gainesville campus
6672 of the University of Florida and all furnishings, equipment, and
6673 other chattels or choses in action used in the operation of
6674 Shands Teaching Hospital and Clinics ~~the hospital,~~ to Shands
6675 Teaching Hospital and Clinics, Inc., a private not-for-profit
6676 corporation organized ~~solely~~ for the primary purpose of
6677 supporting the University of Florida Board of Trustees' health
6678 affairs mission of community service and patient care, education
6679 and training of health professionals, and clinical research. In
6680 furtherance of that primary purpose, Shands Teaching Hospital
6681 and Clinics, Inc., shall operate ~~operating~~ the hospital and
6682 ancillary health care facilities as deemed ~~of the health center~~
6683 ~~and other health care facilities and programs determined to be~~
6684 necessary by the board of Shands Teaching Hospital and Clinics,
6685 Inc. ~~the nonprofit corporation.~~ The rental for the hospital
6686 facilities shall be an amount equal to the debt service on bonds
6687 or revenue certificates issued solely for capital improvements
6688 to the hospital facilities or as otherwise provided by law.
6689 (b) The University of Florida Board of Trustees shall
6690 provide in the lease or by separate contract or agreement with
6691 Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6692 ~~corporation~~ for the following:
6693 1. Approval of the articles of incorporation of Shands
6694 Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6695 ~~corporation~~ by the University of Florida Board of Trustees. ~~and~~
6696 ~~the~~
6697 2. Governance of Shands Teaching Hospital and Clinics,
6698 Inc., ~~the not-for-profit corporation~~ by a board of directors
6699 appointed, subject to removal, and chaired by the President of

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6700 the University of Florida, or his or her designee, and vice
6701 chaired by the Vice President for Health Affairs of the
6702 University of Florida, or his or her designee.
6703 3.~~2.~~ ~~The~~ Use of hospital facilities and personnel in
6704 support of community service and patient care, ~~the~~ research
6705 programs, and ~~of~~ the teaching roles ~~role~~ of the health center.
6706 4.~~3.~~ ~~The~~ Continued recognition of the collective bargaining
6707 units and collective bargaining agreements as currently composed
6708 and recognition of the certified labor organizations
6709 representing those units and agreements.
6710 5.~~4.~~ ~~The~~ Use of hospital facilities and personnel in
6711 connection with research programs conducted by the health
6712 center.
6713 6.~~5.~~ Reimbursement to Shands Teaching Hospital and Clinics,
6714 Inc., ~~the hospital~~ for indigent patients, state-mandated
6715 programs, underfunded state programs, and costs to Shands
6716 Teaching Hospital and Clinics, Inc., ~~the hospital~~ for support of
6717 the teaching and research programs of the health center. Such
6718 reimbursement shall be appropriated to either the health center
6719 or Shands Teaching Hospital and Clinics, Inc., ~~the hospital~~ each
6720 year by the Legislature after review and approval of the request
6721 for funds.
6722 7. Audit of the financial statements of Shands Teaching
6723 Hospital and Clinics, Inc., in accordance with generally
6724 accepted accounting principles as prescribed by the Governmental
6725 Accounting Standards Board for a separate corporation affiliated
6726 with a governmental entity that holds a voting majority interest
6727 of the affiliated corporation's governing board. The financial
6728 statements shall be provided to the University of Florida Board

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6729 of Trustees for attachment to its audited financial statement
6730 that is provided to the Auditor General. The University of
6731 Florida may obtain additional financial information from Shands
6732 Teaching Hospital and Clinics, Inc., upon request by the Auditor
6733 General. This subparagraph applies equally to any not-for-profit
6734 subsidiary of Shands Teaching Hospitals and Clinics, Inc., which
6735 directly delivers health care services and also qualifies as an
6736 instrumentality of the state under the governance control and
6737 the primary purpose standards specified in this section.
6738 (c) The University of Florida Board of Trustees may, with
6739 the approval of the Legislature, increase the hospital
6740 facilities or remodel or renovate them if~~, provided that~~ the
6741 rental paid by Shands Teaching Hospital and Clinics, Inc., ~~the~~
6742 ~~hospital~~ for such new, remodeled, or renovated facilities is
6743 sufficient to amortize the costs thereof over a reasonable
6744 period of time or fund the debt service for any bonds or revenue
6745 certificates issued to finance such improvements.
6746 (d) The University of Florida Board of Trustees may ~~is~~
6747 ~~authorized to~~ provide to Shands Teaching Hospital and Clinics,
6748 Inc., ~~the not-for-profit corporation leasing the hospital~~
6749 ~~facilities~~ and its not-for-profit subsidiaries and affiliates,
6750 and any successor corporation that acts in support of the board
6751 of trustees, comprehensive general liability insurance,
6752 including professional liability, from a self-insurance trust
6753 program established pursuant to s. 1004.24.
6754 (e) Shands Teaching Hospital and Clinics, Inc., in support
6755 of the health affairs mission of the University of Florida Board
6756 of Trustees and with the board's prior approval, may create or
6757 have created for-profit or not-for-profit subsidiaries and

