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 collect premiums or cost sharing for a home and community-
5 based delivery system; providing that implementation of
6 Medicaid waiver programs and services authorized under ch.
7 393, F.S., are subject to certain funding limitations;
8 requiring that certain provisions relating to agency cost
9 containment initiatives be included in contracts with
10 independent support coordinators and service providers;
11 providing for establishment of agency corrective action
12 plans and redesign of the waiver program under certain
13 circumstances; requiring the plan to be submitted to the
14 Legislature; amending s. 393.063, F.S.; defining the term
15 "Down syndrome"; amending s. 408.040, F.S.; prohibiting
16 the agency from imposing sanctions related to patient day
17 utilization by patients eligible for care under Title XIX
18 of the Social Security Act for a nursing home, effective
19 on a specified date; amending s. 408.0435, F.S.; extending
20 the certificate-of-need moratorium for additional
21 community nursing home beds; designating ss. 409.016-
22 409.803, F.S., as pt. I of ch. 409, F.S., and entitling
23 the part "Social and Economic Assistance"; designating ss.
24 409.810-409.821, F.S., as pt. II of ch. 409, F.S., and
25 entitling the part "Kidcare"; designating ss. 409.901-
26 409.9205, F.S., as part III of ch. 409, F.S., and
27 entitling the part "Medicaid"; amending s. 409.9021, F.S.;
28 revising the time period during which a Medicaid applicant

29 must agree to forfeiture of all entitlements upon a
30 judicial or administrative finding of fraud; amending s.
31 409.905, F.S.; requiring the Agency for Health Care
32 Administration to set reimbursements rates for hospitals
33 that provide Medicaid services based on allowable-cost
34 reporting from the hospitals; removing requirements for
35 prior authorization for the provision of certain services;
36 providing the methodology for the rate calculation and
37 adjustments; requiring the rates to be subject to certain
38 limits or ceilings; authorizing the agency to require
39 prior authorization of home health services under certain
40 conditions; providing that exemptions to the limits or
41 ceilings may be provided in the General Appropriations
42 Act; deleting provisions relating to agency adjustments to
43 a hospital's inpatient per diem rate; directing the agency
44 to develop a plan to convert inpatient hospital rates to a
45 prospective payment system that categorizes each case into
46 diagnosis-related groups; requiring a report to the
47 Governor and Legislature; amending s. 409.906, F.S.;
48 providing conditions under which the agency shall seek
49 federal approval to develop a system to require payment of
50 premiums or other cost sharing by the parents of certain
51 children receiving Medicaid home and community-based
52 waiver services; authorizing the Department of Children
53 and Family Services to collect certain income information;
54 requiring a report to the Legislature; amending s.
55 409.907, F.S.; providing additional requirements for
56 provider agreements for Medicare crossover providers;

57 providing that the agency is not obligated to enroll
58 certain providers as Medicare crossover providers;
59 specifying additional requirements for certain providers;
60 providing the agency may establish additional criteria for
61 providers to promote program integrity; amending s.
62 409.908, F.S.; revising provisions relating to
63 reimbursement of Medicaid direct care providers to include
64 additional, specified medically necessary care; amending
65 s. 409.9081, F.S.; providing conditions for copayments by
66 Medicaid recipients for nonemergency care and services
67 provided in a hospital emergency; amending s. 409.911,
68 F.S.; providing for expiration of the Medicaid Low-Income
69 Pool Council; amending s. 409.912, F.S.; providing payment
70 requirements for provider service networks; providing for
71 the expiration of various provisions relating to agency
72 contracts and agreements with certain entities on
73 specified dates to conform to the reorganization of
74 Medicaid managed care; requiring the agency to contract on
75 a prepaid or fixed-sum basis with certain prepaid dental
76 health plans; eliminating obsolete provisions and updating
77 provisions, to conform; amending ss. 409.91195 and
78 409.91196, F.S.; conforming cross-references; repealing s.
79 409.91207, F.S., relating to the medical home pilot
80 project; amending s. 409.91211, F.S.; conforming cross-
81 references; providing for future repeal of s. 409.91211,
82 F.S., relating to the Medicaid managed care pilot program;
83 amending s. 409.9122, F.S.; providing for the expiration
84 of provisions relating to mandatory enrollment in a

85 Medicaid managed care plan or MediPass on specified dates
86 to conform to the reorganization of Medicaid managed care;
87 eliminating obsolete provisions; providing for the agency
88 to assign Medicaid recipients with HIV/AIDS in specified
89 counties to a managed care plan that is a health
90 maintenance organization under certain conditions;
91 requiring the agency to develop a process to enable any
92 recipient with access to employer-sponsored coverage to
93 opt out of eligible plans in the Medicaid program;
94 requiring the agency, contingent on federal approval, to
95 enable recipients with access to other coverage or related
96 products that provide access to specified health care
97 services to opt out of eligible plans in the Medicaid
98 program; requiring the agency to maintain and operate the
99 Medicaid Encounter Data System; requiring the agency to
100 conduct a review of encounter data and publish the results
101 of the review before adjusting rates for prepaid plans;
102 authorizing the agency to establish a designated payment
103 for specified Medicare Advantage Special Needs members;
104 authorizing the agency to develop a designated payment for
105 Medicaid-only covered services for which the state is
106 responsible; requiring the agency to establish, and
107 managed care plans to use, a uniform method of accounting
108 for and reporting medical and nonmedical costs;
109 authorizing the agency to create exceptions to mandatory
110 enrollment in managed care under specified circumstances;
111 requiring the agency to contract with a provider service
112 network to function as a third-party administrator and

113 managing entity for the MediPass program; providing
114 contract provisions; providing for the expiration of such
115 contract requirements on a specified date; requiring the
116 agency to contract with a single provider service network
117 to function as a third-party administrator and managing
118 entity for the Medically Needy program; providing contract
119 provisions; providing for the expiration of such contract
120 requirements on a specified date; amending s. 430.04,
121 F.S.; eliminating obsolete provisions; requiring the
122 Department of Elderly Affairs to develop a transition plan
123 for specified elders and disabled adults receiving long-
124 term care Medicaid services when eligible plans become
125 available; providing for expiration of the plan; amending
126 s. 430.2053, F.S.; eliminating obsolete provisions;
127 providing additional duties of aging resource centers;
128 providing an additional exception to direct services that
129 may not be provided by an aging resource center; providing
130 an expiration date for certain services administered
131 through aging resource centers; providing for the
132 cessation of specified payments by the department as
133 eligible plans become available; providing for a
134 memorandum of understanding between the agency and aging
135 resource centers under certain circumstances; eliminating
136 provisions requiring reports; repealing s. 430.701, F.S.,
137 relating to legislative findings and intent and approval
138 for action relating to provider enrollment levels;
139 repealing s. 430.702, F.S., relating to the Long-Term Care
140 Community Diversion Pilot Project Act; repealing s.

141 430.703, F.S., relating to definitions; repealing s.
142 430.7031, F.S., relating to the nursing home transition
143 program; repealing s. 430.704, F.S., relating to
144 evaluation of long-term care through the pilot projects;
145 repealing s. 430.705, F.S., relating to implementation of
146 long-term care community diversion pilot projects;
147 repealing s. 430.706, F.S., relating to quality of care;
148 repealing s. 430.707, F.S., relating to contracts;
149 repealing s. 430.708, F.S., relating to certificate of
150 need; repealing s. 430.709, F.S., relating to reports and
151 evaluations; renumbering ss. 409.9301, 409.942, 409.944,
152 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.
153 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
154 402.87, F.S., respectively; amending ss. 443.111 and
155 641.386, F.S.; conforming cross-references; amending s.
156 766.118, F.S.; providing a limitation on noneconomic
157 damages for negligence of practitioners providing medical
158 services and medical care to Medicaid recipients; defining
159 terms for purposes of the limitation; requiring the agency
160 to develop a plan to implement and seek federal approval
161 for the medically needy program for Medicaid enrollees;
162 requiring the agency to develop a reorganization plan for
163 realignment of administrative resources of the Medicaid
164 program; requiring the plan to be submitted to the
165 Governor and Legislature; amending s. 393.0662, F.S.;
166 including certain individuals with Down syndrome or a
167 developmental disability as eligible to participate in the
168 iBudget system; amending s. 409.902, F.S.; restricting

169 Medicaid eligibility to citizens of the United States who
170 meet certain criteria; amending s. 641.19, F.S.; defining
171 the term "provider service network" for purposes of pt. I
172 of ch. 641, F.S.; creating s. 641.2019, F.S.; providing
173 conditions under which a prepaid provider service network
174 may obtain a certificate of authority under s. 641.21,
175 F.S.; amending s. 641.2261, F.S.; providing an exception
176 for provider service networks from certain federal
177 solvency requirements; providing for severability;
178 providing effective dates and a contingent effective date.
179
180 Be It Enacted by the Legislature of the State of Florida:
181
182 Section 1. Section 393.0661, Florida Statutes, is amended
183 to read:
184 393.0661 Home and community-based services delivery
185 system; comprehensive redesign.—The Legislature finds that the
186 home and community-based services delivery system for persons
187 with developmental disabilities and the availability of
188 appropriated funds are two of the critical elements in making
189 services available. Therefore, it is the intent of the
190 Legislature that the Agency for Persons with Disabilities shall
191 develop and implement a comprehensive redesign of the system.
192 (1) The redesign of the home and community-based services
193 system shall include, at a minimum, all actions necessary to
194 achieve an appropriate rate structure, client choice within a
195 specified service package, appropriate assessment strategies, an
196 efficient billing process that contains reconciliation and

197 monitoring components, and a redefined role for support
198 coordinators that avoids potential conflicts of interest and
199 ensures that family/client budgets are linked to levels of need.
200 (a) The agency shall use an assessment instrument that the
201 agency deems to be reliable and valid, including, but not
202 limited to, the Department of Children and Family Services'
203 Individual Cost Guidelines or the agency's Questionnaire for
204 Situational Information. The agency may contract with an
205 external vendor or may use support coordinators to complete
206 client assessments if it develops sufficient safeguards and
207 training to ensure ongoing inter-rater reliability.
208 (b) The agency, with the concurrence of the Agency for
209 Health Care Administration, may contract for the determination
210 of medical necessity and establishment of individual budgets.
211 (2) A provider of services rendered to persons with
212 developmental disabilities pursuant to a federally approved
213 waiver shall be reimbursed according to a rate methodology based
214 upon an analysis of the expenditure history and prospective
215 costs of providers participating in the waiver program, or under
216 any other methodology developed by the Agency for Health Care
217 Administration, in consultation with the Agency for Persons with
218 Disabilities, and approved by the Federal Government in
219 accordance with the waiver.
220 (3) The Agency for Health Care Administration, in
221 consultation with the agency, shall seek federal approval and
222 implement a four-tiered waiver system to serve eligible clients
223 through the developmental disabilities and family and supported
224 living waivers. For the purpose of this waiver program, eligible

225 clients shall include individuals with a diagnosis of Down
226 syndrome or a developmental disability as defined in s. 393.063.
227 The agency shall assign all clients receiving services through
228 the developmental disabilities waiver to a tier based on the
229 Department of Children and Family Services' Individual Cost
230 Guidelines, the agency's Questionnaire for Situational
231 Information, or another such assessment instrument deemed to be
232 valid and reliable by the agency; client characteristics,
233 including, but not limited to, age; and other appropriate
234 assessment methods.
235 (a) Tier one is limited to clients who have service needs
236 that cannot be met in tier two, three, or four for intensive
237 medical or adaptive needs and that are essential for avoiding
238 institutionalization, or who possess behavioral problems that
239 are exceptional in intensity, duration, or frequency and present
240 a substantial risk of harm to themselves or others. Total annual
241 expenditures under tier one may not exceed $150,000 per client
242 each year, provided that expenditures for clients in tier one
243 with a documented medical necessity requiring intensive
244 behavioral residential habilitation services, intensive
245 behavioral residential habilitation services with medical needs,
246 or special medical home care, as provided in the Developmental
247 Disabilities Waiver Services Coverage and Limitations Handbook,
248 are not subject to the $150,000 limit on annual expenditures.
249 (b) Tier two is limited to clients whose service needs
250 include a licensed residential facility and who are authorized
251 to receive a moderate level of support for standard residential
252 habilitation services or a minimal level of support for behavior

253 focus residential habilitation services, or clients in supported
254 living who receive more than 6 hours a day of in-home support
255 services. Total annual expenditures under tier two may not
256 exceed $53,625 per client each year.
257 (c) Tier three includes, but is not limited to, clients
258 requiring residential placements, clients in independent or
259 supported living situations, and clients who live in their
260 family home. Total annual expenditures under tier three may not
261 exceed $34,125 per client each year.
262 (d) Tier four includes individuals who were enrolled in
263 the family and supported living waiver on July 1, 2007, who
264 shall be assigned to this tier without the assessments required
265 by this section. Tier four also includes, but is not limited to,
266 clients in independent or supported living situations and
267 clients who live in their family home. Total annual expenditures
268 under tier four may not exceed $14,422 per client each year.
269 (e) The Agency for Health Care Administration shall also
270 seek federal approval to provide a consumer-directed option for
271 persons with developmental disabilities which corresponds to the
272 funding levels in each of the waiver tiers. The agency shall
273 implement the four-tiered waiver system beginning with tiers
274 one, three, and four and followed by tier two. The agency and
275 the Agency for Health Care Administration may adopt rules
276 necessary to administer this subsection.
277 (f) The agency shall seek federal waivers and amend
278 contracts as necessary to make changes to services defined in
279 federal waiver programs administered by the agency as follows:
280 1. Supported living coaching services may not exceed 20

281 hours per month for persons who also receive in-home support
282 services.
283 2. Limited support coordination services is the only type
284 of support coordination service that may be provided to persons
285 under the age of 18 who live in the family home.
286 3. Personal care assistance services are limited to 180
287 hours per calendar month and may not include rate modifiers.
288 Additional hours may be authorized for persons who have
289 intensive physical, medical, or adaptive needs if such hours are
290 essential for avoiding institutionalization.
291 4. Residential habilitation services are limited to 8
292 hours per day. Additional hours may be authorized for persons
293 who have intensive medical or adaptive needs and if such hours
294 are essential for avoiding institutionalization, or for persons
295 who possess behavioral problems that are exceptional in
296 intensity, duration, or frequency and present a substantial risk
297 of harming themselves or others. This restriction shall be in
298 effect until the four-tiered waiver system is fully implemented.
299 5. Chore services, nonresidential support services, and
300 homemaker services are eliminated. The agency shall expand the
301 definition of in-home support services to allow the service
302 provider to include activities previously provided in these
303 eliminated services.
304 6. Massage therapy, medication review, and psychological
305 assessment services are eliminated.
306 7. The agency shall conduct supplemental cost plan reviews
307 to verify the medical necessity of authorized services for plans
308 that have increased by more than 8 percent during either of the

309 2 preceding fiscal years.
310 8. The agency shall implement a consolidated residential
311 habilitation rate structure to increase savings to the state
312 through a more cost-effective payment method and establish
313 uniform rates for intensive behavioral residential habilitation
314 services.
315 9. Pending federal approval, the agency may extend current
316 support plans for clients receiving services under Medicaid
317 waivers for 1 year beginning July 1, 2007, or from the date
318 approved, whichever is later. Clients who have a substantial
319 change in circumstances which threatens their health and safety
320 may be reassessed during this year in order to determine the
321 necessity for a change in their support plan.
322 10. The agency shall develop a plan to eliminate
323 redundancies and duplications between in-home support services,
324 companion services, personal care services, and supported living
325 coaching by limiting or consolidating such services.
326 11. The agency shall develop a plan to reduce the
327 intensity and frequency of supported employment services to
328 clients in stable employment situations who have a documented
329 history of at least 3 years' employment with the same company or
330 in the same industry.
331 (4) The geographic differential for Miami-Dade, Broward,
332 and Palm Beach Counties for residential habilitation services
333 shall be 7.5 percent.
334 (5) The geographic differential for Monroe County for
335 residential habilitation services shall be 20 percent.
336 (6) Effective January 1, 2010, and except as otherwise

337 provided in this section, a client served by the home and
338 community-based services waiver or the family and supported
339 living waiver funded through the agency shall have his or her
340 cost plan adjusted to reflect the amount of expenditures for the
341 previous state fiscal year plus 5 percent if such amount is less
342 than the client's existing cost plan. The agency shall use
343 actual paid claims for services provided during the previous
344 fiscal year that are submitted by October 31 to calculate the
345 revised cost plan amount. If the client was not served for the
346 entire previous state fiscal year or there was any single change
347 in the cost plan amount of more than 5 percent during the
348 previous state fiscal year, the agency shall set the cost plan
349 amount at an estimated annualized expenditure amount plus 5
350 percent. The agency shall estimate the annualized expenditure
351 amount by calculating the average of monthly expenditures,
352 beginning in the fourth month after the client enrolled,
353 interrupted services are resumed, or the cost plan was changed
354 by more than 5 percent and ending on August 31, 2009, and
355 multiplying the average by 12. In order to determine whether a
356 client was not served for the entire year, the agency shall
357 include any interruption of a waiver-funded service or services
358 lasting at least 18 days. If at least 3 months of actual
359 expenditure data are not available to estimate annualized
360 expenditures, the agency may not rebase a cost plan pursuant to
361 this subsection. The agency may not rebase the cost plan of any
362 client who experiences a significant change in recipient
363 condition or circumstance which results in a change of more than
364 5 percent to his or her cost plan between July 1 and the date

365 that a rebased cost plan would take effect pursuant to this
366 subsection.
367 (7) The agency shall collect premiums or cost sharing
368 pursuant to s. 409.906(13)(d).
369 (8) ~~(7)~~ ~~Nothing in~~ This section or related ~~in any~~
370 ~~administrative~~ rule does not ~~shall be construed to~~ prevent or
371 limit the Agency for Health Care Administration, in consultation
372 with the Agency for Persons with Disabilities, from adjusting
373 fees, reimbursement rates, lengths of stay, number of visits, or
374 number of services, or from limiting enrollment, or making any
375 other adjustment necessary to comply with the availability of
376 moneys and any limitations or directions provided ~~for~~ in the
377 General Appropriations Act.
378 (9) ~~(8)~~ The Agency for Persons with Disabilities shall
379 submit quarterly status reports to the Executive Office of the
380 Governor, the chair of the Senate Ways and Means Committee or
381 its successor, and the chair of the House Fiscal Council or its
382 successor regarding the financial status of home and community-
383 based services, including the number of enrolled individuals who
384 are receiving services through one or more programs; the number
385 of individuals who have requested services who are not enrolled
386 but who are receiving services through one or more programs,
387 with a description indicating the programs from which the
388 individual is receiving services; the number of individuals who
389 have refused an offer of services but who choose to remain on
390 the list of individuals waiting for services; the number of
391 individuals who have requested services but who are receiving no
392 services; a frequency distribution indicating the length of time

393 individuals have been waiting for services; and information
394 concerning the actual and projected costs compared to the amount
395 of the appropriation available to the program and any projected
396 surpluses or deficits. If at any time an analysis by the agency,
397 in consultation with the Agency for Health Care Administration,
398 indicates that the cost of services is expected to exceed the
399 amount appropriated, the agency shall submit a plan in
400 accordance with subsection (8) ~~(7)~~ to the Executive Office of
401 the Governor, the chair of the Senate Ways and Means Committee
402 or its successor, and the chair of the House Fiscal Council or
403 its successor to remain within the amount appropriated. The
404 agency shall work with the Agency for Health Care Administration
405 to implement the plan so as to remain within the appropriation.
406 (10) Implementation of Medicaid waiver programs and
407 services authorized under this chapter is limited by the funds
408 appropriated for the individual budgets pursuant to s. 393.0662
409 and the four-tiered waiver system pursuant to subsection (3).
410 Contracts with independent support coordinators and service
411 providers must include provisions requiring compliance with
412 agency cost containment initiatives. The agency shall implement
413 monitoring and accounting procedures necessary to track actual
414 expenditures and project future spending compared to available
415 appropriations for Medicaid waiver programs. When necessary
416 based on projected deficits, the agency must establish specific
417 corrective action plans that incorporate corrective actions of
418 contracted providers that are sufficient to align program
419 expenditures with annual appropriations. If deficits continue
420 during the 2012-2013 fiscal year, the agency in conjunction with

