1 A bill to be entitled
2 An act relating to Medicaid; amending s. 393.0661, F.S.;
3 requiring the Agency for Persons with Disabilities to
4 establish a transition plan for current Medicaid
5 recipients of home and community-based services under
6 certain circumstances; providing for expiration of the
7 section on a specified date; amending s. 393.0662, F.S.;
8 requiring the Agency for Persons with Disabilities to
9 complete the transition for current Medicaid recipients of
10 home and community-based services to the iBudget system by
11 a specified date; requiring the Agency for Persons with
12 Disabilities to develop a transition plan for current
13 Medicaid recipients of home and community-based services
14 to managed care plans; providing for expiration of the
15 section on a specified date; amending s. 408.040, F.S.;
16 providing for suspension of certain conditions precedent
17 to the issuance of a certificate of need for a nursing
18 home, effective on a specified date; amending s. 408.0435,
19 F.S.; extending the certificate-of-need moratorium for
20 additional community nursing home beds; designating ss.
21 409.016-409.803, F.S., as pt. I of ch. 409, F.S., and
22 entitling the part "Social and Economic Assistance";
23 designating ss. 409.810-409.821, F.S., as pt. II of ch.
24 409, F.S., and entitling the part "Kidcare"; designating
25 ss. 409.901-409.9205, F.S., as part III of ch. 409, F.S.,
26 and entitling the part "Medicaid"; amending s. 409.905,
27 F.S.; requiring the Agency for Health Care Administration
28 to set reimbursements rates for hospitals that provide

29 Medicaid services based on allowable-cost reporting from
30 the hospitals; providing the methodology for the rate
31 calculation and adjustments; requiring the rates to be
32 subject to certain limits or ceilings; providing that
33 exemptions to the limits or ceilings may be provided in
34 the General Appropriations Act; deleting provisions
35 relating to agency adjustments to a hospital's inpatient
36 per diem rate; directing the agency to develop a plan to
37 convert inpatient hospital rates to a prospective payment
38 system that categorizes each case into diagnosis-related
39 groups; requiring a report to the Governor and
40 Legislature; amending s. 409.911, F.S.; providing for
41 expiration of the Medicaid Low-Income Pool Council;
42 amending s. 409.912, F.S.; providing payment requirements
43 for provider service networks; providing for the
44 expiration of various provisions relating to agency
45 contracts and agreements with certain entities on
46 specified dates to conform to the reorganization of
47 Medicaid managed care; requiring the agency to contract on
48 a prepaid or fixed-sum basis with certain prepaid dental
49 health plans; eliminating obsolete provisions and updating
50 provisions, to conform; amending ss. 409.91195 and
51 409.91196, F.S.; conforming cross-references; repealing s.
52 409.91207, F.S., relating to the medical home pilot
53 project; amending s. 409.91211, F.S.; conforming cross-
54 references; providing for future repeal of s. 409.91211,
55 F.S., relating to the Medicaid managed care pilot program;
56 amending s. 409.9122, F.S.; providing for the expiration

57 of provisions relating to mandatory enrollment in a
58 Medicaid managed care plan or MediPass on specified dates
59 to conform to the reorganization of Medicaid managed care;
60 eliminating obsolete provisions; requiring the agency to
61 develop a process to enable any recipient with access to
62 employer-sponsored coverage to opt out of eligible plans
63 in the Medicaid program; requiring the agency, contingent
64 on federal approval, to enable recipients with access to
65 other coverage or related products that provide access to
66 specified health care services to opt out of eligible
67 plans in the Medicaid program; requiring the agency to
68 maintain and operate the Medicaid Encounter Data System;
69 requiring the agency to conduct a review of encounter data
70 and publish the results of the review before adjusting
71 rates for prepaid plans; authorizing the agency to
72 establish a designated payment for specified Medicare
73 Advantage Special Needs members; authorizing the agency to
74 develop a designated payment for Medicaid-only covered
75 services for which the state is responsible; requiring the
76 agency to establish, and managed care plans to use, a
77 uniform method of accounting for and reporting medical and
78 nonmedical costs; authorizing the agency to create
79 exceptions to mandatory enrollment in managed care under
80 specified circumstances; requiring the agency to contract
81 with a provider service network to function as a third-
82 party administrator and managing entity for the MediPass
83 program; providing contract provisions; providing for the
84 expiration of such contract requirements on a specified

85 date; amending s. 430.04, F.S.; eliminating obsolete
86 provisions; requiring the Department of Elderly Affairs to
87 develop a transition plan for specified elders and
88 disabled adults receiving long-term care Medicaid services
89 when eligible plans become available; providing for
90 expiration of the plan; amending s. 430.2053, F.S.;
91 eliminating obsolete provisions; providing additional
92 duties of aging resource centers; providing an additional
93 exception to direct services that may not be provided by
94 an aging resource center; providing an expiration date for
95 certain services administered through aging resource
96 centers; providing for the cessation of specified payments
97 by the department as eligible plans become available;
98 providing for a memorandum of understanding between the
99 agency and aging resource centers under certain
100 circumstances; eliminating provisions requiring reports;
101 repealing s. 430.701, F.S., relating to legislative
102 findings and intent and approval for action relating to
103 provider enrollment levels; repealing s. 430.702, F.S.,
104 relating to the Long-Term Care Community Diversion Pilot
105 Project Act; repealing s. 430.703, F.S., relating to
106 definitions; repealing s. 430.7031, F.S., relating to the
107 nursing home transition program; repealing s. 430.704,
108 F.S., relating to evaluation of long-term care through the
109 pilot projects; repealing s. 430.705, F.S., relating to
110 implementation of long-term care community diversion pilot
111 projects; repealing s. 430.706, F.S., relating to quality
112 of care; repealing s. 430.707, F.S., relating to

113 contracts; repealing s. 430.708, F.S., relating to
114 certificate of need; repealing s. 430.709, F.S., relating
115 to reports and evaluations; renumbering ss. 409.9301,
116 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531,
117 F.S., as ss. 402.81, 402.82, 402.83, 402.84, 402.85,
118 402.86, and 402.87, F.S., respectively; amending ss.
119 443.111 and 641.386, F.S.; conforming cross-references;
120 directing the agency to develop a plan to implement the
121 enrollment of the medically needy into managed care;
122 providing effective dates and a contingent effective date.
123
124 Be It Enacted by the Legislature of the State of Florida:
125
126 Section 1. Section 393.0661, Florida Statutes, is amended
127 to read:
128 393.0661 Home and community-based services delivery
129 system; comprehensive redesign.—The Legislature finds that the
130 home and community-based services delivery system for persons
131 with developmental disabilities and the availability of
132 appropriated funds are two of the critical elements in making
133 services available. Therefore, it is the intent of the
134 Legislature that the Agency for Persons with Disabilities shall
135 develop and implement a comprehensive redesign of the system.
136 (1) The redesign of the home and community-based services
137 system shall include, at a minimum, all actions necessary to
138 achieve an appropriate rate structure, client choice within a
139 specified service package, appropriate assessment strategies, an
140 efficient billing process that contains reconciliation and

141 monitoring components, and a redefined role for support
142 coordinators that avoids potential conflicts of interest and
143 ensures that family/client budgets are linked to levels of need.
144 (a) The agency shall use an assessment instrument that the
145 agency deems to be reliable and valid, including, but not
146 limited to, the Department of Children and Family Services'
147 Individual Cost Guidelines or the agency's Questionnaire for
148 Situational Information. The agency may contract with an
149 external vendor or may use support coordinators to complete
150 client assessments if it develops sufficient safeguards and
151 training to ensure ongoing inter-rater reliability.
152 (b) The agency, with the concurrence of the Agency for
153 Health Care Administration, may contract for the determination
154 of medical necessity and establishment of individual budgets.
155 (2) A provider of services rendered to persons with
156 developmental disabilities pursuant to a federally approved
157 waiver shall be reimbursed according to a rate methodology based
158 upon an analysis of the expenditure history and prospective
159 costs of providers participating in the waiver program, or under
160 any other methodology developed by the Agency for Health Care
161 Administration, in consultation with the Agency for Persons with
162 Disabilities, and approved by the Federal Government in
163 accordance with the waiver.
164 (3) The Agency for Health Care Administration, in
165 consultation with the agency, shall seek federal approval and
166 implement a four-tiered waiver system to serve eligible clients
167 through the developmental disabilities and family and supported
168 living waivers. The agency shall assign all clients receiving

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169 services through the developmental disabilities waiver to a tier
170 based on the Department of Children and Family Services'
171 Individual Cost Guidelines, the agency's Questionnaire for
172 Situational Information, or another such assessment instrument
173 deemed to be valid and reliable by the agency; client
174 characteristics, including, but not limited to, age; and other
175 appropriate assessment methods.
176 (a) Tier one is limited to clients who have service needs
177 that cannot be met in tier two, three, or four for intensive
178 medical or adaptive needs and that are essential for avoiding
179 institutionalization, or who possess behavioral problems that
180 are exceptional in intensity, duration, or frequency and present
181 a substantial risk of harm to themselves or others. Total annual
182 expenditures under tier one may not exceed $150,000 per client
183 each year, provided that expenditures for clients in tier one
184 with a documented medical necessity requiring intensive
185 behavioral residential habilitation services, intensive
186 behavioral residential habilitation services with medical needs,
187 or special medical home care, as provided in the Developmental
188 Disabilities Waiver Services Coverage and Limitations Handbook,
189 are not subject to the $150,000 limit on annual expenditures.
190 (b) Tier two is limited to clients whose service needs
191 include a licensed residential facility and who are authorized
192 to receive a moderate level of support for standard residential
193 habilitation services or a minimal level of support for behavior
194 focus residential habilitation services, or clients in supported
195 living who receive more than 6 hours a day of in-home support
196 services. Total annual expenditures under tier two may not

197 exceed $53,625 per client each year.
198 (c) Tier three includes, but is not limited to, clients
199 requiring residential placements, clients in independent or
200 supported living situations, and clients who live in their
201 family home. Total annual expenditures under tier three may not
202 exceed $34,125 per client each year.
203 (d) Tier four includes individuals who were enrolled in
204 the family and supported living waiver on July 1, 2007, who
205 shall be assigned to this tier without the assessments required
206 by this section. Tier four also includes, but is not limited to,
207 clients in independent or supported living situations and
208 clients who live in their family home. Total annual expenditures
209 under tier four may not exceed $14,422 per client each year.
210 (e) The Agency for Health Care Administration shall also
211 seek federal approval to provide a consumer-directed option for
212 persons with developmental disabilities which corresponds to the
213 funding levels in each of the waiver tiers. The agency shall
214 implement the four-tiered waiver system beginning with tiers
215 one, three, and four and followed by tier two. The agency and
216 the Agency for Health Care Administration may adopt rules
217 necessary to administer this subsection.
218 (f) The agency shall seek federal waivers and amend
219 contracts as necessary to make changes to services defined in
220 federal waiver programs administered by the agency as follows:
221 1. Supported living coaching services may not exceed 20
222 hours per month for persons who also receive in-home support
223 services.
224 2. Limited support coordination services is the only type

225 of support coordination service that may be provided to persons
226 under the age of 18 who live in the family home.
227 3. Personal care assistance services are limited to 180
228 hours per calendar month and may not include rate modifiers.
229 Additional hours may be authorized for persons who have
230 intensive physical, medical, or adaptive needs if such hours are
231 essential for avoiding institutionalization.
232 4. Residential habilitation services are limited to 8
233 hours per day. Additional hours may be authorized for persons
234 who have intensive medical or adaptive needs and if such hours
235 are essential for avoiding institutionalization, or for persons
236 who possess behavioral problems that are exceptional in
237 intensity, duration, or frequency and present a substantial risk
238 of harming themselves or others. This restriction shall be in
239 effect until the four-tiered waiver system is fully implemented.
240 5. Chore services, nonresidential support services, and
241 homemaker services are eliminated. The agency shall expand the
242 definition of in-home support services to allow the service
243 provider to include activities previously provided in these
244 eliminated services.
245 6. Massage therapy, medication review, and psychological
246 assessment services are eliminated.
247 7. The agency shall conduct supplemental cost plan reviews
248 to verify the medical necessity of authorized services for plans
249 that have increased by more than 8 percent during either of the
250 2 preceding fiscal years.
251 8. The agency shall implement a consolidated residential
252 habilitation rate structure to increase savings to the state

253 through a more cost-effective payment method and establish
254 uniform rates for intensive behavioral residential habilitation
255 services.
256 9. Pending federal approval, the agency may extend current
257 support plans for clients receiving services under Medicaid
258 waivers for 1 year beginning July 1, 2007, or from the date
259 approved, whichever is later. Clients who have a substantial
260 change in circumstances which threatens their health and safety
261 may be reassessed during this year in order to determine the
262 necessity for a change in their support plan.
263 10. The agency shall develop a plan to eliminate
264 redundancies and duplications between in-home support services,
265 companion services, personal care services, and supported living
266 coaching by limiting or consolidating such services.
267 11. The agency shall develop a plan to reduce the
268 intensity and frequency of supported employment services to
269 clients in stable employment situations who have a documented
270 history of at least 3 years' employment with the same company or
271 in the same industry.
272 (4) The geographic differential for Miami-Dade, Broward,
273 and Palm Beach Counties for residential habilitation services
274 shall be 7.5 percent.
275 (5) The geographic differential for Monroe County for
276 residential habilitation services shall be 20 percent.
277 (6) Effective January 1, 2010, and except as otherwise
278 provided in this section, a client served by the home and
279 community-based services waiver or the family and supported
280 living waiver funded through the agency shall have his or her

281 cost plan adjusted to reflect the amount of expenditures for the
282 previous state fiscal year plus 5 percent if such amount is less
283 than the client's existing cost plan. The agency shall use
284 actual paid claims for services provided during the previous
285 fiscal year that are submitted by October 31 to calculate the
286 revised cost plan amount. If the client was not served for the
287 entire previous state fiscal year or there was any single change
288 in the cost plan amount of more than 5 percent during the
289 previous state fiscal year, the agency shall set the cost plan
290 amount at an estimated annualized expenditure amount plus 5
291 percent. The agency shall estimate the annualized expenditure
292 amount by calculating the average of monthly expenditures,
293 beginning in the fourth month after the client enrolled,
294 interrupted services are resumed, or the cost plan was changed
295 by more than 5 percent and ending on August 31, 2009, and
296 multiplying the average by 12. In order to determine whether a
297 client was not served for the entire year, the agency shall
298 include any interruption of a waiver-funded service or services
299 lasting at least 18 days. If at least 3 months of actual
300 expenditure data are not available to estimate annualized
301 expenditures, the agency may not rebase a cost plan pursuant to
302 this subsection. The agency may not rebase the cost plan of any
303 client who experiences a significant change in recipient
304 condition or circumstance which results in a change of more than
305 5 percent to his or her cost plan between July 1 and the date
306 that a rebased cost plan would take effect pursuant to this
307 subsection.
308 (7) Nothing in this section or in any administrative rule

309 shall be construed to prevent or limit the Agency for Health
310 Care Administration, in consultation with the Agency for Persons
311 with Disabilities, from adjusting fees, reimbursement rates,
312 lengths of stay, number of visits, or number of services, or
313 from limiting enrollment, or making any other adjustment
314 necessary to comply with the availability of moneys and any
315 limitations or directions provided for in the General
316 Appropriations Act.
317 (8) The Agency for Persons with Disabilities shall submit
318 quarterly status reports to the Executive Office of the
319 Governor, the chair of the Senate Ways and Means Committee or
320 its successor, and the chair of the House Fiscal Council or its
321 successor regarding the financial status of home and community-
322 based services, including the number of enrolled individuals who
323 are receiving services through one or more programs; the number
324 of individuals who have requested services who are not enrolled
325 but who are receiving services through one or more programs,
326 with a description indicating the programs from which the
327 individual is receiving services; the number of individuals who
328 have refused an offer of services but who choose to remain on
329 the list of individuals waiting for services; the number of
330 individuals who have requested services but who are receiving no
331 services; a frequency distribution indicating the length of time
332 individuals have been waiting for services; and information
333 concerning the actual and projected costs compared to the amount
334 of the appropriation available to the program and any projected
335 surpluses or deficits. If at any time an analysis by the agency,
336 in consultation with the Agency for Health Care Administration,

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337 indicates that the cost of services is expected to exceed the
338 amount appropriated, the agency shall submit a plan in
339 accordance with subsection (7) to the Executive Office of the
340 Governor, the chair of the Senate Ways and Means Committee or
341 its successor, and the chair of the House Fiscal Council or its
342 successor to remain within the amount appropriated. The agency
343 shall work with the Agency for Health Care Administration to
344 implement the plan so as to remain within the appropriation.
345 (9) The agency shall develop a transition plan for
346 recipients who are receiving services in one of the four waiver
347 tiers at the time eligible managed care plans are available in
348 each recipient's region as defined in s. 409.989 to enroll those
349 recipients in eligible plans.
350 (10) This section expires October 1, 2016.
351 Section 2. Section 393.0662, Florida Statutes, is amended
352 to read:
353 393.0662 Individual budgets for delivery of home and
354 community-based services; iBudget system established.—The
355 Legislature finds that improved financial management of the
356 existing home and community-based Medicaid waiver program is
357 necessary to avoid deficits that impede the provision of
358 services to individuals who are on the waiting list for
359 enrollment in the program. The Legislature further finds that
360 clients and their families should have greater flexibility to
361 choose the services that best allow them to live in their
362 community within the limits of an established budget. Therefore,
363 the Legislature intends that the agency, in consultation with
364 the Agency for Health Care Administration, develop and implement

365 a comprehensive redesign of the service delivery system using
366 individual budgets as the basis for allocating the funds
367 appropriated for the home and community-based services Medicaid
368 waiver program among eligible enrolled clients. The service
369 delivery system that uses individual budgets shall be called the
370 iBudget system.
371 (1) The agency shall establish an individual budget,
372 referred to as an iBudget, for each individual served by the
373 home and community-based services Medicaid waiver program. The
374 funds appropriated to the agency shall be allocated through the
375 iBudget system to eligible, Medicaid-enrolled clients. The
376 iBudget system shall be designed to provide for: enhanced client
377 choice within a specified service package; appropriate
378 assessment strategies; an efficient consumer budgeting and
379 billing process that includes reconciliation and monitoring
380 components; a redefined role for support coordinators that
381 avoids potential conflicts of interest; a flexible and
382 streamlined service review process; and a methodology and
383 process that ensures the equitable allocation of available funds
384 to each client based on the client's level of need, as
385 determined by the variables in the allocation algorithm.
386 (a) In developing each client's iBudget, the agency shall
387 use an allocation algorithm and methodology. The algorithm shall
388 use variables that have been determined by the agency to have a
389 statistically validated relationship to the client's level of
390 need for services provided through the home and community-based
391 services Medicaid waiver program. The algorithm and methodology
392 may consider individual characteristics, including, but not

393 limited to, a client's age and living situation, information
394 from a formal assessment instrument that the agency determines
395 is valid and reliable, and information from other assessment
396 processes.
397 (b) The allocation methodology shall provide the algorithm
398 that determines the amount of funds allocated to a client's
399 iBudget. The agency may approve an increase in the amount of
400 funds allocated, as determined by the algorithm, based on the
401 client having one or more of the following needs that cannot be
402 accommodated within the funding as determined by the algorithm
403 and having no other resources, supports, or services available
404 to meet the need:
405 1. An extraordinary need that would place the health and
406 safety of the client, the client's caregiver, or the public in
407 immediate, serious jeopardy unless the increase is approved. An
408 extraordinary need may include, but is not limited to:
409 a. A documented history of significant, potentially life-
410 threatening behaviors, such as recent attempts at suicide,
411 arson, nonconsensual sexual behavior, or self-injurious behavior
412 requiring medical attention;
413 b. A complex medical condition that requires active
414 intervention by a licensed nurse on an ongoing basis that cannot
415 be taught or delegated to a nonlicensed person;
416 c. A chronic comorbid condition. As used in this
417 subparagraph, the term "comorbid condition" means a medical
418 condition existing simultaneously but independently with another
419 medical condition in a patient; or
420 d. A need for total physical assistance with activities

421 such as eating, bathing, toileting, grooming, and personal
422 hygiene.
423
424 However, the presence of an extraordinary need alone does not
425 warrant an increase in the amount of funds allocated to a
426 client's iBudget as determined by the algorithm.
427 2. A significant need for one-time or temporary support or
428 services that, if not provided, would place the health and
429 safety of the client, the client's caregiver, or the public in
430 serious jeopardy, unless the increase is approved. A significant
431 need may include, but is not limited to, the provision of
432 environmental modifications, durable medical equipment, services
433 to address the temporary loss of support from a caregiver, or
434 special services or treatment for a serious temporary condition
435 when the service or treatment is expected to ameliorate the
436 underlying condition. As used in this subparagraph, the term
437 "temporary" means a period of fewer than 12 continuous months.
438 However, the presence of such significant need for one-time or
439 temporary supports or services alone does not warrant an
440 increase in the amount of funds allocated to a client's iBudget
441 as determined by the algorithm.
442 3. A significant increase in the need for services after
443 the beginning of the service plan year that would place the
444 health and safety of the client, the client's caregiver, or the
445 public in serious jeopardy because of substantial changes in the
446 client's circumstances, including, but not limited to, permanent
447 or long-term loss or incapacity of a caregiver, loss of services
448 authorized under the state Medicaid plan due to a change in age,

449 or a significant change in medical or functional status which
450 requires the provision of additional services on a permanent or
451 long-term basis that cannot be accommodated within the client's
452 current iBudget. As used in this subparagraph, the term "long-
453 term" means a period of 12 or more continuous months. However,
454 such significant increase in need for services of a permanent or
455 long-term nature alone does not warrant an increase in the
456 amount of funds allocated to a client's iBudget as determined by
457 the algorithm.
458
459 The agency shall reserve portions of the appropriation for the
460 home and community-based services Medicaid waiver program for
461 adjustments required pursuant to this paragraph and may use the
462 services of an independent actuary in determining the amount of
463 the portions to be reserved.
464 (c) A client's iBudget shall be the total of the amount
465 determined by the algorithm and any additional funding provided
466 pursuant to paragraph (b). A client's annual expenditures for
467 home and community-based services Medicaid waiver services may
468 not exceed the limits of his or her iBudget. The total of all
469 clients' projected annual iBudget expenditures may not exceed
470 the agency's appropriation for waiver services.
471 (2) The Agency for Health Care Administration, in
472 consultation with the agency, shall seek federal approval to
473 amend current waivers, request a new waiver, and amend contracts
474 as necessary to implement the iBudget system to serve eligible,
475 enrolled clients through the home and community-based services
476 Medicaid waiver program and the Consumer-Directed Care Plus

477 Program.
478 (3) The agency shall transition all eligible, enrolled
479 clients to the iBudget system. The agency may gradually phase in
480 the iBudget system and must complete the phase in by January 1,
481 2015.
482 (a) While the agency phases in the iBudget system, the
483 agency may continue to serve eligible, enrolled clients under
484 the four-tiered waiver system established under s. 393.065 while
485 those clients await transitioning to the iBudget system.
486 (b) The agency shall design the phase-in process to ensure
487 that a client does not experience more than one-half of any
488 expected overall increase or decrease to his or her existing
489 annualized cost plan during the first year that the client is
490 provided an iBudget due solely to the transition to the iBudget
491 system.
492 (4) A client must use all available services authorized
493 under the state Medicaid plan, school-based services, private
494 insurance and other benefits, and any other resources that may
495 be available to the client before using funds from his or her
496 iBudget to pay for support and services.
497 (5) The service limitations in s. 393.0661(3)(f)1., 2.,
498 and 3. do not apply to the iBudget system.
499 (6) Rates for any or all services established under rules
500 of the Agency for Health Care Administration shall be designated
501 as the maximum rather than a fixed amount for individuals who
502 receive an iBudget, except for services specifically identified
503 in those rules that the agency determines are not appropriate
504 for negotiation, which may include, but are not limited to,

505 residential habilitation services.
506 (7) The agency shall ensure that clients and caregivers
507 have access to training and education to inform them about the
508 iBudget system and enhance their ability for self-direction.
509 Such training shall be offered in a variety of formats and at a
510 minimum shall address the policies and processes of the iBudget
511 system; the roles and responsibilities of consumers, caregivers,
512 waiver support coordinators, providers, and the agency;
513 information available to help the client make decisions
514 regarding the iBudget system; and examples of support and
515 resources available in the community.
516 (8) The agency shall collect data to evaluate the
517 implementation and outcomes of the iBudget system.
518 (9) The agency and the Agency for Health Care
519 Administration may adopt rules specifying the allocation
520 algorithm and methodology; criteria and processes for clients to
521 access reserved funds for extraordinary needs, temporarily or
522 permanently changed needs, and one-time needs; and processes and
523 requirements for selection and review of services, development
524 of support and cost plans, and management of the iBudget system
525 as needed to administer this section.
526 (10) The agency shall develop a transition plan for
527 recipients who are receiving services through the iBudget system
528 at the time eligible managed care plans are available in each
529 recipient's region defined in s. 409.989 to enroll those
530 recipients in eligible plans.
531 (11) This section expires October 1, 2016.