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6758 affiliates, or both. The University of Florida Board of
6759 Trustees, which may act through the president of the university
6760 or his or her designee, may control Shands Teaching Hospital and
6761 Clinics, Inc. For purposes of sovereign immunity pursuant to s.
6762 768.28(2), Shands Teaching Hospital and Clinics, Inc., and any
6763 not-for-profit subsidiary that directly delivers health care
6764 services and whose governing board is chaired by the president
6765 of the university or his or her designee and is controlled by
6766 the University of Florida Board of Trustees, that may act
6767 through the president of the university or his or her designee,
6768 and whose primary purpose is the support of the University of
6769 Florida Board of Trustees' health affairs mission, shall be
6770 conclusively deemed a corporation primarily acting as an
6771 instrumentality of the state.
6772 (f) ~~(e)~~ If ~~In the event that~~ the lease of Shands Teaching
6773 Hospital and Clinics ~~the hospital facilities~~ to Shands Teaching
6774 Hospital and Clinics, Inc., ~~the not-for-profit corporation~~ is
6775 terminated for any reason, the University of Florida Board of
6776 Trustees shall resume management and operation of Shands
6777 Teaching Hospital and Clinics ~~the hospital facilities~~. In such
6778 event, the University of Florida Board of Trustees may use ~~is~~
6779 ~~authorized to utilize~~ revenues generated from the operation of
6780 Shands Teaching Hospital and Clinics ~~the hospital facilities~~ to
6781 pay the costs and expenses of operating the hospital facility
6782 for the remainder of the fiscal year in which such termination
6783 occurs.
6784 (5)(a) Shands Jacksonville Medical Center, Inc., and its
6785 parent, Shands Jacksonville HealthCare, Inc., are private not-
6786 for-profit corporations organized primarily to support the

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6787 health affairs mission of the University of Florida Board of
6788 Trustees in community service and patient care, education and
6789 training of health affairs professionals, and clinical research.
6790 Shands Jacksonville Medical Center, Inc., is a teaching hospital
6791 affiliated with the University of Florida Board of Trustees and
6792 is located, in part, on the Jacksonville Campus of the
6793 University of Florida. Shands Jacksonville Medical Center, Inc.,
6794 and Shands Jacksonville HealthCare, Inc., in support of the
6795 health affairs mission of the University of Florida Board of
6796 Trustees and with its prior approval, may create or have created
6797 for-profit or not-for-profit subsidiaries or affiliates, or
6798 both.
6799 (b) The University of Florida Board of Trustees shall
6800 provide in the lease or by separate contract or agreement with
6801 Shands Jacksonville Medical Center, Inc., and Shands
6802 Jacksonville HealthCare, Inc., for the following:
6803 1. Approval of the articles of incorporation of Shands
6804 Jacksonville Medical Center, Inc., and of Shands Jacksonville
6805 HealthCare, Inc., by the University of Florida Board of
6806 Trustees, which may act through the president of the university
6807 or his or her designee. In approving the articles of
6808 incorporation of Shands Jacksonville Medical Center, Inc., and
6809 of Shands Jacksonville HealthCare, Inc., the president of the
6810 university, or his or her designee, may act as the chair of the
6811 board of directors, or the president of the university or his or
6812 her designee or members of the University of Florida Board of
6813 Trustees may act as the approving body of Shands Jacksonville
6814 Medical Center, Inc., or Shands Jacksonville HealthCare, Inc.
6815 2. Governance of Shands Jacksonville Medical Center, Inc.,

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6816 and of Shands Jacksonville HealthCare, Inc., by boards of
6817 directors appointed, subject to removal, and chaired by the
6818 President of the University of Florida, or his or her designee.
6819 One director of each board may be so appointed after being
6820 nominated by the mayor of the City of Jacksonville subject to
6821 the applicable standards for directors of such board. If there
6822 is a vice chair of the board of directors of Shands Jacksonville
6823 Medical Center, Inc., or Shands Jacksonville HealthCare, Inc.,
6824 the Vice President for Health Affairs of the University of
6825 Florida, or his or her designee or the designee of the president
6826 of the university, shall hold that position.
6827 3. Use of the Shands Jacksonville Medical Center, Inc.,
6828 hospital facilities and personnel in support of community
6829 service and patient care, research programs, and the teaching
6830 roles of the health center of the University of Florida Board of
6831 Trustees.
6832 4. Reimbursement to Shands Jacksonville Medical Center,
6833 Inc., for indigent patients, state-mandated programs,
6834 underfunded state programs, and costs to the not-for-profit
6835 corporation for support of the teaching and research programs of
6836 the health center. Such reimbursement shall be appropriated to
6837 the health center or the not-for-profit corporation each year by
6838 the Legislature after review and approval of the request for
6839 funds.
6840 5. Audit of the financial statements of Shands Jacksonville
6841 Medical Center, Inc., and Shands Jacksonville HealthCare, Inc.,
6842 in accordance with generally accepted accounting principles as
6843 prescribed by the Governmental Accounting Standards Board for a
6844 separate corporation affiliated with a governmental entity that