421 the Agency for Health Care Administration shall develop a plan
422 to redesign the waiver program and submit the plan to the
423 President of the Senate and the Speaker of the House of
424 Representatives by September 30, 2013. At a minimum, the plan
425 must include the following elements:
426 (a) Budget predictability.—Agency budget recommendations
427 must include specific steps to restrict spending to budgeted
428 amounts based on alternatives to the iBudget and four-tiered
429 Medicaid waiver models.
430 (b) Services.—The agency shall identify core services that
431 are essential to provide for client health and safety and
432 recommend elimination of coverage for other services that are
433 not affordable based on available resources.
434 (c) Flexibility.—The redesign shall be responsive to
435 individual needs and to the extent possible encourage client
436 control over allocated resources for their needs.
437 (d) Support coordination services.-The plan shall modify
438 the manner of providing support coordination services to improve
439 management of service utilization and increase accountability
440 and responsiveness to agency priorities.
441 (e) Reporting.—The agency shall provide monthly reports to
442 the President of the Senate and the Speaker of the House of
443 Representatives on plan progress and development on July 31,
444 2013, and August 31, 2013.
445 (f) Implementation.—The implementation of a redesigned
446 program is subject to legislative approval and shall occur no
447 later than July 1, 2014. The Agency for Health Care
448 Administration shall seek federal waivers as needed to implement

449 the redesigned plan approved by the Legislature.
450 Section 2. Subsections (13) through (40) of section
451 393.063, Florida Statutes, are renumbered as subsections (14)
452 through (41), respectively, and a new subsection (13) is added
453 to that section to read:
454 393.063 Definitions.—For the purposes of this chapter, the
455 term:
456 (13) "Down syndrome" means a disorder caused by the
457 presence of an extra chromosome 21.
458 Section 3. Paragraph (e) of subsection (1) of section
459 408.040, Florida Statutes, is redesignated as paragraph (d), and
460 paragraph (b) and present paragraph (d) of that subsection are
461 amended to read:
462 408.040 Conditions and monitoring.—
463 (1)
464 (b) The agency may consider, in addition to the other
465 criteria specified in s. 408.035, a statement of intent by the
466 applicant that a specified percentage of the annual patient days
467 at the facility will be utilized by patients eligible for care
468 under Title XIX of the Social Security Act. Any certificate of
469 need issued to a nursing home in reliance upon an applicant's
470 statements that a specified percentage of annual patient days
471 will be utilized by residents eligible for care under Title XIX
472 of the Social Security Act must include a statement that such
473 certification is a condition of issuance of the certificate of
474 need. The certificate-of-need program shall notify the Medicaid
475 program office and the Department of Elderly Affairs when it
476 imposes conditions as authorized in this paragraph in an area in

477 which a community diversion pilot project is implemented.
478 <u>Effective July 1, 2012, the agency may not impose sanctions</u>
479 <u>related to patient day utilization by patients eligible for care</u>
480 <u>under Title XIX of the Social Security Act for nursing homes.</u>
481 ~~(d) If a nursing home is located in a county in which a~~
482 ~~long-term care community diversion pilot project has been~~
483 ~~implemented under s. 430.705 or in a county in which an~~
484 ~~integrated, fixed-payment delivery program for Medicaid~~
485 ~~recipients who are 60 years of age or older or dually eligible~~
486 ~~for Medicare and Medicaid has been implemented under s.~~
487 ~~409.912(5), the nursing home may request a reduction in the~~
488 ~~percentage of annual patient days used by residents who are~~
489 ~~eligible for care under Title XIX of the Social Security Act,~~
490 ~~which is a condition of the nursing home's certificate of need.~~
491 ~~The agency shall automatically grant the nursing home's request~~
492 ~~if the reduction is not more than 15 percent of the nursing~~
493 ~~home's annual Medicaid-patient-days condition. A nursing home~~
494 ~~may submit only one request every 2 years for an automatic~~
495 ~~reduction. A requesting nursing home must notify the agency in~~
496 ~~writing at least 60 days in advance of its intent to reduce its~~
497 ~~annual Medicaid-patient-days condition by not more than 15~~
498 ~~percent. The agency must acknowledge the request in writing and~~
499 ~~must change its records to reflect the revised certificate-of-~~
500 ~~need condition. This paragraph expires June 30, 2011.~~
501 Section 4. Subsection (1) of section 408.0435, Florida
502 Statutes, is amended to read:
503 408.0435 Moratorium on nursing home certificates of need.—
504 (1) Notwithstanding the establishment of need as provided

505 for in this chapter, a certificate of need for additional
506 community nursing home beds may not be approved by the agency
507 until Medicaid managed care is implemented statewide pursuant to
508 ss. 409.961-409.985 or October 1, 2016, whichever is earlier
509 ~~July 1, 2011~~.
510 Section 5. Sections 409.016 through 409.803, Florida
511 Statutes, are designated as part I of chapter 409, Florida
512 Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."
513 Section 6. Sections 409.810 through 409.821, Florida
514 Statutes, are designated as part II of chapter 409, Florida
515 Statutes, and entitled "KIDCARE."
516 Section 7. Sections 409.901 through 409.9205, Florida
517 Statutes, are designated as part III of chapter 409, Florida
518 Statutes, and entitled "MEDICAID."
519 Section 8. Section 409.9021, Florida Statutes, is amended
520 to read:
521 409.9021 Forfeiture of eligibility agreement.—As a
522 condition of Medicaid eligibility, subject to federal approval,
523 a Medicaid applicant shall agree in writing to forfeit all
524 entitlements to any goods or services provided through the
525 Medicaid program for the next 10 years if he or she has been
526 found to have committed Medicaid fraud, through judicial or
527 administrative determination~~, two times in a period of 5 years~~.
528 This provision applies only to the Medicaid recipient found to
529 have committed or participated in Medicaid ~~the~~ fraud and does
530 not apply to any family member of the recipient who was not
531 involved in the fraud.
532 Section 9. Subsections (2) and (4) and paragraph (c) of

533 subsection (5) of section 409.905, Florida Statutes, are
534 amended, and paragraph (g) is added to subsection (5), to read:
535 409.905 Mandatory Medicaid services.—The agency may make
536 payments for the following services, which are required of the
537 state by Title XIX of the Social Security Act, furnished by
538 Medicaid providers to recipients who are determined to be
539 eligible on the dates on which the services were provided. Any
540 service under this section shall be provided only when medically
541 necessary and in accordance with state and federal law.
542 Mandatory services rendered by providers in mobile units to
543 Medicaid recipients may be restricted by the agency. Nothing in
544 this section shall be construed to prevent or limit the agency
545 from adjusting fees, reimbursement rates, lengths of stay,
546 number of visits, number of services, or any other adjustments
547 necessary to comply with the availability of moneys and any
548 limitations or directions provided for in the General
549 Appropriations Act or chapter 216.
550 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
551 SERVICES.—The agency shall pay for early and periodic screening
552 and diagnosis of a recipient under age 21 to ascertain physical
553 and mental problems and conditions and ~~provide treatment to~~
554 ~~correct or ameliorate these problems and conditions. These~~
555 ~~services include~~ all services determined by the agency to be
556 medically necessary for the treatment, correction, or
557 amelioration of these problems and conditions, including
558 personal care, private duty nursing, durable medical equipment,
559 physical therapy, occupational therapy, speech therapy,
560 respiratory therapy, and immunizations.

561 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
562 nursing and home health aide services, supplies, appliances, and
563 durable medical equipment, necessary to assist a recipient
564 living at home. An entity that provides <u>such</u> services <u>must</u>
565 ~~pursuant to this subsection shall~~ be licensed under part III of
566 chapter 400. These services, equipment, and supplies, or
567 reimbursement therefor, may be limited as provided in the
568 General Appropriations Act and do not include services,
569 equipment, or supplies provided to a person residing in a
570 hospital or nursing facility.
571 (a) ~~In providing home health care services,~~ The agency
572 <u>shall</u> ~~may~~ require prior authorization of <u>home health services</u>
573 ~~care~~ based on diagnosis, utilization rates, <u>and</u> ~~or~~ billing
574 rates. ~~The agency shall require prior authorization for visits~~
575 ~~for home health services that are not associated with a skilled~~
576 ~~nursing visit when the home health agency billing rates exceed~~
577 ~~the state average by 50 percent or more.~~ The home health agency
578 must submit the recipient's plan of care and documentation that
579 supports the recipient's diagnosis to the agency when requesting
580 prior authorization.
581 (b) The agency shall implement a comprehensive utilization
582 management program ~~that requires prior authorization~~ of all
583 private duty nursing services, an individualized treatment plan
584 that includes information about medication and treatment orders,
585 treatment goals, methods of care to be used, and plans for care
586 coordination by nurses and other health professionals. The
587 utilization management program <u>must</u> ~~shall~~ also include a process
588 for periodically reviewing the ongoing use of private duty

589 nursing services. The assessment of need shall be based on a
590 child's condition<u>;</u>~~,~~ family support and care supplements<u>;</u>~~,~~ a
591 family's ability to provide care<u>;</u>~~, and~~ a family's and child's
592 schedule regarding work, school, sleep, and care for other
593 family dependents<u>; and a determination of the medical necessity</u>
594 <u>for private duty nursing instead of other more cost-effective</u>
595 <u>in-home services</u>. When implemented, the private duty nursing
596 utilization management program shall replace the current
597 authorization program used by the agency ~~for Health Care~~
598 ~~Administration~~ and the Children's Medical Services program of
599 the Department of Health. The agency may competitively bid ~~on~~ a
600 contract to select a qualified organization to provide
601 utilization management of private duty nursing services. The
602 agency <u>may</u> ~~is authorized to~~ seek federal waivers to implement
603 this initiative.
604 (c) The agency may not pay for home health services unless
605 the services are medically necessary and:
606 1. The services are ordered by a physician.
607 2. The written prescription for the services is signed and
608 dated by the recipient's physician before the development of a
609 plan of care and before any request requiring prior
610 authorization.
611 3. The physician ordering the services is not employed,
612 under contract with, or otherwise affiliated with the home
613 health agency rendering the services. However, this subparagraph
614 does not apply to a home health agency affiliated with a
615 retirement community, of which the parent corporation or a
616 related legal entity owns a rural health clinic certified under

617 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
618 under part II of chapter 400, or an apartment or single-family
619 home for independent living. For purposes of this subparagraph,
620 the agency may, on a case-by-case basis, provide an exception
621 for medically fragile children who are younger than 21 years of
622 age.
623 4. The physician ordering the services has examined the
624 recipient within the 30 days preceding the initial request for
625 the services and biannually thereafter.
626 5. The written prescription for the services includes the
627 recipient's acute or chronic medical condition or diagnosis, the
628 home health service required, and, for skilled nursing services,
629 the frequency and duration of the services.
630 6. The national provider identifier, Medicaid
631 identification number, or medical practitioner license number of
632 the physician ordering the services is listed on the written
633 prescription for the services, the claim for home health
634 reimbursement, and the prior authorization request.
635 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
636 all covered services provided for the medical care and treatment
637 of a recipient who is admitted as an inpatient by a licensed
638 physician or dentist to a hospital licensed under part I of
639 chapter 395. However, the agency shall limit the payment for
640 inpatient hospital services for a Medicaid recipient 21 years of
641 age or older to 45 days or the number of days necessary to
642 comply with the General Appropriations Act.
643 (c) The agency shall implement a methodology for
644 establishing base reimbursement rates for each hospital based on

645 allowable costs, as defined by the agency. Rates shall be
646 calculated annually and take effect July 1 of each year based on
647 the most recent complete and accurate cost report submitted by
648 each hospital. Adjustments may not be made to the rates after
649 September 30 of the state fiscal year in which the rate takes
650 effect. Errors in cost reporting or calculation of rates
651 discovered after September 30 must be reconciled in a subsequent
652 rate period. The agency may not make any adjustment to a
653 hospital's reimbursement rate more than 5 years after a hospital
654 is notified of an audited rate established by the agency. The
655 requirement that the agency may not make any adjustment to a
656 hospital's reimbursement rate more than 5 years after a hospital
657 is notified of an audited rate established by the agency is
658 remedial and shall apply to actions by providers involving
659 Medicaid claims for hospital services. Hospital rates shall be
660 subject to such limits or ceilings as may be established in law
661 or described in the agency's hospital reimbursement plan.
662 Specific exemptions to the limits or ceilings may be provided in
663 the General Appropriations Act. ~~The agency shall adjust a~~
664 ~~hospital's current inpatient per diem rate to reflect the cost~~
665 ~~of serving the Medicaid population at that institution if:~~
666 ~~1. The hospital experiences an increase in Medicaid~~
667 ~~caseload by more than 25 percent in any year, primarily~~
668 ~~resulting from the closure of a hospital in the same service~~
669 ~~area occurring after July 1, 1995;~~
670 ~~2. The hospital's Medicaid per diem rate is at least 25~~
671 ~~percent below the Medicaid per patient cost for that year; or~~
672 ~~3. The hospital is located in a county that has six or~~

673 ~~fewer general acute care hospitals, began offering obstetrical~~
674 ~~services on or after September 1999, and has submitted a request~~
675 ~~in writing to the agency for a rate adjustment after July 1,~~
676 ~~2000, but before September 30, 2000, in which case such~~
677 ~~hospital's Medicaid inpatient per diem rate shall be adjusted to~~
678 ~~cost, effective July 1, 2002.~~
679
680 ~~By October 1 of each year, the agency must provide estimated~~
681 ~~costs for any adjustment in a hospital inpatient per diem rate~~
682 ~~to the Executive Office of the Governor, the House of~~
683 ~~Representatives General Appropriations Committee, and the Senate~~
684 ~~Appropriations Committee. Before the agency implements a change~~
685 ~~in a hospital's inpatient per diem rate pursuant to this~~
686 ~~paragraph, the Legislature must have specifically appropriated~~
687 ~~sufficient funds in the General Appropriations Act to support~~
688 ~~the increase in cost as estimated by the agency.~~
689 (g) The agency shall develop a plan to convert inpatient
690 hospital rates to a prospective payment system that categorizes
691 each case into diagnosis-related groups (DRG) and assigns a
692 payment weight based on the average resources used to treat
693 Medicaid patients in that DRG. To the extent possible, the
694 agency shall propose an adaptation of an existing prospective
695 payment system, such as the one used by Medicare, and shall
696 propose such adjustments as are necessary for the Medicaid
697 population and to maintain budget neutrality for inpatient
698 hospital expenditures. The agency shall submit the Medicaid DRG
699 plan, identifying all steps necessary for the transition and any
700 costs associated with plan implementation, to the Governor, the

701 President of the Senate, and the Speaker of the House of
702 Representatives no later than January 1, 2013.
703 Section 10. Paragraph (d) is added to subsection (13) of
704 section 409.906, Florida Statutes, to read:
705 409.906 Optional Medicaid services.—Subject to specific
706 appropriations, the agency may make payments for services which
707 are optional to the state under Title XIX of the Social Security
708 Act and are furnished by Medicaid providers to recipients who
709 are determined to be eligible on the dates on which the services
710 were provided. Any optional service that is provided shall be
711 provided only when medically necessary and in accordance with
712 state and federal law. Optional services rendered by providers
713 in mobile units to Medicaid recipients may be restricted or
714 prohibited by the agency. Nothing in this section shall be
715 construed to prevent or limit the agency from adjusting fees,
716 reimbursement rates, lengths of stay, number of visits, or
717 number of services, or making any other adjustments necessary to
718 comply with the availability of moneys and any limitations or
719 directions provided for in the General Appropriations Act or
720 chapter 216. If necessary to safeguard the state's systems of
721 providing services to elderly and disabled persons and subject
722 to the notice and review provisions of s. 216.177, the Governor
723 may direct the Agency for Health Care Administration to amend
724 the Medicaid state plan to delete the optional Medicaid service
725 known as "Intermediate Care Facilities for the Developmentally
726 Disabled." Optional services may include:
727 (13) HOME AND COMMUNITY-BASED SERVICES.—
728 (d) The agency shall request federal approval to develop a

729 system to require payment of premiums or other cost sharing by
730 the parents of a child who is being served by a waiver under
731 this subsection if the adjusted household income is greater than
732 100 percent of the federal poverty level. The amount of the
733 premium or cost sharing shall be calculated using a sliding
734 scale based on the size of the family, the amount of the
735 parent's adjusted gross income, and the federal poverty
736 guidelines. The premium and cost sharing system developed by the
737 agency shall not adversely affect federal funding to the state.
738 After the agency receives federal approval, the Department of
739 Children and Family Services may collect income information from
740 parents of children who will be affected by this paragraph. The
741 agency shall prepare a report to include the estimated
742 operational cost of implementing the premium and cost sharing
743 system and the estimated revenues to be collected from parents
744 of children in the waiver program. The report shall be delivered
745 to the President of the Senate and the Speaker of the House of
746 Representatives by June 30, 2012.
747 Section 11. Paragraphs (d) and (e) of subsection (5) of
748 section 409.907, Florida Statutes, are amended to read:
749 409.907 Medicaid provider agreements.—The agency may make
750 payments for medical assistance and related services rendered to
751 Medicaid recipients only to an individual or entity who has a
752 provider agreement in effect with the agency, who is performing
753 services or supplying goods in accordance with federal, state,
754 and local law, and who agrees that no person shall, on the
755 grounds of handicap, race, color, or national origin, or for any
756 other reason, be subjected to discrimination under any program

757 or activity for which the provider receives payment from the
758 agency.
759 (5) The agency:
760 (d) May enroll entities as Medicare crossover-only
761 providers for payment and claims processing purposes only. The
762 provider agreement shall:
763 1. Require that the provider be able to demonstrate to the
764 satisfaction of the agency that the provider is an eligible
765 Medicare provider and has a current provider agreement in place
766 with the Centers for Medicare and Medicaid Services.
767 2. Require the provider to notify the agency immediately
768 in writing upon being suspended or disenrolled as a Medicare
769 provider. If the provider does not provide such notification
770 within 5 business days after suspension or disenrollment,
771 sanctions may be imposed pursuant to this chapter and the
772 provider may be required to return funds paid to the provider
773 during the period of time that the provider was suspended or
774 disenrolled as a Medicare provider.
775 3. Require the applicant to submit an attestation, as
776 approved by the agency, that the provider meets the requirements
777 of Florida Medicaid provider enrollment criteria.
778 4. Require the applicant to submit fingerprints as
779 required by the agency.
780 5.~~3.~~ Require that all records pertaining to health care
781 services provided to each of the provider's recipients be kept
782 for a minimum of 6 years. The agreement shall also require that
783 records and any information relating to payments claimed by the
784 provider for services under the agreement be delivered to the

785 agency or the Office of the Attorney General Medicaid Fraud
786 Control Unit when requested. If a provider does not provide such
787 records and information when requested, sanctions may be imposed
788 pursuant to this chapter.
789 6.4. Disclose that the agreement is for the purposes of
790 paying and processing Medicare crossover claims only.
791
792 This paragraph pertains solely to Medicare crossover-only
793 providers. In order to become a standard Medicaid provider, the
794 requirements of this section and applicable rules must be met.
795 This paragraph does not create an entitlement or obligation of
796 the agency to enroll all Medicare providers that may be
797 considered a Medicare crossover-only provider in the Medicaid
798 program.
799 (e) Providers that are required to post a surety bond as
800 part of the Medicaid enrollment process are excluded for
801 enrollment under paragraph (d) and must complete a full Medicaid
802 application. The agency may establish additional criteria to
803 promote program integrity.
804 Section 12. Paragraph (b) of subsection (2) of section
805 409.908, Florida Statutes, is amended to read:
806 409.908 Reimbursement of Medicaid providers.—Subject to
807 specific appropriations, the agency shall reimburse Medicaid
808 providers, in accordance with state and federal law, according
809 to methodologies set forth in the rules of the agency and in
810 policy manuals and handbooks incorporated by reference therein.
811 These methodologies may include fee schedules, reimbursement
812 methods based on cost reporting, negotiated fees, competitive