532 Section 3. Paragraph (e) of subsection (1) of section
533 408.040, Florida Statutes, is redesignated as paragraph (d), and
534 paragraph (b) and present paragraph (d) of that subsection are
535 amended to read:
536 408.040 Conditions and monitoring.—
537 (1)
538 (b) The agency may consider, in addition to the other
539 criteria specified in s. 408.035, a statement of intent by the
540 applicant that a specified percentage of the annual patient days
541 at the facility will be utilized by patients eligible for care
542 under Title XIX of the Social Security Act. Any certificate of
543 need issued to a nursing home in reliance upon an applicant's
544 statements that a specified percentage of annual patient days
545 will be utilized by residents eligible for care under Title XIX
546 of the Social Security Act must include a statement that such
547 certification is a condition of issuance of the certificate of
548 need. The certificate-of-need program shall notify the Medicaid
549 program office and the Department of Elderly Affairs when it
550 imposes conditions as authorized in this paragraph in an area in
551 which a community diversion pilot project is implemented.
552 Effective July 1, 2012, the agency may not consider, or impose
553 conditions or sanctions related to, patient day utilization by
554 patients eligible for care under Title XIX the Social Security
555 Act in making certificate-of-need determinations for nursing
556 homes.
557 ~~(d) If a nursing home is located in a county in which a~~
558 ~~long-term care community diversion pilot project has been~~
559 ~~implemented under s. 430.705 or in a county in which an~~

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560 ~~integrated, fixed-payment delivery program for Medicaid~~
561 ~~recipients who are 60 years of age or older or dually eligible~~
562 ~~for Medicare and Medicaid has been implemented under s.~~
563 ~~409.912(5), the nursing home may request a reduction in the~~
564 ~~percentage of annual patient days used by residents who are~~
565 ~~eligible for care under Title XIX of the Social Security Act,~~
566 ~~which is a condition of the nursing home's certificate of need.~~
567 ~~The agency shall automatically grant the nursing home's request~~
568 ~~if the reduction is not more than 15 percent of the nursing~~
569 ~~home's annual Medicaid-patient-days condition. A nursing home~~
570 ~~may submit only one request every 2 years for an automatic~~
571 ~~reduction. A requesting nursing home must notify the agency in~~
572 ~~writing at least 60 days in advance of its intent to reduce its~~
573 ~~annual Medicaid-patient-days condition by not more than 15~~
574 ~~percent. The agency must acknowledge the request in writing and~~
575 ~~must change its records to reflect the revised certificate-of-~~
576 ~~need condition. This paragraph expires June 30, 2011.~~
577 Section 4. Subsection (1) of section 408.0435, Florida
578 Statutes, is amended to read:
579 408.0435 Moratorium on nursing home certificates of need.—
580 (1) Notwithstanding the establishment of need as provided
581 for in this chapter, a certificate of need for additional
582 community nursing home beds may not be approved by the agency
583 until Medicaid managed care is implemented statewide pursuant to
584 ss. 409.961-409.992 or October 1, 2016, whichever is earlier
585 ~~July 1, 2011~~.

586 Section 5. Sections 409.016 through 409.803, Florida
587 Statutes, are designated as part I of chapter 409, Florida
588 Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."
589 Section 6. Sections 409.810 through 409.821, Florida
590 Statutes, are designated as part II of chapter 409, Florida
591 Statutes, and entitled "KIDCARE."
592 Section 7. Sections 409.901 through 409.9205, Florida
593 Statutes, are designated as part III of chapter 409, Florida
594 Statutes, and entitled "MEDICAID."
595 Section 8. Paragraph (c) of subsection (5) of section
596 409.905, Florida Statutes, is amended, and paragraph (g) is
597 added that subsection, to read:
598 409.905 Mandatory Medicaid services.—The agency may make
599 payments for the following services, which are required of the
600 state by Title XIX of the Social Security Act, furnished by
601 Medicaid providers to recipients who are determined to be
602 eligible on the dates on which the services were provided. Any
603 service under this section shall be provided only when medically
604 necessary and in accordance with state and federal law.
605 Mandatory services rendered by providers in mobile units to
606 Medicaid recipients may be restricted by the agency. Nothing in
607 this section shall be construed to prevent or limit the agency
608 from adjusting fees, reimbursement rates, lengths of stay,
609 number of visits, number of services, or any other adjustments
610 necessary to comply with the availability of moneys and any
611 limitations or directions provided for in the General
612 Appropriations Act or chapter 216.
613 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for

614 all covered services provided for the medical care and treatment
615 of a recipient who is admitted as an inpatient by a licensed
616 physician or dentist to a hospital licensed under part I of
617 chapter 395. However, the agency shall limit the payment for
618 inpatient hospital services for a Medicaid recipient 21 years of
619 age or older to 45 days or the number of days necessary to
620 comply with the General Appropriations Act.
621 (c) The agency shall implement a methodology for
622 establishing base reimbursement rates for each hospital based on
623 allowable costs, as defined by the agency. Rates shall be
624 calculated annually and take effect July 1 of each year based on
625 the most recent complete and accurate cost report submitted by
626 each hospital. Adjustments may not be made to the rates after
627 September 30 of the state fiscal year in which the rate takes
628 effect. Errors in cost reporting or calculation of rates
629 discovered after September 30 must be reconciled in a subsequent
630 rate period. Cost reports must be reconciled within 5 years
631 after the end of the applicable fiscal year. Hospital rates
632 shall be subject to such limits or ceilings as may be
633 established in law or described in the agency's hospital
634 reimbursement plan. Specific exemptions to the limits or
635 ceilings may be provided in the General Appropriations Act. The
636 agency shall adjust a hospital's current inpatient per diem rate
637 to reflect the cost of serving the Medicaid population at that
638 institution if:
639 1. The hospital experiences an increase in Medicaid
640 caseload by more than 25 percent in any year, primarily
641 resulting from the closure of a hospital in the same service

642 ~~area occurring after July 1, 1995;~~
643 ~~2. The hospital's Medicaid per diem rate is at least 25~~
644 ~~percent below the Medicaid per patient cost for that year; or~~
645 ~~3. The hospital is located in a county that has six or~~
646 ~~fewer general acute care hospitals, began offering obstetrical~~
647 ~~services on or after September 1999, and has submitted a request~~
648 ~~in writing to the agency for a rate adjustment after July 1,~~
649 ~~2000, but before September 30, 2000, in which case such~~
650 ~~hospital's Medicaid inpatient per diem rate shall be adjusted to~~
651 ~~cost, effective July 1, 2002.~~
652
653 ~~By October 1 of each year, the agency must provide estimated~~
654 ~~costs for any adjustment in a hospital inpatient per diem rate~~
655 ~~to the Executive Office of the Governor, the House of~~
656 ~~Representatives General Appropriations Committee, and the Senate~~
657 ~~Appropriations Committee. Before the agency implements a change~~
658 ~~in a hospital's inpatient per diem rate pursuant to this~~
659 ~~paragraph, the Legislature must have specifically appropriated~~
660 ~~sufficient funds in the General Appropriations Act to support~~
661 ~~the increase in cost as estimated by the agency.~~
662 (g) The agency shall develop a plan to convert inpatient
663 hospital rates to a prospective payment system that categorizes
664 each case into diagnosis-related groups (DRG) and assigns a
665 payment weight based on the average resources used to treat
666 Medicaid patients in that DRG. To the extent possible, the
667 agency shall propose an adaptation of an existing prospective
668 payment system, such as the one used by Medicare, and shall
669 propose such adjustments as are necessary for the Medicaid

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

670 population and to maintain budget neutrality for inpatient
671 hospital expenditures. The agency shall submit the Medicaid DRG
672 plan, identifying all steps necessary for the transition and any
673 costs associated with plan implementation, to the Governor, the
674 President of the Senate, and the Speaker of the House of
675 Representatives no later than January 1, 2013.
676 Section 9. Subsection (10) of section 409.911, Florida
677 Statutes, is amended to read:
678 409.911 Disproportionate share program.—Subject to
679 specific allocations established within the General
680 Appropriations Act and any limitations established pursuant to
681 chapter 216, the agency shall distribute, pursuant to this
682 section, moneys to hospitals providing a disproportionate share
683 of Medicaid or charity care services by making quarterly
684 Medicaid payments as required. Notwithstanding the provisions of
685 s. 409.915, counties are exempt from contributing toward the
686 cost of this special reimbursement for hospitals serving a
687 disproportionate share of low-income patients.
688 (10) The Agency for Health Care Administration shall
689 create a Medicaid Low-Income Pool Council by July 1, 2006. The
690 Low-Income Pool Council shall consist of 24 members, including 2
691 members appointed by the President of the Senate, 2 members
692 appointed by the Speaker of the House of Representatives, 3
693 representatives of statutory teaching hospitals, 3
694 representatives of public hospitals, 3 representatives of
695 nonprofit hospitals, 3 representatives of for-profit hospitals,
696 2 representatives of rural hospitals, 2 representatives of units
697 of local government which contribute funding, 1 representative

698 of family practice teaching hospitals, 1 representative of
699 federally qualified health centers, 1 representative from the
700 Department of Health, and 1 nonvoting representative of the
701 Agency for Health Care Administration who shall serve as chair
702 of the council. Except for a full-time employee of a public
703 entity, an individual who qualifies as a lobbyist under s.
704 11.045 or s. 112.3215 may not serve as a member of the council.
705 Of the members appointed by the Senate President, only one shall
706 be a physician. Of the members appointed by the Speaker of the
707 House of Representatives, only one shall be a physician. The
708 physician member appointed by the Senate President and the
709 physician member appointed by the Speaker of the House of
710 Representatives must be physicians who routinely take calls in a
711 trauma center, as defined in s. 395.4001, or a hospital
712 emergency department. The council shall:
713 (a) Make recommendations on the financing of the low-
714 income pool and the disproportionate share hospital program and
715 the distribution of their funds.
716 (b) Advise the Agency for Health Care Administration on
717 the development of the low-income pool plan required by the
718 federal Centers for Medicare and Medicaid Services pursuant to
719 the Medicaid reform waiver.
720 (c) Advise the Agency for Health Care Administration on
721 the distribution of hospital funds used to adjust inpatient
722 hospital rates, rebase rates, or otherwise exempt hospitals from
723 reimbursement limits as financed by intergovernmental transfers.
724 (d) Submit its findings and recommendations to the
725 Governor and the Legislature no later than February 1 of each

726 year.

727

728 This subsection expires October 1, 2014.

729 Section 10. Subsection (4) of section 409.91195, Florida
730 Statutes, is amended to read:

731 409.91195 Medicaid Pharmaceutical and Therapeutics
732 Committee.—There is created a Medicaid Pharmaceutical and
733 Therapeutics Committee within the agency for the purpose of
734 developing a Medicaid preferred drug list.

735 (4) Upon recommendation of the committee, the agency shall
736 adopt a preferred drug list as described in s. 409.912(37)(39).
737 To the extent feasible, the committee shall review all drug
738 classes included on the preferred drug list every 12 months, and
739 may recommend additions to and deletions from the preferred drug
740 list, such that the preferred drug list provides for medically
741 appropriate drug therapies for Medicaid patients which achieve
742 cost savings contained in the General Appropriations Act.

743 Section 11. Subsection (1) of section 409.91196, Florida
744 Statutes, is amended to read:

745 409.91196 Supplemental rebate agreements; public records
746 and public meetings exemption.—

747 (1) The rebate amount, percent of rebate, manufacturer's
748 pricing, and supplemental rebate, and other trade secrets as
749 defined in s. 688.002 that the agency has identified for use in
750 negotiations, held by the Agency for Health Care Administration
751 under s. 409.912(37)(39)(a)7. are confidential and exempt from
752 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

753 Section 12. Section 409.912, Florida Statutes, is amended
754 to read:
755 409.912 Cost-effective purchasing of health care.—The
756 agency shall purchase goods and services for Medicaid recipients
757 in the most cost-effective manner consistent with the delivery
758 of quality medical care. To ensure that medical services are
759 effectively utilized, the agency may, in any case, require a
760 confirmation or second physician's opinion of the correct
761 diagnosis for purposes of authorizing future services under the
762 Medicaid program. This section does not restrict access to
763 emergency services or poststabilization care services as defined
764 in 42 C.F.R. part 438.114. Such confirmation or second opinion
765 shall be rendered in a manner approved by the agency. The agency
766 shall maximize the use of prepaid per capita and prepaid
767 aggregate fixed-sum basis services when appropriate and other
768 alternative service delivery and reimbursement methodologies,
769 including competitive bidding pursuant to s. 287.057, designed
770 to facilitate the cost-effective purchase of a case-managed
771 continuum of care. The agency shall also require providers to
772 minimize the exposure of recipients to the need for acute
773 inpatient, custodial, and other institutional care and the
774 inappropriate or unnecessary use of high-cost services. The
775 agency shall contract with a vendor to monitor and evaluate the
776 clinical practice patterns of providers in order to identify
777 trends that are outside the normal practice patterns of a
778 provider's professional peers or the national guidelines of a
779 provider's professional association. The vendor must be able to
780 provide information and counseling to a provider whose practice

781 patterns are outside the norms, in consultation with the agency,
782 to improve patient care and reduce inappropriate utilization.
783 The agency may mandate prior authorization, drug therapy
784 management, or disease management participation for certain
785 populations of Medicaid beneficiaries, certain drug classes, or
786 particular drugs to prevent fraud, abuse, overuse, and possible
787 dangerous drug interactions. The Pharmaceutical and Therapeutics
788 Committee shall make recommendations to the agency on drugs for
789 which prior authorization is required. The agency shall inform
790 the Pharmaceutical and Therapeutics Committee of its decisions
791 regarding drugs subject to prior authorization. The agency is
792 authorized to limit the entities it contracts with or enrolls as
793 Medicaid providers by developing a provider network through
794 provider credentialing. The agency may competitively bid single-
795 source-provider contracts if procurement of goods or services
796 results in demonstrated cost savings to the state without
797 limiting access to care. The agency may limit its network based
798 on the assessment of beneficiary access to care, provider
799 availability, provider quality standards, time and distance
800 standards for access to care, the cultural competence of the
801 provider network, demographic characteristics of Medicaid
802 beneficiaries, practice and provider-to-beneficiary standards,
803 appointment wait times, beneficiary use of services, provider
804 turnover, provider profiling, provider licensure history,
805 previous program integrity investigations and findings, peer
806 review, provider Medicaid policy and billing compliance records,
807 clinical and medical record audits, and other factors. Providers
808 are ~~shall~~ not ~~be~~ entitled to enrollment in the Medicaid provider

809 network. The agency shall determine instances in which allowing
810 Medicaid beneficiaries to purchase durable medical equipment and
811 other goods is less expensive to the Medicaid program than long-
812 term rental of the equipment or goods. The agency may establish
813 rules to facilitate purchases in lieu of long-term rentals in
814 order to protect against fraud and abuse in the Medicaid program
815 as defined in s. 409.913. The agency may seek federal waivers
816 necessary to administer these policies.
817 (1) The agency shall work with the Department of Children
818 and Family Services to ensure access of children and families in
819 the child protection system to needed and appropriate mental
820 health and substance abuse services. This subsection expires
821 October 1, 2014.
822 (2) The agency may enter into agreements with appropriate
823 agents of other state agencies or of any agency of the Federal
824 Government and accept such duties in respect to social welfare
825 or public aid as may be necessary to implement the provisions of
826 Title XIX of the Social Security Act and ss. 409.901-409.920.
827 This subsection expires October 1, 2016.
828 (3) The agency may contract with health maintenance
829 organizations certified pursuant to part I of chapter 641 for
830 the provision of services to recipients. This subsection expires
831 October 1, 2014.
832 (4) The agency may contract with:
833 (a) An entity that provides no prepaid health care
834 services other than Medicaid services under contract with the
835 agency and which is owned and operated by a county, county
836 health department, or county-owned and operated hospital to

837 provide health care services on a prepaid or fixed-sum basis to
838 recipients, which entity may provide such prepaid services
839 either directly or through arrangements with other providers.
840 Such prepaid health care services entities must be licensed
841 under parts I and III of chapter 641. An entity recognized under
842 this paragraph which demonstrates to the satisfaction of the
843 Office of Insurance Regulation of the Financial Services
844 Commission that it is backed by the full faith and credit of the
845 county in which it is located may be exempted from s. 641.225.
846 This paragraph expires October 1, 2014.
847 (b) An entity that is providing comprehensive behavioral
848 health care services to certain Medicaid recipients through a
849 capitated, prepaid arrangement pursuant to the federal waiver
850 provided for by s. 409.905(5). Such entity must be licensed
851 under chapter 624, chapter 636, or chapter 641, or authorized
852 under paragraph (c) or paragraph (d), and must possess the
853 clinical systems and operational competence to manage risk and
854 provide comprehensive behavioral health care to Medicaid
855 recipients. As used in this paragraph, the term "comprehensive
856 behavioral health care services" means covered mental health and
857 substance abuse treatment services that are available to
858 Medicaid recipients. The secretary of the Department of Children
859 and Family Services shall approve provisions of procurements
860 related to children in the department's care or custody before
861 enrolling such children in a prepaid behavioral health plan. Any
862 contract awarded under this paragraph must be competitively
863 procured. In developing the behavioral health care prepaid plan
864 procurement document, the agency shall ensure that the

865 procurement document requires the contractor to develop and
866 implement a plan to ensure compliance with s. 394.4574 related
867 to services provided to residents of licensed assisted living
868 facilities that hold a limited mental health license. Except as
869 provided in subparagraph 5. ~~8.~~, and except in counties where the
870 Medicaid managed care pilot program is authorized pursuant to s.
871 409.91211, the agency shall seek federal approval to contract
872 with a single entity meeting these requirements to provide
873 comprehensive behavioral health care services to all Medicaid
874 recipients not enrolled in a Medicaid managed care plan
875 authorized under s. 409.91211, a provider service network
876 authorized under paragraph (d), or a Medicaid health maintenance
877 organization in an AHCA area. In an AHCA area where the Medicaid
878 managed care pilot program is authorized pursuant to s.
879 409.91211 in one or more counties, the agency may procure a
880 contract with a single entity to serve the remaining counties as
881 an AHCA area or the remaining counties may be included with an
882 adjacent AHCA area and are subject to this paragraph. Each
883 entity must offer a sufficient choice of providers in its
884 network to ensure recipient access to care and the opportunity
885 to select a provider with whom they are satisfied. The network
886 shall include all public mental health hospitals. To ensure
887 unimpaired access to behavioral health care services by Medicaid
888 recipients, all contracts issued pursuant to this paragraph must
889 require 80 percent of the capitation paid to the managed care
890 plan, including health maintenance organizations and capitated
891 provider service networks, to be expended for the provision of
892 behavioral health care services. If the managed care plan

893 expends less than 80 percent of the capitation paid for the
894 provision of behavioral health care services, the difference
895 shall be returned to the agency. The agency shall provide the
896 plan with a certification letter indicating the amount of
897 capitation paid during each calendar year for behavioral health
898 care services pursuant to this section. The agency may reimburse
899 for substance abuse treatment services on a fee-for-service
900 basis until the agency finds that adequate funds are available
901 for capitated, prepaid arrangements.

902 1. ~~By January 1, 2001,~~ The agency shall modify the
903 contracts with the entities providing comprehensive inpatient
904 and outpatient mental health care services to Medicaid
905 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
906 Counties, to include substance abuse treatment services.