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6845 holds a voting majority interest of the affiliated corporation's
6846 governing board. The financial statements shall be provided to
6847 the University of Florida Board of Trustees for attachment to
6848 its audited financial statement that is provided to the Auditor
6849 General. The University of Florida may obtain additional
6850 financial information from Shands Jacksonville Medical Center,
6851 Inc., and Shands Jacksonville HealthCare, Inc., upon request by
6852 the Auditor General. This subparagraph applies equally to any
6853 not-for-profit subsidiary that directly delivers health care
6854 services and also qualifies as an instrumentality of the state
6855 under the governance control and primary purpose standards
6856 specified in this section.
6857 (c) The University of Florida Board of Trustees, which may
6858 act through the president of the university or his or her
6859 designee, may control Shands Jacksonville Medical Center, Inc.,
6860 and Shands Jacksonville HealthCare, Inc.
6861 (d) For purposes of sovereign immunity pursuant to s.
6862 768.28(2), Shands Jacksonville Medical Center, Inc., Shands
6863 Jacksonville HealthCare, Inc., and any not-for-profit subsidiary
6864 that directly delivers health care services and whose governing
6865 board is chaired by the President of the University of Florida
6866 or his or her designee and is controlled by the University of
6867 Florida Board of Trustees, that may act through the president of
6868 the university or his or designee, and whose primary purpose is
6869 the support of the University of Florida Board of Trustees'
6870 health affairs mission, shall be conclusively deemed
6871 corporations primarily acting as instrumentalities of the state.
6872 (e) ~~(f)~~ The University of Florida Board of Trustees may ~~is~~
6873 ~~authorized to~~ provide to Shands Jacksonville HealthCare, Inc.,

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6874 and Shands Jacksonville Medical Center, Inc., and any of their
6875 ~~its~~ not-for-profit subsidiaries and affiliates and any successor
6876 corporation that acts in support of the board of trustees,
6877 comprehensive general liability coverage, including professional
6878 liability, from the self-insurance programs established pursuant
6879 to s. 1004.24.
6880 Section 97. Sections 409.9121, 409.919, and 624.915,
6881 Florida Statutes, are repealed.
6882 Section 98. Section 409.942, Florida Statutes, is
6883 transferred and renumbered as section 414.29, Florida Statutes.
6884 Section 99. Paragraph (a) of subsection (1) of section
6885 443.111, Florida Statutes, is amended to read:
6886 443.111 Payment of benefits.—
6887 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
6888 in accordance with rules adopted by the Agency for Workforce
6889 Innovation, subject to the following requirements:
6890 (a) Benefits are payable by mail or electronically.
6891 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a
6892 system for the payment of benefits by electronic funds transfer,
6893 including, but not limited to, debit cards, electronic payment
6894 cards, or any other means of electronic payment that the agency
6895 deems to be commercially viable or cost-effective. Commodities
6896 or services related to the development of such a system shall be
6897 procured by competitive solicitation, unless they are purchased
6898 from a state term contract pursuant to s. 287.056. The agency
6899 shall adopt rules necessary to administer the system.
6900 Section 100. Sections 409.944, 409.945, and 409.946,
6901 Florida Statutes, are transferred and renumbered as sections
6902 163.464, 163.465, and 163.466, Florida Statutes, respectively.

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6903 Section 101. Sections 409.953 and 409.9531, Florida
6904 Statutes, are transferred and renumbered as sections 402.81 and
6905 402.82, Florida Statutes, respectively.
6906 Section 102. The Agency for Health Care Administration
6907 shall submit a reorganizational plan to the Governor, the
6908 Speaker of the House of Representatives, and the President of
6909 the Senate by January 1, 2012, which converts the agency from a
6910 check-writing and fraud-chasing agency into a contract
6911 compliance and monitoring agency.
6912 Section 103. Effective December 1, 2011, if the Legislature
6913 has not received a letter from the Governor stating that the
6914 federal Centers for Medicare and Medicaid has approved the
6915 waivers necessary to implement the Medicaid managed care reforms
6916 contained in this act, the State of Florida shall withdraw from
6917 the Medicaid program effective December 31, 2011.
6918 Section 104. If any provision of this act or its
6919 application to any person or circumstance is held invalid, the
6920 invalidity does not affect other provisions or applications of
6921 the act which can be given effect without the invalid provision
6922 or application, and to this end the provisions of this act are
6923 severable.
6924 Section 105. This act shall take effect upon becoming a
6925 law.

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