813 bidding pursuant to s. 287.057, and other mechanisms the agency
814 considers efficient and effective for purchasing services or
815 goods on behalf of recipients. If a provider is reimbursed based
816 on cost reporting and submits a cost report late and that cost
817 report would have been used to set a lower reimbursement rate
818 for a rate semester, then the provider's rate for that semester
819 shall be retroactively calculated using the new cost report, and
820 full payment at the recalculated rate shall be effected
821 retroactively. Medicare-granted extensions for filing cost
822 reports, if applicable, shall also apply to Medicaid cost
823 reports. Payment for Medicaid compensable services made on
824 behalf of Medicaid eligible persons is subject to the
825 availability of moneys and any limitations or directions
826 provided for in the General Appropriations Act or chapter 216.
827 Further, nothing in this section shall be construed to prevent
828 or limit the agency from adjusting fees, reimbursement rates,
829 lengths of stay, number of visits, or number of services, or
830 making any other adjustments necessary to comply with the
831 availability of moneys and any limitations or directions
832 provided for in the General Appropriations Act, provided the
833 adjustment is consistent with legislative intent.
834 (2)
835 (b) Subject to any limitations or directions provided for
836 in the General Appropriations Act, the agency shall establish
837 and implement a Florida Title XIX Long-Term Care Reimbursement
838 Plan (Medicaid) for nursing home care in order to provide care
839 and services in conformance with the applicable state and
840 federal laws, rules, regulations, and quality and safety

841 standards and to ensure that individuals eligible for medical
842 assistance have reasonable geographic access to such care.
843 1. The agency shall amend the long-term care reimbursement
844 plan and cost reporting system to create direct care and
845 indirect care subcomponents of the patient care component of the
846 per diem rate. These two subcomponents together shall equal the
847 patient care component of the per diem rate. Separate cost-based
848 ceilings shall be calculated for each patient care subcomponent.
849 The direct care subcomponent of the per diem rate shall be
850 limited by the cost-based class ceiling, and the indirect care
851 subcomponent may be limited by the lower of the cost-based class
852 ceiling, the target rate class ceiling, or the individual
853 provider target.
854 2. The direct care subcomponent shall include salaries and
855 benefits of direct care staff providing nursing services
856 including registered nurses, licensed practical nurses, and
857 certified nursing assistants who deliver care directly to
858 residents in the nursing home facility. This excludes nursing
859 administration, minimum data set, and care plan coordinators,
860 staff development, and the staffing coordinator. The direct care
861 subcomponent also includes medically necessary dental care,
862 vision care, hearing care, and podiatric care.
863 3. All other patient care costs shall be included in the
864 indirect care cost subcomponent of the patient care per diem
865 rate. There shall be no costs directly or indirectly allocated
866 to the direct care subcomponent from a home office or management
867 company.
868 4. On July 1 of each year, the agency shall report to the

869 Legislature direct and indirect care costs, including average
870 direct and indirect care costs per resident per facility and
871 direct care and indirect care salaries and benefits per category
872 of staff member per facility.
873 5. In order to offset the cost of general and professional
874 liability insurance, the agency shall amend the plan to allow
875 for interim rate adjustments to reflect increases in the cost of
876 general or professional liability insurance for nursing homes.
877 This provision shall be implemented to the extent existing
878 appropriations are available.
879
880 It is the intent of the Legislature that the reimbursement plan
881 achieve the goal of providing access to health care for nursing
882 home residents who require large amounts of care while
883 encouraging diversion services as an alternative to nursing home
884 care for residents who can be served within the community. The
885 agency shall base the establishment of any maximum rate of
886 payment, whether overall or component, on the available moneys
887 as provided for in the General Appropriations Act. The agency
888 may base the maximum rate of payment on the results of
889 scientifically valid analysis and conclusions derived from
890 objective statistical data pertinent to the particular maximum
891 rate of payment.
892 Section 13. Paragraph (c) of subsection (1) of section
893 409.9081, Florida Statutes, is amended to read:
894 409.9081 Copayments.—
895 (1) The agency shall require, subject to federal
896 regulations and limitations, each Medicaid recipient ~~to~~ pay at

897 the time of service a nominal copayment for the following
898 Medicaid services:
899 (c) Hospital emergency department visits for nonemergency
900 care: 5 percent of up to the first $300 of the Medicaid payment
901 for emergency room services, not to exceed $15. The agency shall
902 seek federal approval to require Medicaid recipients to pay $100
903 copayment for nonemergency services and care furnished in a
904 hospital emergency department. Upon waiver approval, a Medicaid
905 recipient who requests such services and care must pay a $100
906 copayment to the hospital for the nonemergency services and care
907 provided in the hospital emergency department.
908 Section 14. Subsection (10) of section 409.911, Florida
909 Statutes, is amended to read:
910 409.911 Disproportionate share program.—Subject to
911 specific allocations established within the General
912 Appropriations Act and any limitations established pursuant to
913 chapter 216, the agency shall distribute, pursuant to this
914 section, moneys to hospitals providing a disproportionate share
915 of Medicaid or charity care services by making quarterly
916 Medicaid payments as required. Notwithstanding the provisions of
917 s. 409.915, counties are exempt from contributing toward the
918 cost of this special reimbursement for hospitals serving a
919 disproportionate share of low-income patients.
920 (10) The Agency for Health Care Administration shall
921 create a Medicaid Low-Income Pool Council by July 1, 2006. The
922 Low-Income Pool Council shall consist of 24 members, including 2
923 members appointed by the President of the Senate, 2 members
924 appointed by the Speaker of the House of Representatives, 3

925 representatives of statutory teaching hospitals, 3
926 representatives of public hospitals, 3 representatives of
927 nonprofit hospitals, 3 representatives of for-profit hospitals,
928 2 representatives of rural hospitals, 2 representatives of units
929 of local government which contribute funding, 1 representative
930 of family practice teaching hospitals, 1 representative of
931 federally qualified health centers, 1 representative from the
932 Department of Health, and 1 nonvoting representative of the
933 Agency for Health Care Administration who shall serve as chair
934 of the council. Except for a full-time employee of a public
935 entity, an individual who qualifies as a lobbyist under s.
936 11.045 or s. 112.3215 may not serve as a member of the council.
937 Of the members appointed by the Senate President, only one shall
938 be a physician. Of the members appointed by the Speaker of the
939 House of Representatives, only one shall be a physician. The
940 physician member appointed by the Senate President and the
941 physician member appointed by the Speaker of the House of
942 Representatives must be physicians who routinely take calls in a
943 trauma center, as defined in s. 395.4001, or a hospital
944 emergency department. The council shall:
945 (a) Make recommendations on the financing of the low-
946 income pool and the disproportionate share hospital program and
947 the distribution of their funds.
948 (b) Advise the Agency for Health Care Administration on
949 the development of the low-income pool plan required by the
950 federal Centers for Medicare and Medicaid Services pursuant to
951 the Medicaid reform waiver.
952 (c) Advise the Agency for Health Care Administration on

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

953 the distribution of hospital funds used to adjust inpatient
954 hospital rates, rebase rates, or otherwise exempt hospitals from
955 reimbursement limits as financed by intergovernmental transfers.
956 (d) Submit its findings and recommendations to the
957 Governor and the Legislature no later than February 1 of each
958 year.
959
960 This subsection expires October 1, 2014.
961 Section 15. Subsection (4) of section 409.91195, Florida
962 Statutes, is amended to read:
963 409.91195 Medicaid Pharmaceutical and Therapeutics
964 Committee.—There is created a Medicaid Pharmaceutical and
965 Therapeutics Committee within the agency for the purpose of
966 developing a Medicaid preferred drug list.
967 (4) Upon recommendation of the committee, the agency shall
968 adopt a preferred drug list as described in s. 409.912(37) (39).
969 To the extent feasible, the committee shall review all drug
970 classes included on the preferred drug list every 12 months, and
971 may recommend additions to and deletions from the preferred drug
972 list, such that the preferred drug list provides for medically
973 appropriate drug therapies for Medicaid patients which achieve
974 cost savings contained in the General Appropriations Act.
975 Section 16. Subsection (1) of section 409.91196, Florida
976 Statutes, is amended to read:
977 409.91196 Supplemental rebate agreements; public records
978 and public meetings exemption.—
979 (1) The rebate amount, percent of rebate, manufacturer's
980 pricing, and supplemental rebate, and other trade secrets as

981 defined in s. 688.002 that the agency has identified for use in
982 negotiations, held by the Agency for Health Care Administration
983 under s. 409.912(37) ~~(39)~~(a)7. are confidential and exempt from
984 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
985 Section 17. Section 409.912, Florida Statutes, is amended
986 to read:
987 409.912 Cost-effective purchasing of health care.—The
988 agency shall purchase goods and services for Medicaid recipients
989 in the most cost-effective manner consistent with the delivery
990 of quality medical care. To ensure that medical services are
991 effectively utilized, the agency may, in any case, require a
992 confirmation or second physician's opinion of the correct
993 diagnosis for purposes of authorizing future services under the
994 Medicaid program. This section does not restrict access to
995 emergency services or poststabilization care services as defined
996 in 42 C.F.R. part 438.114. Such confirmation or second opinion
997 shall be rendered in a manner approved by the agency. The agency
998 shall maximize the use of prepaid per capita and prepaid
999 aggregate fixed-sum basis services when appropriate and other
1000 alternative service delivery and reimbursement methodologies,
1001 including competitive bidding pursuant to s. 287.057, designed
1002 to facilitate the cost-effective purchase of a case-managed
1003 continuum of care. The agency shall also require providers to
1004 minimize the exposure of recipients to the need for acute
1005 inpatient, custodial, and other institutional care and the
1006 inappropriate or unnecessary use of high-cost services. The
1007 agency shall contract with a vendor to monitor and evaluate the
1008 clinical practice patterns of providers in order to identify

1009 trends that are outside the normal practice patterns of a
1010 provider's professional peers or the national guidelines of a
1011 provider's professional association. The vendor must be able to
1012 provide information and counseling to a provider whose practice
1013 patterns are outside the norms, in consultation with the agency,
1014 to improve patient care and reduce inappropriate utilization.
1015 The agency may mandate prior authorization, drug therapy
1016 management, or disease management participation for certain
1017 populations of Medicaid beneficiaries, certain drug classes, or
1018 particular drugs to prevent fraud, abuse, overuse, and possible
1019 dangerous drug interactions. The Pharmaceutical and Therapeutics
1020 Committee shall make recommendations to the agency on drugs for
1021 which prior authorization is required. The agency shall inform
1022 the Pharmaceutical and Therapeutics Committee of its decisions
1023 regarding drugs subject to prior authorization. The agency is
1024 authorized to limit the entities it contracts with or enrolls as
1025 Medicaid providers by developing a provider network through
1026 provider credentialing. The agency may competitively bid single-
1027 source-provider contracts if procurement of goods or services
1028 results in demonstrated cost savings to the state without
1029 limiting access to care. The agency may limit its network based
1030 on the assessment of beneficiary access to care, provider
1031 availability, provider quality standards, time and distance
1032 standards for access to care, the cultural competence of the
1033 provider network, demographic characteristics of Medicaid
1034 beneficiaries, practice and provider-to-beneficiary standards,
1035 appointment wait times, beneficiary use of services, provider
1036 turnover, provider profiling, provider licensure history,

1037 previous program integrity investigations and findings, peer
1038 review, provider Medicaid policy and billing compliance records,
1039 clinical and medical record audits, and other factors. Providers
1040 are ~~shall~~ not ~~be~~ entitled to enrollment in the Medicaid provider
1041 network. The agency shall determine instances in which allowing
1042 Medicaid beneficiaries to purchase durable medical equipment and
1043 other goods is less expensive to the Medicaid program than long-
1044 term rental of the equipment or goods. The agency may establish
1045 rules to facilitate purchases in lieu of long-term rentals in
1046 order to protect against fraud and abuse in the Medicaid program
1047 as defined in s. 409.913. The agency may seek federal waivers
1048 necessary to administer these policies.
1049 (1) The agency shall work with the Department of Children
1050 and Family Services to ensure access of children and families in
1051 the child protection system to needed and appropriate mental
1052 health and substance abuse services. This subsection expires
1053 October 1, 2014.
1054 (2) The agency may enter into agreements with appropriate
1055 agents of other state agencies or of any agency of the Federal
1056 Government and accept such duties in respect to social welfare
1057 or public aid as may be necessary to implement the provisions of
1058 Title XIX of the Social Security Act and ss. 409.901-409.920.
1059 This subsection expires October 1, 2016.
1060 (3) The agency may contract with health maintenance
1061 organizations certified pursuant to part I of chapter 641 for
1062 the provision of services to recipients. This subsection expires
1063 October 1, 2014.
1064 (4) The agency may contract with:

1065 (a) An entity that provides no prepaid health care
1066 services other than Medicaid services under contract with the
1067 agency and which is owned and operated by a county, county
1068 health department, or county-owned and operated hospital to
1069 provide health care services on a prepaid or fixed-sum basis to
1070 recipients, which entity may provide such prepaid services
1071 either directly or through arrangements with other providers.
1072 Such prepaid health care services entities must be licensed
1073 under parts I and III of chapter 641. An entity recognized under
1074 this paragraph which demonstrates to the satisfaction of the
1075 Office of Insurance Regulation of the Financial Services
1076 Commission that it is backed by the full faith and credit of the
1077 county in which it is located may be exempted from s. 641.225.
1078 This paragraph expires October 1, 2014.
1079 (b) An entity that is providing comprehensive behavioral
1080 health care services to certain Medicaid recipients through a
1081 capitated, prepaid arrangement pursuant to the federal waiver
1082 provided for by s. 409.905(5). Such entity must be licensed
1083 under chapter 624, chapter 636, or chapter 641, or authorized
1084 under paragraph (c) or paragraph (d), and must possess the
1085 clinical systems and operational competence to manage risk and
1086 provide comprehensive behavioral health care to Medicaid
1087 recipients. As used in this paragraph, the term "comprehensive
1088 behavioral health care services" means covered mental health and
1089 substance abuse treatment services that are available to
1090 Medicaid recipients. The secretary of the Department of Children
1091 and Family Services shall approve provisions of procurements
1092 related to children in the department's care or custody before

1093 enrolling such children in a prepaid behavioral health plan. Any
1094 contract awarded under this paragraph must be competitively
1095 procured. In developing the behavioral health care prepaid plan
1096 procurement document, the agency shall ensure that the
1097 procurement document requires the contractor to develop and
1098 implement a plan to ensure compliance with s. 394.4574 related
1099 to services provided to residents of licensed assisted living
1100 facilities that hold a limited mental health license. Except as
1101 provided in subparagraph 5. ~~8.~~, and except in counties where the
1102 Medicaid managed care pilot program is authorized pursuant to s.
1103 409.91211, the agency shall seek federal approval to contract
1104 with a single entity meeting these requirements to provide
1105 comprehensive behavioral health care services to all Medicaid
1106 recipients not enrolled in a Medicaid managed care plan
1107 authorized under s. 409.91211, a provider service network
1108 authorized under paragraph (d), or a Medicaid health maintenance
1109 organization in an AHCA area. In an AHCA area where the Medicaid
1110 managed care pilot program is authorized pursuant to s.
1111 409.91211 in one or more counties, the agency may procure a
1112 contract with a single entity to serve the remaining counties as
1113 an AHCA area or the remaining counties may be included with an
1114 adjacent AHCA area and are subject to this paragraph. Each
1115 entity must offer a sufficient choice of providers in its
1116 network to ensure recipient access to care and the opportunity
1117 to select a provider with whom they are satisfied. The network
1118 shall include all public mental health hospitals. To ensure
1119 unimpaired access to behavioral health care services by Medicaid
1120 recipients, all contracts issued pursuant to this paragraph must

1121 require 80 percent of the capitation paid to the managed care
1122 plan, including health maintenance organizations and capitated
1123 provider service networks, to be expended for the provision of
1124 behavioral health care services. If the managed care plan
1125 expends less than 80 percent of the capitation paid for the
1126 provision of behavioral health care services, the difference
1127 shall be returned to the agency. The agency shall provide the
1128 plan with a certification letter indicating the amount of
1129 capitation paid during each calendar year for behavioral health
1130 care services pursuant to this section. The agency may reimburse
1131 for substance abuse treatment services on a fee-for-service
1132 basis until the agency finds that adequate funds are available
1133 for capitated, prepaid arrangements.
1134 1. ~~By January 1, 2001,~~ The agency shall modify the
1135 contracts with the entities providing comprehensive inpatient
1136 and outpatient mental health care services to Medicaid
1137 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
1138 Counties, to include substance abuse treatment services.
1139 ~~2. By July 1, 2003, the agency and the Department of~~
1140 ~~Children and Family Services shall execute a written agreement~~
1141 ~~that requires collaboration and joint development of all policy,~~
1142 ~~budgets, procurement documents, contracts, and monitoring plans~~
1143 ~~that have an impact on the state and Medicaid community mental~~
1144 ~~health and targeted case management programs.~~
1145 2.~~3.~~ Except as provided in subparagraph 5. ~~8., by July 1,~~
1146 ~~2006~~, the agency and the Department of Children and Family
1147 Services shall contract with managed care entities in each AHCA
1148 area except area 6 or arrange to provide comprehensive inpatient

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1149 and outpatient mental health and substance abuse services
1150 through capitated prepaid arrangements to all Medicaid
1151 recipients who are eligible to participate in such plans under
1152 federal law and regulation. In AHCA areas where eligible
1153 individuals number less than 150,000, the agency shall contract
1154 with a single managed care plan to provide comprehensive
1155 behavioral health services to all recipients who are not
1156 enrolled in a Medicaid health maintenance organization, a
1157 provider service network authorized under paragraph (d), or a
1158 Medicaid capitated managed care plan authorized under s.
1159 409.91211. The agency may contract with more than one
1160 comprehensive behavioral health provider to provide care to
1161 recipients who are not enrolled in a Medicaid capitated managed
1162 care plan authorized under s. 409.91211, a provider service
1163 network authorized under paragraph (d), or a Medicaid health
1164 maintenance organization in AHCA areas where the eligible
1165 population exceeds 150,000. In an AHCA area where the Medicaid
1166 managed care pilot program is authorized pursuant to s.
1167 409.91211 in one or more counties, the agency may procure a
1168 contract with a single entity to serve the remaining counties as
1169 an AHCA area or the remaining counties may be included with an
1170 adjacent AHCA area and shall be subject to this paragraph.
1171 Contracts for comprehensive behavioral health providers awarded
1172 pursuant to this section shall be competitively procured. Both
1173 for-profit and not-for-profit corporations are eligible to
1174 compete. Managed care plans contracting with the agency under
1175 subsection (3) or paragraph (d), shall provide and receive
1176 payment for the same comprehensive behavioral health benefits as

1177 provided in AHCA rules, including handbooks incorporated by
1178 reference. In AHCA area 11, the agency shall contract with at
1179 least two comprehensive behavioral health care providers to
1180 provide behavioral health care to recipients in that area who
1181 are enrolled in, or assigned to, the MediPass program. One of
1182 the behavioral health care contracts must be with the existing
1183 provider service network pilot project, as described in
1184 paragraph (d), for the purpose of demonstrating the cost-
1185 effectiveness of the provision of quality mental health services
1186 through a public hospital-operated managed care model. Payment
1187 shall be at an agreed-upon capitated rate to ensure cost
1188 savings. Of the recipients in area 11 who are assigned to
1189 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
1190 MediPass-enrolled recipients shall be assigned to the existing
1191 provider service network in area 11 for their behavioral care.
1192 ~~4. By October 1, 2003, the agency and the department shall~~
1193 ~~submit a plan to the Governor, the President of the Senate, and~~
1194 ~~the Speaker of the House of Representatives which provides for~~
1195 ~~the full implementation of capitated prepaid behavioral health~~
1196 ~~care in all areas of the state.~~
1197 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
1198 ~~of the state where the agency is able to establish sufficient~~
1199 ~~capitation rates.~~
1200 ~~b. If the agency determines that the proposed capitation~~
1201 ~~rate in any area is insufficient to provide appropriate~~
1202 ~~services, the agency may adjust the capitation rate to ensure~~
1203 ~~that care will be available. The agency and the department may~~
1204 ~~use existing general revenue to address any additional required~~