907 ~~2. By July 1, 2003, the agency and the Department of~~
908 ~~Children and Family Services shall execute a written agreement~~
909 ~~that requires collaboration and joint development of all policy,~~
910 ~~budgets, procurement documents, contracts, and monitoring plans~~
911 ~~that have an impact on the state and Medicaid community mental~~
912 ~~health and targeted case management programs.~~

913 2.~~3.~~ Except as provided in subparagraph 5. ~~8., by July 1,~~
914 ~~2006~~, the agency and the Department of Children and Family
915 Services shall contract with managed care entities in each AHCA
916 area except area 6 or arrange to provide comprehensive inpatient
917 and outpatient mental health and substance abuse services
918 through capitated prepaid arrangements to all Medicaid
919 recipients who are eligible to participate in such plans under
920 federal law and regulation. In AHCA areas where eligible

921 individuals number less than 150,000, the agency shall contract
922 with a single managed care plan to provide comprehensive
923 behavioral health services to all recipients who are not
924 enrolled in a Medicaid health maintenance organization, a
925 provider service network authorized under paragraph (d), or a
926 Medicaid capitated managed care plan authorized under s.
927 409.91211. The agency may contract with more than one
928 comprehensive behavioral health provider to provide care to
929 recipients who are not enrolled in a Medicaid capitated managed
930 care plan authorized under s. 409.91211, a provider service
931 network authorized under paragraph (d), or a Medicaid health
932 maintenance organization in AHCA areas where the eligible
933 population exceeds 150,000. In an AHCA area where the Medicaid
934 managed care pilot program is authorized pursuant to s.
935 409.91211 in one or more counties, the agency may procure a
936 contract with a single entity to serve the remaining counties as
937 an AHCA area or the remaining counties may be included with an
938 adjacent AHCA area and shall be subject to this paragraph.
939 Contracts for comprehensive behavioral health providers awarded
940 pursuant to this section shall be competitively procured. Both
941 for-profit and not-for-profit corporations are eligible to
942 compete. Managed care plans contracting with the agency under
943 subsection (3) or paragraph (d), shall provide and receive
944 payment for the same comprehensive behavioral health benefits as
945 provided in AHCA rules, including handbooks incorporated by
946 reference. In AHCA area 11, the agency shall contract with at
947 least two comprehensive behavioral health care providers to
948 provide behavioral health care to recipients in that area who

949 are enrolled in, or assigned to, the MediPass program. One of
950 the behavioral health care contracts must be with the existing
951 provider service network pilot project, as described in
952 paragraph (d), for the purpose of demonstrating the cost-
953 effectiveness of the provision of quality mental health services
954 through a public hospital-operated managed care model. Payment
955 shall be at an agreed-upon capitated rate to ensure cost
956 savings. Of the recipients in area 11 who are assigned to
957 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
958 MediPass-enrolled recipients shall be assigned to the existing
959 provider service network in area 11 for their behavioral care.
960 ~~4. By October 1, 2003, the agency and the department shall~~
961 ~~submit a plan to the Governor, the President of the Senate, and~~
962 ~~the Speaker of the House of Representatives which provides for~~
963 ~~the full implementation of capitated prepaid behavioral health~~
964 ~~care in all areas of the state.~~
965 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
966 ~~of the state where the agency is able to establish sufficient~~
967 ~~capitation rates.~~
968 ~~b. If the agency determines that the proposed capitation~~
969 ~~rate in any area is insufficient to provide appropriate~~
970 ~~services, the agency may adjust the capitation rate to ensure~~
971 ~~that care will be available. The agency and the department may~~
972 ~~use existing general revenue to address any additional required~~
973 ~~match but may not over-obligate existing funds on an annualized~~
974 ~~basis.~~
975 ~~c. Subject to any limitations provided in the General~~
976 ~~Appropriations Act, the agency, in compliance with appropriate~~

977 ~~federal authorization, shall develop policies and procedures~~
978 ~~that allow for certification of local and state funds.~~
979 3.~~5.~~ Children residing in a statewide inpatient
980 psychiatric program, or in a Department of Juvenile Justice or a
981 Department of Children and Family Services residential program
982 approved as a Medicaid behavioral health overlay services
983 provider may not be included in a behavioral health care prepaid
984 health plan or any other Medicaid managed care plan pursuant to
985 this paragraph.
986 ~~6. In converting to a prepaid system of delivery, the~~
987 ~~agency shall in its procurement document require an entity~~
988 ~~providing only comprehensive behavioral health care services to~~
989 ~~prevent the displacement of indigent care patients by enrollees~~
990 ~~in the Medicaid prepaid health plan providing behavioral health~~
991 ~~care services from facilities receiving state funding to provide~~
992 ~~indigent behavioral health care, to facilities licensed under~~
993 ~~chapter 395 which do not receive state funding for indigent~~
994 ~~behavioral health care, or reimburse the unsubsidized facility~~
995 ~~for the cost of behavioral health care provided to the displaced~~
996 ~~indigent care patient.~~
997 4.~~7.~~ Traditional community mental health providers under
998 contract with the Department of Children and Family Services
999 pursuant to part IV of chapter 394, child welfare providers
1000 under contract with the Department of Children and Family
1001 Services in areas 1 and 6, and inpatient mental health providers
1002 licensed pursuant to chapter 395 must be offered an opportunity
1003 to accept or decline a contract to participate in any provider
1004 network for prepaid behavioral health services.

1005 5.~~8.~~ All Medicaid-eligible children, except children in
1006 area 1 and children in Highlands County, Hardee County, Polk
1007 County, or Manatee County of area 6, that are open for child
1008 welfare services in the HomeSafeNet system, shall receive their
1009 behavioral health care services through a specialty prepaid plan
1010 operated by community-based lead agencies through a single
1011 agency or formal agreements among several agencies. The
1012 specialty prepaid plan must result in savings to the state
1013 comparable to savings achieved in other Medicaid managed care
1014 and prepaid programs. Such plan must provide mechanisms to
1015 maximize state and local revenues. The specialty prepaid plan
1016 shall be developed by the agency and the Department of Children
1017 and Family Services. The agency may seek federal waivers to
1018 implement this initiative. Medicaid-eligible children whose
1019 cases are open for child welfare services in the HomeSafeNet
1020 system and who reside in AHCA area 10 are exempt from the
1021 specialty prepaid plan upon the development of a service
1022 delivery mechanism for children who reside in area 10 as
1023 specified in s. 409.91211(3)(dd).
1024
1025 This paragraph expires October 1, 2014.
1026 (c) A federally qualified health center or an entity owned
1027 by one or more federally qualified health centers or an entity
1028 owned by other migrant and community health centers receiving
1029 non-Medicaid financial support from the Federal Government to
1030 provide health care services on a prepaid or fixed-sum basis to
1031 recipients. A federally qualified health center or an entity
1032 that is owned by one or more federally qualified health centers

1033 and is reimbursed by the agency on a prepaid basis is exempt
1034 from parts I and III of chapter 641, but must comply with the
1035 solvency requirements in s. 641.2261(2) and meet the appropriate
1036 requirements governing financial reserve, quality assurance, and
1037 patients' rights established by the agency. This paragraph
1038 expires October 1, 2014.
1039 (d)1. A provider service network may be reimbursed on a
1040 fee-for-service or prepaid basis. Prepaid provider service
1041 networks shall receive per-member, per-month payments. A
1042 provider service network that does not choose to be a prepaid
1043 plan shall receive fee-for-service rates with a shared savings
1044 settlement. The fee-for-service option shall be available to a
1045 provider service network only for the first 5 years of the
1046 plan's operation or until the contract year beginning October 1,
1047 2014, whichever is later. The agency shall annually conduct cost
1048 reconciliations to determine the amount of cost savings achieved
1049 by fee-for-service provider service networks for the dates of
1050 service in the period being reconciled. Only payments for
1051 covered services for dates of service within the reconciliation
1052 period and paid within 6 months after the last date of service
1053 in the reconciliation period shall be included. The agency shall
1054 perform the necessary adjustments for the inclusion of claims
1055 incurred but not reported within the reconciliation for claims
1056 that could be received and paid by the agency after the 6-month
1057 claims processing time lag. The agency shall provide the results
1058 of the reconciliations to the fee-for-service provider service
1059 networks within 45 days after the end of the reconciliation
1060 period. The fee-for-service provider service networks shall

1061 review and provide written comments or a letter of concurrence
1062 to the agency within 45 days after receipt of the reconciliation
1063 results. This reconciliation shall be considered final.
1064 2. A provider service network which is reimbursed by the
1065 agency on a prepaid basis shall be exempt from parts I and III
1066 of chapter 641, but must comply with the solvency requirements
1067 in s. 641.2261(2) and meet appropriate financial reserve,
1068 quality assurance, and patient rights requirements as
1069 established by the agency.
1070 3. Medicaid recipients assigned to a provider service
1071 network shall be chosen equally from those who would otherwise
1072 have been assigned to prepaid plans and MediPass. The agency is
1073 authorized to seek federal Medicaid waivers as necessary to
1074 implement the provisions of this section. This subparagraph
1075 expires October 1, 2014. ~~Any contract previously awarded to a~~
1076 ~~provider service network operated by a hospital pursuant to this~~
1077 ~~subsection shall remain in effect for a period of 3 years~~
1078 ~~following the current contract expiration date, regardless of~~
1079 ~~any contractual provisions to the contrary.~~
1080 4. A provider service network is a network established or
1081 organized and operated by a health care provider, or group of
1082 affiliated health care providers, including minority physician
1083 networks and emergency room diversion programs that meet the
1084 requirements of s. 409.91211, which provides a substantial
1085 proportion of the health care items and services under a
1086 contract directly through the provider or affiliated group of
1087 providers and may make arrangements with physicians or other
1088 health care professionals, health care institutions, or any

1089 combination of such individuals or institutions to assume all or
1090 part of the financial risk on a prospective basis for the
1091 provision of basic health services by the physicians, by other
1092 health professionals, or through the institutions. The health
1093 care providers must have a controlling interest in the governing
1094 body of the provider service network organization.

1095 (e) An entity that provides only comprehensive behavioral
1096 health care services to certain Medicaid recipients through an
1097 administrative services organization agreement. Such an entity
1098 must possess the clinical systems and operational competence to
1099 provide comprehensive health care to Medicaid recipients. As
1100 used in this paragraph, the term "comprehensive behavioral
1101 health care services" means covered mental health and substance
1102 abuse treatment services that are available to Medicaid
1103 recipients. Any contract awarded under this paragraph must be
1104 competitively procured. The agency must ensure that Medicaid
1105 recipients have available the choice of at least two managed
1106 care plans for their behavioral health care services. This
1107 paragraph expires October 1, 2014.

1108 ~~(f) An entity that provides in-home physician services to~~
1109 ~~test the cost-effectiveness of enhanced home-based medical care~~
1110 ~~to Medicaid recipients with degenerative neurological diseases~~
1111 ~~and other diseases or disabling conditions associated with high~~
1112 ~~costs to Medicaid. The program shall be designed to serve very~~
1113 ~~disabled persons and to reduce Medicaid reimbursed costs for~~
1114 ~~inpatient, outpatient, and emergency department services. The~~
1115 ~~agency shall contract with vendors on a risk-sharing basis.~~

1116 ~~(g) Children's provider networks that provide care~~

1117 ~~coordination and care management for Medicaid-eligible pediatric~~
1118 ~~patients, primary care, authorization of specialty care, and~~
1119 ~~other urgent and emergency care through organized providers~~
1120 ~~designed to service Medicaid eligibles under age 18 and~~
1121 ~~pediatric emergency departments' diversion programs. The~~
1122 ~~networks shall provide after-hour operations, including evening~~
1123 ~~and weekend hours, to promote, when appropriate, the use of the~~
1124 ~~children's networks rather than hospital emergency departments.~~
1125 (f)~~(h)~~ An entity authorized in s. 430.205 to contract with
1126 the agency and the Department of Elderly Affairs to provide
1127 health care and social services on a prepaid or fixed-sum basis
1128 to elderly recipients. Such prepaid health care services
1129 entities are exempt from the provisions of part I of chapter 641
1130 for the first 3 years of operation. An entity recognized under
1131 this paragraph that demonstrates to the satisfaction of the
1132 Office of Insurance Regulation that it is backed by the full
1133 faith and credit of one or more counties in which it operates
1134 may be exempted from s. 641.225. This paragraph expires October
1135 1, 2013.
1136 (g)~~(i)~~ A Children's Medical Services Network, as defined
1137 in s. 391.021. This paragraph expires October 1, 2014.
1138 ~~(5) The Agency for Health Care Administration, in~~
1139 ~~partnership with the Department of Elderly Affairs, shall create~~
1140 ~~an integrated, fixed-payment delivery program for Medicaid~~
1141 ~~recipients who are 60 years of age or older or dually eligible~~
1142 ~~for Medicare and Medicaid. The Agency for Health Care~~
1143 ~~Administration shall implement the integrated program initially~~
1144 ~~on a pilot basis in two areas of the state. The pilot areas~~

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1145 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
1146 ~~Administration. Enrollment in the pilot areas shall be on a~~
1147 ~~voluntary basis and in accordance with approved federal waivers~~
1148 ~~and this section. The agency and its program contractors and~~
1149 ~~providers shall not enroll any individual in the integrated~~
1150 ~~program because the individual or the person legally responsible~~
1151 ~~for the individual fails to choose to enroll in the integrated~~
1152 ~~program. Enrollment in the integrated program shall be~~
1153 ~~exclusively by affirmative choice of the eligible individual or~~
1154 ~~by the person legally responsible for the individual. The~~
1155 ~~integrated program must transfer all Medicaid services for~~
1156 ~~eligible elderly individuals who choose to participate into an~~
1157 ~~integrated-care management model designed to serve Medicaid~~
1158 ~~recipients in the community. The integrated program must combine~~
1159 ~~all funding for Medicaid services provided to individuals who~~
1160 ~~are 60 years of age or older or dually eligible for Medicare and~~
1161 ~~Medicaid into the integrated program, including funds for~~
1162 ~~Medicaid home and community-based waiver services; all Medicaid~~
1163 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
1164 ~~for Medicaid nursing home services unless the agency is able to~~
1165 ~~demonstrate how the integration of the funds will improve~~
1166 ~~coordinated care for these services in a less costly manner; and~~
1167 ~~Medicare coinsurance and deductibles for persons dually eligible~~
1168 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~
1169 ~~(a) Individuals who are 60 years of age or older or dually~~
1170 ~~eligible for Medicare and Medicaid and enrolled in the~~
1171 ~~developmental disabilities waiver program, the family and~~
1172 ~~supported-living waiver program, the project AIDS care waiver~~

1173 ~~program, the traumatic brain injury and spinal cord injury~~
1174 ~~waiver program, the consumer-directed care waiver program, and~~
1175 ~~the program of all-inclusive care for the elderly program, and~~
1176 ~~residents of institutional care facilities for the~~
1177 ~~developmentally disabled, must be excluded from the integrated~~
1178 ~~program.~~
1179 ~~(b) Managed care entities who meet or exceed the agency's~~
1180 ~~minimum standards are eligible to operate the integrated~~
1181 ~~program. Entities eligible to participate include managed care~~
1182 ~~organizations licensed under chapter 641, including entities~~
1183 ~~eligible to participate in the nursing home diversion program,~~
1184 ~~other qualified providers as defined in s. 430.703(7), community~~
1185 ~~care for the elderly lead agencies, and other state-certified~~
1186 ~~community service networks that meet comparable standards as~~
1187 ~~defined by the agency, in consultation with the Department of~~
1188 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~
1189 ~~financially solvent and able to take on financial risk for~~
1190 ~~managed care. Community service networks that are certified~~
1191 ~~pursuant to the comparable standards defined by the agency are~~
1192 ~~not required to be licensed under chapter 641. Managed care~~
1193 ~~entities who operate the integrated program shall be subject to~~
1194 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
1195 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~
1196 ~~are 60 years of age or older, or both.~~
1197 ~~(c) The agency must ensure that the capitation-rate-~~
1198 ~~setting methodology for the integrated program is actuarially~~
1199 ~~sound and reflects the intent to provide quality care in the~~
1200 ~~least restrictive setting. The agency must also require~~

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1201 ~~integrated-program providers to develop a credentialing system~~
1202 ~~for service providers and to contract with all Gold Seal nursing~~
1203 ~~homes, where feasible, and exclude, where feasible, chronically~~
1204 ~~poor-performing facilities and providers as defined by the~~
1205 ~~agency. The integrated program must develop and maintain an~~
1206 ~~informal provider grievance system that addresses provider~~
1207 ~~payment and contract problems. The agency shall also establish a~~
1208 ~~formal grievance system to address those issues that were not~~
1209 ~~resolved through the informal grievance system. The integrated~~
1210 ~~program must provide that if the recipient resides in a~~
1211 ~~noncontracted residential facility licensed under chapter 400 or~~
1212 ~~chapter 429 at the time of enrollment in the integrated program,~~
1213 ~~the recipient must be permitted to continue to reside in the~~
1214 ~~noncontracted facility as long as the recipient desires. The~~
1215 ~~integrated program must also provide that, in the absence of a~~
1216 ~~contract between the integrated-program provider and the~~
1217 ~~residential facility licensed under chapter 400 or chapter 429,~~
1218 ~~current Medicaid rates must prevail. The integrated-program~~
1219 ~~provider must ensure that electronic nursing home claims that~~
1220 ~~contain sufficient information for processing are paid within 10~~
1221 ~~business days after receipt. Alternately, the integrated-program~~
1222 ~~provider may establish a capitated payment mechanism to~~
1223 ~~prospectively pay nursing homes at the beginning of each month.~~
1224 ~~The agency and the Department of Elderly Affairs must jointly~~
1225 ~~develop procedures to manage the services provided through the~~
1226 ~~integrated program in order to ensure quality and recipient~~
1227 ~~choice.~~
1228 ~~(d) The Office of Program Policy Analysis and Government~~

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1229 ~~Accountability, in consultation with the Auditor General, shall~~
1230 ~~comprehensively evaluate the pilot project for the integrated,~~
1231 ~~fixed-payment delivery program for Medicaid recipients created~~
1232 ~~under this subsection. The evaluation shall begin as soon as~~
1233 ~~Medicaid recipients are enrolled in the managed care pilot~~
1234 ~~program plans and shall continue for 24 months thereafter. The~~
1235 ~~evaluation must include assessments of each managed care plan in~~
1236 ~~the integrated program with regard to cost savings; consumer~~
1237 ~~education, choice, and access to services; coordination of care;~~
1238 ~~and quality of care. The evaluation must describe administrative~~
1239 ~~or legal barriers to the implementation and operation of the~~
1240 ~~pilot program and include recommendations regarding statewide~~
1241 ~~expansion of the pilot program. The office shall submit its~~
1242 ~~evaluation report to the Governor, the President of the Senate,~~
1243 ~~and the Speaker of the House of Representatives no later than~~
1244 ~~December 31, 2009.~~
1245 ~~(e) The agency may seek federal waivers or Medicaid state~~
1246 ~~plan amendments and adopt rules as necessary to administer the~~
1247 ~~integrated program. The agency may implement the approved~~
1248 ~~federal waivers and other provisions as specified in this~~
1249 ~~subsection.~~
1250 ~~(f) The implementation of the integrated, fixed-payment~~
1251 ~~delivery program created under this subsection is subject to an~~
1252 ~~appropriation in the General Appropriations Act.~~
1253 (5) ~~(6)~~ The agency may contract with any public or private
1254 entity otherwise authorized by this section on a prepaid or
1255 fixed-sum basis for the provision of health care services to
1256 recipients. An entity may provide prepaid services to

1257 recipients, either directly or through arrangements with other
1258 entities, if each entity involved in providing services:
1259 (a) Is organized primarily for the purpose of providing
1260 health care or other services of the type regularly offered to
1261 Medicaid recipients;
1262 (b) Ensures that services meet the standards set by the
1263 agency for quality, appropriateness, and timeliness;
1264 (c) Makes provisions satisfactory to the agency for
1265 insolvency protection and ensures that neither enrolled Medicaid
1266 recipients nor the agency will be liable for the debts of the
1267 entity;
1268 (d) Submits to the agency, if a private entity, a
1269 financial plan that the agency finds to be fiscally sound and
1270 that provides for working capital in the form of cash or
1271 equivalent liquid assets excluding revenues from Medicaid
1272 premium payments equal to at least the first 3 months of
1273 operating expenses or $200,000, whichever is greater;
1274 (e) Furnishes evidence satisfactory to the agency of
1275 adequate liability insurance coverage or an adequate plan of
1276 self-insurance to respond to claims for injuries arising out of
1277 the furnishing of health care;
1278 (f) Provides, through contract or otherwise, for periodic
1279 review of its medical facilities and services, as required by
1280 the agency; and
1281 (g) Provides organizational, operational, financial, and
1282 other information required by the agency.
1283
1284 This subsection expires October 1, 2014.

1285 (6)~~(7)~~ The agency may contract on a prepaid or fixed-sum
1286 basis with any health insurer that:
1287 (a) Pays for health care services provided to enrolled
1288 Medicaid recipients in exchange for a premium payment paid by
1289 the agency;
1290 (b) Assumes the underwriting risk; and
1291 (c) Is organized and licensed under applicable provisions
1292 of the Florida Insurance Code and is currently in good standing
1293 with the Office of Insurance Regulation.
1294
1295 This subsection expires October 1, 2014.
1296 (7)~~(8)(a)~~ The agency may contract on a prepaid or fixed-
1297 sum basis with an exclusive provider organization to provide
1298 health care services to Medicaid recipients provided that the
1299 exclusive provider organization meets applicable managed care
1300 plan requirements in this section, ss. 409.9122, 409.9123,
1301 409.9128, and 627.6472, and other applicable provisions of law.
1302 This subsection expires October 1, 2014.
1303 ~~(b) For a period of no longer than 24 months after the~~
1304 ~~effective date of this paragraph, when a member of an exclusive~~
1305 ~~provider organization that is contracted by the agency to~~
1306 ~~provide health care services to Medicaid recipients in rural~~
1307 ~~areas without a health maintenance organization obtains services~~
1308 ~~from a provider that participates in the Medicaid program in~~
1309 ~~this state, the provider shall be paid in accordance with the~~
1310 ~~appropriate fee schedule for services provided to eligible~~
1311 ~~Medicaid recipients. The agency may seek waiver authority to~~
1312 ~~implement this paragraph.~~

1313 (8) ~~(9)~~ The Agency for Health Care Administration may
1314 provide cost-effective purchasing of chiropractic services on a
1315 fee-for-service basis to Medicaid recipients through
1316 arrangements with a statewide chiropractic preferred provider
1317 organization incorporated in this state as a not-for-profit
1318 corporation. The agency shall ensure that the benefit limits and
1319 prior authorization requirements in the current Medicaid program
1320 shall apply to the services provided by the chiropractic
1321 preferred provider organization. This subsection expires October
1322 1, 2014.
1323 (9) ~~(10)~~ The agency shall not contract on a prepaid or
1324 fixed-sum basis for Medicaid services with an entity which knows
1325 or reasonably should know that any officer, director, agent,
1326 managing employee, or owner of stock or beneficial interest in
1327 excess of 5 percent common or preferred stock, or the entity
1328 itself, has been found guilty of, regardless of adjudication, or
1329 entered a plea of nolo contendere, or guilty, to:
1330 (a) Fraud;
1331 (b) Violation of federal or state antitrust statutes,
1332 including those proscribing price fixing between competitors and
1333 the allocation of customers among competitors;
1334 (c) Commission of a felony involving embezzlement, theft,
1335 forgery, income tax evasion, bribery, falsification or
1336 destruction of records, making false statements, receiving
1337 stolen property, making false claims, or obstruction of justice;
1338 or
1339 (d) Any crime in any jurisdiction which directly relates
1340 to the provision of health services on a prepaid or fixed-sum

1341 basis.
1342
1343 This subsection expires October 1, 2014.
1344 (10) ~~(11)~~ The agency, after notifying the Legislature, may
1345 apply for waivers of applicable federal laws and regulations as
1346 necessary to implement more appropriate systems of health care
1347 for Medicaid recipients and reduce the cost of the Medicaid
1348 program to the state and federal governments and shall implement
1349 such programs, after legislative approval, within a reasonable
1350 period of time after federal approval. These programs must be
1351 designed primarily to reduce the need for inpatient care,
1352 custodial care and other long-term or institutional care, and
1353 other high-cost services. Prior to seeking legislative approval
1354 of such a waiver as authorized by this subsection, the agency
1355 shall provide notice and an opportunity for public comment.
1356 Notice shall be provided to all persons who have made requests
1357 of the agency for advance notice and shall be published in the
1358 Florida Administrative Weekly not less than 28 days prior to the
1359 intended action. This subsection expires October 1, 2016.
1360 (11) ~~(12)~~ The agency shall establish a postpayment
1361 utilization control program designed to identify recipients who
1362 may inappropriately overuse or underuse Medicaid services and
1363 shall provide methods to correct such misuse. This subsection
1364 expires October 1, 2014.
1365 (12) ~~(13)~~ The agency shall develop and provide coordinated
1366 systems of care for Medicaid recipients and may contract with
1367 public or private entities to develop and administer such
1368 systems of care among public and private health care providers

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1369 in a given geographic area. This subsection expires October 1,
1370 2014.
1371 (13) ~~(14)(a)~~ The agency shall operate or contract for the
1372 operation of utilization management and incentive systems
1373 designed to encourage cost-effective use of services and to
1374 eliminate services that are medically unnecessary. The agency
1375 shall track Medicaid provider prescription and billing patterns
1376 and evaluate them against Medicaid medical necessity criteria
1377 and coverage and limitation guidelines adopted by rule. Medical
1378 necessity determination requires that service be consistent with
1379 symptoms or confirmed diagnosis of illness or injury under
1380 treatment and not in excess of the patient's needs. The agency
1381 shall conduct reviews of provider exceptions to peer group norms
1382 and shall, using statistical methodologies, provider profiling,
1383 and analysis of billing patterns, detect and investigate
1384 abnormal or unusual increases in billing or payment of claims
1385 for Medicaid services and medically unnecessary provision of
1386 services. Providers that demonstrate a pattern of submitting
1387 claims for medically unnecessary services shall be referred to
1388 the Medicaid program integrity unit for investigation. In its
1389 annual report, required in s. 409.913, the agency shall report
1390 on its efforts to control overutilization as described in this
1391 subsection ~~paragraph~~. This subsection expires October 1, 2014.
1392 ~~(b) The agency shall develop a procedure for determining~~
1393 ~~whether health care providers and service vendors can provide~~
1394 ~~the Medicaid program using a business case that demonstrates~~
1395 ~~whether a particular good or service can offset the cost of~~
1396 ~~providing the good or service in an alternative setting or~~

1397 ~~through other means and therefore should receive a higher~~
1398 ~~reimbursement. The business case must include, but need not be~~
1399 ~~limited to:~~
1400 ~~1. A detailed description of the good or service to be~~
1401 ~~provided, a description and analysis of the agency's current~~
1402 ~~performance of the service, and a rationale documenting how~~
1403 ~~providing the service in an alternative setting would be in the~~
1404 ~~best interest of the state, the agency, and its clients.~~
1405 ~~2. A cost-benefit analysis documenting the estimated~~
1406 ~~specific direct and indirect costs, savings, performance~~
1407 ~~improvements, risks, and qualitative and quantitative benefits~~
1408 ~~involved in or resulting from providing the service. The cost-~~
1409 ~~benefit analysis must include a detailed plan and timeline~~
1410 ~~identifying all actions that must be implemented to realize~~
1411 ~~expected benefits. The Secretary of Health Care Administration~~
1412 ~~shall verify that all costs, savings, and benefits are valid and~~
1413 ~~achievable.~~
1414 ~~(c) If the agency determines that the increased~~
1415 ~~reimbursement is cost-effective, the agency shall recommend a~~
1416 ~~change in the reimbursement schedule for that particular good or~~
1417 ~~service. If, within 12 months after implementing any rate change~~
1418 ~~under this procedure, the agency determines that costs were not~~
1419 ~~offset by the increased reimbursement schedule, the agency may~~
1420 ~~revert to the former reimbursement schedule for the particular~~
1421 ~~good or service.~~
1422 (14) ~~(15)~~(a) The agency shall operate the Comprehensive
1423 Assessment and Review for Long-Term Care Services (CARES)
1424 nursing facility preadmission screening program to ensure that

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1425 Medicaid payment for nursing facility care is made only for
1426 individuals whose conditions require such care and to ensure
1427 that long-term care services are provided in the setting most
1428 appropriate to the needs of the person and in the most
1429 economical manner possible. The CARES program shall also ensure
1430 that individuals participating in Medicaid home and community-
1431 based waiver programs meet criteria for those programs,
1432 consistent with approved federal waivers.
1433 (b) The agency shall operate the CARES program through an
1434 interagency agreement with the Department of Elderly Affairs.
1435 The agency, in consultation with the Department of Elderly
1436 Affairs, may contract for any function or activity of the CARES
1437 program, including any function or activity required by 42
1438 C.F.R. part 483.20, relating to preadmission screening and
1439 resident review.
1440 (c) Prior to making payment for nursing facility services
1441 for a Medicaid recipient, the agency must verify that the
1442 nursing facility preadmission screening program has determined
1443 that the individual requires nursing facility care and that the
1444 individual cannot be safely served in community-based programs.
1445 The nursing facility preadmission screening program shall refer
1446 a Medicaid recipient to a community-based program if the
1447 individual could be safely served at a lower cost and the
1448 recipient chooses to participate in such program. For
1449 individuals whose nursing home stay is initially funded by
1450 Medicare and Medicare coverage is being terminated for lack of
1451 progress towards rehabilitation, CARES staff shall consult with
1452 the person making the determination of progress toward

1453 rehabilitation to ensure that the recipient is not being
1454 inappropriately disqualified from Medicare coverage. If, in
1455 their professional judgment, CARES staff believes that a
1456 Medicare beneficiary is still making progress toward
1457 rehabilitation, they may assist the Medicare beneficiary with an
1458 appeal of the disqualification from Medicare coverage. The use
1459 of CARES teams to review Medicare denials for coverage under
1460 this section is authorized only if it is determined that such
1461 reviews qualify for federal matching funds through Medicaid. The
1462 agency shall seek or amend federal waivers as necessary to
1463 implement this section.
1464 (d) For the purpose of initiating immediate prescreening
1465 and diversion assistance for individuals residing in nursing
1466 homes and in order to make families aware of alternative long-
1467 term care resources so that they may choose a more cost-
1468 effective setting for long-term placement, CARES staff shall
1469 conduct an assessment and review of a sample of individuals
1470 whose nursing home stay is expected to exceed 20 days,
1471 regardless of the initial funding source for the nursing home
1472 placement. CARES staff shall provide counseling and referral
1473 services to these individuals regarding choosing appropriate
1474 long-term care alternatives. This paragraph does not apply to
1475 continuing care facilities licensed under chapter 651 or to
1476 retirement communities that provide a combination of nursing
1477 home, independent living, and other long-term care services.
1478 (e) By January 15 of each year, the agency shall submit a
1479 report to the Legislature describing the operations of the CARES
1480 program. The report must describe:

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1481 1. Rate of diversion to community alternative programs;
1482 2. CARES program staffing needs to achieve additional
1483 diversions;
1484 3. Reasons the program is unable to place individuals in
1485 less restrictive settings when such individuals desired such
1486 services and could have been served in such settings;
1487 4. Barriers to appropriate placement, including barriers
1488 due to policies or operations of other agencies or state-funded
1489 programs; and
1490 5. Statutory changes necessary to ensure that individuals
1491 in need of long-term care services receive care in the least
1492 restrictive environment.
1493 (f) The Department of Elderly Affairs shall track
1494 individuals over time who are assessed under the CARES program
1495 and who are diverted from nursing home placement. By January 15
1496 of each year, the department shall submit to the Legislature a
1497 longitudinal study of the individuals who are diverted from
1498 nursing home placement. The study must include:
1499 1. The demographic characteristics of the individuals
1500 assessed and diverted from nursing home placement, including,
1501 but not limited to, age, race, gender, frailty, caregiver
1502 status, living arrangements, and geographic location;
1503 2. A summary of community services provided to individuals
1504 for 1 year after assessment and diversion;
1505 3. A summary of inpatient hospital admissions for
1506 individuals who have been diverted; and
1507 4. A summary of the length of time between diversion and
1508 subsequent entry into a nursing home or death.

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1509

1510 This subsection expires October 1, 2013.

1511 (15) ~~(16)~~ (a) The agency shall identify health care
1512 utilization and price patterns within the Medicaid program which
1513 are not cost-effective or medically appropriate and assess the
1514 effectiveness of new or alternate methods of providing and
1515 monitoring service, and may implement such methods as it
1516 considers appropriate. Such methods may include disease
1517 management initiatives, an integrated and systematic approach
1518 for managing the health care needs of recipients who are at risk
1519 of or diagnosed with a specific disease by using best practices,
1520 prevention strategies, clinical-practice improvement, clinical
1521 interventions and protocols, outcomes research, information
1522 technology, and other tools and resources to reduce overall
1523 costs and improve measurable outcomes.

1524 (b) The responsibility of the agency under this subsection
1525 shall include the development of capabilities to identify actual
1526 and optimal practice patterns; patient and provider educational
1527 initiatives; methods for determining patient compliance with
1528 prescribed treatments; fraud, waste, and abuse prevention and
1529 detection programs; and beneficiary case management programs.

1530 1. The practice pattern identification program shall
1531 evaluate practitioner prescribing patterns based on national and
1532 regional practice guidelines, comparing practitioners to their
1533 peer groups. The agency and its Drug Utilization Review Board
1534 shall consult with the Department of Health and a panel of
1535 practicing health care professionals consisting of the
1536 following: the Speaker of the House of Representatives and the

1537 President of the Senate shall each appoint three physicians
1538 licensed under chapter 458 or chapter 459; and the Governor
1539 shall appoint two pharmacists licensed under chapter 465 and one
1540 dentist licensed under chapter 466 who is an oral surgeon. Terms
1541 of the panel members shall expire at the discretion of the
1542 appointing official. The advisory panel shall be responsible for
1543 evaluating treatment guidelines and recommending ways to
1544 incorporate their use in the practice pattern identification
1545 program. Practitioners who are prescribing inappropriately or
1546 inefficiently, as determined by the agency, may have their
1547 prescribing of certain drugs subject to prior authorization or
1548 may be terminated from all participation in the Medicaid
1549 program.

1550 2. The agency shall also develop educational interventions
1551 designed to promote the proper use of medications by providers
1552 and beneficiaries.

1553 3. The agency shall implement a pharmacy fraud, waste, and
1554 abuse initiative that may include a surety bond or letter of
1555 credit requirement for participating pharmacies, enhanced
1556 provider auditing practices, the use of additional fraud and
1557 abuse software, recipient management programs for beneficiaries
1558 inappropriately using their benefits, and other steps that will
1559 eliminate provider and recipient fraud, waste, and abuse. The
1560 initiative shall address enforcement efforts to reduce the
1561 number and use of counterfeit prescriptions.

1562 4. By September 30, 2002, the agency shall contract with
1563 an entity in the state to implement a wireless handheld clinical
1564 pharmacology drug information database for practitioners. The

1565 initiative shall be designed to enhance the agency's efforts to
1566 reduce fraud, abuse, and errors in the prescription drug benefit
1567 program and to otherwise further the intent of this paragraph.
1568 5. By April 1, 2006, the agency shall contract with an
1569 entity to design a database of clinical utilization information
1570 or electronic medical records for Medicaid providers. This
1571 system must be web-based and allow providers to review on a
1572 real-time basis the utilization of Medicaid services, including,
1573 but not limited to, physician office visits, inpatient and
1574 outpatient hospitalizations, laboratory and pathology services,
1575 radiological and other imaging services, dental care, and
1576 patterns of dispensing prescription drugs in order to coordinate
1577 care and identify potential fraud and abuse.
1578 6. The agency may apply for any federal waivers needed to
1579 administer this paragraph.
1580
1581 This subsection expires October 1, 2014.
1582 (16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum
1583 basis shall meet the surplus requirements of s. 641.225. If an
1584 entity's surplus falls below an amount equal to the surplus
1585 requirements of s. 641.225, the agency shall prohibit the entity
1586 from engaging in marketing and preenrollment activities, shall
1587 cease to process new enrollments, and may not renew the entity's
1588 contract until the required balance is achieved. The
1589 requirements of this subsection do not apply:
1590 (a) Where a public entity agrees to fund any deficit
1591 incurred by the contracting entity; or
1592 (b) Where the entity's performance and obligations are

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1593 guaranteed in writing by a guaranteeing organization which:
1594 1. Has been in operation for at least 5 years and has
1595 assets in excess of $50 million; or
1596 2. Submits a written guarantee acceptable to the agency
1597 which is irrevocable during the term of the contracting entity's
1598 contract with the agency and, upon termination of the contract,
1599 until the agency receives proof of satisfaction of all
1600 outstanding obligations incurred under the contract.
1601
1602 This subsection expires October 1, 2014.
1603 (17) ~~(18)~~ (a) The agency may require an entity contracting
1604 on a prepaid or fixed-sum basis to establish a restricted
1605 insolvency protection account with a federally guaranteed
1606 financial institution licensed to do business in this state. The
1607 entity shall deposit into that account 5 percent of the
1608 capitation payments made by the agency each month until a
1609 maximum total of 2 percent of the total current contract amount
1610 is reached. The restricted insolvency protection account may be
1611 drawn upon with the authorized signatures of two persons
1612 designated by the entity and two representatives of the agency.
1613 If the agency finds that the entity is insolvent, the agency may
1614 draw upon the account solely with the two authorized signatures
1615 of representatives of the agency, and the funds may be disbursed
1616 to meet financial obligations incurred by the entity under the
1617 prepaid contract. If the contract is terminated, expired, or not
1618 continued, the account balance must be released by the agency to
1619 the entity upon receipt of proof of satisfaction of all
1620 outstanding obligations incurred under this contract.

1621 (b) The agency may waive the insolvency protection account
1622 requirement in writing when evidence is on file with the agency
1623 of adequate insolvency insurance and reinsurance that will
1624 protect enrollees if the entity becomes unable to meet its
1625 obligations.
1626
1627 This subsection expires October 1, 2014.
1628 (18) ~~(19)~~ An entity that contracts with the agency on a
1629 prepaid or fixed-sum basis for the provision of Medicaid
1630 services shall reimburse any hospital or physician that is
1631 outside the entity's authorized geographic service area as
1632 specified in its contract with the agency, and that provides
1633 services authorized by the entity to its members, at a rate
1634 negotiated with the hospital or physician for the provision of
1635 services or according to the lesser of the following:
1636 (a) The usual and customary charges made to the general
1637 public by the hospital or physician; or
1638 (b) The Florida Medicaid reimbursement rate established
1639 for the hospital or physician.
1640
1641 This subsection expires October 1, 2014.
1642 (19) ~~(20)~~ When a merger or acquisition of a Medicaid
1643 prepaid contractor has been approved by the Office of Insurance
1644 Regulation pursuant to s. 628.4615, the agency shall approve the
1645 assignment or transfer of the appropriate Medicaid prepaid
1646 contract upon request of the surviving entity of the merger or
1647 acquisition if the contractor and the other entity have been in
1648 good standing with the agency for the most recent 12-month

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1649 period, unless the agency determines that the assignment or
1650 transfer would be detrimental to the Medicaid recipients or the
1651 Medicaid program. To be in good standing, an entity must not
1652 have failed accreditation or committed any material violation of
1653 the requirements of s. 641.52 and must meet the Medicaid
1654 contract requirements. For purposes of this section, a merger or
1655 acquisition means a change in controlling interest of an entity,
1656 including an asset or stock purchase. This subsection expires
1657 October 1, 2014.
1658 (20) ~~(21)~~ Any entity contracting with the agency pursuant
1659 to this section to provide health care services to Medicaid
1660 recipients is prohibited from engaging in any of the following
1661 practices or activities:
1662 (a) Practices that are discriminatory, including, but not
1663 limited to, attempts to discourage participation on the basis of
1664 actual or perceived health status.
1665 (b) Activities that could mislead or confuse recipients,
1666 or misrepresent the organization, its marketing representatives,
1667 or the agency. Violations of this paragraph include, but are not
1668 limited to:
1669 1. False or misleading claims that marketing
1670 representatives are employees or representatives of the state or
1671 county, or of anyone other than the entity or the organization
1672 by whom they are reimbursed.
1673 2. False or misleading claims that the entity is
1674 recommended or endorsed by any state or county agency, or by any
1675 other organization which has not certified its endorsement in
1676 writing to the entity.

1677 3. False or misleading claims that the state or county
1678 recommends that a Medicaid recipient enroll with an entity.
1679 4. Claims that a Medicaid recipient will lose benefits
1680 under the Medicaid program, or any other health or welfare
1681 benefits to which the recipient is legally entitled, if the
1682 recipient does not enroll with the entity.
1683 (c) Granting or offering of any monetary or other valuable
1684 consideration for enrollment, except as authorized by subsection
1685 (23) ~~(24)~~.
1686 (d) Door-to-door solicitation of recipients who have not
1687 contacted the entity or who have not invited the entity to make
1688 a presentation.
1689 (e) Solicitation of Medicaid recipients by marketing
1690 representatives stationed in state offices unless approved and
1691 supervised by the agency or its agent and approved by the
1692 affected state agency when solicitation occurs in an office of
1693 the state agency. The agency shall ensure that marketing
1694 representatives stationed in state offices shall market their
1695 managed care plans to Medicaid recipients only in designated
1696 areas and in such a way as to not interfere with the recipients'
1697 activities in the state office.
1698 (f) Enrollment of Medicaid recipients.
1699
1700 This subsection expires October 1, 2014.
1701 (21) ~~(22)~~ The agency may impose a fine for a violation of
1702 this section or the contract with the agency by a person or
1703 entity that is under contract with the agency. With respect to
1704 any nonwillful violation, such fine shall not exceed $2,500 per

1705 violation. In no event shall such fine exceed an aggregate
1706 amount of $10,000 for all nonwillful violations arising out of
1707 the same action. With respect to any knowing and willful
1708 violation of this section or the contract with the agency, the
1709 agency may impose a fine upon the entity in an amount not to
1710 exceed $20,000 for each such violation. In no event shall such
1711 fine exceed an aggregate amount of $100,000 for all knowing and
1712 willful violations arising out of the same action. This
1713 subsection expires October 1, 2014.
1714 (22) ~~(23)~~ A health maintenance organization or a person or
1715 entity exempt from chapter 641 that is under contract with the
1716 agency for the provision of health care services to Medicaid
1717 recipients may not use or distribute marketing materials used to
1718 solicit Medicaid recipients, unless such materials have been
1719 approved by the agency. The provisions of this subsection do not
1720 apply to general advertising and marketing materials used by a
1721 health maintenance organization to solicit both non-Medicaid
1722 subscribers and Medicaid recipients. This subsection expires
1723 October 1, 2014.
1724 (23) ~~(24)~~ Upon approval by the agency, health maintenance
1725 organizations and persons or entities exempt from chapter 641
1726 that are under contract with the agency for the provision of
1727 health care services to Medicaid recipients may be permitted
1728 within the capitation rate to provide additional health benefits
1729 that the agency has found are of high quality, are practicably
1730 available, provide reasonable value to the recipient, and are
1731 provided at no additional cost to the state. This subsection
1732 expires October 1, 2014.

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1733 (24) ~~(25)~~ The agency shall utilize the statewide health
1734 maintenance organization complaint hotline for the purpose of
1735 investigating and resolving Medicaid and prepaid health plan
1736 complaints, maintaining a record of complaints and confirmed
1737 problems, and receiving disenrollment requests made by
1738 recipients. This subsection expires October 1, 2014.
1739 (25) ~~(26)~~ The agency shall require the publication of the
1740 health maintenance organization's and the prepaid health plan's
1741 consumer services telephone numbers and the "800" telephone
1742 number of the statewide health maintenance organization
1743 complaint hotline on each Medicaid identification card issued by
1744 a health maintenance organization or prepaid health plan
1745 contracting with the agency to serve Medicaid recipients and on
1746 each subscriber handbook issued to a Medicaid recipient. This
1747 subsection expires October 1, 2014.
1748 (26) ~~(27)~~ The agency shall establish a health care quality
1749 improvement system for those entities contracting with the
1750 agency pursuant to this section, incorporating all the standards
1751 and guidelines developed by the Medicaid Bureau of the Health
1752 Care Financing Administration as a part of the quality assurance
1753 reform initiative. The system shall include, but need not be
1754 limited to, the following:
1755 (a) Guidelines for internal quality assurance programs,
1756 including standards for:
1757 1. Written quality assurance program descriptions.
1758 2. Responsibilities of the governing body for monitoring,
1759 evaluating, and making improvements to care.
1760 3. An active quality assurance committee.