1205 ~~match but may not over-obligate existing funds on an annualized~~
1206 ~~basis.~~
1207 ~~c. Subject to any limitations provided in the General~~
1208 ~~Appropriations Act, the agency, in compliance with appropriate~~
1209 ~~federal authorization, shall develop policies and procedures~~
1210 ~~that allow for certification of local and state funds.~~
1211 <u>3.</u>~~5.~~ Children residing in a statewide inpatient
1212 psychiatric program, or in a Department of Juvenile Justice or a
1213 Department of Children and Family Services residential program
1214 approved as a Medicaid behavioral health overlay services
1215 provider may not be included in a behavioral health care prepaid
1216 health plan or any other Medicaid managed care plan pursuant to
1217 this paragraph.
1218 ~~6. In converting to a prepaid system of delivery, the~~
1219 ~~agency shall in its procurement document require an entity~~
1220 ~~providing only comprehensive behavioral health care services to~~
1221 ~~prevent the displacement of indigent care patients by enrollees~~
1222 ~~in the Medicaid prepaid health plan providing behavioral health~~
1223 ~~care services from facilities receiving state funding to provide~~
1224 ~~indigent behavioral health care, to facilities licensed under~~
1225 ~~chapter 395 which do not receive state funding for indigent~~
1226 ~~behavioral health care, or reimburse the unsubsidized facility~~
1227 ~~for the cost of behavioral health care provided to the displaced~~
1228 ~~indigent care patient.~~
1229 <u>4.</u>~~7.~~ Traditional community mental health providers under
1230 contract with the Department of Children and Family Services
1231 pursuant to part IV of chapter 394, child welfare providers
1232 under contract with the Department of Children and Family

1233 Services in areas 1 and 6, and inpatient mental health providers
1234 licensed pursuant to chapter 395 must be offered an opportunity
1235 to accept or decline a contract to participate in any provider
1236 network for prepaid behavioral health services.
1237 5.~~8.~~ All Medicaid-eligible children, except children in
1238 area 1 and children in Highlands County, Hardee County, Polk
1239 County, or Manatee County of area 6, that are open for child
1240 welfare services in the statewide automated child welfare
1241 information ~~HomeSafeNet~~ system, shall receive their behavioral
1242 health care services through a specialty prepaid plan operated
1243 by community-based lead agencies through a single agency or
1244 formal agreements among several agencies. The specialty prepaid
1245 plan must result in savings to the state comparable to savings
1246 achieved in other Medicaid managed care and prepaid programs.
1247 Such plan must provide mechanisms to maximize state and local
1248 revenues. The specialty prepaid plan shall be developed by the
1249 agency and the Department of Children and Family Services. The
1250 agency may seek federal waivers to implement this initiative.
1251 Medicaid-eligible children whose cases are open for child
1252 welfare services in the statewide automated child welfare
1253 information ~~HomeSafeNet~~ system and who reside in AHCA area 10
1254 shall be enrolled in a capitated provider service network or
1255 other capitated managed care plan, which, in coordination with
1256 available community-based care providers specified in s.
1257 409.1671, shall provide sufficient medical, developmental, and
1258 behavioral health services to meet the needs of these children
1259 ~~are exempt from the specialty prepaid plan upon the development~~
1260 ~~of a service delivery mechanism for children who reside in area~~

1261 ~~10 as specified in s. 409.91211(3)(dd)~~.
1262
1263 This paragraph expires October 1, 2014.
1264 (c) A federally qualified health center or an entity owned
1265 by one or more federally qualified health centers or an entity
1266 owned by other migrant and community health centers receiving
1267 non-Medicaid financial support from the Federal Government to
1268 provide health care services on a prepaid or fixed-sum basis to
1269 recipients. A federally qualified health center or an entity
1270 that is owned by one or more federally qualified health centers
1271 and is reimbursed by the agency on a prepaid basis is exempt
1272 from parts I and III of chapter 641, but must comply with the
1273 solvency requirements in s. 641.2261(2) and meet the appropriate
1274 requirements governing financial reserve, quality assurance, and
1275 patients' rights established by the agency. This paragraph
1276 expires October 1, 2014.
1277 (d)1. A provider service network, which may be reimbursed
1278 on a fee-for-service or prepaid basis. Prepaid provider service
1279 networks shall receive per-member, per-month payments. A
1280 provider service network that does not choose to be a prepaid
1281 plan shall receive fee-for-service rates with a shared savings
1282 settlement. The fee-for-service option shall be available to a
1283 provider service network only for the first 2 years of the
1284 plan's operation or until the contract year beginning September
1285 1, 2014, whichever is later. The agency shall annually conduct
1286 cost reconciliations to determine the amount of cost savings
1287 achieved by fee-for-service provider service networks for the
1288 dates of service in the period being reconciled. Only payments

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1289 for covered services for dates of service within the
1290 reconciliation period and paid within 6 months after the last
1291 date of service in the reconciliation period shall be included.
1292 The agency shall perform the necessary adjustments for the
1293 inclusion of claims incurred but not reported within the
1294 reconciliation for claims that could be received and paid by the
1295 agency after the 6-month claims processing time lag. The agency
1296 shall provide the results of the reconciliations to the fee-for-
1297 service provider service networks within 45 days after the end
1298 of the reconciliation period. The fee-for-service provider
1299 service networks shall review and provide written comments or a
1300 letter of concurrence to the agency within 45 days after receipt
1301 of the reconciliation results. This reconciliation shall be
1302 considered final.
1303 2. A provider service network which is reimbursed by the
1304 agency on a prepaid basis shall be exempt from parts I and III
1305 of chapter 641, but must comply with the solvency requirements
1306 in s. 641.2261(2) and meet appropriate financial reserve,
1307 quality assurance, and patient rights requirements as
1308 established by the agency.
1309 3. Medicaid recipients assigned to a provider service
1310 network shall be chosen equally from those who would otherwise
1311 have been assigned to prepaid plans and MediPass. The agency is
1312 authorized to seek federal Medicaid waivers as necessary to
1313 implement the provisions of this section. This subparagraph
1314 expires October 1, 2014. ~~Any contract previously awarded to a~~
1315 ~~provider service network operated by a hospital pursuant to this~~
1316 ~~subsection shall remain in effect for a period of 3 years~~

1317 ~~following the current contract expiration date, regardless of~~
1318 ~~any contractual provisions to the contrary.~~
1319 4. A provider service network is a network established or
1320 organized and operated by a health care provider, or group of
1321 affiliated health care providers, including minority physician
1322 networks and emergency room diversion programs that meet the
1323 requirements of s. 409.91211, which provides a substantial
1324 proportion of the health care items and services under a
1325 contract directly through the provider or affiliated group of
1326 providers and may make arrangements with physicians or other
1327 health care professionals, health care institutions, or any
1328 combination of such individuals or institutions to assume all or
1329 part of the financial risk on a prospective basis for the
1330 provision of basic health services by the physicians, by other
1331 health professionals, or through the institutions. The health
1332 care providers must have a controlling interest in the governing
1333 body of the provider service network organization.
1334 (e) An entity that provides only comprehensive behavioral
1335 health care services to certain Medicaid recipients through an
1336 administrative services organization agreement. Such an entity
1337 must possess the clinical systems and operational competence to
1338 provide comprehensive health care to Medicaid recipients. As
1339 used in this paragraph, the term "comprehensive behavioral
1340 health care services" means covered mental health and substance
1341 abuse treatment services that are available to Medicaid
1342 recipients. Any contract awarded under this paragraph must be
1343 competitively procured. The agency must ensure that Medicaid
1344 recipients have available the choice of at least two managed

1345 care plans for their behavioral health care services. This
1346 paragraph expires October 1, 2014.
1347 ~~(f) An entity that provides in-home physician services to~~
1348 ~~test the cost-effectiveness of enhanced home-based medical care~~
1349 ~~to Medicaid recipients with degenerative neurological diseases~~
1350 ~~and other diseases or disabling conditions associated with high~~
1351 ~~costs to Medicaid. The program shall be designed to serve very~~
1352 ~~disabled persons and to reduce Medicaid reimbursed costs for~~
1353 ~~inpatient, outpatient, and emergency department services. The~~
1354 ~~agency shall contract with vendors on a risk-sharing basis.~~
1355 ~~(g) Children's provider networks that provide care~~
1356 ~~coordination and care management for Medicaid-eligible pediatric~~
1357 ~~patients, primary care, authorization of specialty care, and~~
1358 ~~other urgent and emergency care through organized providers~~
1359 ~~designed to service Medicaid eligibles under age 18 and~~
1360 ~~pediatric emergency departments' diversion programs. The~~
1361 ~~networks shall provide after-hour operations, including evening~~
1362 ~~and weekend hours, to promote, when appropriate, the use of the~~
1363 ~~children's networks rather than hospital emergency departments.~~
1364 (f) ~~(h)~~ An entity authorized in s. 430.205 to contract with
1365 the agency and the Department of Elderly Affairs to provide
1366 health care and social services on a prepaid or fixed-sum basis
1367 to elderly recipients. Such prepaid health care services
1368 entities are exempt from the provisions of part I of chapter 641
1369 for the first 3 years of operation. An entity recognized under
1370 this paragraph that demonstrates to the satisfaction of the
1371 Office of Insurance Regulation that it is backed by the full
1372 faith and credit of one or more counties in which it operates

1373 may be exempted from s. 641.225. This paragraph expires October
1374 1, 2013.
1375 (g)~~(i)~~ A Children's Medical Services Network, as defined
1376 in s. 391.021. This paragraph expires October 1, 2014.
1377 ~~(5) The Agency for Health Care Administration, in~~
1378 ~~partnership with the Department of Elderly Affairs, shall create~~
1379 ~~an integrated, fixed-payment delivery program for Medicaid~~
1380 ~~recipients who are 60 years of age or older or dually eligible~~
1381 ~~for Medicare and Medicaid. The Agency for Health Care~~
1382 ~~Administration shall implement the integrated program initially~~
1383 ~~on a pilot basis in two areas of the state. The pilot areas~~
1384 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
1385 ~~Administration. Enrollment in the pilot areas shall be on a~~
1386 ~~voluntary basis and in accordance with approved federal waivers~~
1387 ~~and this section. The agency and its program contractors and~~
1388 ~~providers shall not enroll any individual in the integrated~~
1389 ~~program because the individual or the person legally responsible~~
1390 ~~for the individual fails to choose to enroll in the integrated~~
1391 ~~program. Enrollment in the integrated program shall be~~
1392 ~~exclusively by affirmative choice of the eligible individual or~~
1393 ~~by the person legally responsible for the individual. The~~
1394 ~~integrated program must transfer all Medicaid services for~~
1395 ~~eligible elderly individuals who choose to participate into an~~
1396 ~~integrated-care management model designed to serve Medicaid~~
1397 ~~recipients in the community. The integrated program must combine~~
1398 ~~all funding for Medicaid services provided to individuals who~~
1399 ~~are 60 years of age or older or dually eligible for Medicare and~~
1400 ~~Medicaid into the integrated program, including funds for~~

1401 ~~Medicaid home and community-based waiver services; all Medicaid~~
1402 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
1403 ~~for Medicaid nursing home services unless the agency is able to~~
1404 ~~demonstrate how the integration of the funds will improve~~
1405 ~~coordinated care for these services in a less costly manner; and~~
1406 ~~Medicare coinsurance and deductibles for persons dually eligible~~
1407 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~
1408 ~~(a) Individuals who are 60 years of age or older or dually~~
1409 ~~eligible for Medicare and Medicaid and enrolled in the~~
1410 ~~developmental disabilities waiver program, the family and~~
1411 ~~supported-living waiver program, the project AIDS care waiver~~
1412 ~~program, the traumatic brain injury and spinal cord injury~~
1413 ~~waiver program, the consumer-directed care waiver program, and~~
1414 ~~the program of all-inclusive care for the elderly program, and~~
1415 ~~residents of institutional care facilities for the~~
1416 ~~developmentally disabled, must be excluded from the integrated~~
1417 ~~program.~~
1418 ~~(b) Managed care entities who meet or exceed the agency's~~
1419 ~~minimum standards are eligible to operate the integrated~~
1420 ~~program. Entities eligible to participate include managed care~~
1421 ~~organizations licensed under chapter 641, including entities~~
1422 ~~eligible to participate in the nursing home diversion program,~~
1423 ~~other qualified providers as defined in s. 430.703(7), community~~
1424 ~~care for the elderly lead agencies, and other state-certified~~
1425 ~~community service networks that meet comparable standards as~~
1426 ~~defined by the agency, in consultation with the Department of~~
1427 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~
1428 ~~financially solvent and able to take on financial risk for~~

1429 ~~managed care. Community service networks that are certified~~
1430 ~~pursuant to the comparable standards defined by the agency are~~
1431 ~~not required to be licensed under chapter 641. Managed care~~
1432 ~~entities who operate the integrated program shall be subject to~~
1433 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
1434 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~
1435 ~~are 60 years of age or older, or both.~~
1436 ~~(c) The agency must ensure that the capitation-rate-~~
1437 ~~setting methodology for the integrated program is actuarially~~
1438 ~~sound and reflects the intent to provide quality care in the~~
1439 ~~least restrictive setting. The agency must also require~~
1440 ~~integrated-program providers to develop a credentialing system~~
1441 ~~for service providers and to contract with all Gold Seal nursing~~
1442 ~~homes, where feasible, and exclude, where feasible, chronically~~
1443 ~~poor-performing facilities and providers as defined by the~~
1444 ~~agency. The integrated program must develop and maintain an~~
1445 ~~informal provider grievance system that addresses provider~~
1446 ~~payment and contract problems. The agency shall also establish a~~
1447 ~~formal grievance system to address those issues that were not~~
1448 ~~resolved through the informal grievance system. The integrated~~
1449 ~~program must provide that if the recipient resides in a~~
1450 ~~noncontracted residential facility licensed under chapter 400 or~~
1451 ~~chapter 429 at the time of enrollment in the integrated program,~~
1452 ~~the recipient must be permitted to continue to reside in the~~
1453 ~~noncontracted facility as long as the recipient desires. The~~
1454 ~~integrated program must also provide that, in the absence of a~~
1455 ~~contract between the integrated-program provider and the~~
1456 ~~residential facility licensed under chapter 400 or chapter 429,~~

1457 ~~current Medicaid rates must prevail. The integrated-program~~
1458 ~~provider must ensure that electronic nursing home claims that~~
1459 ~~contain sufficient information for processing are paid within 10~~
1460 ~~business days after receipt. Alternately, the integrated-program~~
1461 ~~provider may establish a capitated payment mechanism to~~
1462 ~~prospectively pay nursing homes at the beginning of each month.~~
1463 ~~The agency and the Department of Elderly Affairs must jointly~~
1464 ~~develop procedures to manage the services provided through the~~
1465 ~~integrated program in order to ensure quality and recipient~~
1466 ~~choice.~~
1467 ~~(d) The Office of Program Policy Analysis and Government~~
1468 ~~Accountability, in consultation with the Auditor General, shall~~
1469 ~~comprehensively evaluate the pilot project for the integrated,~~
1470 ~~fixed-payment delivery program for Medicaid recipients created~~
1471 ~~under this subsection. The evaluation shall begin as soon as~~
1472 ~~Medicaid recipients are enrolled in the managed care pilot~~
1473 ~~program plans and shall continue for 24 months thereafter. The~~
1474 ~~evaluation must include assessments of each managed care plan in~~
1475 ~~the integrated program with regard to cost savings; consumer~~
1476 ~~education, choice, and access to services; coordination of care;~~
1477 ~~and quality of care. The evaluation must describe administrative~~
1478 ~~or legal barriers to the implementation and operation of the~~
1479 ~~pilot program and include recommendations regarding statewide~~
1480 ~~expansion of the pilot program. The office shall submit its~~
1481 ~~evaluation report to the Governor, the President of the Senate,~~
1482 ~~and the Speaker of the House of Representatives no later than~~
1483 ~~December 31, 2009.~~
1484 ~~(e) The agency may seek federal waivers or Medicaid state~~

1485 ~~plan amendments and adopt rules as necessary to administer the~~
1486 ~~integrated program. The agency may implement the approved~~
1487 ~~federal waivers and other provisions as specified in this~~
1488 ~~subsection.~~
1489 ~~(f) The implementation of the integrated, fixed-payment~~
1490 ~~delivery program created under this subsection is subject to an~~
1491 ~~appropriation in the General Appropriations Act.~~
1492 <u>(5)</u> ~~(6)~~ The agency may contract with any public or private
1493 entity otherwise authorized by this section on a prepaid or
1494 fixed-sum basis for the provision of health care services to
1495 recipients. An entity may provide prepaid services to
1496 recipients, either directly or through arrangements with other
1497 entities, if each entity involved in providing services:
1498 (a) Is organized primarily for the purpose of providing
1499 health care or other services of the type regularly offered to
1500 Medicaid recipients;
1501 (b) Ensures that services meet the standards set by the
1502 agency for quality, appropriateness, and timeliness;
1503 (c) Makes provisions satisfactory to the agency for
1504 insolvency protection and ensures that neither enrolled Medicaid
1505 recipients nor the agency will be liable for the debts of the
1506 entity;
1507 (d) Submits to the agency, if a private entity, a
1508 financial plan that the agency finds to be fiscally sound and
1509 that provides for working capital in the form of cash or
1510 equivalent liquid assets excluding revenues from Medicaid
1511 premium payments equal to at least the first 3 months of
1512 operating expenses or $200,000, whichever is greater;

1513 (e) Furnishes evidence satisfactory to the agency of
1514 adequate liability insurance coverage or an adequate plan of
1515 self-insurance to respond to claims for injuries arising out of
1516 the furnishing of health care;
1517 (f) Provides, through contract or otherwise, for periodic
1518 review of its medical facilities and services, as required by
1519 the agency; and
1520 (g) Provides organizational, operational, financial, and
1521 other information required by the agency.
1522
1523 This subsection expires October 1, 2014.
1524 (6) ~~(7)~~ The agency may contract on a prepaid or fixed-sum
1525 basis with any health insurer that:
1526 (a) Pays for health care services provided to enrolled
1527 Medicaid recipients in exchange for a premium payment paid by
1528 the agency;
1529 (b) Assumes the underwriting risk; and
1530 (c) Is organized and licensed under applicable provisions
1531 of the Florida Insurance Code and is currently in good standing
1532 with the Office of Insurance Regulation.
1533
1534 This subsection expires October 1, 2014.
1535 (7) ~~(8)(a)~~ The agency may contract on a prepaid or fixed-
1536 sum basis with an exclusive provider organization to provide
1537 health care services to Medicaid recipients provided that the
1538 exclusive provider organization meets applicable managed care
1539 plan requirements in this section, ss. 409.9122, 409.9123,
1540 409.9128, and 627.6472, and other applicable provisions of law.