1761 4. Quality assurance program supervision.
1762 5. Requiring the program to have adequate resources to
1763 effectively carry out its specified activities.
1764 6. Provider participation in the quality assurance
1765 program.
1766 7. Delegation of quality assurance program activities.
1767 8. Credentialing and recredentialing.
1768 9. Enrollee rights and responsibilities.
1769 10. Availability and accessibility to services and care.
1770 11. Ambulatory care facilities.
1771 12. Accessibility and availability of medical records, as
1772 well as proper recordkeeping and process for record review.
1773 13. Utilization review.
1774 14. A continuity of care system.
1775 15. Quality assurance program documentation.
1776 16. Coordination of quality assurance activity with other
1777 management activity.
1778 17. Delivering care to pregnant women and infants; to
1779 elderly and disabled recipients, especially those who are at
1780 risk of institutional placement; to persons with developmental
1781 disabilities; and to adults who have chronic, high-cost medical
1782 conditions.
1783 (b) Guidelines which require the entities to conduct
1784 quality-of-care studies which:
1785 1. Target specific conditions and specific health service
1786 delivery issues for focused monitoring and evaluation.
1787 2. Use clinical care standards or practice guidelines to
1788 objectively evaluate the care the entity delivers or fails to

1789 deliver for the targeted clinical conditions and health services
1790 delivery issues.
1791 3. Use quality indicators derived from the clinical care
1792 standards or practice guidelines to screen and monitor care and
1793 services delivered.
1794 (c) Guidelines for external quality review of each
1795 contractor which require: focused studies of patterns of care;
1796 individual care review in specific situations; and followup
1797 activities on previous pattern-of-care study findings and
1798 individual-care-review findings. In designing the external
1799 quality review function and determining how it is to operate as
1800 part of the state's overall quality improvement system, the
1801 agency shall construct its external quality review organization
1802 and entity contracts to address each of the following:
1803 1. Delineating the role of the external quality review
1804 organization.
1805 2. Length of the external quality review organization
1806 contract with the state.
1807 3. Participation of the contracting entities in designing
1808 external quality review organization review activities.
1809 4. Potential variation in the type of clinical conditions
1810 and health services delivery issues to be studied at each plan.
1811 5. Determining the number of focused pattern-of-care
1812 studies to be conducted for each plan.
1813 6. Methods for implementing focused studies.
1814 7. Individual care review.
1815 8. Followup activities.
1816

1817 This subsection expires October 1, 2016.
1818 (27) ~~(28)~~ In order to ensure that children receive health
1819 care services for which an entity has already been compensated,
1820 an entity contracting with the agency pursuant to this section
1821 shall achieve an annual Early and Periodic Screening, Diagnosis,
1822 and Treatment (EPSDT) Service screening rate of at least 60
1823 percent for those recipients continuously enrolled for at least
1824 8 months. The agency shall develop a method by which the EPSDT
1825 screening rate shall be calculated. For any entity which does
1826 not achieve the annual 60 percent rate, the entity must submit a
1827 corrective action plan for the agency's approval. If the entity
1828 does not meet the standard established in the corrective action
1829 plan during the specified timeframe, the agency is authorized to
1830 impose appropriate contract sanctions. At least annually, the
1831 agency shall publicly release the EPSDT Services screening rates
1832 of each entity it has contracted with on a prepaid basis to
1833 serve Medicaid recipients. This subsection expires October 1,
1834 2014.
1835 (28) ~~(29)~~ The agency shall perform enrollments and
1836 disenrollments for Medicaid recipients who are eligible for
1837 MediPass or managed care plans. Notwithstanding the prohibition
1838 contained in paragraph (20) ~~(21)~~ (f), managed care plans may
1839 perform preenrollments of Medicaid recipients under the
1840 supervision of the agency or its agents. For the purposes of
1841 this section, the term "preenrollment" means the provision of
1842 marketing and educational materials to a Medicaid recipient and
1843 assistance in completing the application forms, but does not
1844 include actual enrollment into a managed care plan. An

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1845 application for enrollment may not be deemed complete until the
1846 agency or its agent verifies that the recipient made an
1847 informed, voluntary choice. The agency, in cooperation with the
1848 Department of Children and Family Services, may test new
1849 marketing initiatives to inform Medicaid recipients about their
1850 managed care options at selected sites. The agency may contract
1851 with a third party to perform managed care plan and MediPass
1852 enrollment and disenrollment services for Medicaid recipients
1853 and may adopt rules to administer such services. The agency may
1854 adjust the capitation rate only to cover the costs of a third-
1855 party enrollment and disenrollment contract, and for agency
1856 supervision and management of the managed care plan enrollment
1857 and disenrollment contract. <u>This subsection expires October 1,</u>
1858 <u>2014.</u>
1859 <u>(29)</u> ~~(30)~~ Any lists of providers made available to Medicaid
1860 recipients, MediPass enrollees, or managed care plan enrollees
1861 shall be arranged alphabetically showing the provider's name and
1862 specialty and, separately, by specialty in alphabetical order.
1863 <u>This subsection expires October 1, 2014.</u>
1864 <u>(30)</u> ~~(31)~~ The agency shall establish an enhanced managed
1865 care quality assurance oversight function, to include at least
1866 the following components:
1867 (a) At least quarterly analysis and followup, including
1868 sanctions as appropriate, of managed care participant
1869 utilization of services.
1870 (b) At least quarterly analysis and followup, including
1871 sanctions as appropriate, of quality findings of the Medicaid
1872 peer review organization and other external quality assurance

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1873 programs.
1874 (c) At least quarterly analysis and followup, including
1875 sanctions as appropriate, of the fiscal viability of managed
1876 care plans.
1877 (d) At least quarterly analysis and followup, including
1878 sanctions as appropriate, of managed care participant
1879 satisfaction and disenrollment surveys.
1880 (e) The agency shall conduct regular and ongoing Medicaid
1881 recipient satisfaction surveys.
1882
1883 The analyses and followup activities conducted by the agency
1884 under its enhanced managed care quality assurance oversight
1885 function shall not duplicate the activities of accreditation
1886 reviewers for entities regulated under part III of chapter 641,
1887 but may include a review of the finding of such reviewers. This
1888 subsection expires October 1, 2014.
1889 (31) ~~(32)~~ Each managed care plan that is under contract
1890 with the agency to provide health care services to Medicaid
1891 recipients shall annually conduct a background check with the
1892 Department of Law Enforcement of all persons with ownership
1893 interest of 5 percent or more or executive management
1894 responsibility for the managed care plan and shall submit to the
1895 agency information concerning any such person who has been found
1896 guilty of, regardless of adjudication, or has entered a plea of
1897 nolo contendere or guilty to, any of the offenses listed in s.
1898 435.04. This subsection expires October 1, 2014.
1899 (32) ~~(33)~~ The agency shall, by rule, develop a process
1900 whereby a Medicaid managed care plan enrollee who wishes to

1901 enter hospice care may be disenrolled from the managed care plan
1902 within 24 hours after contacting the agency regarding such
1903 request. The agency rule shall include a methodology for the
1904 agency to recoup managed care plan payments on a pro rata basis
1905 if payment has been made for the enrollment month when
1906 disenrollment occurs. This subsection expires October 1, 2014.
1907 (33) ~~(34)~~ The agency and entities that contract with the
1908 agency to provide health care services to Medicaid recipients
1909 under this section or ss. 409.91211 and 409.9122 must comply
1910 with the provisions of s. 641.513 in providing emergency
1911 services and care to Medicaid recipients and MediPass
1912 recipients. Where feasible, safe, and cost-effective, the agency
1913 shall encourage hospitals, emergency medical services providers,
1914 and other public and private health care providers to work
1915 together in their local communities to enter into agreements or
1916 arrangements to ensure access to alternatives to emergency
1917 services and care for those Medicaid recipients who need
1918 nonemergent care. The agency shall coordinate with hospitals,
1919 emergency medical services providers, private health plans,
1920 capitated managed care networks as established in s. 409.91211,
1921 and other public and private health care providers to implement
1922 the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
1923 and 641.31097 to develop and implement emergency department
1924 diversion programs for Medicaid recipients. This subsection
1925 expires October 1, 2014.
1926 (34) ~~(35)~~ All entities providing health care services to
1927 Medicaid recipients shall make available, and encourage all
1928 pregnant women and mothers with infants to receive, and provide

1929 documentation in the medical records to reflect, the following:
1930 (a) Healthy Start prenatal or infant screening.
1931 (b) Healthy Start care coordination, when screening or
1932 other factors indicate need.
1933 (c) Healthy Start enhanced services in accordance with the
1934 prenatal or infant screening results.
1935 (d) Immunizations in accordance with recommendations of
1936 the Advisory Committee on Immunization Practices of the United
1937 States Public Health Service and the American Academy of
1938 Pediatrics, as appropriate.
1939 (e) Counseling and services for family planning to all
1940 women and their partners.
1941 (f) A scheduled postpartum visit for the purpose of
1942 voluntary family planning, to include discussion of all methods
1943 of contraception, as appropriate.
1944 (g) Referral to the Special Supplemental Nutrition Program
1945 for Women, Infants, and Children (WIC).
1946
1947 This subsection expires October 1, 2014.
1948 (35) ~~(36)~~ Any entity that provides Medicaid prepaid health
1949 plan services shall ensure the appropriate coordination of
1950 health care services with an assisted living facility in cases
1951 where a Medicaid recipient is both a member of the entity's
1952 prepaid health plan and a resident of the assisted living
1953 facility. If the entity is at risk for Medicaid targeted case
1954 management and behavioral health services, the entity shall
1955 inform the assisted living facility of the procedures to follow
1956 should an emergent condition arise. This subsection expires

1957 October 1, 2014.
1958 (37) The agency may seek and implement federal waivers
1959 necessary to provide for cost-effective purchasing of home
1960 health services, private duty nursing services, transportation,
1961 independent laboratory services, and durable medical equipment
1962 and supplies through competitive bidding pursuant to s. 287.057.
1963 The agency may request appropriate waivers from the federal
1964 Health Care Financing Administration in order to competitively
1965 bid such services. The agency may exclude providers not selected
1966 through the bidding process from the Medicaid provider network.
1967 (36)(38) The agency shall enter into agreements with not-
1968 for-profit organizations based in this state for the purpose of
1969 providing vision screening. This subsection expires October 1,
1970 2014.
1971 (37)(39)(a) The agency shall implement a Medicaid
1972 prescribed-drug spending-control program that includes the
1973 following components:
1974 1. A Medicaid preferred drug list, which shall be a
1975 listing of cost-effective therapeutic options recommended by the
1976 Medicaid Pharmacy and Therapeutics Committee established
1977 pursuant to s. 409.91195 and adopted by the agency for each
1978 therapeutic class on the preferred drug list. At the discretion
1979 of the committee, and when feasible, the preferred drug list
1980 should include at least two products in a therapeutic class. The
1981 agency may post the preferred drug list and updates to the
1982 preferred drug list on an Internet website without following the
1983 rulemaking procedures of chapter 120. Antiretroviral agents are
1984 excluded from the preferred drug list. The agency shall also

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1985 limit the amount of a prescribed drug dispensed to no more than
1986 a 34-day supply unless the drug products' smallest marketed
1987 package is greater than a 34-day supply, or the drug is
1988 determined by the agency to be a maintenance drug in which case
1989 a 100-day maximum supply may be authorized. The agency is
1990 authorized to seek any federal waivers necessary to implement
1991 these cost-control programs and to continue participation in the
1992 federal Medicaid rebate program, or alternatively to negotiate
1993 state-only manufacturer rebates. The agency may adopt rules to
1994 implement this subparagraph. The agency shall continue to
1995 provide unlimited contraceptive drugs and items. The agency must
1996 establish procedures to ensure that:
1997 a. There is a response to a request for prior consultation
1998 by telephone or other telecommunication device within 24 hours
1999 after receipt of a request for prior consultation; and
2000 b. A 72-hour supply of the drug prescribed is provided in
2001 an emergency or when the agency does not provide a response
2002 within 24 hours as required by sub-subparagraph a.
2003 2. Reimbursement to pharmacies for Medicaid prescribed
2004 drugs shall be set at the lesser of: the average wholesale price
2005 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2006 plus 4.75 percent, the federal upper limit (FUL), the state
2007 maximum allowable cost (SMAC), or the usual and customary (UAC)
2008 charge billed by the provider.
2009 3. The agency shall develop and implement a process for
2010 managing the drug therapies of Medicaid recipients who are using
2011 significant numbers of prescribed drugs each month. The
2012 management process may include, but is not limited to,

2013 comprehensive, physician-directed medical-record reviews, claims
2014 analyses, and case evaluations to determine the medical
2015 necessity and appropriateness of a patient's treatment plan and
2016 drug therapies. The agency may contract with a private
2017 organization to provide drug-program-management services. The
2018 Medicaid drug benefit management program shall include
2019 initiatives to manage drug therapies for HIV/AIDS patients,
2020 patients using 20 or more unique prescriptions in a 180-day
2021 period, and the top 1,000 patients in annual spending. The
2022 agency shall enroll any Medicaid recipient in the drug benefit
2023 management program if he or she meets the specifications of this
2024 provision and is not enrolled in a Medicaid health maintenance
2025 organization.
2026 4. The agency may limit the size of its pharmacy network
2027 based on need, competitive bidding, price negotiations,
2028 credentialing, or similar criteria. The agency shall give
2029 special consideration to rural areas in determining the size and
2030 location of pharmacies included in the Medicaid pharmacy
2031 network. A pharmacy credentialing process may include criteria
2032 such as a pharmacy's full-service status, location, size,
2033 patient educational programs, patient consultation, disease
2034 management services, and other characteristics. The agency may
2035 impose a moratorium on Medicaid pharmacy enrollment when it is
2036 determined that it has a sufficient number of Medicaid-
2037 participating providers. The agency must allow dispensing
2038 practitioners to participate as a part of the Medicaid pharmacy
2039 network regardless of the practitioner's proximity to any other
2040 entity that is dispensing prescription drugs under the Medicaid

2041 program. A dispensing practitioner must meet all credentialing
2042 requirements applicable to his or her practice, as determined by
2043 the agency.
2044 5. The agency shall develop and implement a program that
2045 requires Medicaid practitioners who prescribe drugs to use a
2046 counterfeit-proof prescription pad for Medicaid prescriptions.
2047 The agency shall require the use of standardized counterfeit-
2048 proof prescription pads by Medicaid-participating prescribers or
2049 prescribers who write prescriptions for Medicaid recipients. The
2050 agency may implement the program in targeted geographic areas or
2051 statewide.
2052 6. The agency may enter into arrangements that require
2053 manufacturers of generic drugs prescribed to Medicaid recipients
2054 to provide rebates of at least 15.1 percent of the average
2055 manufacturer price for the manufacturer's generic products.
2056 These arrangements shall require that if a generic-drug
2057 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2058 at a level below 15.1 percent, the manufacturer must provide a
2059 supplemental rebate to the state in an amount necessary to
2060 achieve a 15.1-percent rebate level.
2061 7. The agency may establish a preferred drug list as
2062 described in this subsection, and, pursuant to the establishment
2063 of such preferred drug list, it is authorized to negotiate
2064 supplemental rebates from manufacturers that are in addition to
2065 those required by Title XIX of the Social Security Act and at no
2066 less than 14 percent of the average manufacturer price as
2067 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2068 the federal or supplemental rebate, or both, equals or exceeds

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2069 29 percent. There is no upper limit on the supplemental rebates
2070 the agency may negotiate. The agency may determine that specific
2071 products, brand-name or generic, are competitive at lower rebate
2072 percentages. Agreement to pay the minimum supplemental rebate
2073 percentage will guarantee a manufacturer that the Medicaid
2074 Pharmaceutical and Therapeutics Committee will consider a
2075 product for inclusion on the preferred drug list. However, a
2076 pharmaceutical manufacturer is not guaranteed placement on the
2077 preferred drug list by simply paying the minimum supplemental
2078 rebate. Agency decisions will be made on the clinical efficacy
2079 of a drug and recommendations of the Medicaid Pharmaceutical and
2080 Therapeutics Committee, as well as the price of competing
2081 products minus federal and state rebates. The agency is
2082 authorized to contract with an outside agency or contractor to
2083 conduct negotiations for supplemental rebates. For the purposes
2084 of this section, the term "supplemental rebates" means cash
2085 rebates. Effective July 1, 2004, value-added programs as a
2086 substitution for supplemental rebates are prohibited. The agency
2087 is authorized to seek any federal waivers to implement this
2088 initiative.
2089 8. The Agency for Health Care Administration shall expand
2090 home delivery of pharmacy products. To assist Medicaid patients
2091 in securing their prescriptions and reduce program costs, the
2092 agency shall expand its current mail-order-pharmacy diabetes-
2093 supply program to include all generic and brand-name drugs used
2094 by Medicaid patients with diabetes. Medicaid recipients in the
2095 current program may obtain nondiabetes drugs on a voluntary
2096 basis. This initiative is limited to the geographic area covered

2097 by the current contract. The agency may seek and implement any
2098 federal waivers necessary to implement this subparagraph.
2099 9. The agency shall limit to one dose per month any drug
2100 prescribed to treat erectile dysfunction.
2101 10.a. The agency may implement a Medicaid behavioral drug
2102 management system. The agency may contract with a vendor that
2103 has experience in operating behavioral drug management systems
2104 to implement this program. The agency is authorized to seek
2105 federal waivers to implement this program.
2106 b. The agency, in conjunction with the Department of
2107 Children and Family Services, may implement the Medicaid
2108 behavioral drug management system that is designed to improve
2109 the quality of care and behavioral health prescribing practices
2110 based on best practice guidelines, improve patient adherence to
2111 medication plans, reduce clinical risk, and lower prescribed
2112 drug costs and the rate of inappropriate spending on Medicaid
2113 behavioral drugs. The program may include the following
2114 elements:
2115 (I) Provide for the development and adoption of best
2116 practice guidelines for behavioral health-related drugs such as
2117 antipsychotics, antidepressants, and medications for treating
2118 bipolar disorders and other behavioral conditions; translate
2119 them into practice; review behavioral health prescribers and
2120 compare their prescribing patterns to a number of indicators
2121 that are based on national standards; and determine deviations
2122 from best practice guidelines.
2123 (II) Implement processes for providing feedback to and
2124 educating prescribers using best practice educational materials

2125 and peer-to-peer consultation.
2126 (III) Assess Medicaid beneficiaries who are outliers in
2127 their use of behavioral health drugs with regard to the numbers
2128 and types of drugs taken, drug dosages, combination drug
2129 therapies, and other indicators of improper use of behavioral
2130 health drugs.
2131 (IV) Alert prescribers to patients who fail to refill
2132 prescriptions in a timely fashion, are prescribed multiple same-
2133 class behavioral health drugs, and may have other potential
2134 medication problems.
2135 (V) Track spending trends for behavioral health drugs and
2136 deviation from best practice guidelines.
2137 (VI) Use educational and technological approaches to
2138 promote best practices, educate consumers, and train prescribers
2139 in the use of practice guidelines.
2140 (VII) Disseminate electronic and published materials.
2141 (VIII) Hold statewide and regional conferences.
2142 (IX) Implement a disease management program with a model
2143 quality-based medication component for severely mentally ill
2144 individuals and emotionally disturbed children who are high
2145 users of care.
2146 11.a. The agency shall implement a Medicaid prescription
2147 drug management system. The agency may contract with a vendor
2148 that has experience in operating prescription drug management
2149 systems in order to implement this system. Any management system
2150 that is implemented in accordance with this subparagraph must
2151 rely on cooperation between physicians and pharmacists to
2152 determine appropriate practice patterns and clinical guidelines

2153 to improve the prescribing, dispensing, and use of drugs in the
2154 Medicaid program. The agency may seek federal waivers to
2155 implement this program.
2156 b. The drug management system must be designed to improve
2157 the quality of care and prescribing practices based on best
2158 practice guidelines, improve patient adherence to medication
2159 plans, reduce clinical risk, and lower prescribed drug costs and
2160 the rate of inappropriate spending on Medicaid prescription
2161 drugs. The program must:
2162 (I) Provide for the development and adoption of best
2163 practice guidelines for the prescribing and use of drugs in the
2164 Medicaid program, including translating best practice guidelines
2165 into practice; reviewing prescriber patterns and comparing them
2166 to indicators that are based on national standards and practice
2167 patterns of clinical peers in their community, statewide, and
2168 nationally; and determine deviations from best practice
2169 guidelines.
2170 (II) Implement processes for providing feedback to and
2171 educating prescribers using best practice educational materials
2172 and peer-to-peer consultation.
2173 (III) Assess Medicaid recipients who are outliers in their
2174 use of a single or multiple prescription drugs with regard to
2175 the numbers and types of drugs taken, drug dosages, combination
2176 drug therapies, and other indicators of improper use of
2177 prescription drugs.
2178 (IV) Alert prescribers to patients who fail to refill
2179 prescriptions in a timely fashion, are prescribed multiple drugs
2180 that may be redundant or contraindicated, or may have other

2181 potential medication problems.
2182 (V) Track spending trends for prescription drugs and
2183 deviation from best practice guidelines.
2184 (VI) Use educational and technological approaches to
2185 promote best practices, educate consumers, and train prescribers
2186 in the use of practice guidelines.
2187 (VII) Disseminate electronic and published materials.
2188 (VIII) Hold statewide and regional conferences.
2189 (IX) Implement disease management programs in cooperation
2190 with physicians and pharmacists, along with a model quality-
2191 based medication component for individuals having chronic
2192 medical conditions.
2193 12. The agency is authorized to contract for drug rebate
2194 administration, including, but not limited to, calculating
2195 rebate amounts, invoicing manufacturers, negotiating disputes
2196 with manufacturers, and maintaining a database of rebate
2197 collections.
2198 13. The agency may specify the preferred daily dosing form
2199 or strength for the purpose of promoting best practices with
2200 regard to the prescribing of certain drugs as specified in the
2201 General Appropriations Act and ensuring cost-effective
2202 prescribing practices.
2203 14. The agency may require prior authorization for
2204 Medicaid-covered prescribed drugs. The agency may, but is not
2205 required to, prior-authorize the use of a product:
2206 a. For an indication not approved in labeling;
2207 b. To comply with certain clinical guidelines; or
2208 c. If the product has the potential for overuse, misuse,

2209 or abuse.
2210
2211 The agency may require the prescribing professional to provide
2212 information about the rationale and supporting medical evidence
2213 for the use of a drug. The agency may post prior authorization
2214 criteria and protocol and updates to the list of drugs that are
2215 subject to prior authorization on an Internet website without
2216 amending its rule or engaging in additional rulemaking.
2217 15. The agency, in conjunction with the Pharmaceutical and
2218 Therapeutics Committee, may require age-related prior
2219 authorizations for certain prescribed drugs. The agency may
2220 preauthorize the use of a drug for a recipient who may not meet
2221 the age requirement or may exceed the length of therapy for use
2222 of this product as recommended by the manufacturer and approved
2223 by the Food and Drug Administration. Prior authorization may
2224 require the prescribing professional to provide information
2225 about the rationale and supporting medical evidence for the use
2226 of a drug.
2227 16. The agency shall implement a step-therapy prior
2228 authorization approval process for medications excluded from the
2229 preferred drug list. Medications listed on the preferred drug
2230 list must be used within the previous 12 months prior to the
2231 alternative medications that are not listed. The step-therapy
2232 prior authorization may require the prescriber to use the
2233 medications of a similar drug class or for a similar medical
2234 indication unless contraindicated in the Food and Drug
2235 Administration labeling. The trial period between the specified
2236 steps may vary according to the medical indication. The step-

2237 therapy approval process shall be developed in accordance with
2238 the committee as stated in s. 409.91195(7) and (8). A drug
2239 product may be approved without meeting the step-therapy prior
2240 authorization criteria if the prescribing physician provides the
2241 agency with additional written medical or clinical documentation
2242 that the product is medically necessary because:
2243 a. There is not a drug on the preferred drug list to treat
2244 the disease or medical condition which is an acceptable clinical
2245 alternative;
2246 b. The alternatives have been ineffective in the treatment
2247 of the beneficiary's disease; or
2248 c. Based on historic evidence and known characteristics of
2249 the patient and the drug, the drug is likely to be ineffective,
2250 or the number of doses have been ineffective.
2251
2252 The agency shall work with the physician to determine the best
2253 alternative for the patient. The agency may adopt rules waiving
2254 the requirements for written clinical documentation for specific
2255 drugs in limited clinical situations.
2256 17. The agency shall implement a return and reuse program
2257 for drugs dispensed by pharmacies to institutional recipients,
2258 which includes payment of a $5 restocking fee for the
2259 implementation and operation of the program. The return and
2260 reuse program shall be implemented electronically and in a
2261 manner that promotes efficiency. The program must permit a
2262 pharmacy to exclude drugs from the program if it is not
2263 practical or cost-effective for the drug to be included and must
2264 provide for the return to inventory of drugs that cannot be