1541 This subsection expires October 1, 2014.
1542 ~~(b) For a period of no longer than 24 months after the~~
1543 ~~effective date of this paragraph, when a member of an exclusive~~
1544 ~~provider organization that is contracted by the agency to~~
1545 ~~provide health care services to Medicaid recipients in rural~~
1546 ~~areas without a health maintenance organization obtains services~~
1547 ~~from a provider that participates in the Medicaid program in~~
1548 ~~this state, the provider shall be paid in accordance with the~~
1549 ~~appropriate fee schedule for services provided to eligible~~
1550 ~~Medicaid recipients. The agency may seek waiver authority to~~
1551 ~~implement this paragraph.~~
1552 (8) ~~(9)~~ The Agency for Health Care Administration may
1553 provide cost-effective purchasing of chiropractic services on a
1554 fee-for-service basis to Medicaid recipients through
1555 arrangements with a statewide chiropractic preferred provider
1556 organization incorporated in this state as a not-for-profit
1557 corporation. The agency shall ensure that the benefit limits and
1558 prior authorization requirements in the current Medicaid program
1559 shall apply to the services provided by the chiropractic
1560 preferred provider organization. This subsection expires October
1561 1, 2014.
1562 (9) ~~(10)~~ The agency shall not contract on a prepaid or
1563 fixed-sum basis for Medicaid services with an entity which knows
1564 or reasonably should know that any officer, director, agent,
1565 managing employee, or owner of stock or beneficial interest in
1566 excess of 5 percent common or preferred stock, or the entity
1567 itself, has been found guilty of, regardless of adjudication, or
1568 entered a plea of nolo contendere, or guilty, to:

1569 (a) Fraud;
1570 (b) Violation of federal or state antitrust statutes,
1571 including those proscribing price fixing between competitors and
1572 the allocation of customers among competitors;
1573 (c) Commission of a felony involving embezzlement, theft,
1574 forgery, income tax evasion, bribery, falsification or
1575 destruction of records, making false statements, receiving
1576 stolen property, making false claims, or obstruction of justice;
1577 or
1578 (d) Any crime in any jurisdiction which directly relates
1579 to the provision of health services on a prepaid or fixed-sum
1580 basis.
1581
1582 This subsection expires October 1, 2014.
1583 (10) ~~(11)~~ The agency, after notifying the Legislature, may
1584 apply for waivers of applicable federal laws and regulations as
1585 necessary to implement more appropriate systems of health care
1586 for Medicaid recipients and reduce the cost of the Medicaid
1587 program to the state and federal governments and shall implement
1588 such programs, after legislative approval, within a reasonable
1589 period of time after federal approval. These programs must be
1590 designed primarily to reduce the need for inpatient care,
1591 custodial care and other long-term or institutional care, and
1592 other high-cost services. Prior to seeking legislative approval
1593 of such a waiver as authorized by this subsection, the agency
1594 shall provide notice and an opportunity for public comment.
1595 Notice shall be provided to all persons who have made requests
1596 of the agency for advance notice and shall be published in the

1597 Florida Administrative Weekly not less than 28 days prior to the
1598 intended action. This subsection expires October 1, 2016.
1599 (11) ~~(12)~~ The agency shall establish a postpayment
1600 utilization control program designed to identify recipients who
1601 may inappropriately overuse or underuse Medicaid services and
1602 shall provide methods to correct such misuse. This subsection
1603 expires October 1, 2014.
1604 (12) ~~(13)~~ The agency shall develop and provide coordinated
1605 systems of care for Medicaid recipients and may contract with
1606 public or private entities to develop and administer such
1607 systems of care among public and private health care providers
1608 in a given geographic area. This subsection expires October 1,
1609 2014.
1610 (13) ~~(14)(a)~~ The agency shall operate or contract for the
1611 operation of utilization management and incentive systems
1612 designed to encourage cost-effective use of services and to
1613 eliminate services that are medically unnecessary. The agency
1614 shall track Medicaid provider prescription and billing patterns
1615 and evaluate them against Medicaid medical necessity criteria
1616 and coverage and limitation guidelines adopted by rule. Medical
1617 necessity determination requires that service be consistent with
1618 symptoms or confirmed diagnosis of illness or injury under
1619 treatment and not in excess of the patient's needs. The agency
1620 shall conduct reviews of provider exceptions to peer group norms
1621 and shall, using statistical methodologies, provider profiling,
1622 and analysis of billing patterns, detect and investigate
1623 abnormal or unusual increases in billing or payment of claims
1624 for Medicaid services and medically unnecessary provision of

1625 services. Providers that demonstrate a pattern of submitting
1626 claims for medically unnecessary services shall be referred to
1627 the Medicaid program integrity unit for investigation. In its
1628 annual report, required in s. 409.913, the agency shall report
1629 on its efforts to control overutilization as described in this
1630 subsection ~~paragraph~~. This subsection expires October 1, 2014.
1631 ~~(b) The agency shall develop a procedure for determining~~
1632 ~~whether health care providers and service vendors can provide~~
1633 ~~the Medicaid program using a business case that demonstrates~~
1634 ~~whether a particular good or service can offset the cost of~~
1635 ~~providing the good or service in an alternative setting or~~
1636 ~~through other means and therefore should receive a higher~~
1637 ~~reimbursement. The business case must include, but need not be~~
1638 ~~limited to:~~
1639 ~~1. A detailed description of the good or service to be~~
1640 ~~provided, a description and analysis of the agency's current~~
1641 ~~performance of the service, and a rationale documenting how~~
1642 ~~providing the service in an alternative setting would be in the~~
1643 ~~best interest of the state, the agency, and its clients.~~
1644 ~~2. A cost-benefit analysis documenting the estimated~~
1645 ~~specific direct and indirect costs, savings, performance~~
1646 ~~improvements, risks, and qualitative and quantitative benefits~~
1647 ~~involved in or resulting from providing the service. The cost-~~
1648 ~~benefit analysis must include a detailed plan and timeline~~
1649 ~~identifying all actions that must be implemented to realize~~
1650 ~~expected benefits. The Secretary of Health Care Administration~~
1651 ~~shall verify that all costs, savings, and benefits are valid and~~
1652 ~~achievable.~~

1653 ~~(c) If the agency determines that the increased~~
1654 ~~reimbursement is cost-effective, the agency shall recommend a~~
1655 ~~change in the reimbursement schedule for that particular good or~~
1656 ~~service. If, within 12 months after implementing any rate change~~
1657 ~~under this procedure, the agency determines that costs were not~~
1658 ~~offset by the increased reimbursement schedule, the agency may~~
1659 ~~revert to the former reimbursement schedule for the particular~~
1660 ~~good or service.~~
1661 (14) ~~(15)~~(a) The agency shall operate the Comprehensive
1662 Assessment and Review for Long-Term Care Services (CARES)
1663 nursing facility preadmission screening program to ensure that
1664 Medicaid payment for nursing facility care is made only for
1665 individuals whose conditions require such care and to ensure
1666 that long-term care services are provided in the setting most
1667 appropriate to the needs of the person and in the most
1668 economical manner possible. The CARES program shall also ensure
1669 that individuals participating in Medicaid home and community-
1670 based waiver programs meet criteria for those programs,
1671 consistent with approved federal waivers.
1672 (b) The agency shall operate the CARES program through an
1673 interagency agreement with the Department of Elderly Affairs.
1674 The agency, in consultation with the Department of Elderly
1675 Affairs, may contract for any function or activity of the CARES
1676 program, including any function or activity required by 42
1677 C.F.R. part 483.20, relating to preadmission screening and
1678 resident review.
1679 (c) Prior to making payment for nursing facility services
1680 for a Medicaid recipient, the agency must verify that the

1681 nursing facility preadmission screening program has determined
1682 that the individual requires nursing facility care and that the
1683 individual cannot be safely served in community-based programs.
1684 The nursing facility preadmission screening program shall refer
1685 a Medicaid recipient to a community-based program if the
1686 individual could be safely served at a lower cost and the
1687 recipient chooses to participate in such program. For
1688 individuals whose nursing home stay is initially funded by
1689 Medicare and Medicare coverage is being terminated for lack of
1690 progress towards rehabilitation, CARES staff shall consult with
1691 the person making the determination of progress toward
1692 rehabilitation to ensure that the recipient is not being
1693 inappropriately disqualified from Medicare coverage. If, in
1694 their professional judgment, CARES staff believes that a
1695 Medicare beneficiary is still making progress toward
1696 rehabilitation, they may assist the Medicare beneficiary with an
1697 appeal of the disqualification from Medicare coverage. The use
1698 of CARES teams to review Medicare denials for coverage under
1699 this section is authorized only if it is determined that such
1700 reviews qualify for federal matching funds through Medicaid. The
1701 agency shall seek or amend federal waivers as necessary to
1702 implement this section.
1703 (d) For the purpose of initiating immediate prescreening
1704 and diversion assistance for individuals residing in nursing
1705 homes and in order to make families aware of alternative long-
1706 term care resources so that they may choose a more cost-
1707 effective setting for long-term placement, CARES staff shall
1708 conduct an assessment and review of a sample of individuals

1709 whose nursing home stay is expected to exceed 20 days,
1710 regardless of the initial funding source for the nursing home
1711 placement. CARES staff shall provide counseling and referral
1712 services to these individuals regarding choosing appropriate
1713 long-term care alternatives. This paragraph does not apply to
1714 continuing care facilities licensed under chapter 651 or to
1715 retirement communities that provide a combination of nursing
1716 home, independent living, and other long-term care services.
1717 (e) By January 15 of each year, the agency shall submit a
1718 report to the Legislature describing the operations of the CARES
1719 program. The report must describe:
1720 1. Rate of diversion to community alternative programs;
1721 2. CARES program staffing needs to achieve additional
1722 diversions;
1723 3. Reasons the program is unable to place individuals in
1724 less restrictive settings when such individuals desired such
1725 services and could have been served in such settings;
1726 4. Barriers to appropriate placement, including barriers
1727 due to policies or operations of other agencies or state-funded
1728 programs; and
1729 5. Statutory changes necessary to ensure that individuals
1730 in need of long-term care services receive care in the least
1731 restrictive environment.
1732 (f) The Department of Elderly Affairs shall track
1733 individuals over time who are assessed under the CARES program
1734 and who are diverted from nursing home placement. By January 15
1735 of each year, the department shall submit to the Legislature a
1736 longitudinal study of the individuals who are diverted from

1737 nursing home placement. The study must include:
1738 1. The demographic characteristics of the individuals
1739 assessed and diverted from nursing home placement, including,
1740 but not limited to, age, race, gender, frailty, caregiver
1741 status, living arrangements, and geographic location;
1742 2. A summary of community services provided to individuals
1743 for 1 year after assessment and diversion;
1744 3. A summary of inpatient hospital admissions for
1745 individuals who have been diverted; and
1746 4. A summary of the length of time between diversion and
1747 subsequent entry into a nursing home or death.
1748
1749 <u>This subsection expires October 1, 2013.</u>
1750 <u>(15)</u> ~~(16)~~ (a) The agency shall identify health care
1751 utilization and price patterns within the Medicaid program which
1752 are not cost-effective or medically appropriate and assess the
1753 effectiveness of new or alternate methods of providing and
1754 monitoring service, and may implement such methods as it
1755 considers appropriate. Such methods may include disease
1756 management initiatives, an integrated and systematic approach
1757 for managing the health care needs of recipients who are at risk
1758 of or diagnosed with a specific disease by using best practices,
1759 prevention strategies, clinical-practice improvement, clinical
1760 interventions and protocols, outcomes research, information
1761 technology, and other tools and resources to reduce overall
1762 costs and improve measurable outcomes.
1763 (b) The responsibility of the agency under this subsection
1764 shall include the development of capabilities to identify actual

1765 and optimal practice patterns; patient and provider educational
1766 initiatives; methods for determining patient compliance with
1767 prescribed treatments; fraud, waste, and abuse prevention and
1768 detection programs; and beneficiary case management programs.
1769 1. The practice pattern identification program shall
1770 evaluate practitioner prescribing patterns based on national and
1771 regional practice guidelines, comparing practitioners to their
1772 peer groups. The agency and its Drug Utilization Review Board
1773 shall consult with the Department of Health and a panel of
1774 practicing health care professionals consisting of the
1775 following: the Speaker of the House of Representatives and the
1776 President of the Senate shall each appoint three physicians
1777 licensed under chapter 458 or chapter 459; and the Governor
1778 shall appoint two pharmacists licensed under chapter 465 and one
1779 dentist licensed under chapter 466 who is an oral surgeon. Terms
1780 of the panel members shall expire at the discretion of the
1781 appointing official. The advisory panel shall be responsible for
1782 evaluating treatment guidelines and recommending ways to
1783 incorporate their use in the practice pattern identification
1784 program. Practitioners who are prescribing inappropriately or
1785 inefficiently, as determined by the agency, may have their
1786 prescribing of certain drugs subject to prior authorization or
1787 may be terminated from all participation in the Medicaid
1788 program.
1789 2. The agency shall also develop educational interventions
1790 designed to promote the proper use of medications by providers
1791 and beneficiaries.
1792 3. The agency shall implement a pharmacy fraud, waste, and

1793 abuse initiative that may include a surety bond or letter of
1794 credit requirement for participating pharmacies, enhanced
1795 provider auditing practices, the use of additional fraud and
1796 abuse software, recipient management programs for beneficiaries
1797 inappropriately using their benefits, and other steps that will
1798 eliminate provider and recipient fraud, waste, and abuse. The
1799 initiative shall address enforcement efforts to reduce the
1800 number and use of counterfeit prescriptions.
1801 4. By September 30, 2002, the agency shall contract with
1802 an entity in the state to implement a wireless handheld clinical
1803 pharmacology drug information database for practitioners. The
1804 initiative shall be designed to enhance the agency's efforts to
1805 reduce fraud, abuse, and errors in the prescription drug benefit
1806 program and to otherwise further the intent of this paragraph.
1807 5. By April 1, 2006, the agency shall contract with an
1808 entity to design a database of clinical utilization information
1809 or electronic medical records for Medicaid providers. This
1810 system must be web-based and allow providers to review on a
1811 real-time basis the utilization of Medicaid services, including,
1812 but not limited to, physician office visits, inpatient and
1813 outpatient hospitalizations, laboratory and pathology services,
1814 radiological and other imaging services, dental care, and
1815 patterns of dispensing prescription drugs in order to coordinate
1816 care and identify potential fraud and abuse.
1817 6. The agency may apply for any federal waivers needed to
1818 administer this paragraph.
1819
1820 This subsection expires October 1, 2014.

1821 (16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum
1822 basis shall meet the surplus requirements of s. 641.225. If an
1823 entity's surplus falls below an amount equal to the surplus
1824 requirements of s. 641.225, the agency shall prohibit the entity
1825 from engaging in marketing and preenrollment activities, shall
1826 cease to process new enrollments, and may not renew the entity's
1827 contract until the required balance is achieved. The
1828 requirements of this subsection do not apply:
1829 (a) Where a public entity agrees to fund any deficit
1830 incurred by the contracting entity; or
1831 (b) Where the entity's performance and obligations are
1832 guaranteed in writing by a guaranteeing organization which:
1833 1. Has been in operation for at least 5 years and has
1834 assets in excess of $50 million; or
1835 2. Submits a written guarantee acceptable to the agency
1836 which is irrevocable during the term of the contracting entity's
1837 contract with the agency and, upon termination of the contract,
1838 until the agency receives proof of satisfaction of all
1839 outstanding obligations incurred under the contract.
1840
1841 This subsection expires October 1, 2014.
1842 (17) ~~(18)~~(a) The agency may require an entity contracting
1843 on a prepaid or fixed-sum basis to establish a restricted
1844 insolvency protection account with a federally guaranteed
1845 financial institution licensed to do business in this state. The
1846 entity shall deposit into that account 5 percent of the
1847 capitation payments made by the agency each month until a
1848 maximum total of 2 percent of the total current contract amount

1849 is reached. The restricted insolvency protection account may be
1850 drawn upon with the authorized signatures of two persons
1851 designated by the entity and two representatives of the agency.
1852 If the agency finds that the entity is insolvent, the agency may
1853 draw upon the account solely with the two authorized signatures
1854 of representatives of the agency, and the funds may be disbursed
1855 to meet financial obligations incurred by the entity under the
1856 prepaid contract. If the contract is terminated, expired, or not
1857 continued, the account balance must be released by the agency to
1858 the entity upon receipt of proof of satisfaction of all
1859 outstanding obligations incurred under this contract.

1860 (b) The agency may waive the insolvency protection account
1861 requirement in writing when evidence is on file with the agency
1862 of adequate insolvency insurance and reinsurance that will
1863 protect enrollees if the entity becomes unable to meet its
1864 obligations.

1865 (18) ~~(19)~~ An entity that contracts with the agency on a
1866 prepaid or fixed-sum basis for the provision of Medicaid
1867 services shall reimburse any hospital or physician that is
1868 outside the entity's authorized geographic service area as
1869 specified in its contract with the agency, and that provides
1870 services authorized by the entity to its members, at a rate
1871 negotiated with the hospital or physician for the provision of
1872 services or according to the lesser of the following:

1873 (a) The usual and customary charges made to the general
1874 public by the hospital or physician; or

1875 (b) The Florida Medicaid reimbursement rate established
1876 for the hospital or physician.

1877
1878 This subsection expires October 1, 2014.
1879 (19) ~~(20)~~ When a merger or acquisition of a Medicaid
1880 prepaid contractor has been approved by the Office of Insurance
1881 Regulation pursuant to s. 628.4615, the agency shall approve the
1882 assignment or transfer of the appropriate Medicaid prepaid
1883 contract upon request of the surviving entity of the merger or
1884 acquisition if the contractor and the other entity have been in
1885 good standing with the agency for the most recent 12-month
1886 period, unless the agency determines that the assignment or
1887 transfer would be detrimental to the Medicaid recipients or the
1888 Medicaid program. To be in good standing, an entity must not
1889 have failed accreditation or committed any material violation of
1890 the requirements of s. 641.52 and must meet the Medicaid
1891 contract requirements. For purposes of this section, a merger or
1892 acquisition means a change in controlling interest of an entity,
1893 including an asset or stock purchase. This subsection expires
1894 October 1, 2014.
1895 (20) ~~(21)~~ Any entity contracting with the agency pursuant
1896 to this section to provide health care services to Medicaid
1897 recipients is prohibited from engaging in any of the following
1898 practices or activities:
1899 (a) Practices that are discriminatory, including, but not
1900 limited to, attempts to discourage participation on the basis of
1901 actual or perceived health status.
1902 (b) Activities that could mislead or confuse recipients,
1903 or misrepresent the organization, its marketing representatives,
1904 or the agency. Violations of this paragraph include, but are not

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1905 limited to:
1906 1. False or misleading claims that marketing
1907 representatives are employees or representatives of the state or
1908 county, or of anyone other than the entity or the organization
1909 by whom they are reimbursed.
1910 2. False or misleading claims that the entity is
1911 recommended or endorsed by any state or county agency, or by any
1912 other organization which has not certified its endorsement in
1913 writing to the entity.
1914 3. False or misleading claims that the state or county
1915 recommends that a Medicaid recipient enroll with an entity.
1916 4. Claims that a Medicaid recipient will lose benefits
1917 under the Medicaid program, or any other health or welfare
1918 benefits to which the recipient is legally entitled, if the
1919 recipient does not enroll with the entity.
1920 (c) Granting or offering of any monetary or other valuable
1921 consideration for enrollment, except as authorized by subsection
1922 (23) ~~(24)~~.
1923 (d) Door-to-door solicitation of recipients who have not
1924 contacted the entity or who have not invited the entity to make
1925 a presentation.
1926 (e) Solicitation of Medicaid recipients by marketing
1927 representatives stationed in state offices unless approved and
1928 supervised by the agency or its agent and approved by the
1929 affected state agency when solicitation occurs in an office of
1930 the state agency. The agency shall ensure that marketing
1931 representatives stationed in state offices shall market their
1932 managed care plans to Medicaid recipients only in designated

1933 areas and in such a way as to not interfere with the recipients'
1934 activities in the state office.
1935 (f) Enrollment of Medicaid recipients.
1936 (21) ~~(22)~~ The agency may impose a fine for a violation of
1937 this section or the contract with the agency by a person or
1938 entity that is under contract with the agency. With respect to
1939 any nonwillful violation, such fine shall not exceed $2,500 per
1940 violation. In no event shall such fine exceed an aggregate
1941 amount of $10,000 for all nonwillful violations arising out of
1942 the same action. With respect to any knowing and willful
1943 violation of this section or the contract with the agency, the
1944 agency may impose a fine upon the entity in an amount not to
1945 exceed $20,000 for each such violation. In no event shall such
1946 fine exceed an aggregate amount of $100,000 for all knowing and
1947 willful violations arising out of the same action. This
1948 subsection expires October 1, 2014.
1949 (22) ~~(23)~~ A health maintenance organization or a person or
1950 entity exempt from chapter 641 that is under contract with the
1951 agency for the provision of health care services to Medicaid
1952 recipients may not use or distribute marketing materials used to
1953 solicit Medicaid recipients, unless such materials have been
1954 approved by the agency. The provisions of this subsection do not
1955 apply to general advertising and marketing materials used by a
1956 health maintenance organization to solicit both non-Medicaid
1957 subscribers and Medicaid recipients. This subsection expires
1958 October 1, 2014.
1959 (23) ~~(24)~~ Upon approval by the agency, health maintenance
1960 organizations and persons or entities exempt from chapter 641

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1961 that are under contract with the agency for the provision of
1962 health care services to Medicaid recipients may be permitted
1963 within the capitation rate to provide additional health benefits
1964 that the agency has found are of high quality, are practicably
1965 available, provide reasonable value to the recipient, and are
1966 provided at no additional cost to the state. This subsection
1967 expires October 1, 2014.
1968 (24) ~~(25)~~ The agency shall utilize the statewide health
1969 maintenance organization complaint hotline for the purpose of
1970 investigating and resolving Medicaid and prepaid health plan
1971 complaints, maintaining a record of complaints and confirmed
1972 problems, and receiving disenrollment requests made by
1973 recipients. This subsection expires October 1, 2014.
1974 (25) ~~(26)~~ The agency shall require the publication of the
1975 health maintenance organization's and the prepaid health plan's
1976 consumer services telephone numbers and the "800" telephone
1977 number of the statewide health maintenance organization
1978 complaint hotline on each Medicaid identification card issued by
1979 a health maintenance organization or prepaid health plan
1980 contracting with the agency to serve Medicaid recipients and on
1981 each subscriber handbook issued to a Medicaid recipient. This
1982 subsection expires October 1, 2014.
1983 (26) ~~(27)~~ The agency shall establish a health care quality
1984 improvement system for those entities contracting with the
1985 agency pursuant to this section, incorporating all the standards
1986 and guidelines developed by the Medicaid Bureau of the Health
1987 Care Financing Administration as a part of the quality assurance
1988 reform initiative. The system shall include, but need not be

1989 limited to, the following:
1990 (a) Guidelines for internal quality assurance programs,
1991 including standards for:
1992 1. Written quality assurance program descriptions.
1993 2. Responsibilities of the governing body for monitoring,
1994 evaluating, and making improvements to care.
1995 3. An active quality assurance committee.
1996 4. Quality assurance program supervision.
1997 5. Requiring the program to have adequate resources to
1998 effectively carry out its specified activities.
1999 6. Provider participation in the quality assurance
2000 program.
2001 7. Delegation of quality assurance program activities.
2002 8. Credentialing and recredentialing.
2003 9. Enrollee rights and responsibilities.
2004 10. Availability and accessibility to services and care.
2005 11. Ambulatory care facilities.
2006 12. Accessibility and availability of medical records, as
2007 well as proper recordkeeping and process for record review.
2008 13. Utilization review.
2009 14. A continuity of care system.
2010 15. Quality assurance program documentation.
2011 16. Coordination of quality assurance activity with other
2012 management activity.
2013 17. Delivering care to pregnant women and infants; to
2014 elderly and disabled recipients, especially those who are at
2015 risk of institutional placement; to persons with developmental
2016 disabilities; and to adults who have chronic, high-cost medical

2017 conditions.
2018 (b) Guidelines which require the entities to conduct
2019 quality-of-care studies which:
2020 1. Target specific conditions and specific health service
2021 delivery issues for focused monitoring and evaluation.
2022 2. Use clinical care standards or practice guidelines to
2023 objectively evaluate the care the entity delivers or fails to
2024 deliver for the targeted clinical conditions and health services
2025 delivery issues.
2026 3. Use quality indicators derived from the clinical care
2027 standards or practice guidelines to screen and monitor care and
2028 services delivered.
2029 (c) Guidelines for external quality review of each
2030 contractor which require: focused studies of patterns of care;
2031 individual care review in specific situations; and followup
2032 activities on previous pattern-of-care study findings and
2033 individual-care-review findings. In designing the external
2034 quality review function and determining how it is to operate as
2035 part of the state's overall quality improvement system, the
2036 agency shall construct its external quality review organization
2037 and entity contracts to address each of the following:
2038 1. Delineating the role of the external quality review
2039 organization.
2040 2. Length of the external quality review organization
2041 contract with the state.
2042 3. Participation of the contracting entities in designing
2043 external quality review organization review activities.
2044 4. Potential variation in the type of clinical conditions

2045 and health services delivery issues to be studied at each plan.
2046 5. Determining the number of focused pattern-of-care
2047 studies to be conducted for each plan.
2048 6. Methods for implementing focused studies.
2049 7. Individual care review.
2050 8. Followup activities.
2051
2052 This subsection expires October 1, 2016.
2053 (27) ~~(28)~~ In order to ensure that children receive health
2054 care services for which an entity has already been compensated,
2055 an entity contracting with the agency pursuant to this section
2056 shall achieve an annual Early and Periodic Screening, Diagnosis,
2057 and Treatment (EPSDT) Service screening rate of at least 60
2058 percent for those recipients continuously enrolled for at least
2059 8 months. The agency shall develop a method by which the EPSDT
2060 screening rate shall be calculated. For any entity which does
2061 not achieve the annual 60 percent rate, the entity must submit a
2062 corrective action plan for the agency's approval. If the entity
2063 does not meet the standard established in the corrective action
2064 plan during the specified timeframe, the agency is authorized to
2065 impose appropriate contract sanctions. At least annually, the
2066 agency shall publicly release the EPSDT Services screening rates
2067 of each entity it has contracted with on a prepaid basis to
2068 serve Medicaid recipients. This subsection expires October 1,
2069 2014.
2070 (28) ~~(29)~~ The agency shall perform enrollments and
2071 disenrollments for Medicaid recipients who are eligible for
2072 MediPass or managed care plans. Notwithstanding the prohibition

2073 contained in paragraph (20) ~~(21)~~(f), managed care plans may
2074 perform preenrollments of Medicaid recipients under the
2075 supervision of the agency or its agents. For the purposes of
2076 this section, the term "preenrollment" means the provision of
2077 marketing and educational materials to a Medicaid recipient and
2078 assistance in completing the application forms, but does not
2079 include actual enrollment into a managed care plan. An
2080 application for enrollment may not be deemed complete until the
2081 agency or its agent verifies that the recipient made an
2082 informed, voluntary choice. The agency, in cooperation with the
2083 Department of Children and Family Services, may test new
2084 marketing initiatives to inform Medicaid recipients about their
2085 managed care options at selected sites. The agency may contract
2086 with a third party to perform managed care plan and MediPass
2087 enrollment and disenrollment services for Medicaid recipients
2088 and may adopt rules to administer such services. The agency may
2089 adjust the capitation rate only to cover the costs of a third-
2090 party enrollment and disenrollment contract, and for agency
2091 supervision and management of the managed care plan enrollment
2092 and disenrollment contract. This subsection expires October 1,
2093 2014.

2094 (29) ~~(30)~~ Any lists of providers made available to Medicaid
2095 recipients, MediPass enrollees, or managed care plan enrollees
2096 shall be arranged alphabetically showing the provider's name and
2097 specialty and, separately, by specialty in alphabetical order.
2098 This subsection expires October 1, 2014.

2099 (30) ~~(31)~~ The agency shall establish an enhanced managed
2100 care quality assurance oversight function, to include at least

2101 the following components:
2102 (a) At least quarterly analysis and followup, including
2103 sanctions as appropriate, of managed care participant
2104 utilization of services.
2105 (b) At least quarterly analysis and followup, including
2106 sanctions as appropriate, of quality findings of the Medicaid
2107 peer review organization and other external quality assurance
2108 programs.
2109 (c) At least quarterly analysis and followup, including
2110 sanctions as appropriate, of the fiscal viability of managed
2111 care plans.
2112 (d) At least quarterly analysis and followup, including
2113 sanctions as appropriate, of managed care participant
2114 satisfaction and disenrollment surveys.
2115 (e) The agency shall conduct regular and ongoing Medicaid
2116 recipient satisfaction surveys.
2117
2118 The analyses and followup activities conducted by the agency
2119 under its enhanced managed care quality assurance oversight
2120 function shall not duplicate the activities of accreditation
2121 reviewers for entities regulated under part III of chapter 641,
2122 but may include a review of the finding of such reviewers. This
2123 subsection expires October 1, 2014.
2124 (31)(32) Each managed care plan that is under contract
2125 with the agency to provide health care services to Medicaid
2126 recipients shall annually conduct a background check with the
2127 Department of Law Enforcement of all persons with ownership
2128 interest of 5 percent or more or executive management

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2129 responsibility for the managed care plan and shall submit to the
2130 agency information concerning any such person who has been found
2131 guilty of, regardless of adjudication, or has entered a plea of
2132 nolo contendere or guilty to, any of the offenses listed in s.
2133 435.04. This subsection expires October 1, 2014.
2134 (32) ~~(33)~~ The agency shall, by rule, develop a process
2135 whereby a Medicaid managed care plan enrollee who wishes to
2136 enter hospice care may be disenrolled from the managed care plan
2137 within 24 hours after contacting the agency regarding such
2138 request. The agency rule shall include a methodology for the
2139 agency to recoup managed care plan payments on a pro rata basis
2140 if payment has been made for the enrollment month when
2141 disenrollment occurs. This subsection expires October 1, 2014.
2142 (33) ~~(34)~~ The agency and entities that contract with the
2143 agency to provide health care services to Medicaid recipients
2144 under this section or ss. 409.91211 and 409.9122 must comply
2145 with the provisions of s. 641.513 in providing emergency
2146 services and care to Medicaid recipients and MediPass
2147 recipients. Where feasible, safe, and cost-effective, the agency
2148 shall encourage hospitals, emergency medical services providers,
2149 and other public and private health care providers to work
2150 together in their local communities to enter into agreements or
2151 arrangements to ensure access to alternatives to emergency
2152 services and care for those Medicaid recipients who need
2153 nonemergent care. The agency shall coordinate with hospitals,
2154 emergency medical services providers, private health plans,
2155 capitated managed care networks as established in s. 409.91211,
2156 and other public and private health care providers to implement

2157 the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
2158 and 641.31097 to develop and implement emergency department
2159 diversion programs for Medicaid recipients. This subsection
2160 expires October 1, 2014.
2161 (34) ~~(35)~~ All entities providing health care services to
2162 Medicaid recipients shall make available, and encourage all
2163 pregnant women and mothers with infants to receive, and provide
2164 documentation in the medical records to reflect, the following:
2165 (a) Healthy Start prenatal or infant screening.
2166 (b) Healthy Start care coordination, when screening or
2167 other factors indicate need.
2168 (c) Healthy Start enhanced services in accordance with the
2169 prenatal or infant screening results.
2170 (d) Immunizations in accordance with recommendations of
2171 the Advisory Committee on Immunization Practices of the United
2172 States Public Health Service and the American Academy of
2173 Pediatrics, as appropriate.
2174 (e) Counseling and services for family planning to all
2175 women and their partners.
2176 (f) A scheduled postpartum visit for the purpose of
2177 voluntary family planning, to include discussion of all methods
2178 of contraception, as appropriate.
2179 (g) Referral to the Special Supplemental Nutrition Program
2180 for Women, Infants, and Children (WIC).
2181
2182 This subsection expires October 1, 2014.
2183 (35) ~~(36)~~ Any entity that provides Medicaid prepaid health
2184 plan services shall ensure the appropriate coordination of

2185 health care services with an assisted living facility in cases
2186 where a Medicaid recipient is both a member of the entity's
2187 prepaid health plan and a resident of the assisted living
2188 facility. If the entity is at risk for Medicaid targeted case
2189 management and behavioral health services, the entity shall
2190 inform the assisted living facility of the procedures to follow
2191 should an emergent condition arise. This subsection expires
2192 October 1, 2014.
2193 ~~(37) The agency may seek and implement federal waivers~~
2194 ~~necessary to provide for cost-effective purchasing of home~~
2195 ~~health services, private duty nursing services, transportation,~~
2196 ~~independent laboratory services, and durable medical equipment~~
2197 ~~and supplies through competitive bidding pursuant to s. 287.057.~~
2198 ~~The agency may request appropriate waivers from the federal~~
2199 ~~Health Care Financing Administration in order to competitively~~
2200 ~~bid such services. The agency may exclude providers not selected~~
2201 ~~through the bidding process from the Medicaid provider network.~~
2202 (36) ~~(38)~~ The agency shall enter into agreements with not-
2203 for-profit organizations based in this state for the purpose of
2204 providing vision screening. This subsection expires October 1,
2205 2014.
2206 (37) ~~(39)~~(a) The agency shall implement a Medicaid
2207 prescribed-drug spending-control program that includes the
2208 following components:
2209 1. A Medicaid preferred drug list, which shall be a
2210 listing of cost-effective therapeutic options recommended by the
2211 Medicaid Pharmacy and Therapeutics Committee established
2212 pursuant to s. 409.91195 and adopted by the agency for each

2213 therapeutic class on the preferred drug list. At the discretion
2214 of the committee, and when feasible, the preferred drug list
2215 should include at least two products in a therapeutic class. The
2216 agency may post the preferred drug list and updates to the
2217 preferred drug list on an Internet website without following the
2218 rulemaking procedures of chapter 120. Antiretroviral agents are
2219 excluded from the preferred drug list. The agency shall also
2220 limit the amount of a prescribed drug dispensed to no more than
2221 a 34-day supply unless the drug products' smallest marketed
2222 package is greater than a 34-day supply, or the drug is
2223 determined by the agency to be a maintenance drug in which case
2224 a 100-day maximum supply may be authorized. The agency is
2225 authorized to seek any federal waivers necessary to implement
2226 these cost-control programs and to continue participation in the
2227 federal Medicaid rebate program, or alternatively to negotiate
2228 state-only manufacturer rebates. The agency may adopt rules to
2229 implement this subparagraph. The agency shall continue to
2230 provide unlimited contraceptive drugs and items. The agency must
2231 establish procedures to ensure that:
2232 a. There is a response to a request for prior consultation
2233 by telephone or other telecommunication device within 24 hours
2234 after receipt of a request for prior consultation; and
2235 b. A 72-hour supply of the drug prescribed is provided in
2236 an emergency or when the agency does not provide a response
2237 within 24 hours as required by sub-subparagraph a.
2238 2. Reimbursement to pharmacies for Medicaid prescribed
2239 drugs shall be set at the lesser of: the average wholesale price
2240 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)

2241 plus 4.75 percent, the federal upper limit (FUL), the state
2242 maximum allowable cost (SMAC), or the usual and customary (UAC)
2243 charge billed by the provider.
2244 3. The agency shall develop and implement a process for
2245 managing the drug therapies of Medicaid recipients who are using
2246 significant numbers of prescribed drugs each month. The
2247 management process may include, but is not limited to,
2248 comprehensive, physician-directed medical-record reviews, claims
2249 analyses, and case evaluations to determine the medical
2250 necessity and appropriateness of a patient's treatment plan and
2251 drug therapies. The agency may contract with a private
2252 organization to provide drug-program-management services. The
2253 Medicaid drug benefit management program shall include
2254 initiatives to manage drug therapies for HIV/AIDS patients,
2255 patients using 20 or more unique prescriptions in a 180-day
2256 period, and the top 1,000 patients in annual spending. The
2257 agency shall enroll any Medicaid recipient in the drug benefit
2258 management program if he or she meets the specifications of this
2259 provision and is not enrolled in a Medicaid health maintenance
2260 organization.
2261 4. The agency may limit the size of its pharmacy network
2262 based on need, competitive bidding, price negotiations,
2263 credentialing, or similar criteria. The agency shall give
2264 special consideration to rural areas in determining the size and
2265 location of pharmacies included in the Medicaid pharmacy
2266 network. A pharmacy credentialing process may include criteria
2267 such as a pharmacy's full-service status, location, size,
2268 patient educational programs, patient consultation, disease

2269 management services, and other characteristics. The agency may
2270 impose a moratorium on Medicaid pharmacy enrollment when it is
2271 determined that it has a sufficient number of Medicaid-
2272 participating providers. The agency must allow dispensing
2273 practitioners to participate as a part of the Medicaid pharmacy
2274 network regardless of the practitioner's proximity to any other
2275 entity that is dispensing prescription drugs under the Medicaid
2276 program. A dispensing practitioner must meet all credentialing
2277 requirements applicable to his or her practice, as determined by
2278 the agency.
2279 5. The agency shall develop and implement a program that
2280 requires Medicaid practitioners who prescribe drugs to use a
2281 counterfeit-proof prescription pad for Medicaid prescriptions.
2282 The agency shall require the use of standardized counterfeit-
2283 proof prescription pads by Medicaid-participating prescribers or
2284 prescribers who write prescriptions for Medicaid recipients. The
2285 agency may implement the program in targeted geographic areas or
2286 statewide.
2287 6. The agency may enter into arrangements that require
2288 manufacturers of generic drugs prescribed to Medicaid recipients
2289 to provide rebates of at least 15.1 percent of the average
2290 manufacturer price for the manufacturer's generic products.
2291 These arrangements shall require that if a generic-drug
2292 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2293 at a level below 15.1 percent, the manufacturer must provide a
2294 supplemental rebate to the state in an amount necessary to
2295 achieve a 15.1-percent rebate level.
2296 7. The agency may establish a preferred drug list as

2297 described in this subsection, and, pursuant to the establishment
2298 of such preferred drug list, it is authorized to negotiate
2299 supplemental rebates from manufacturers that are in addition to
2300 those required by Title XIX of the Social Security Act and at no
2301 less than 14 percent of the average manufacturer price as
2302 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2303 the federal or supplemental rebate, or both, equals or exceeds
2304 29 percent. There is no upper limit on the supplemental rebates
2305 the agency may negotiate. The agency may determine that specific
2306 products, brand-name or generic, are competitive at lower rebate
2307 percentages. Agreement to pay the minimum supplemental rebate
2308 percentage will guarantee a manufacturer that the Medicaid
2309 Pharmaceutical and Therapeutics Committee will consider a
2310 product for inclusion on the preferred drug list. However, a
2311 pharmaceutical manufacturer is not guaranteed placement on the
2312 preferred drug list by simply paying the minimum supplemental
2313 rebate. Agency decisions will be made on the clinical efficacy
2314 of a drug and recommendations of the Medicaid Pharmaceutical and
2315 Therapeutics Committee, as well as the price of competing
2316 products minus federal and state rebates. The agency is
2317 authorized to contract with an outside agency or contractor to
2318 conduct negotiations for supplemental rebates. For the purposes
2319 of this section, the term "supplemental rebates" means cash
2320 rebates. Effective July 1, 2004, value-added programs as a
2321 substitution for supplemental rebates are prohibited. The agency
2322 is authorized to seek any federal waivers to implement this
2323 initiative.
2324 8. The Agency for Health Care Administration shall expand

2325 home delivery of pharmacy products. To assist Medicaid patients
2326 in securing their prescriptions and reduce program costs, the
2327 agency shall expand its current mail-order-pharmacy diabetes-
2328 supply program to include all generic and brand-name drugs used
2329 by Medicaid patients with diabetes. Medicaid recipients in the
2330 current program may obtain nondiabetes drugs on a voluntary
2331 basis. This initiative is limited to the geographic area covered
2332 by the current contract. The agency may seek and implement any
2333 federal waivers necessary to implement this subparagraph.
2334 9. The agency shall limit to one dose per month any drug
2335 prescribed to treat erectile dysfunction.
2336 10.a. The agency may implement a Medicaid behavioral drug
2337 management system. The agency may contract with a vendor that
2338 has experience in operating behavioral drug management systems
2339 to implement this program. The agency is authorized to seek
2340 federal waivers to implement this program.
2341 b. The agency, in conjunction with the Department of
2342 Children and Family Services, may implement the Medicaid
2343 behavioral drug management system that is designed to improve
2344 the quality of care and behavioral health prescribing practices
2345 based on best practice guidelines, improve patient adherence to
2346 medication plans, reduce clinical risk, and lower prescribed
2347 drug costs and the rate of inappropriate spending on Medicaid
2348 behavioral drugs. The program may include the following
2349 elements:
2350 (I) Provide for the development and adoption of best
2351 practice guidelines for behavioral health-related drugs such as
2352 antipsychotics, antidepressants, and medications for treating

2353 bipolar disorders and other behavioral conditions; translate
2354 them into practice; review behavioral health prescribers and
2355 compare their prescribing patterns to a number of indicators
2356 that are based on national standards; and determine deviations
2357 from best practice guidelines.
2358 (II) Implement processes for providing feedback to and
2359 educating prescribers using best practice educational materials
2360 and peer-to-peer consultation.
2361 (III) Assess Medicaid beneficiaries who are outliers in
2362 their use of behavioral health drugs with regard to the numbers
2363 and types of drugs taken, drug dosages, combination drug
2364 therapies, and other indicators of improper use of behavioral
2365 health drugs.
2366 (IV) Alert prescribers to patients who fail to refill
2367 prescriptions in a timely fashion, are prescribed multiple same-
2368 class behavioral health drugs, and may have other potential
2369 medication problems.
2370 (V) Track spending trends for behavioral health drugs and
2371 deviation from best practice guidelines.
2372 (VI) Use educational and technological approaches to
2373 promote best practices, educate consumers, and train prescribers
2374 in the use of practice guidelines.
2375 (VII) Disseminate electronic and published materials.
2376 (VIII) Hold statewide and regional conferences.
2377 (IX) Implement a disease management program with a model
2378 quality-based medication component for severely mentally ill
2379 individuals and emotionally disturbed children who are high
2380 users of care.