2265 credited or returned in a cost-effective manner. The agency
2266 shall determine if the program has reduced the amount of
2267 Medicaid prescription drugs which are destroyed on an annual
2268 basis and if there are additional ways to ensure more
2269 prescription drugs are not destroyed which could safely be
2270 reused. The agency's conclusion and recommendations shall be
2271 reported to the Legislature by December 1, 2005.
2272 (b) The agency shall implement this subsection to the
2273 extent that funds are appropriated to administer the Medicaid
2274 prescribed-drug spending-control program. The agency may
2275 contract all or any part of this program to private
2276 organizations.
2277 (c) The agency shall submit quarterly reports to the
2278 Governor, the President of the Senate, and the Speaker of the
2279 House of Representatives which must include, but need not be
2280 limited to, the progress made in implementing this subsection
2281 and its effect on Medicaid prescribed-drug expenditures.
2282 (38)~~(40)~~ Notwithstanding the provisions of chapter 287,
2283 the agency may, at its discretion, renew a contract or contracts
2284 for fiscal intermediary services one or more times for such
2285 periods as the agency may decide; however, all such renewals may
2286 not combine to exceed a total period longer than the term of the
2287 original contract.
2288 (39)~~(41)~~ The agency shall provide for the development of a
2289 demonstration project by establishment in Miami-Dade County of a
2290 long-term-care facility licensed pursuant to chapter 395 to
2291 improve access to health care for a predominantly minority,
2292 medically underserved, and medically complex population and to

2293 evaluate alternatives to nursing home care and general acute
2294 care for such population. Such project is to be located in a
2295 health care condominium and colocated with licensed facilities
2296 providing a continuum of care. The establishment of this project
2297 is not subject to the provisions of s. 408.036 or s. 408.039.
2298 This subsection expires October 1, 2013.
2299 ~~(42) The agency shall develop and implement a utilization~~
2300 ~~management program for Medicaid-eligible recipients for the~~
2301 ~~management of occupational, physical, respiratory, and speech~~
2302 ~~therapies. The agency shall establish a utilization program that~~
2303 ~~may require prior authorization in order to ensure medically~~
2304 ~~necessary and cost-effective treatments. The program shall be~~
2305 ~~operated in accordance with a federally approved waiver program~~
2306 ~~or state plan amendment. The agency may seek a federal waiver or~~
2307 ~~state plan amendment to implement this program. The agency may~~
2308 ~~also competitively procure these services from an outside vendor~~
2309 ~~on a regional or statewide basis.~~
2310 (40)~~(43)~~ The agency shall ~~may~~ contract on a prepaid or
2311 fixed-sum basis with appropriately licensed prepaid dental
2312 health plans to provide dental services. This subsection expires
2313 October 1, 2014.
2314 (41)~~(44)~~ The Agency for Health Care Administration shall
2315 ensure that any Medicaid managed care plan as defined in s.
2316 409.9122(2)(f), whether paid on a capitated basis or a shared
2317 savings basis, is cost-effective. For purposes of this
2318 subsection, the term "cost-effective" means that a network's
2319 per-member, per-month costs to the state, including, but not
2320 limited to, fee-for-service costs, administrative costs, and

2321 case-management fees, if any, must be no greater than the
2322 state's costs associated with contracts for Medicaid services
2323 established under subsection (3), which may be adjusted for
2324 health status. The agency shall conduct actuarially sound
2325 adjustments for health status in order to ensure such cost-
2326 effectiveness and shall annually publish the results on its
2327 Internet website. Contracts established pursuant to this
2328 subsection which are not cost-effective may not be renewed. This
2329 subsection expires October 1, 2014.
2330 (42) ~~(45)~~ Subject to the availability of funds, the agency
2331 shall mandate a recipient's participation in a provider lock-in
2332 program, when appropriate, if a recipient is found by the agency
2333 to have used Medicaid goods or services at a frequency or amount
2334 not medically necessary, limiting the receipt of goods or
2335 services to medically necessary providers after the 21-day
2336 appeal process has ended, for a period of not less than 1 year.
2337 The lock-in programs shall include, but are not limited to,
2338 pharmacies, medical doctors, and infusion clinics. The
2339 limitation does not apply to emergency services and care
2340 provided to the recipient in a hospital emergency department.
2341 The agency shall seek any federal waivers necessary to implement
2342 this subsection. The agency shall adopt any rules necessary to
2343 comply with or administer this subsection. This subsection
2344 expires October 1, 2014.
2345 (43) ~~(46)~~ The agency shall seek a federal waiver for
2346 permission to terminate the eligibility of a Medicaid recipient
2347 who has been found to have committed fraud, through judicial or
2348 administrative determination, two times in a period of 5 years.

2349 ~~(47) The agency shall conduct a study of available~~
2350 ~~electronic systems for the purpose of verifying the identity and~~
2351 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
2352 ~~to the Legislature a plan to implement an electronic~~
2353 ~~verification system for Medicaid recipients by January 31, 2005.~~
2354 (44) ~~(48)~~ (a) A provider is not entitled to enrollment in
2355 the Medicaid provider network. The agency may implement a
2356 Medicaid fee-for-service provider network controls, including,
2357 but not limited to, competitive procurement and provider
2358 credentialing. If a credentialing process is used, the agency
2359 may limit its provider network based upon the following
2360 considerations: beneficiary access to care, provider
2361 availability, provider quality standards and quality assurance
2362 processes, cultural competency, demographic characteristics of
2363 beneficiaries, practice standards, service wait times, provider
2364 turnover, provider licensure and accreditation history, program
2365 integrity history, peer review, Medicaid policy and billing
2366 compliance records, clinical and medical record audit findings,
2367 and such other areas that are considered necessary by the agency
2368 to ensure the integrity of the program.
2369 (b) The agency shall limit its network of durable medical
2370 equipment and medical supply providers. For dates of service
2371 after January 1, 2009, the agency shall limit payment for
2372 durable medical equipment and supplies to providers that meet
2373 all the requirements of this paragraph.
2374 1. Providers must be accredited by a Centers for Medicare
2375 and Medicaid Services deemed accreditation organization for
2376 suppliers of durable medical equipment, prosthetics, orthotics,

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2377 and supplies. The provider must maintain accreditation and is
2378 subject to unannounced reviews by the accrediting organization.
2379 2. Providers must provide the services or supplies
2380 directly to the Medicaid recipient or caregiver at the provider
2381 location or recipient's residence or send the supplies directly
2382 to the recipient's residence with receipt of mailed delivery.
2383 Subcontracting or consignment of the service or supply to a
2384 third party is prohibited.
2385 3. Notwithstanding subparagraph 2., a durable medical
2386 equipment provider may store nebulizers at a physician's office
2387 for the purpose of having the physician's staff issue the
2388 equipment if it meets all of the following conditions:
2389 a. The physician must document the medical necessity and
2390 need to prevent further deterioration of the patient's
2391 respiratory status by the timely delivery of the nebulizer in
2392 the physician's office.
2393 b. The durable medical equipment provider must have
2394 written documentation of the competency and training by a
2395 Florida-licensed registered respiratory therapist of any durable
2396 medical equipment staff who participate in the training of
2397 physician office staff for the use of nebulizers, including
2398 cleaning, warranty, and special needs of patients.
2399 c. The physician's office must have documented the
2400 training and competency of any staff member who initiates the
2401 delivery of nebulizers to patients. The durable medical
2402 equipment provider must maintain copies of all physician office
2403 training.
2404 d. The physician's office must maintain inventory records

2405 of stored nebulizers, including documentation of the durable
2406 medical equipment provider source.
2407 e. A physician contracted with a Medicaid durable medical
2408 equipment provider may not have a financial relationship with
2409 that provider or receive any financial gain from the delivery of
2410 nebulizers to patients.
2411 4. Providers must have a physical business location and a
2412 functional landline business phone. The location must be within
2413 the state or not more than 50 miles from the Florida state line.
2414 The agency may make exceptions for providers of durable medical
2415 equipment or supplies not otherwise available from other
2416 enrolled providers located within the state.
2417 5. Physical business locations must be clearly identified
2418 as a business that furnishes durable medical equipment or
2419 medical supplies by signage that can be read from 20 feet away.
2420 The location must be readily accessible to the public during
2421 normal, posted business hours and must operate at least 5 hours
2422 per day and at least 5 days per week, with the exception of
2423 scheduled and posted holidays. The location may not be located
2424 within or at the same numbered street address as another
2425 enrolled Medicaid durable medical equipment or medical supply
2426 provider or as an enrolled Medicaid pharmacy that is also
2427 enrolled as a durable medical equipment provider. A licensed
2428 orthotist or prosthetist that provides only orthotic or
2429 prosthetic devices as a Medicaid durable medical equipment
2430 provider is exempt from this paragraph.
2431 6. Providers must maintain a stock of durable medical
2432 equipment and medical supplies on site that is readily available

2433 to meet the needs of the durable medical equipment business
2434 location's customers.
2435 7. Providers must provide a surety bond of $50,000 for
2436 each provider location, up to a maximum of 5 bonds statewide or
2437 an aggregate bond of $250,000 statewide, as identified by
2438 Federal Employer Identification Number. Providers who post a
2439 statewide or an aggregate bond must identify all of their
2440 locations in any Medicaid durable medical equipment and medical
2441 supply provider enrollment application or bond renewal. Each
2442 provider location's surety bond must be renewed annually and the
2443 provider must submit proof of renewal even if the original bond
2444 is a continuous bond. A licensed orthotist or prosthetist that
2445 provides only orthotic or prosthetic devices as a Medicaid
2446 durable medical equipment provider is exempt from the provisions
2447 in this paragraph.
2448 8. Providers must obtain a level 2 background screening,
2449 in accordance with chapter 435 and s. 408.809, for each provider
2450 employee in direct contact with or providing direct services to
2451 recipients of durable medical equipment and medical supplies in
2452 their homes. This requirement includes, but is not limited to,
2453 repair and service technicians, fitters, and delivery staff. The
2454 provider shall pay for the cost of the background screening.
2455 9. The following providers are exempt from subparagraphs
2456 1. and 7.:
2457 a. Durable medical equipment providers owned and operated
2458 by a government entity.
2459 b. Durable medical equipment providers that are operating
2460 within a pharmacy that is currently enrolled as a Medicaid

2461 pharmacy provider.
2462 c. Active, Medicaid-enrolled orthopedic physician groups,
2463 primarily owned by physicians, which provide only orthotic and
2464 prosthetic devices.
2465 (45) ~~(49)~~ The agency shall contract with established
2466 minority physician networks that provide services to
2467 historically underserved minority patients. The networks must
2468 provide cost-effective Medicaid services, comply with the
2469 requirements to be a MediPass provider, and provide their
2470 primary care physicians with access to data and other management
2471 tools necessary to assist them in ensuring the appropriate use
2472 of services, including inpatient hospital services and
2473 pharmaceuticals.
2474 (a) The agency shall provide for the development and
2475 expansion of minority physician networks in each service area to
2476 provide services to Medicaid recipients who are eligible to
2477 participate under federal law and rules.
2478 (b) The agency shall reimburse each minority physician
2479 network as a fee-for-service provider, including the case
2480 management fee for primary care, if any, or as a capitated rate
2481 provider for Medicaid services. Any savings shall be shared with
2482 the minority physician networks pursuant to the contract.
2483 (c) For purposes of this subsection, the term "cost-
2484 effective" means that a network's per-member, per-month costs to
2485 the state, including, but not limited to, fee-for-service costs,
2486 administrative costs, and case-management fees, if any, must be
2487 no greater than the state's costs associated with contracts for
2488 Medicaid services established under subsection (3), which shall

2489 be actuarially adjusted for case mix, model, and service area.
2490 The agency shall conduct actuarially sound audits adjusted for
2491 case mix and model in order to ensure such cost-effectiveness
2492 and shall annually publish the audit results on its Internet
2493 website. Contracts established pursuant to this subsection which
2494 are not cost-effective may not be renewed.
2495 (d) The agency may apply for any federal waivers needed to
2496 implement this subsection.
2497
2498 This subsection expires October 1, 2014.
2499 (46) ~~(50)~~ To the extent permitted by federal law and as
2500 allowed under s. 409.906, the agency shall provide reimbursement
2501 for emergency mental health care services for Medicaid
2502 recipients in crisis stabilization facilities licensed under s.
2503 394.875 as long as those services are less expensive than the
2504 same services provided in a hospital setting.
2505 (47) ~~(51)~~ The agency shall work with the Agency for Persons
2506 with Disabilities to develop a home and community-based waiver
2507 to serve children and adults who are diagnosed with familial
2508 dysautonomia or Riley-Day syndrome caused by a mutation of the
2509 IKBKAP gene on chromosome 9. The agency shall seek federal
2510 waiver approval and implement the approved waiver subject to the
2511 availability of funds and any limitations provided in the
2512 General Appropriations Act. The agency may adopt rules to
2513 implement this waiver program.
2514 (48) ~~(52)~~ The agency shall implement a program of all-
2515 inclusive care for children. The program of all-inclusive care
2516 for children shall be established to provide in-home hospice-

2517 like support services to children diagnosed with a life-
2518 threatening illness and enrolled in the Children's Medical
2519 Services network to reduce hospitalizations as appropriate. The
2520 agency, in consultation with the Department of Health, may
2521 implement the program of all-inclusive care for children after
2522 obtaining approval from the Centers for Medicare and Medicaid
2523 Services.
2524 (49) ~~(53)~~ Before seeking an amendment to the state plan for
2525 purposes of implementing programs authorized by the Deficit
2526 Reduction Act of 2005, the agency shall notify the Legislature.
2527 Section 13. Section 409.91207, Florida Statutes, is
2528 repealed.
2529 Section 14. Paragraphs (e), (l), (p), (w), and (dd) of
2530 subsection (3) of section 409.91211, Florida Statutes, are
2531 amended to read:
2532 409.91211 Medicaid managed care pilot program.—
2533 (3) The agency shall have the following powers, duties,
2534 and responsibilities with respect to the pilot program:
2535 (e) To implement policies and guidelines for phasing in
2536 financial risk for approved provider service networks that, for
2537 purposes of this paragraph, include the Children's Medical
2538 Services Network, over the period of the waiver and the
2539 extension thereof. These policies and guidelines must include an
2540 option for a provider service network to be paid fee-for-service
2541 rates. For any provider service network established in a managed
2542 care pilot area, the option to be paid fee-for-service rates
2543 must include a savings-settlement mechanism that is consistent
2544 with s. 409.912(41) ~~(44)~~. This model must be converted to a risk-

2545 adjusted capitated rate by the beginning of the final year of
2546 operation under the waiver extension, and may be converted
2547 earlier at the option of the provider service network. Federally
2548 qualified health centers may be offered an opportunity to accept
2549 or decline a contract to participate in any provider network for
2550 prepaid primary care services.
2551 (l) To implement a system that prohibits capitated managed
2552 care plans, their representatives, and providers employed by or
2553 contracted with the capitated managed care plans from recruiting
2554 persons eligible for or enrolled in Medicaid, from providing
2555 inducements to Medicaid recipients to select a particular
2556 capitated managed care plan, and from prejudicing Medicaid
2557 recipients against other capitated managed care plans. The
2558 system shall require the entity performing choice counseling to
2559 determine if the recipient has made a choice of a plan or has
2560 opted out because of duress, threats, payment to the recipient,
2561 or incentives promised to the recipient by a third party. If the
2562 choice counseling entity determines that the decision to choose
2563 a plan was unlawfully influenced or a plan violated any of the
2564 provisions of s. 409.912(20) ~~(21)~~, the choice counseling entity
2565 shall immediately report the violation to the agency's program
2566 integrity section for investigation. Verification of choice
2567 counseling by the recipient shall include a stipulation that the
2568 recipient acknowledges the provisions of this subsection.
2569 (p) To implement standards for plan compliance, including,
2570 but not limited to, standards for quality assurance and
2571 performance improvement, standards for peer or professional
2572 reviews, grievance policies, and policies for maintaining

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2573 program integrity. The agency shall develop a data-reporting
2574 system, seek input from managed care plans in order to establish
2575 requirements for patient-encounter reporting, and ensure that
2576 the data reported is accurate and complete.
2577 1. In performing the duties required under this section,
2578 the agency shall work with managed care plans to establish a
2579 uniform system to measure and monitor outcomes for a recipient
2580 of Medicaid services.
2581 2. The system shall use financial, clinical, and other
2582 criteria based on pharmacy, medical services, and other data
2583 that is related to the provision of Medicaid services,
2584 including, but not limited to:
2585 a. The Health Plan Employer Data and Information Set
2586 (HEDIS) or measures that are similar to HEDIS.
2587 b. Member satisfaction.
2588 c. Provider satisfaction.
2589 d. Report cards on plan performance and best practices.
2590 e. Compliance with the requirements for prompt payment of
2591 claims under ss. 627.613, 641.3155, and 641.513.
2592 f. Utilization and quality data for the purpose of
2593 ensuring access to medically necessary services, including
2594 underutilization or inappropriate denial of services.
2595 3. The agency shall require the managed care plans that
2596 have contracted with the agency to establish a quality assurance
2597 system that incorporates the provisions of s. 409.912(26) ~~(27)~~
2598 and any standards, rules, and guidelines developed by the
2599 agency.
2600 4. The agency shall establish an encounter database in

2601 order to compile data on health services rendered by health care
2602 practitioners who provide services to patients enrolled in
2603 managed care plans in the demonstration sites. The encounter
2604 database shall:
2605 a. Collect the following for each type of patient
2606 encounter with a health care practitioner or facility,
2607 including:
2608 (I) The demographic characteristics of the patient.
2609 (II) The principal, secondary, and tertiary diagnosis.
2610 (III) The procedure performed.
2611 (IV) The date and location where the procedure was
2612 performed.
2613 (V) The payment for the procedure, if any.
2614 (VI) If applicable, the health care practitioner's
2615 universal identification number.
2616 (VII) If the health care practitioner rendering the
2617 service is a dependent practitioner, the modifiers appropriate
2618 to indicate that the service was delivered by the dependent
2619 practitioner.
2620 b. Collect appropriate information relating to
2621 prescription drugs for each type of patient encounter.
2622 c. Collect appropriate information related to health care
2623 costs and utilization from managed care plans participating in
2624 the demonstration sites.
2625 5. To the extent practicable, when collecting the data the
2626 agency shall use a standardized claim form or electronic
2627 transfer system that is used by health care practitioners,
2628 facilities, and payors.

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2629 6. Health care practitioners and facilities in the
2630 demonstration sites shall electronically submit, and managed
2631 care plans participating in the demonstration sites shall
2632 electronically receive, information concerning claims payments
2633 and any other information reasonably related to the encounter
2634 database using a standard format as required by the agency.
2635 7. The agency shall establish reasonable deadlines for
2636 phasing in the electronic transmittal of full encounter data.
2637 8. The system must ensure that the data reported is
2638 accurate and complete.
2639 (w) To implement procedures to minimize the risk of
2640 Medicaid fraud and abuse in all plans operating in the Medicaid
2641 managed care pilot program authorized in this section.
2642 1. The agency shall ensure that applicable provisions of
2643 this chapter and chapters 414, 626, 641, and 932 which relate to
2644 Medicaid fraud and abuse are applied and enforced at the
2645 demonstration project sites.
2646 2. Providers must have the certification, license, and
2647 credentials that are required by law and waiver requirements.
2648 3. The agency shall ensure that the plan is in compliance
2649 with s. 409.912(20) and (21) ~~and (22)~~.
2650 4. The agency shall require that each plan establish
2651 functions and activities governing program integrity in order to
2652 reduce the incidence of fraud and abuse. Plans must report
2653 instances of fraud and abuse pursuant to chapter 641.
2654 5. The plan shall have written administrative and
2655 management arrangements or procedures, including a mandatory
2656 compliance plan, which are designed to guard against fraud and

2657 abuse. The plan shall designate a compliance officer who has
2658 sufficient experience in health care.
2659 6.a. The agency shall require all managed care plan
2660 contractors in the pilot program to report all instances of
2661 suspected fraud and abuse. A failure to report instances of
2662 suspected fraud and abuse is a violation of law and subject to
2663 the penalties provided by law.
2664 b. An instance of fraud and abuse in the managed care
2665 plan, including, but not limited to, defrauding the state health
2666 care benefit program by misrepresentation of fact in reports,
2667 claims, certifications, enrollment claims, demographic
2668 statistics, or patient-encounter data; misrepresentation of the
2669 qualifications of persons rendering health care and ancillary
2670 services; bribery and false statements relating to the delivery
2671 of health care; unfair and deceptive marketing practices; and
2672 false claims actions in the provision of managed care, is a
2673 violation of law and subject to the penalties provided by law.
2674 c. The agency shall require that all contractors make all
2675 files and relevant billing and claims data accessible to state
2676 regulators and investigators and that all such data is linked
2677 into a unified system to ensure consistent reviews and
2678 investigations.
2679 (dd) To implement service delivery mechanisms within a
2680 specialty plan in area 10 to provide behavioral health care
2681 services to Medicaid-eligible children whose cases are open for
2682 child welfare services in the HomeSafeNet system. These services
2683 must be coordinated with community-based care providers as
2684 specified in s. 409.1671, where available, and be sufficient to

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2685 meet the developmental, behavioral, and emotional needs of these
2686 children. Children in area 10 who have an open case in the
2687 HomeSafeNet system shall be enrolled into the specialty plan.
2688 These service delivery mechanisms must be implemented no later
2689 than July 1, 2011, in AHCA area 10 in order for the children in
2690 AHCA area 10 to remain exempt from the statewide plan under s.
2691 409.912(4)(b)5.~~8.~~ An administrative fee may be paid to the
2692 specialty plan for the coordination of services based on the
2693 receipt of the state share of that fee being provided through
2694 intergovernmental transfers.
2695 Section 15. Effective October 1, 2014, section 409.91211,
2696 Florida Statutes, is repealed.
2697 Section 16. Section 409.9122, Florida Statutes, is amended
2698 to read:
2699 409.9122 Mandatory Medicaid managed care enrollment;
2700 programs and procedures.—
2701 (1) It is the intent of the Legislature that the MediPass
2702 program be cost-effective, provide quality health care, and
2703 improve access to health services, and that the program be
2704 statewide. This subsection expires October 1, 2014.
2705 (2)(a) The agency shall enroll in a managed care plan or
2706 MediPass all Medicaid recipients, except those Medicaid
2707 recipients who are: in an institution; enrolled in the Medicaid
2708 medically needy program; or eligible for both Medicaid and
2709 Medicare. Upon enrollment, individuals will be able to change
2710 their managed care option during the 90-day opt out period
2711 required by federal Medicaid regulations. The agency is
2712 authorized to seek the necessary Medicaid state plan amendment