2381 11.a. The agency shall implement a Medicaid prescription
2382 drug management system. The agency may contract with a vendor
2383 that has experience in operating prescription drug management
2384 systems in order to implement this system. Any management system
2385 that is implemented in accordance with this subparagraph must
2386 rely on cooperation between physicians and pharmacists to
2387 determine appropriate practice patterns and clinical guidelines
2388 to improve the prescribing, dispensing, and use of drugs in the
2389 Medicaid program. The agency may seek federal waivers to
2390 implement this program.
2391 b. The drug management system must be designed to improve
2392 the quality of care and prescribing practices based on best
2393 practice guidelines, improve patient adherence to medication
2394 plans, reduce clinical risk, and lower prescribed drug costs and
2395 the rate of inappropriate spending on Medicaid prescription
2396 drugs. The program must:
2397 (I) Provide for the development and adoption of best
2398 practice guidelines for the prescribing and use of drugs in the
2399 Medicaid program, including translating best practice guidelines
2400 into practice; reviewing prescriber patterns and comparing them
2401 to indicators that are based on national standards and practice
2402 patterns of clinical peers in their community, statewide, and
2403 nationally; and determine deviations from best practice
2404 guidelines.
2405 (II) Implement processes for providing feedback to and
2406 educating prescribers using best practice educational materials
2407 and peer-to-peer consultation.
2408 (III) Assess Medicaid recipients who are outliers in their

2409 use of a single or multiple prescription drugs with regard to
2410 the numbers and types of drugs taken, drug dosages, combination
2411 drug therapies, and other indicators of improper use of
2412 prescription drugs.
2413 (IV) Alert prescribers to patients who fail to refill
2414 prescriptions in a timely fashion, are prescribed multiple drugs
2415 that may be redundant or contraindicated, or may have other
2416 potential medication problems.
2417 (V) Track spending trends for prescription drugs and
2418 deviation from best practice guidelines.
2419 (VI) Use educational and technological approaches to
2420 promote best practices, educate consumers, and train prescribers
2421 in the use of practice guidelines.
2422 (VII) Disseminate electronic and published materials.
2423 (VIII) Hold statewide and regional conferences.
2424 (IX) Implement disease management programs in cooperation
2425 with physicians and pharmacists, along with a model quality-
2426 based medication component for individuals having chronic
2427 medical conditions.
2428 12. The agency is authorized to contract for drug rebate
2429 administration, including, but not limited to, calculating
2430 rebate amounts, invoicing manufacturers, negotiating disputes
2431 with manufacturers, and maintaining a database of rebate
2432 collections.
2433 13. The agency may specify the preferred daily dosing form
2434 or strength for the purpose of promoting best practices with
2435 regard to the prescribing of certain drugs as specified in the
2436 General Appropriations Act and ensuring cost-effective

2437 prescribing practices.
2438 14. The agency may require prior authorization for
2439 Medicaid-covered prescribed drugs. The agency may, but is not
2440 required to, prior-authorize the use of a product:
2441 a. For an indication not approved in labeling;
2442 b. To comply with certain clinical guidelines; or
2443 c. If the product has the potential for overuse, misuse,
2444 or abuse.
2445
2446 The agency may require the prescribing professional to provide
2447 information about the rationale and supporting medical evidence
2448 for the use of a drug. The agency may post prior authorization
2449 criteria and protocol and updates to the list of drugs that are
2450 subject to prior authorization on an Internet website without
2451 amending its rule or engaging in additional rulemaking.
2452 15. The agency, in conjunction with the Pharmaceutical and
2453 Therapeutics Committee, may require age-related prior
2454 authorizations for certain prescribed drugs. The agency may
2455 preauthorize the use of a drug for a recipient who may not meet
2456 the age requirement or may exceed the length of therapy for use
2457 of this product as recommended by the manufacturer and approved
2458 by the Food and Drug Administration. Prior authorization may
2459 require the prescribing professional to provide information
2460 about the rationale and supporting medical evidence for the use
2461 of a drug.
2462 16. The agency shall implement a step-therapy prior
2463 authorization approval process for medications excluded from the
2464 preferred drug list. Medications listed on the preferred drug

2465 list must be used within the previous 12 months prior to the
2466 alternative medications that are not listed. The step-therapy
2467 prior authorization may require the prescriber to use the
2468 medications of a similar drug class or for a similar medical
2469 indication unless contraindicated in the Food and Drug
2470 Administration labeling. The trial period between the specified
2471 steps may vary according to the medical indication. The step-
2472 therapy approval process shall be developed in accordance with
2473 the committee as stated in s. 409.91195(7) and (8). A drug
2474 product may be approved without meeting the step-therapy prior
2475 authorization criteria if the prescribing physician provides the
2476 agency with additional written medical or clinical documentation
2477 that the product is medically necessary because:
2478 a. There is not a drug on the preferred drug list to treat
2479 the disease or medical condition which is an acceptable clinical
2480 alternative;
2481 b. The alternatives have been ineffective in the treatment
2482 of the beneficiary's disease; or
2483 c. Based on historic evidence and known characteristics of
2484 the patient and the drug, the drug is likely to be ineffective,
2485 or the number of doses have been ineffective.
2486
2487 The agency shall work with the physician to determine the best
2488 alternative for the patient. The agency may adopt rules waiving
2489 the requirements for written clinical documentation for specific
2490 drugs in limited clinical situations.
2491 17. The agency shall implement a return and reuse program
2492 for drugs dispensed by pharmacies to institutional recipients,

2493 which includes payment of a $5 restocking fee for the
2494 implementation and operation of the program. The return and
2495 reuse program shall be implemented electronically and in a
2496 manner that promotes efficiency. The program must permit a
2497 pharmacy to exclude drugs from the program if it is not
2498 practical or cost-effective for the drug to be included and must
2499 provide for the return to inventory of drugs that cannot be
2500 credited or returned in a cost-effective manner. The agency
2501 shall determine if the program has reduced the amount of
2502 Medicaid prescription drugs which are destroyed on an annual
2503 basis and if there are additional ways to ensure more
2504 prescription drugs are not destroyed which could safely be
2505 reused. The agency's conclusion and recommendations shall be
2506 reported to the Legislature by December 1, 2005.
2507 (b) The agency shall implement this subsection to the
2508 extent that funds are appropriated to administer the Medicaid
2509 prescribed-drug spending-control program. The agency may
2510 contract all or any part of this program to private
2511 organizations.
2512 (c) The agency shall submit quarterly reports to the
2513 Governor, the President of the Senate, and the Speaker of the
2514 House of Representatives which must include, but need not be
2515 limited to, the progress made in implementing this subsection
2516 and its effect on Medicaid prescribed-drug expenditures.
2517 (38) ~~(40)~~ Notwithstanding the provisions of chapter 287,
2518 the agency may, at its discretion, renew a contract or contracts
2519 for fiscal intermediary services one or more times for such
2520 periods as the agency may decide; however, all such renewals may

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

2521 not combine to exceed a total period longer than the term of the
2522 original contract.
2523 (39) ~~(41)~~ The agency shall provide for the development of a
2524 demonstration project by establishment in Miami-Dade County of a
2525 long-term-care facility licensed pursuant to chapter 395 to
2526 improve access to health care for a predominantly minority,
2527 medically underserved, and medically complex population and to
2528 evaluate alternatives to nursing home care and general acute
2529 care for such population. Such project is to be located in a
2530 health care condominium and colocated with licensed facilities
2531 providing a continuum of care. The establishment of this project
2532 is not subject to the provisions of s. 408.036 or s. 408.039.
2533 This subsection expires October 1, 2013.
2534 (40) ~~(42)~~ The agency shall develop and implement a
2535 utilization management program for Medicaid-eligible recipients
2536 for the management of occupational, physical, respiratory, and
2537 speech therapies. The agency shall establish a utilization
2538 program that may require prior authorization in order to ensure
2539 medically necessary and cost-effective treatments. The program
2540 shall be operated in accordance with a federally approved waiver
2541 program or state plan amendment. The agency may seek a federal
2542 waiver or state plan amendment to implement this program. The
2543 agency may also competitively procure these services from an
2544 outside vendor on a regional or statewide basis. This subsection
2545 expires October 1, 2014.
2546 (41) ~~(43)~~ The agency shall ~~may~~ contract on a prepaid or
2547 fixed-sum basis with appropriately licensed prepaid dental
2548 health plans to provide dental services. This subsection expires

2549 October 1, 2014.
2550 (42) ~~(44)~~ The Agency for Health Care Administration shall
2551 ensure that any Medicaid managed care plan as defined in s.
2552 409.9122(2)(f), whether paid on a capitated basis or a shared
2553 savings basis, is cost-effective. For purposes of this
2554 subsection, the term "cost-effective" means that a network's
2555 per-member, per-month costs to the state, including, but not
2556 limited to, fee-for-service costs, administrative costs, and
2557 case-management fees, if any, must be no greater than the
2558 state's costs associated with contracts for Medicaid services
2559 established under subsection (3), which may be adjusted for
2560 health status. The agency shall conduct actuarially sound
2561 adjustments for health status in order to ensure such cost-
2562 effectiveness and shall annually publish the results on its
2563 Internet website. Contracts established pursuant to this
2564 subsection which are not cost-effective may not be renewed. This
2565 subsection expires October 1, 2014.
2566 (43) ~~(45)~~ Subject to the availability of funds, the agency
2567 shall mandate a recipient's participation in a provider lock-in
2568 program, when appropriate, if a recipient is found by the agency
2569 to have used Medicaid goods or services at a frequency or amount
2570 not medically necessary, limiting the receipt of goods or
2571 services to medically necessary providers after the 21-day
2572 appeal process has ended, for a period of not less than 1 year.
2573 The lock-in programs shall include, but are not limited to,
2574 pharmacies, medical doctors, and infusion clinics. The
2575 limitation does not apply to emergency services and care
2576 provided to the recipient in a hospital emergency department.

2577 The agency shall seek any federal waivers necessary to implement
2578 this subsection. The agency shall adopt any rules necessary to
2579 comply with or administer this subsection. This subsection
2580 expires October 1, 2014.
2581 (44) ~~(46)~~ The agency shall seek a federal waiver for
2582 permission to terminate the eligibility of a Medicaid recipient
2583 who has been found to have committed fraud, through judicial or
2584 administrative determination, two times in a period of 5 years.
2585 ~~(47) The agency shall conduct a study of available~~
2586 ~~electronic systems for the purpose of verifying the identity and~~
2587 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
2588 ~~to the Legislature a plan to implement an electronic~~
2589 ~~verification system for Medicaid recipients by January 31, 2005.~~
2590 (45) ~~(48)~~(a) A provider is not entitled to enrollment in
2591 the Medicaid provider network. The agency may implement a
2592 Medicaid fee-for-service provider network controls, including,
2593 but not limited to, competitive procurement and provider
2594 credentialing. If a credentialing process is used, the agency
2595 may limit its provider network based upon the following
2596 considerations: beneficiary access to care, provider
2597 availability, provider quality standards and quality assurance
2598 processes, cultural competency, demographic characteristics of
2599 beneficiaries, practice standards, service wait times, provider
2600 turnover, provider licensure and accreditation history, program
2601 integrity history, peer review, Medicaid policy and billing
2602 compliance records, clinical and medical record audit findings,
2603 and such other areas that are considered necessary by the agency
2604 to ensure the integrity of the program.

2605 (b) The agency shall limit its network of durable medical
2606 equipment and medical supply providers. For dates of service
2607 after January 1, 2009, the agency shall limit payment for
2608 durable medical equipment and supplies to providers that meet
2609 all the requirements of this paragraph.
2610 1. Providers must be accredited by a Centers for Medicare
2611 and Medicaid Services deemed accreditation organization for
2612 suppliers of durable medical equipment, prosthetics, orthotics,
2613 and supplies. The provider must maintain accreditation and is
2614 subject to unannounced reviews by the accrediting organization.
2615 2. Providers must provide the services or supplies
2616 directly to the Medicaid recipient or caregiver at the provider
2617 location or recipient's residence or send the supplies directly
2618 to the recipient's residence with receipt of mailed delivery.
2619 Subcontracting or consignment of the service or supply to a
2620 third party is prohibited.
2621 3. Notwithstanding subparagraph 2., a durable medical
2622 equipment provider may store nebulizers at a physician's office
2623 for the purpose of having the physician's staff issue the
2624 equipment if it meets all of the following conditions:
2625 a. The physician must document the medical necessity and
2626 need to prevent further deterioration of the patient's
2627 respiratory status by the timely delivery of the nebulizer in
2628 the physician's office.
2629 b. The durable medical equipment provider must have
2630 written documentation of the competency and training by a
2631 Florida-licensed registered respiratory therapist of any durable
2632 medical equipment staff who participate in the training of

2633 physician office staff for the use of nebulizers, including
2634 cleaning, warranty, and special needs of patients.
2635 c. The physician's office must have documented the
2636 training and competency of any staff member who initiates the
2637 delivery of nebulizers to patients. The durable medical
2638 equipment provider must maintain copies of all physician office
2639 training.
2640 d. The physician's office must maintain inventory records
2641 of stored nebulizers, including documentation of the durable
2642 medical equipment provider source.
2643 e. A physician contracted with a Medicaid durable medical
2644 equipment provider may not have a financial relationship with
2645 that provider or receive any financial gain from the delivery of
2646 nebulizers to patients.
2647 4. Providers must have a physical business location and a
2648 functional landline business phone. The location must be within
2649 the state or not more than 50 miles from the Florida state line.
2650 The agency may make exceptions for providers of durable medical
2651 equipment or supplies not otherwise available from other
2652 enrolled providers located within the state.
2653 5. Physical business locations must be clearly identified
2654 as a business that furnishes durable medical equipment or
2655 medical supplies by signage that can be read from 20 feet away.
2656 The location must be readily accessible to the public during
2657 normal, posted business hours and must operate at least 5 hours
2658 per day and at least 5 days per week, with the exception of
2659 scheduled and posted holidays. The location may not be located
2660 within or at the same numbered street address as another

2661 enrolled Medicaid durable medical equipment or medical supply
2662 provider or as an enrolled Medicaid pharmacy that is also
2663 enrolled as a durable medical equipment provider. A licensed
2664 orthotist or prosthetist that provides only orthotic or
2665 prosthetic devices as a Medicaid durable medical equipment
2666 provider is exempt from this paragraph.
2667 6. Providers must maintain a stock of durable medical
2668 equipment and medical supplies on site that is readily available
2669 to meet the needs of the durable medical equipment business
2670 location's customers.
2671 7. Providers must provide a surety bond of $50,000 for
2672 each provider location, up to a maximum of 5 bonds statewide or
2673 an aggregate bond of $250,000 statewide, as identified by
2674 Federal Employer Identification Number. Providers who post a
2675 statewide or an aggregate bond must identify all of their
2676 locations in any Medicaid durable medical equipment and medical
2677 supply provider enrollment application or bond renewal. Each
2678 provider location's surety bond must be renewed annually and the
2679 provider must submit proof of renewal even if the original bond
2680 is a continuous bond. A licensed orthotist or prosthetist that
2681 provides only orthotic or prosthetic devices as a Medicaid
2682 durable medical equipment provider is exempt from the provisions
2683 in this paragraph.
2684 8. Providers must obtain a level 2 background screening,
2685 in accordance with chapter 435 and s. 408.809, for each provider
2686 employee in direct contact with or providing direct services to
2687 recipients of durable medical equipment and medical supplies in
2688 their homes. This requirement includes, but is not limited to,

repair and service technicians, fitters, and delivery staff. The provider shall pay for the cost of the background screening.

9. The following providers are exempt from subparagraphs 1. and 7.:

a. Durable medical equipment providers owned and operated by a government entity.

b. Durable medical equipment providers that are operating within a pharmacy that is currently enrolled as a Medicaid pharmacy provider.

c. Active, Medicaid-enrolled orthopedic physician groups, primarily owned by physicians, which provide only orthotic and prosthetic devices.

(46) ~~(49)~~ The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

(b) The agency shall reimburse each minority physician network as a fee-for-service provider, including the case management fee for primary care, if any, or as a capitated rate

2717 provider for Medicaid services. Any savings shall be shared with
2718 the minority physician networks pursuant to the contract.
2719 (c) For purposes of this subsection, the term "cost-
2720 effective" means that a network's per-member, per-month costs to
2721 the state, including, but not limited to, fee-for-service costs,
2722 administrative costs, and case-management fees, if any, must be
2723 no greater than the state's costs associated with contracts for
2724 Medicaid services established under subsection (3), which shall
2725 be actuarially adjusted for case mix, model, and service area.
2726 The agency shall conduct actuarially sound audits adjusted for
2727 case mix and model in order to ensure such cost-effectiveness
2728 and shall annually publish the audit results on its Internet
2729 website. Contracts established pursuant to this subsection which
2730 are not cost-effective may not be renewed.
2731 (d) The agency may apply for any federal waivers needed to
2732 implement this subsection.
2733
2734 This subsection expires October 1, 2014.
2735 (47) ~~(50)~~ To the extent permitted by federal law and as
2736 allowed under s. 409.906, the agency shall provide reimbursement
2737 for emergency mental health care services for Medicaid
2738 recipients in crisis stabilization facilities licensed under s.
2739 394.875 as long as those services are less expensive than the
2740 same services provided in a hospital setting.
2741 (48) ~~(51)~~ The agency shall work with the Agency for Persons
2742 with Disabilities to develop a home and community-based waiver
2743 to serve children and adults who are diagnosed with familial
2744 dysautonomia or Riley-Day syndrome caused by a mutation of the

2745 IKBKAP gene on chromosome 9. The agency shall seek federal
2746 waiver approval and implement the approved waiver subject to the
2747 availability of funds and any limitations provided in the
2748 General Appropriations Act. The agency may adopt rules to
2749 implement this waiver program.
2750 (49) ~~(52)~~ The agency shall implement a program of all-
2751 inclusive care for children. The program of all-inclusive care
2752 for children shall be established to provide in-home hospice-
2753 like support services to children diagnosed with a life-
2754 threatening illness and enrolled in the Children's Medical
2755 Services network to reduce hospitalizations as appropriate. The
2756 agency, in consultation with the Department of Health, may
2757 implement the program of all-inclusive care for children after
2758 obtaining approval from the Centers for Medicare and Medicaid
2759 Services.
2760 (50) ~~(53)~~ Before seeking an amendment to the state plan for
2761 purposes of implementing programs authorized by the Deficit
2762 Reduction Act of 2005, the agency shall notify the Legislature.
2763 (51) The agency may not pay for psychotropic medication
2764 prescribed for a child in the Medicaid program without the
2765 express and informed consent of the child's parent or legal
2766 guardian. The physician shall document the consent in the
2767 child's medical record and provide the pharmacy with a signed
2768 attestation of this documentation with the prescription. The
2769 express and informed consent or court authorization for a
2770 prescription of psychotropic medication for a child in the
2771 custody of the Department of Children and Family Services shall
2772 be obtained pursuant to s. 39.407.