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2713 to implement this policy. However, to the extent permitted by
2714 federal law, the agency may enroll in a managed care plan or
2715 MediPass a Medicaid recipient who is exempt from mandatory
2716 managed care enrollment, provided that:
2717 1. The recipient's decision to enroll in a managed care
2718 plan or MediPass is voluntary;
2719 2. If the recipient chooses to enroll in a managed care
2720 plan, the agency has determined that the managed care plan
2721 provides specific programs and services which address the
2722 special health needs of the recipient; and
2723 3. The agency receives any necessary waivers from the
2724 federal Centers for Medicare and Medicaid Services.
2725
2726 ~~The agency shall develop rules to establish policies by which~~
2727 ~~exceptions to the mandatory managed care enrollment requirement~~
2728 ~~may be made on a case-by-case basis. The rules shall include the~~
2729 ~~specific criteria to be applied when making a determination as~~
2730 ~~to whether to exempt a recipient from mandatory enrollment in a~~
2731 ~~managed care plan or MediPass.~~ School districts participating in
2732 the certified school match program pursuant to ss. 409.908(21)
2733 and 1011.70 shall be reimbursed by Medicaid, subject to the
2734 limitations of s. 1011.70(1), for a Medicaid-eligible child
2735 participating in the services as authorized in s. 1011.70, as
2736 provided for in s. 409.9071, regardless of whether the child is
2737 enrolled in MediPass or a managed care plan. Managed care plans
2738 shall make a good faith effort to execute agreements with school
2739 districts regarding the coordinated provision of services
2740 authorized under s. 1011.70. County health departments

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2741 delivering school-based services pursuant to ss. 381.0056 and
2742 381.0057 shall be reimbursed by Medicaid for the federal share
2743 for a Medicaid-eligible child who receives Medicaid-covered
2744 services in a school setting, regardless of whether the child is
2745 enrolled in MediPass or a managed care plan. Managed care plans
2746 shall make a good faith effort to execute agreements with county
2747 health departments regarding the coordinated provision of
2748 services to a Medicaid-eligible child. To ensure continuity of
2749 care for Medicaid patients, the agency, the Department of
2750 Health, and the Department of Education shall develop procedures
2751 for ensuring that a student's managed care plan or MediPass
2752 provider receives information relating to services provided in
2753 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
2754 (b) A Medicaid recipient shall not be enrolled in or
2755 assigned to a managed care plan or MediPass unless the managed
2756 care plan or MediPass has complied with the quality-of-care
2757 standards specified in paragraphs (3)(a) and (b), respectively.
2758 (c) Medicaid recipients shall have a choice of managed
2759 care plans or MediPass. The Agency for Health Care
2760 Administration, the Department of Health, the Department of
2761 Children and Family Services, and the Department of Elderly
2762 Affairs shall cooperate to ensure that each Medicaid recipient
2763 receives clear and easily understandable information that meets
2764 the following requirements:
2765 1. Explains the concept of managed care, including
2766 MediPass.
2767 2. Provides information on the comparative performance of
2768 managed care plans and MediPass in the areas of quality,

2769 credentialing, preventive health programs, network size and
2770 availability, and patient satisfaction.
2771 3. Explains where additional information on each managed
2772 care plan and MediPass in the recipient's area can be obtained.
2773 4. Explains that recipients have the right to choose their
2774 managed care coverage at the time they first enroll in Medicaid
2775 and again at regular intervals set by the agency. However, if a
2776 recipient does not choose a managed care plan or MediPass, the
2777 agency will assign the recipient to a managed care plan or
2778 MediPass according to the criteria specified in this section.
2779 5. Explains the recipient's right to complain, file a
2780 grievance, or change managed care plans or MediPass providers if
2781 the recipient is not satisfied with the managed care plan or
2782 MediPass.
2783 (d) The agency shall develop a mechanism for providing
2784 information to Medicaid recipients for the purpose of making a
2785 managed care plan or MediPass selection. Examples of such
2786 mechanisms may include, but not be limited to, interactive
2787 information systems, mailings, and mass marketing materials.
2788 Managed care plans and MediPass providers are prohibited from
2789 providing inducements to Medicaid recipients to select their
2790 plans or from prejudicing Medicaid recipients against other
2791 managed care plans or MediPass providers.
2792 (e) Medicaid recipients who are already enrolled in a
2793 managed care plan or MediPass shall be offered the opportunity
2794 to change managed care plans or MediPass providers on a
2795 staggered basis, as defined by the agency. All Medicaid
2796 recipients shall have 30 days in which to make a choice of

2797 managed care plans or MediPass providers. Those Medicaid
2798 recipients who do not make a choice shall be assigned in
2799 accordance with paragraph (f). To facilitate continuity of care,
2800 for a Medicaid recipient who is also a recipient of Supplemental
2801 Security Income (SSI), prior to assigning the SSI recipient to a
2802 managed care plan or MediPass, the agency shall determine
2803 whether the SSI recipient has an ongoing relationship with a
2804 MediPass provider or managed care plan, and if so, the agency
2805 shall assign the SSI recipient to that MediPass provider or
2806 managed care plan. Those SSI recipients who do not have such a
2807 provider relationship shall be assigned to a managed care plan
2808 or MediPass provider in accordance with paragraph (f).
2809 (f) If a Medicaid recipient does not choose a managed care
2810 plan or MediPass provider, the agency shall assign the Medicaid
2811 recipient to a managed care plan or MediPass provider. Medicaid
2812 recipients eligible for managed care plan enrollment who are
2813 subject to mandatory assignment but who fail to make a choice
2814 shall be assigned to managed care plans until an enrollment of
2815 35 percent in MediPass and 65 percent in managed care plans, of
2816 all those eligible to choose managed care, is achieved. Once
2817 this enrollment is achieved, the assignments shall be divided in
2818 order to maintain an enrollment in MediPass and managed care
2819 plans which is in a 35 percent and 65 percent proportion,
2820 respectively. Thereafter, assignment of Medicaid recipients who
2821 fail to make a choice shall be based proportionally on the
2822 preferences of recipients who have made a choice in the previous
2823 period. Such proportions shall be revised at least quarterly to
2824 reflect an update of the preferences of Medicaid recipients. The

2825 agency shall disproportionately assign Medicaid-eligible
2826 recipients who are required to but have failed to make a choice
2827 of managed care plan or MediPass~~, including children, and who~~
2828 ~~would be assigned to the MediPass program~~ to the ~~children's~~
2829 ~~networks as described in s. 409.912(4)(g),~~ Children's Medical
2830 Services Network as defined in s. 391.021, exclusive provider
2831 organizations, provider service networks, minority physician
2832 networks, and pediatric emergency department diversion programs
2833 authorized by this chapter or the General Appropriations Act, in
2834 such manner as the agency deems appropriate, until the agency
2835 has determined that the networks and programs have sufficient
2836 numbers to be operated economically. For purposes of this
2837 paragraph, when referring to assignment, the term "managed care
2838 plans" includes health maintenance organizations, exclusive
2839 provider organizations, provider service networks, minority
2840 physician networks, Children's Medical Services Network, and
2841 pediatric emergency department diversion programs authorized by
2842 this chapter or the General Appropriations Act. When making
2843 assignments, the agency shall take into account the following
2844 criteria:
2845 1. A managed care plan has sufficient network capacity to
2846 meet the need of members.
2847 2. The managed care plan or MediPass has previously
2848 enrolled the recipient as a member, or one of the managed care
2849 plan's primary care providers or MediPass providers has
2850 previously provided health care to the recipient.
2851 3. The agency has knowledge that the member has previously
2852 expressed a preference for a particular managed care plan or

2853 MediPass provider as indicated by Medicaid fee-for-service
2854 claims data, but has failed to make a choice.
2855 4. The managed care plan's or MediPass primary care
2856 providers are geographically accessible to the recipient's
2857 residence.
2858 (g) When more than one managed care plan or MediPass
2859 provider meets the criteria specified in paragraph (f), the
2860 agency shall make recipient assignments consecutively by family
2861 unit.
2862 (h) The agency may not engage in practices that are
2863 designed to favor one managed care plan over another or that are
2864 designed to influence Medicaid recipients to enroll in MediPass
2865 rather than in a managed care plan or to enroll in a managed
2866 care plan rather than in MediPass. This subsection does not
2867 prohibit the agency from reporting on the performance of
2868 MediPass or any managed care plan, as measured by performance
2869 criteria developed by the agency.
2870 (i) After a recipient has made his or her selection or has
2871 been enrolled in a managed care plan or MediPass, the recipient
2872 shall have 90 days to exercise the opportunity to voluntarily
2873 disenroll and select another managed care plan or MediPass.
2874 After 90 days, no further changes may be made except for good
2875 cause. Good cause includes, but is not limited to, poor quality
2876 of care, lack of access to necessary specialty services, an
2877 unreasonable delay or denial of service, or fraudulent
2878 enrollment. The agency shall develop criteria for good cause
2879 disenrollment for chronically ill and disabled populations who
2880 are assigned to managed care plans if more appropriate care is

2881 available through the MediPass program. The agency must make a
2882 determination as to whether cause exists. However, the agency
2883 may require a recipient to use the managed care plan's or
2884 MediPass grievance process prior to the agency's determination
2885 of cause, except in cases in which immediate risk of permanent
2886 damage to the recipient's health is alleged. The grievance
2887 process, when utilized, must be completed in time to permit the
2888 recipient to disenroll by the first day of the second month
2889 after the month the disenrollment request was made. If the
2890 managed care plan or MediPass, as a result of the grievance
2891 process, approves an enrollee's request to disenroll, the agency
2892 is not required to make a determination in the case. The agency
2893 must make a determination and take final action on a recipient's
2894 request so that disenrollment occurs no later than the first day
2895 of the second month after the month the request was made. If the
2896 agency fails to act within the specified timeframe, the
2897 recipient's request to disenroll is deemed to be approved as of
2898 the date agency action was required. Recipients who disagree
2899 with the agency's finding that cause does not exist for
2900 disenrollment shall be advised of their right to pursue a
2901 Medicaid fair hearing to dispute the agency's finding.
2902 (j) The agency shall apply for a federal waiver from the
2903 Centers for Medicare and Medicaid Services to lock eligible
2904 Medicaid recipients into a managed care plan or MediPass for 12
2905 months after an open enrollment period. After 12 months'
2906 enrollment, a recipient may select another managed care plan or
2907 MediPass provider. However, nothing shall prevent a Medicaid
2908 recipient from changing primary care providers within the

2909 managed care plan or MediPass program during the 12-month
2910 period.
2911 (k) When a Medicaid recipient does not choose a managed
2912 care plan or MediPass provider, the agency shall assign the
2913 Medicaid recipient to a managed care plan, except in those
2914 counties in which there are fewer than two managed care plans
2915 accepting Medicaid enrollees, in which case assignment shall be
2916 to a managed care plan or a MediPass provider. Medicaid
2917 recipients in counties with fewer than two managed care plans
2918 accepting Medicaid enrollees who are subject to mandatory
2919 assignment but who fail to make a choice shall be assigned to
2920 managed care plans until an enrollment of 35 percent in MediPass
2921 and 65 percent in managed care plans, of all those eligible to
2922 choose managed care, is achieved. Once that enrollment is
2923 achieved, the assignments shall be divided in order to maintain
2924 an enrollment in MediPass and managed care plans which is in a
2925 35 percent and 65 percent proportion, respectively. For purposes
2926 of this paragraph, when referring to assignment, the term
2927 "managed care plans" includes exclusive provider organizations,
2928 provider service networks, Children's Medical Services Network,
2929 minority physician networks, and pediatric emergency department
2930 diversion programs authorized by this chapter or the General
2931 Appropriations Act. When making assignments, the agency shall
2932 take into account the following criteria:
2933 1. A managed care plan has sufficient network capacity to
2934 meet the need of members.
2935 2. The managed care plan or MediPass has previously
2936 enrolled the recipient as a member, or one of the managed care

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2937 plan's primary care providers or MediPass providers has
2938 previously provided health care to the recipient.
2939 3. The agency has knowledge that the member has previously
2940 expressed a preference for a particular managed care plan or
2941 MediPass provider as indicated by Medicaid fee-for-service
2942 claims data, but has failed to make a choice.
2943 4. The managed care plan's or MediPass primary care
2944 providers are geographically accessible to the recipient's
2945 residence.
2946 5. The agency has authority to make mandatory assignments
2947 based on quality of service and performance of managed care
2948 plans.
2949 (l) Notwithstanding the provisions of chapter 287, the
2950 agency may, at its discretion, renew cost-effective contracts
2951 for choice counseling services once or more for such periods as
2952 the agency may decide. However, all such renewals may not
2953 combine to exceed a total period longer than the term of the
2954 original contract.
2955
2956 This subsection expires October 1, 2014.
2957 (3)(a) The agency shall establish quality-of-care
2958 standards for managed care plans. These standards shall be based
2959 upon, but are not limited to:
2960 1. Compliance with the accreditation requirements as
2961 provided in s. 641.512.
2962 2. Compliance with Early and Periodic Screening,
2963 Diagnosis, and Treatment screening requirements.
2964 3. The percentage of voluntary disenrollments.

2965 4. Immunization rates.
2966 5. Standards of the National Committee for Quality
2967 Assurance and other approved accrediting bodies.
2968 6. Recommendations of other authoritative bodies.
2969 7. Specific requirements of the Medicaid program, or
2970 standards designed to specifically assist the unique needs of
2971 Medicaid recipients.
2972 8. Compliance with the health quality improvement system
2973 as established by the agency, which incorporates standards and
2974 guidelines developed by the Medicaid Bureau of the Health Care
2975 Financing Administration as part of the quality assurance reform
2976 initiative.
2977 (b) For the MediPass program, the agency shall establish
2978 standards which are based upon, but are not limited to:
2979 1. Quality-of-care standards which are comparable to those
2980 required of managed care plans.
2981 2. Credentialing standards for MediPass providers.
2982 3. Compliance with Early and Periodic Screening,
2983 Diagnosis, and Treatment screening requirements.
2984 4. Immunization rates.
2985 5. Specific requirements of the Medicaid program, or
2986 standards designed to specifically assist the unique needs of
2987 Medicaid recipients.
2988
2989 This subsection expires October 1, 2014.
2990 (4)(a) Each female recipient may select as her primary
2991 care provider an obstetrician/gynecologist who has agreed to
2992 participate as a MediPass primary care case manager.

2993 (b) The agency shall establish a complaints and grievance
2994 process to assist Medicaid recipients enrolled in the MediPass
2995 program to resolve complaints and grievances. The agency shall
2996 investigate reports of quality-of-care grievances which remain
2997 unresolved to the satisfaction of the enrollee.
2998
2999 This subsection expires October 1, 2014.
3000 (5)(a) The agency shall work cooperatively with the Social
3001 Security Administration to identify beneficiaries who are
3002 jointly eligible for Medicare and Medicaid and shall develop
3003 cooperative programs to encourage these beneficiaries to enroll
3004 in a Medicare participating health maintenance organization or
3005 prepaid health plans.
3006 (b) The agency shall work cooperatively with the
3007 Department of Elderly Affairs to assess the potential cost-
3008 effectiveness of providing MediPass to beneficiaries who are
3009 jointly eligible for Medicare and Medicaid on a voluntary choice
3010 basis. If the agency determines that enrollment of these
3011 beneficiaries in MediPass has the potential for being cost-
3012 effective for the state, the agency shall offer MediPass to
3013 these beneficiaries on a voluntary choice basis in the counties
3014 where MediPass operates.
3015
3016 This subsection expires October 1, 2014.
3017 (6) MediPass enrolled recipients may receive up to 10
3018 visits of reimbursable services by participating Medicaid
3019 physicians licensed under chapter 460 and up to four visits of
3020 reimbursable services by participating Medicaid physicians

3021 licensed under chapter 461. Any further visits must be by prior
3022 authorization by the MediPass primary care provider. However,
3023 nothing in this subsection may be construed to increase the
3024 total number of visits or the total amount of dollars per year
3025 per person under current Medicaid rules, unless otherwise
3026 provided for in the General Appropriations Act. <u>This subsection</u>
3027 <u>expires October 1, 2014.</u>
3028 ~~(7) The agency shall investigate the feasibility of~~
3029 ~~developing managed care plan and MediPass options for the~~
3030 ~~following groups of Medicaid recipients:~~
3031 ~~(a) Pregnant women and infants.~~
3032 ~~(b) Elderly and disabled recipients, especially those who~~
3033 ~~are at risk of nursing home placement.~~
3034 ~~(c) Persons with developmental disabilities.~~
3035 ~~(d) Qualified Medicare beneficiaries.~~
3036 ~~(e) Adults who have chronic, high-cost medical conditions.~~
3037 ~~(f) Adults and children who have mental health problems.~~
3038 ~~(g) Other recipients for whom managed care plans and~~
3039 ~~MediPass offer the opportunity of more cost-effective care and~~
3040 ~~greater access to qualified providers.~~
3041 ~~(8)(a) The agency shall encourage the development of~~
3042 ~~public and private partnerships to foster the growth of health~~
3043 ~~maintenance organizations and prepaid health plans that will~~
3044 ~~provide high-quality health care to Medicaid recipients.~~
3045 ~~(b) Subject to the availability of moneys and any~~
3046 ~~limitations established by the General Appropriations Act or~~
3047 ~~chapter 216, the agency is authorized to enter into contracts~~
3048 ~~with traditional providers of health care to low-income persons~~

3049 ~~to assist such providers with the technical aspects of~~
3050 ~~cooperatively developing Medicaid prepaid health plans.~~
3051 ~~1. The agency may contract with disproportionate share~~
3052 ~~hospitals, county health departments, federally initiated or~~
3053 ~~federally funded community health centers, and counties that~~
3054 ~~operate either a hospital or a community clinic.~~
3055 ~~2. A contract may not be for more than $100,000 per year,~~
3056 ~~and no contract may be extended with any particular provider for~~
3057 ~~more than 2 years. The contract is intended only as seed or~~
3058 ~~development funding and requires a commitment from the~~
3059 ~~interested party.~~
3060 ~~3. A contract must require participation by at least one~~
3061 ~~community health clinic and one disproportionate share hospital.~~
3062 (7) ~~(9)~~(a) The agency shall develop and implement a
3063 comprehensive plan to ensure that recipients are adequately
3064 informed of their choices and rights under all Medicaid managed
3065 care programs and that Medicaid managed care programs meet
3066 acceptable standards of quality in patient care, patient
3067 satisfaction, and financial solvency.
3068 (b) The agency shall provide adequate means for informing
3069 patients of their choice and rights under a managed care plan at
3070 the time of eligibility determination.
3071 (c) The agency shall require managed care plans and
3072 MediPass providers to demonstrate and document plans and
3073 activities, as defined by rule, including outreach and followup,
3074 undertaken to ensure that Medicaid recipients receive the health
3075 care service to which they are entitled.
3076

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3077 This subsection expires October 1, 2014.
3078 (8) ~~(10)~~ The agency shall consult with Medicaid consumers
3079 and their representatives on an ongoing basis regarding
3080 measurements of patient satisfaction, procedures for resolving
3081 patient grievances, standards for ensuring quality of care,
3082 mechanisms for providing patient access to services, and
3083 policies affecting patient care. This subsection expires October
3084 1, 2014.
3085 (9) ~~(11)~~ The agency may extend eligibility for Medicaid
3086 recipients enrolled in licensed and accredited health
3087 maintenance organizations for the duration of the enrollment
3088 period or for 6 months, whichever is earlier, provided the
3089 agency certifies that such an offer will not increase state
3090 expenditures. This subsection expires October 1, 2013.
3091 (10) ~~(12)~~ A managed care plan that has a Medicaid contract
3092 shall at least annually review each primary care physician's
3093 active patient load and shall ensure that additional Medicaid
3094 recipients are not assigned to physicians who have a total
3095 active patient load of more than 3,000 patients. As used in this
3096 subsection, the term "active patient" means a patient who is
3097 seen by the same primary care physician, or by a physician
3098 assistant or advanced registered nurse practitioner under the
3099 supervision of the primary care physician, at least three times
3100 within a calendar year. Each primary care physician shall
3101 annually certify to the managed care plan whether or not his or
3102 her patient load exceeds the limits established under this
3103 subsection and the managed care plan shall accept such
3104 certification on face value as compliance with this subsection.

3105 The agency shall accept the managed care plan's representations
3106 that it is in compliance with this subsection based on the
3107 certification of its primary care physicians, unless the agency
3108 has an objective indication that access to primary care is being
3109 compromised, such as receiving complaints or grievances relating
3110 to access to care. If the agency determines that an objective
3111 indication exists that access to primary care is being
3112 compromised, it may verify the patient load certifications
3113 submitted by the managed care plan's primary care physicians and
3114 that the managed care plan is not assigning Medicaid recipients
3115 to primary care physicians who have an active patient load of
3116 more than 3,000 patients. This subsection expires October 1,
3117 2014.
3118 (11)~~(13)~~ Effective July 1, 2003, the agency shall adjust
3119 the enrollee assignment process of Medicaid managed prepaid
3120 health plans for those Medicaid managed prepaid plans operating
3121 in Miami-Dade County which have executed a contract with the
3122 agency for a minimum of 8 consecutive years in order for the
3123 Medicaid managed prepaid plan to maintain a minimum enrollment
3124 level of 15,000 members per month. When assigning enrollees
3125 pursuant to this subsection, the agency shall give priority to
3126 providers that initially qualified under this subsection until
3127 such providers reach and maintain an enrollment level of 15,000
3128 members per month. A prepaid health plan that has a statewide
3129 Medicaid enrollment of 25,000 or more members is not eligible
3130 for enrollee assignments under this subsection. This subsection
3131 expires October 1, 2014.
3132 (12)~~(14)~~ The agency shall include in its calculation of

3133 the hospital inpatient component of a Medicaid health
3134 maintenance organization's capitation rate any special payments,
3135 including, but not limited to, upper payment limit or
3136 disproportionate share hospital payments, made to qualifying
3137 hospitals through the fee-for-service program. The agency may
3138 seek federal waiver approval or state plan amendment as needed
3139 to implement this adjustment.
3140 (13) The agency shall develop a process to enable any
3141 recipient with access to employer-sponsored health care coverage
3142 to opt out of all eligible plans in the Medicaid program and to
3143 use Medicaid financial assistance to pay for the recipient's
3144 share of cost in any such employer-sponsored coverage.
3145 Contingent on federal approval, the agency shall also enable
3146 recipients with access to other insurance or related products
3147 that provide access to health care services created pursuant to
3148 state law, including any plan or product available pursuant to
3149 the Florida Health Choices Program or any health exchange, to
3150 opt out. The amount of financial assistance provided for each
3151 recipient may not exceed the amount of the Medicaid premium that
3152 would have been paid to a plan for that recipient.
3153 (14) The agency shall maintain and operate the Medicaid
3154 Encounter Data System to collect, process, store, and report on
3155 covered services provided to all Florida Medicaid recipients
3156 enrolled in prepaid managed care plans.
3157 (a) Prepaid managed care plans shall submit encounter data
3158 electronically in a format that complies with the Health
3159 Insurance Portability and Accountability Act provisions for
3160 electronic claims and in accordance with deadlines established

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3161 by the agency. Prepaid managed care plans must certify that the
3162 data reported is accurate and complete.
3163 (b) The agency is responsible for validating the data
3164 submitted by the plans. The agency shall develop methods and
3165 protocols for ongoing analysis of the encounter data that
3166 adjusts for differences in characteristics of prepaid plan
3167 enrollees to allow comparison of service utilization among plans
3168 and against expected levels of use. The analysis shall be used
3169 to identify possible cases of systemic underutilization or
3170 denials of claims and inappropriate service utilization such as
3171 higher-than-expected emergency department encounters. The
3172 analysis shall provide periodic feedback to the plans and enable
3173 the agency to establish corrective action plans when necessary.
3174 One of the focus areas for the analysis shall be the use of
3175 prescription drugs.
3176 (15) The agency may establish a per-member, per-month
3177 payment for Medicare Advantage Special Needs members that are
3178 also eligible for Medicaid as a mechanism for meeting the
3179 state's cost-sharing obligation. The agency may also develop a
3180 per-member, per-month payment only for Medicaid-covered services
3181 for which the state is responsible. The agency shall develop a
3182 mechanism to ensure that such per-member, per-month payment
3183 enhances the value to the state and enrolled members by limiting
3184 cost sharing, enhances the scope of Medicare supplemental
3185 benefits that are equal to or greater than Medicaid coverage for
3186 select services, and improves care coordination.
3187 (16) The agency shall establish, and managed care plans
3188 shall use, a uniform method of accounting for and reporting

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3189 medical and nonmedical costs. The agency shall make such
3190 information available to the public.
3191 (17) The agency may, on a case-by-case basis, exempt a
3192 recipient from mandatory enrollment in a managed care plan when
3193 the recipient has a unique, time-limited disease or condition-
3194 related circumstance and managed care enrollment will interfere
3195 with ongoing care because the recipient's provider does not
3196 participate in the managed care plans available in the
3197 recipient's area.
3198 (18) The agency shall contract with a single provider
3199 service network to function as a third-party administrator and
3200 managing entity for the MediPass program in all counties with
3201 fewer than two prepaid plans. The contractor may earn an
3202 administrative fee, if the fee is less than any savings
3203 determined by the reconciliation process pursuant to s.
3204 409.912(4)(d)1. This subsection expires October 1, 2014, or upon
3205 full implementation of the managed medical assistance program,
3206 whichever is sooner.
3207 Section 17. Subsection (15) of section 430.04, Florida
3208 Statutes, is amended to read:
3209 430.04 Duties and responsibilities of the Department of
3210 Elderly Affairs.—The Department of Elderly Affairs shall:
3211 (15) Administer all Medicaid waivers and programs relating
3212 to elders and their appropriations. The waivers include, but are
3213 not limited to:
3214 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
3215 ~~established in s. 430.502(7), (8), and (9).~~
3216 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.

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3217 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.
3218 (c) ~~(d)~~ The Adult Day Health Care Waiver.
3219 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined
3220 in s. 409.221.
3221 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.
3222 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
3223 Project as described in s. 430.705.
3224 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
3225
3226 The department shall develop a transition plan for recipients
3227 receiving services in long-term care Medicaid waivers for elders
3228 or disabled adults on the date eligible plans become available
3229 in each recipient's region defined in s. 409.981(2) to enroll
3230 those recipients in eligible plans. This subsection expires
3231 October 1, 2013.
3232 Section 18. Section 430.2053, Florida Statutes, is amended
3233 to read:
3234 430.2053 Aging resource centers.—
3235 (1) The department, in consultation with the Agency for
3236 Health Care Administration and the Department of Children and
3237 Family Services, shall develop pilot projects for aging resource
3238 centers. ~~By October 31, 2004, the department, in consultation~~
3239 ~~with the agency and the Department of Children and Family~~
3240 ~~Services, shall develop an implementation plan for aging~~
3241 ~~resource centers and submit the plan to the Governor, the~~
3242 ~~President of the Senate, and the Speaker of the House of~~
3243 ~~Representatives. The plan must include qualifications for~~
3244 ~~designation as a center, the functions to be performed by each~~

3245 ~~center, and a process for determining that a current area agency~~
3246 ~~on aging is ready to assume the functions of an aging resource~~
3247 ~~center.~~
3248 ~~(2) Each area agency on aging shall develop, in~~
3249 ~~consultation with the existing community care for the elderly~~
3250 ~~lead agencies within their planning and service areas, a~~
3251 ~~proposal that describes the process the area agency on aging~~
3252 ~~intends to undertake to transition to an aging resource center~~
3253 ~~prior to July 1, 2005, and that describes the area agency's~~
3254 ~~compliance with the requirements of this section. The proposals~~
3255 ~~must be submitted to the department prior to December 31, 2004.~~
3256 ~~The department shall evaluate all proposals for readiness and,~~
3257 ~~prior to March 1, 2005, shall select three area agencies on~~
3258 ~~aging which meet the requirements of this section to begin the~~
3259 ~~transition to aging resource centers. Those area agencies on~~
3260 ~~aging which are not selected to begin the transition to aging~~
3261 ~~resource centers shall, in consultation with the department and~~
3262 ~~the existing community care for the elderly lead agencies within~~
3263 ~~their planning and service areas, amend their proposals as~~
3264 ~~necessary and resubmit them to the department prior to July 1,~~
3265 ~~2005. The department may transition additional area agencies to~~
3266 ~~aging resource centers as it determines that area agencies are~~
3267 ~~in compliance with the requirements of this section.~~
3268 ~~(3) The Auditor General and the Office of Program Policy~~
3269 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
3270 ~~review and assess the department's process for determining an~~
3271 ~~area agency's readiness to transition to an aging resource~~
3272 ~~center.~~

3273 ~~(a) The review must, at a minimum, address the~~
3274 ~~appropriateness of the department's criteria for selection of an~~
3275 ~~area agency to transition to an aging resource center, the~~
3276 ~~instruments applied, the degree to which the department~~
3277 ~~accurately determined each area agency's compliance with the~~
3278 ~~readiness criteria, the quality of the technical assistance~~
3279 ~~provided by the department to an area agency in correcting any~~
3280 ~~weaknesses identified in the readiness assessment, and the~~
3281 ~~degree to which each area agency overcame any identified~~
3282 ~~weaknesses.~~
3283 ~~(b) Reports of these reviews must be submitted to the~~
3284 ~~appropriate substantive and appropriations committees in the~~
3285 ~~Senate and the House of Representatives on March 1 and September~~
3286 ~~1 of each year until full transition to aging resource centers~~
3287 ~~has been accomplished statewide, except that the first report~~
3288 ~~must be submitted by February 1, 2005, and must address all~~
3289 ~~readiness activities undertaken through December 31, 2004. The~~
3290 ~~perspectives of all participants in this review process must be~~
3291 ~~included in each report.~~
3292 (2) ~~(4)~~ The purposes of an aging resource center shall be:
3293 (a) To provide Florida's elders and their families with a
3294 locally focused, coordinated approach to integrating information
3295 and referral for all available services for elders with the
3296 eligibility determination entities for state and federally
3297 funded long-term-care services.
3298 (b) To provide for easier access to long-term-care
3299 services by Florida's elders and their families by creating
3300 multiple access points to the long-term-care network that flow

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3301 through one established entity with wide community recognition.
3302 (3) ~~(5)~~ The duties of an aging resource center are to:
3303 (a) Develop referral agreements with local community
3304 service organizations, such as senior centers, existing elder
3305 service providers, volunteer associations, and other similar
3306 organizations, to better assist clients who do not need or do
3307 not wish to enroll in programs funded by the department or the
3308 agency. The referral agreements must also include a protocol,
3309 developed and approved by the department, which provides
3310 specific actions that an aging resource center and local
3311 community service organizations must take when an elder or an
3312 elder's representative seeking information on long-term-care
3313 services contacts a local community service organization prior
3314 to contacting the aging resource center. The protocol shall be
3315 designed to ensure that elders and their families are able to
3316 access information and services in the most efficient and least
3317 cumbersome manner possible.
3318 (b) Provide an initial screening of all clients who
3319 request long-term-care services to determine whether the person
3320 would be most appropriately served through any combination of
3321 federally funded programs, state-funded programs, locally funded
3322 or community volunteer programs, or private funding for
3323 services.
3324 (c) Determine eligibility for the programs and services
3325 listed in subsection (9) ~~(11)~~ for persons residing within the
3326 geographic area served by the aging resource center and
3327 determine a priority ranking for services which is based upon
3328 the potential recipient's frailty level and likelihood of

3329 institutional placement without such services.
3330 (d) Manage the availability of financial resources for the
3331 programs and services listed in subsection (9) ~~(11)~~ for persons
3332 residing within the geographic area served by the aging resource
3333 center.
3334 (e) When financial resources become available, refer a
3335 client to the most appropriate entity to begin receiving
3336 services. The aging resource center shall make referrals to lead
3337 agencies for service provision that ensure that individuals who
3338 are vulnerable adults in need of services pursuant to s.
3339 415.104(3)(b), or who are victims of abuse, neglect, or
3340 exploitation in need of immediate services to prevent further
3341 harm and are referred by the adult protective services program,
3342 are given primary consideration for receiving community-care-
3343 for-the-elderly services in compliance with the requirements of
3344 s. 430.205(5)(a) and that other referrals for services are in
3345 compliance with s. 430.205(5)(b).
3346 (f) Convene a work group to advise in the planning,
3347 implementation, and evaluation of the aging resource center. The
3348 work group shall be comprised of representatives of local
3349 service providers, Alzheimer's Association chapters, housing
3350 authorities, social service organizations, advocacy groups,
3351 representatives of clients receiving services through the aging
3352 resource center, and any other persons or groups as determined
3353 by the department. The aging resource center, in consultation
3354 with the work group, must develop annual program improvement
3355 plans that shall be submitted to the department for
3356 consideration. The department shall review each annual

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3357 improvement plan and make recommendations on how to implement
3358 the components of the plan.
3359 (g) Enhance the existing area agency on aging in each
3360 planning and service area by integrating, either physically or
3361 virtually, the staff and services of the area agency on aging
3362 with the staff of the department's local CARES Medicaid ~~nursing~~
3363 ~~home~~ preadmission screening unit and a sufficient number of
3364 staff from the Department of Children and Family Services'
3365 Economic Self-Sufficiency Unit necessary to determine the
3366 financial eligibility for all persons age 60 and older residing
3367 within the area served by the aging resource center that are
3368 seeking Medicaid services, Supplemental Security Income, and
3369 food assistance.
3370 (h) Assist clients who request long-term care services in
3371 being evaluated for eligibility for enrollment in the Medicaid
3372 long-term care managed care program as eligible plans become
3373 available in each of the regions pursuant to s. 409.981(2).
3374 (i) Provide choice counseling for the Medicaid long-term
3375 care managed care program by integrating, either physically or
3376 virtually, choice counseling staff and services as eligible
3377 plans become available in each of the regions pursuant to s.
3378 409.981(2). Pursuant to s. 409.984(1), the agency may contract
3379 directly with the aging resource center to provide choice
3380 counseling services or may contract with another vendor if the
3381 aging resource center does not choose to provide such services.
3382 (j) Assist Medicaid recipients enrolled in the Medicaid
3383 long-term care managed care program with informally resolving
3384 grievances with a managed care network and assist Medicaid

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3385 recipients in accessing the managed care network's formal
3386 grievance process as eligible plans become available in each of
3387 the regions defined in s. 409.981(2).
3388 (4) ~~(6)~~ The department shall select the entities to become
3389 aging resource centers based on each entity's readiness and
3390 ability to perform the duties listed in subsection (3) ~~(5)~~ and
3391 the entity's:
3392 (a) Expertise in the needs of each target population the
3393 center proposes to serve and a thorough knowledge of the
3394 providers that serve these populations.
3395 (b) Strong connections to service providers, volunteer
3396 agencies, and community institutions.
3397 (c) Expertise in information and referral activities.
3398 (d) Knowledge of long-term-care resources, including
3399 resources designed to provide services in the least restrictive
3400 setting.
3401 (e) Financial solvency and stability.
3402 (f) Ability to collect, monitor, and analyze data in a
3403 timely and accurate manner, along with systems that meet the
3404 department's standards.
3405 (g) Commitment to adequate staffing by qualified personnel
3406 to effectively perform all functions.
3407 (h) Ability to meet all performance standards established
3408 by the department.
3409 (5) ~~(7)~~ The aging resource center shall have a governing
3410 body which shall be the same entity described in s. 20.41(7),
3411 and an executive director who may be the same person as
3412 described in s. 20.41(7). The governing body shall annually

3413 evaluate the performance of the executive director.
3414 (6) ~~(8)~~ The aging resource center may not be a provider of
3415 direct services other than choice counseling as eligible plans
3416 become available in each of the regions defined in s.
3417 409.981(2), information and referral services, and screening.
3418 (7) ~~(9)~~ The aging resource center must agree to allow the
3419 department to review any financial information the department
3420 determines is necessary for monitoring or reporting purposes,
3421 including financial relationships.
3422 (8) ~~(10)~~ The duties and responsibilities of the community
3423 care for the elderly lead agencies within each area served by an
3424 aging resource center shall be to:
3425 (a) Develop strong community partnerships to maximize the
3426 use of community resources for the purpose of assisting elders
3427 to remain in their community settings for as long as it is
3428 safely possible.
3429 (b) Conduct comprehensive assessments of clients that have
3430 been determined eligible and develop a care plan consistent with
3431 established protocols that ensures that the unique needs of each
3432 client are met.
3433 (9) ~~(11)~~ The services to be administered through the aging
3434 resource center shall include those funded by the following
3435 programs:
3436 (a) Community care for the elderly.
3437 (b) Home care for the elderly.
3438 (c) Contracted services.
3439 (d) Alzheimer's disease initiative.
3440 (e) Aged and disabled adult Medicaid waiver. This

3441 paragraph expires October 1, 2013.
3442 (f) Assisted living for the frail elderly Medicaid waiver.
3443 This paragraph expires October 1, 2013.
3444 (g) Older Americans Act.
3445 (10) ~~(12)~~ The department shall, prior to designation of an
3446 aging resource center, develop by rule operational and quality
3447 assurance standards and outcome measures to ensure that clients
3448 receiving services through all long-term-care programs
3449 administered through an aging resource center are receiving the
3450 appropriate care they require and that contractors and
3451 subcontractors are adhering to the terms of their contracts and
3452 are acting in the best interests of the clients they are
3453 serving, consistent with the intent of the Legislature to reduce
3454 the use of and cost of nursing home care. The department shall
3455 by rule provide operating procedures for aging resource centers,
3456 which shall include:
3457 (a) Minimum standards for financial operation, including
3458 audit procedures.
3459 (b) Procedures for monitoring and sanctioning of service
3460 providers.
3461 (c) Minimum standards for technology utilized by the aging
3462 resource center.
3463 (d) Minimum staff requirements which shall ensure that the
3464 aging resource center employs sufficient quality and quantity of
3465 staff to adequately meet the needs of the elders residing within
3466 the area served by the aging resource center.
3467 (e) Minimum accessibility standards, including hours of
3468 operation.

3469 (f) Minimum oversight standards for the governing body of
3470 the aging resource center to ensure its continuous involvement
3471 in, and accountability for, all matters related to the
3472 development, implementation, staffing, administration, and
3473 operations of the aging resource center.
3474 (g) Minimum education and experience requirements for
3475 executive directors and other executive staff positions of aging
3476 resource centers.
3477 (h) Minimum requirements regarding any executive staff
3478 positions that the aging resource center must employ and minimum
3479 requirements that a candidate must meet in order to be eligible
3480 for appointment to such positions.
3481 (11) ~~(13)~~ In an area in which the department has designated
3482 an area agency on aging as an aging resource center, the
3483 department and the agency shall not make payments for the
3484 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
3485 Community Diversion Project for such persons who were not
3486 screened and enrolled through the aging resource center. The
3487 department shall cease making payments for recipients in
3488 eligible plans as eligible plans become available in each of the
3489 regions defined in s. 409.981(2).
3490 (12) ~~(14)~~ Each aging resource center shall enter into a
3491 memorandum of understanding with the department for
3492 collaboration with the CARES unit staff. The memorandum of
3493 understanding shall outline the staff person responsible for
3494 each function and shall provide the staffing levels necessary to
3495 carry out the functions of the aging resource center.
3496 (13) ~~(15)~~ Each aging resource center shall enter into a

3497 memorandum of understanding with the Department of Children and
3498 Family Services for collaboration with the Economic Self-
3499 Sufficiency Unit staff. The memorandum of understanding shall
3500 outline which staff persons are responsible for which functions
3501 and shall provide the staffing levels necessary to carry out the
3502 functions of the aging resource center.
3503 (14) As eligible plans become available in each of the
3504 regions defined in s. 409.981(2), if an aging resource center
3505 does not contract with the agency to provide Medicaid long-term
3506 care managed care choice counseling pursuant to s. 409.984(1),
3507 the aging resource center shall enter into a memorandum of
3508 understanding with the agency to coordinate staffing and
3509 collaborate with the choice counseling vendor. The memorandum of
3510 understanding shall identify the staff responsible for each
3511 function and shall provide the staffing levels necessary to
3512 carry out the functions of the aging resource center.
3513 (15) (16) If any of the state activities described in this
3514 section are outsourced, either in part or in whole, the contract
3515 executing the outsourcing shall mandate that the contractor or
3516 its subcontractors shall, either physically or virtually,
3517 execute the provisions of the memorandum of understanding
3518 instead of the state entity whose function the contractor or
3519 subcontractor now performs.
3520 (16) (17) In order to be eligible to begin transitioning to
3521 an aging resource center, an area agency on aging board must
3522 ensure that the area agency on aging which it oversees meets all
3523 of the minimum requirements set by law and in rule.
3524 (18) The department shall monitor the three initial

3525 ~~projects for aging resource centers and report on the progress~~
3526 ~~of those projects to the Governor, the President of the Senate,~~
3527 ~~and the Speaker of the House of Representatives by June 30,~~
3528 ~~2005. The report must include an evaluation of the~~
3529 ~~implementation process.~~
3530 <u>(17)</u> ~~(19)~~ (a) Once an aging resource center is operational,
3531 the department, in consultation with the agency, may develop
3532 capitation rates for any of the programs administered through
3533 the aging resource center. Capitation rates for programs shall
3534 be based on the historical cost experience of the state in
3535 providing those same services to the population age 60 or older
3536 residing within each area served by an aging resource center.
3537 Each capitated rate may vary by geographic area as determined by
3538 the department.
3539 (b) The department and the agency may determine for each
3540 area served by an aging resource center whether it is
3541 appropriate, consistent with federal and state laws and
3542 regulations, to develop and pay separate capitated rates for
3543 each program administered through the aging resource center or
3544 to develop and pay capitated rates for service packages which
3545 include more than one program or service administered through
3546 the aging resource center.
3547 (c) Once capitation rates have been developed and
3548 certified as actuarially sound, the department and the agency
3549 may pay service providers the capitated rates for services when
3550 appropriate.
3551 (d) The department, in consultation with the agency, shall
3552 annually reevaluate and recertify the capitation rates,

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3553 adjusting forward to account for inflation, programmatic
3554 changes.
3555 ~~(20) The department, in consultation with the agency,~~
3556 ~~shall submit to the Governor, the President of the Senate, and~~
3557 ~~the Speaker of the House of Representatives, by December 1,~~
3558 ~~2006, a report addressing the feasibility of administering the~~
3559 ~~following services through aging resource centers beginning July~~
3560 ~~1, 2007:~~
3561 ~~(a) Medicaid nursing home services.~~
3562 ~~(b) Medicaid transportation services.~~
3563 ~~(c) Medicaid hospice care services.~~
3564 ~~(d) Medicaid intermediate care services.~~
3565 ~~(e) Medicaid prescribed drug services.~~
3566 ~~(f) Medicaid assistive care services.~~
3567 ~~(g) Any other long-term-care program or Medicaid service.~~
3568 <u>(18)</u>~~(21)~~ This section shall not be construed to allow an
3569 aging resource center to restrict, manage, or impede the local
3570 fundraising activities of service providers.
3571 Section 19. <u>Effective October 1, 2013, sections 430.701,</u>
3572 <u>430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,</u>
3573 <u>430.708, and 430.709, Florida Statutes, are repealed.</u>
3574 Section 20. <u>Sections 409.9301, 409.942, 409.944, 409.945,</u>
3575 <u>409.946, 409.953, and 409.9531, Florida Statutes, are renumbered</u>
3576 <u>as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and</u>
3577 <u>402.87, Florida Statutes, respectively.</u>
3578 Section 21. Paragraph (a) of subsection (1) of section
3579 443.111, Florida Statutes, is amended to read:
3580 443.111 Payment of benefits.—

3581 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
3582 in accordance with rules adopted by the Agency for Workforce
3583 Innovation, subject to the following requirements:
3584 (a) Benefits are payable by mail or electronically.
3585 Notwithstanding s. 402.84(4) ~~s. 409.942(4)~~, the agency may
3586 develop a system for the payment of benefits by electronic funds
3587 transfer, including, but not limited to, debit cards, electronic
3588 payment cards, or any other means of electronic payment that the
3589 agency deems to be commercially viable or cost-effective.
3590 Commodities or services related to the development of such a
3591 system shall be procured by competitive solicitation, unless
3592 they are purchased from a state term contract pursuant to s.
3593 287.056. The agency shall adopt rules necessary to administer
3594 the system.
3595 Section 22. Subsection (4) of section 641.386, Florida
3596 Statutes, is amended to read:
3597 641.386 Agent licensing and appointment required;
3598 exceptions.—
3599 (4) All agents and health maintenance organizations shall
3600 comply with and be subject to the applicable provisions of ss.
3601 641.309 and 409.912(20) ~~(21)~~, and all companies and entities
3602 appointing agents shall comply with s. 626.451, when marketing
3603 for any health maintenance organization licensed pursuant to
3604 this part, including those organizations under contract with the
3605 Agency for Health Care Administration to provide health care
3606 services to Medicaid recipients or any private entity providing
3607 health care services to Medicaid recipients pursuant to a
3608 prepaid health plan contract with the Agency for Health Care

3609 Administration.

3610 Section 23. The Agency for Health Care Administration
3611 shall develop a plan for implementing s. 409.975(8), Florida
3612 Statutes, and shall immediately seek federal approval to
3613 implement that subsection. The plan shall include a preliminary
3614 calculation of actuarially sound rates and estimated fiscal
3615 impact.

3616 Section 24. Except as otherwise expressly provided in this
3617 act, this act shall take effect July 1, 2011, if HB 7107 or
3618 similar legislation is adopted in the same legislative session
3619 or an extension thereof and becomes law.