2773 Section 18. Section 409.91207, Florida Statutes, is
2774 repealed.
2775 Section 19. Paragraphs (e), (l), (p), (w), and (dd) of
2776 subsection (3) of section 409.91211, Florida Statutes, are
2777 amended to read:
2778 409.91211 Medicaid managed care pilot program.—
2779 (3) The agency shall have the following powers, duties,
2780 and responsibilities with respect to the pilot program:
2781 (e) To implement policies and guidelines for phasing in
2782 financial risk for approved provider service networks that, for
2783 purposes of this paragraph, include the Children's Medical
2784 Services Network, over the period of the waiver and the
2785 extension thereof. These policies and guidelines must include an
2786 option for a provider service network to be paid fee-for-service
2787 rates. For any provider service network established in a managed
2788 care pilot area, the option to be paid fee-for-service rates
2789 must include a savings-settlement mechanism that is consistent
2790 with s. 409.912(42) (44). This model must be converted to a risk-
2791 adjusted capitated rate by the beginning of the final year of
2792 operation under the waiver extension, and may be converted
2793 earlier at the option of the provider service network. Federally
2794 qualified health centers may be offered an opportunity to accept
2795 or decline a contract to participate in any provider network for
2796 prepaid primary care services.
2797 (l) To implement a system that prohibits capitated managed
2798 care plans, their representatives, and providers employed by or
2799 contracted with the capitated managed care plans from recruiting
2800 persons eligible for or enrolled in Medicaid, from providing

2801 inducements to Medicaid recipients to select a particular
2802 capitated managed care plan, and from prejudicing Medicaid
2803 recipients against other capitated managed care plans. The
2804 system shall require the entity performing choice counseling to
2805 determine if the recipient has made a choice of a plan or has
2806 opted out because of duress, threats, payment to the recipient,
2807 or incentives promised to the recipient by a third party. If the
2808 choice counseling entity determines that the decision to choose
2809 a plan was unlawfully influenced or a plan violated any of the
2810 provisions of s. 409.912(20) ~~(21)~~, the choice counseling entity
2811 shall immediately report the violation to the agency's program
2812 integrity section for investigation. Verification of choice
2813 counseling by the recipient shall include a stipulation that the
2814 recipient acknowledges the provisions of this subsection.
2815 (p) To implement standards for plan compliance, including,
2816 but not limited to, standards for quality assurance and
2817 performance improvement, standards for peer or professional
2818 reviews, grievance policies, and policies for maintaining
2819 program integrity. The agency shall develop a data-reporting
2820 system, seek input from managed care plans in order to establish
2821 requirements for patient-encounter reporting, and ensure that
2822 the data reported is accurate and complete.
2823 1. In performing the duties required under this section,
2824 the agency shall work with managed care plans to establish a
2825 uniform system to measure and monitor outcomes for a recipient
2826 of Medicaid services.
2827 2. The system shall use financial, clinical, and other
2828 criteria based on pharmacy, medical services, and other data

2829 that is related to the provision of Medicaid services,
2830 including, but not limited to:
2831 a. The Health Plan Employer Data and Information Set
2832 (HEDIS) or measures that are similar to HEDIS.
2833 b. Member satisfaction.
2834 c. Provider satisfaction.
2835 d. Report cards on plan performance and best practices.
2836 e. Compliance with the requirements for prompt payment of
2837 claims under ss. 627.613, 641.3155, and 641.513.
2838 f. Utilization and quality data for the purpose of
2839 ensuring access to medically necessary services, including
2840 underutilization or inappropriate denial of services.
2841 3. The agency shall require the managed care plans that
2842 have contracted with the agency to establish a quality assurance
2843 system that incorporates the provisions of s. 409.912(26) ~~(27)~~
2844 and any standards, rules, and guidelines developed by the
2845 agency.
2846 4. The agency shall establish an encounter database in
2847 order to compile data on health services rendered by health care
2848 practitioners who provide services to patients enrolled in
2849 managed care plans in the demonstration sites. The encounter
2850 database shall:
2851 a. Collect the following for each type of patient
2852 encounter with a health care practitioner or facility,
2853 including:
2854 (I) The demographic characteristics of the patient.
2855 (II) The principal, secondary, and tertiary diagnosis.
2856 (III) The procedure performed.

2857 (IV) The date and location where the procedure was
2858 performed.
2859 (V) The payment for the procedure, if any.
2860 (VI) If applicable, the health care practitioner's
2861 universal identification number.
2862 (VII) If the health care practitioner rendering the
2863 service is a dependent practitioner, the modifiers appropriate
2864 to indicate that the service was delivered by the dependent
2865 practitioner.
2866 b. Collect appropriate information relating to
2867 prescription drugs for each type of patient encounter.
2868 c. Collect appropriate information related to health care
2869 costs and utilization from managed care plans participating in
2870 the demonstration sites.
2871 5. To the extent practicable, when collecting the data the
2872 agency shall use a standardized claim form or electronic
2873 transfer system that is used by health care practitioners,
2874 facilities, and payors.
2875 6. Health care practitioners and facilities in the
2876 demonstration sites shall electronically submit, and managed
2877 care plans participating in the demonstration sites shall
2878 electronically receive, information concerning claims payments
2879 and any other information reasonably related to the encounter
2880 database using a standard format as required by the agency.
2881 7. The agency shall establish reasonable deadlines for
2882 phasing in the electronic transmittal of full encounter data.
2883 8. The system must ensure that the data reported is
2884 accurate and complete.

2885 (w) To implement procedures to minimize the risk of
2886 Medicaid fraud and abuse in all plans operating in the Medicaid
2887 managed care pilot program authorized in this section.
2888 1. The agency shall ensure that applicable provisions of
2889 this chapter and chapters 414, 626, 641, and 932 which relate to
2890 Medicaid fraud and abuse are applied and enforced at the
2891 demonstration project sites.
2892 2. Providers must have the certification, license, and
2893 credentials that are required by law and waiver requirements.
2894 3. The agency shall ensure that the plan is in compliance
2895 with s. 409.912(20) and (21) ~~and (22)~~.
2896 4. The agency shall require that each plan establish
2897 functions and activities governing program integrity in order to
2898 reduce the incidence of fraud and abuse. Plans must report
2899 instances of fraud and abuse pursuant to chapter 641.
2900 5. The plan shall have written administrative and
2901 management arrangements or procedures, including a mandatory
2902 compliance plan, which are designed to guard against fraud and
2903 abuse. The plan shall designate a compliance officer who has
2904 sufficient experience in health care.
2905 6.a. The agency shall require all managed care plan
2906 contractors in the pilot program to report all instances of
2907 suspected fraud and abuse. A failure to report instances of
2908 suspected fraud and abuse is a violation of law and subject to
2909 the penalties provided by law.
2910 b. An instance of fraud and abuse in the managed care
2911 plan, including, but not limited to, defrauding the state health
2912 care benefit program by misrepresentation of fact in reports,

2913 claims, certifications, enrollment claims, demographic
2914 statistics, or patient-encounter data; misrepresentation of the
2915 qualifications of persons rendering health care and ancillary
2916 services; bribery and false statements relating to the delivery
2917 of health care; unfair and deceptive marketing practices; and
2918 false claims actions in the provision of managed care, is a
2919 violation of law and subject to the penalties provided by law.
2920 c. The agency shall require that all contractors make all
2921 files and relevant billing and claims data accessible to state
2922 regulators and investigators and that all such data is linked
2923 into a unified system to ensure consistent reviews and
2924 investigations.
2925 (dd) To implement service delivery mechanisms within a
2926 specialty plan in area 10 to provide behavioral health care
2927 services to Medicaid-eligible children whose cases are open for
2928 child welfare services in the HomeSafeNet system. These services
2929 must be coordinated with community-based care providers as
2930 specified in s. 409.1671, where available, and be sufficient to
2931 meet the developmental, behavioral, and emotional needs of these
2932 children. Children in area 10 who have an open case in the
2933 HomeSafeNet system shall be enrolled into the specialty plan.
2934 These service delivery mechanisms must be implemented no later
2935 than July 1, 2011, in AHCA area 10 in order for the children in
2936 AHCA area 10 to remain exempt from the statewide plan under s.
2937 409.912(4)(b)5. ~~8.~~ An administrative fee may be paid to the
2938 specialty plan for the coordination of services based on the
2939 receipt of the state share of that fee being provided through
2940 intergovernmental transfers.

2941 Section 20. Effective October 1, 2014, section 409.91211,
2942 Florida Statutes, is repealed.
2943 Section 21. Section 409.9122, Florida Statutes, is amended
2944 to read:
2945 409.9122 Mandatory Medicaid managed care enrollment;
2946 programs and procedures.—
2947 (1) It is the intent of the Legislature that the MediPass
2948 program be cost-effective, provide quality health care, and
2949 improve access to health services, and that the program be
2950 statewide. This subsection expires October 1, 2014.
2951 (2)(a) The agency shall enroll in a managed care plan or
2952 MediPass all Medicaid recipients, except those Medicaid
2953 recipients who are: in an institution; enrolled in the Medicaid
2954 medically needy program; or eligible for both Medicaid and
2955 Medicare. Upon enrollment, individuals will be able to change
2956 their managed care option during the 90-day opt out period
2957 required by federal Medicaid regulations. The agency is
2958 authorized to seek the necessary Medicaid state plan amendment
2959 to implement this policy. However, to the extent permitted by
2960 federal law, the agency may enroll in a managed care plan or
2961 MediPass a Medicaid recipient who is exempt from mandatory
2962 managed care enrollment, provided that:
2963 1. The recipient's decision to enroll in a managed care
2964 plan or MediPass is voluntary;
2965 2. If the recipient chooses to enroll in a managed care
2966 plan, the agency has determined that the managed care plan
2967 provides specific programs and services which address the
2968 special health needs of the recipient; and

2969 3. The agency receives any necessary waivers from the
2970 federal Centers for Medicare and Medicaid Services.
2971
2972 ~~The agency shall develop rules to establish policies by which~~
2973 ~~exceptions to the mandatory managed care enrollment requirement~~
2974 ~~may be made on a case-by-case basis. The rules shall include the~~
2975 ~~specific criteria to be applied when making a determination as~~
2976 ~~to whether to exempt a recipient from mandatory enrollment in a~~
2977 ~~managed care plan or MediPass.~~ School districts participating in
2978 the certified school match program pursuant to ss. 409.908(21)
2979 and 1011.70 shall be reimbursed by Medicaid, subject to the
2980 limitations of s. 1011.70(1), for a Medicaid-eligible child
2981 participating in the services as authorized in s. 1011.70, as
2982 provided for in s. 409.9071, regardless of whether the child is
2983 enrolled in MediPass or a managed care plan. Managed care plans
2984 shall make a good faith effort to execute agreements with school
2985 districts regarding the coordinated provision of services
2986 authorized under s. 1011.70. County health departments
2987 delivering school-based services pursuant to ss. 381.0056 and
2988 381.0057 shall be reimbursed by Medicaid for the federal share
2989 for a Medicaid-eligible child who receives Medicaid-covered
2990 services in a school setting, regardless of whether the child is
2991 enrolled in MediPass or a managed care plan. Managed care plans
2992 shall make a good faith effort to execute agreements with county
2993 health departments regarding the coordinated provision of
2994 services to a Medicaid-eligible child. To ensure continuity of
2995 care for Medicaid patients, the agency, the Department of
2996 Health, and the Department of Education shall develop procedures

2997 for ensuring that a student's managed care plan or MediPass
2998 provider receives information relating to services provided in
2999 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
3000 (b) A Medicaid recipient shall not be enrolled in or
3001 assigned to a managed care plan or MediPass unless the managed
3002 care plan or MediPass has complied with the quality-of-care
3003 standards specified in paragraphs (3)(a) and (b), respectively.
3004 (c) Medicaid recipients shall have a choice of managed
3005 care plans or MediPass. The Agency for Health Care
3006 Administration, the Department of Health, the Department of
3007 Children and Family Services, and the Department of Elderly
3008 Affairs shall cooperate to ensure that each Medicaid recipient
3009 receives clear and easily understandable information that meets
3010 the following requirements:
3011 1. Explains the concept of managed care, including
3012 MediPass.
3013 2. Provides information on the comparative performance of
3014 managed care plans and MediPass in the areas of quality,
3015 credentialing, preventive health programs, network size and
3016 availability, and patient satisfaction.
3017 3. Explains where additional information on each managed
3018 care plan and MediPass in the recipient's area can be obtained.
3019 4. Explains that recipients have the right to choose their
3020 managed care coverage at the time they first enroll in Medicaid
3021 and again at regular intervals set by the agency. However, if a
3022 recipient does not choose a managed care plan or MediPass, the
3023 agency will assign the recipient to a managed care plan or
3024 MediPass according to the criteria specified in this section.

3025 5. Explains the recipient's right to complain, file a
3026 grievance, or change managed care plans or MediPass providers if
3027 the recipient is not satisfied with the managed care plan or
3028 MediPass.
3029 (d) The agency shall develop a mechanism for providing
3030 information to Medicaid recipients for the purpose of making a
3031 managed care plan or MediPass selection. Examples of such
3032 mechanisms may include, but not be limited to, interactive
3033 information systems, mailings, and mass marketing materials.
3034 Managed care plans and MediPass providers are prohibited from
3035 providing inducements to Medicaid recipients to select their
3036 plans or from prejudicing Medicaid recipients against other
3037 managed care plans or MediPass providers.
3038 (e) Medicaid recipients who are already enrolled in a
3039 managed care plan or MediPass shall be offered the opportunity
3040 to change managed care plans or MediPass providers on a
3041 staggered basis, as defined by the agency. All Medicaid
3042 recipients shall have 30 days in which to make a choice of
3043 managed care plans or MediPass providers. Those Medicaid
3044 recipients who do not make a choice shall be assigned in
3045 accordance with paragraph (f). To facilitate continuity of care,
3046 for a Medicaid recipient who is also a recipient of Supplemental
3047 Security Income (SSI), prior to assigning the SSI recipient to a
3048 managed care plan or MediPass, the agency shall determine
3049 whether the SSI recipient has an ongoing relationship with a
3050 MediPass provider or managed care plan, and if so, the agency
3051 shall assign the SSI recipient to that MediPass provider or
3052 managed care plan. Those SSI recipients who do not have such a

3053 provider relationship shall be assigned to a managed care plan
3054 or MediPass provider in accordance with paragraph (f).
3055 (f) If a Medicaid recipient does not choose a managed care
3056 plan or MediPass provider, the agency shall assign the Medicaid
3057 recipient to a managed care plan or MediPass provider. Medicaid
3058 recipients eligible for managed care plan enrollment who are
3059 subject to mandatory assignment but who fail to make a choice
3060 shall be assigned to managed care plans until an enrollment of
3061 35 percent in MediPass and 65 percent in managed care plans, of
3062 all those eligible to choose managed care, is achieved. Once
3063 this enrollment is achieved, the assignments shall be divided in
3064 order to maintain an enrollment in MediPass and managed care
3065 plans which is in a 35 percent and 65 percent proportion,
3066 respectively. Thereafter, assignment of Medicaid recipients who
3067 fail to make a choice shall be based proportionally on the
3068 preferences of recipients who have made a choice in the previous
3069 period. Such proportions shall be revised at least quarterly to
3070 reflect an update of the preferences of Medicaid recipients. The
3071 agency shall disproportionately assign Medicaid-eligible
3072 recipients who are required to but have failed to make a choice
3073 of managed care plan or MediPass~~, including children, and who~~
3074 ~~would be assigned to the MediPass program~~ to <u>the</u> ~~children's~~
3075 ~~networks as described in s. 409.912(4)(g),~~ Children's Medical
3076 Services Network as defined in s. 391.021, exclusive provider
3077 organizations, provider service networks, minority physician
3078 networks, and pediatric emergency department diversion programs
3079 authorized by this chapter or the General Appropriations Act, in
3080 such manner as the agency deems appropriate, until the agency

3081 has determined that the networks and programs have sufficient
3082 numbers to be operated economically. For purposes of this
3083 paragraph, when referring to assignment, the term "managed care
3084 plans" includes health maintenance organizations, exclusive
3085 provider organizations, provider service networks, minority
3086 physician networks, Children's Medical Services Network, and
3087 pediatric emergency department diversion programs authorized by
3088 this chapter or the General Appropriations Act. When making
3089 assignments, the agency shall take into account the following
3090 criteria:
3091 1. A managed care plan has sufficient network capacity to
3092 meet the need of members.
3093 2. The managed care plan or MediPass has previously
3094 enrolled the recipient as a member, or one of the managed care
3095 plan's primary care providers or MediPass providers has
3096 previously provided health care to the recipient.
3097 3. The agency has knowledge that the member has previously
3098 expressed a preference for a particular managed care plan or
3099 MediPass provider as indicated by Medicaid fee-for-service
3100 claims data, but has failed to make a choice.
3101 4. The managed care plan's or MediPass primary care
3102 providers are geographically accessible to the recipient's
3103 residence.
3104 (g) When more than one managed care plan or MediPass
3105 provider meets the criteria specified in paragraph (f), the
3106 agency shall make recipient assignments consecutively by family
3107 unit.
3108 (h) The agency may not engage in practices that are

3109 designed to favor one managed care plan over another or that are
3110 designed to influence Medicaid recipients to enroll in MediPass
3111 rather than in a managed care plan or to enroll in a managed
3112 care plan rather than in MediPass. This subsection does not
3113 prohibit the agency from reporting on the performance of
3114 MediPass or any managed care plan, as measured by performance
3115 criteria developed by the agency.
3116 (i) After a recipient has made his or her selection or has
3117 been enrolled in a managed care plan or MediPass, the recipient
3118 shall have 90 days to exercise the opportunity to voluntarily
3119 disenroll and select another managed care plan or MediPass.
3120 After 90 days, no further changes may be made except for good
3121 cause. Good cause includes, but is not limited to, poor quality
3122 of care, lack of access to necessary specialty services, an
3123 unreasonable delay or denial of service, or fraudulent
3124 enrollment. The agency shall develop criteria for good cause
3125 disenrollment for chronically ill and disabled populations who
3126 are assigned to managed care plans if more appropriate care is
3127 available through the MediPass program. The agency must make a
3128 determination as to whether cause exists. However, the agency
3129 may require a recipient to use the managed care plan's or
3130 MediPass grievance process prior to the agency's determination
3131 of cause, except in cases in which immediate risk of permanent
3132 damage to the recipient's health is alleged. The grievance
3133 process, when utilized, must be completed in time to permit the
3134 recipient to disenroll by the first day of the second month
3135 after the month the disenrollment request was made. If the
3136 managed care plan or MediPass, as a result of the grievance

3137 process, approves an enrollee's request to disenroll, the agency
3138 is not required to make a determination in the case. The agency
3139 must make a determination and take final action on a recipient's
3140 request so that disenrollment occurs no later than the first day
3141 of the second month after the month the request was made. If the
3142 agency fails to act within the specified timeframe, the
3143 recipient's request to disenroll is deemed to be approved as of
3144 the date agency action was required. Recipients who disagree
3145 with the agency's finding that cause does not exist for
3146 disenrollment shall be advised of their right to pursue a
3147 Medicaid fair hearing to dispute the agency's finding.
3148 (j) The agency shall apply for a federal waiver from the
3149 Centers for Medicare and Medicaid Services to lock eligible
3150 Medicaid recipients into a managed care plan or MediPass for 12
3151 months after an open enrollment period. After 12 months'
3152 enrollment, a recipient may select another managed care plan or
3153 MediPass provider. However, nothing shall prevent a Medicaid
3154 recipient from changing primary care providers within the
3155 managed care plan or MediPass program during the 12-month
3156 period.
3157 (k) When a Medicaid recipient does not choose a managed
3158 care plan or MediPass provider, the agency shall assign the
3159 Medicaid recipient to a managed care plan, except in those
3160 counties in which there are fewer than two managed care plans
3161 accepting Medicaid enrollees, in which case assignment shall be
3162 to a managed care plan or a MediPass provider. Medicaid
3163 recipients in counties with fewer than two managed care plans
3164 accepting Medicaid enrollees who are subject to mandatory

3165 assignment but who fail to make a choice shall be assigned to
3166 managed care plans until an enrollment of 35 percent in MediPass
3167 and 65 percent in managed care plans, of all those eligible to
3168 choose managed care, is achieved. Once that enrollment is
3169 achieved, the assignments shall be divided in order to maintain
3170 an enrollment in MediPass and managed care plans which is in a
3171 35 percent and 65 percent proportion, respectively. For purposes
3172 of this paragraph, when referring to assignment, the term
3173 "managed care plans" includes exclusive provider organizations,
3174 provider service networks, Children's Medical Services Network,
3175 minority physician networks, and pediatric emergency department
3176 diversion programs authorized by this chapter or the General
3177 Appropriations Act. When making assignments, the agency shall
3178 take into account the following criteria:
3179 1. A managed care plan has sufficient network capacity to
3180 meet the need of members.
3181 2. The managed care plan or MediPass has previously
3182 enrolled the recipient as a member, or one of the managed care
3183 plan's primary care providers or MediPass providers has
3184 previously provided health care to the recipient.
3185 3. The agency has knowledge that the member has previously
3186 expressed a preference for a particular managed care plan or
3187 MediPass provider as indicated by Medicaid fee-for-service
3188 claims data, but has failed to make a choice.
3189 4. The managed care plan's or MediPass primary care
3190 providers are geographically accessible to the recipient's
3191 residence.
3192 5. The agency has authority to make mandatory assignments

3193 based on quality of service and performance of managed care
3194 plans.
3195 (l) If the Medicaid recipient is diagnosed with HIV/AIDS
3196 and resides in Broward, Miami-Dade, or Palm Beach Counties, the
3197 agency shall assign the Medicaid recipient to a managed care
3198 plan that is a health maintenance organization authorized under
3199 chapter 641, is under contract with the agency on July 1, 2011,
3200 and offers a delivery system through a university-based teaching
3201 and research-oriented organization that specializes in providing
3202 health care services and treatment for individuals diagnosed
3203 with HIV/AIDS.
3204 (m) ~~(l)~~ Notwithstanding the provisions of chapter 287, the
3205 agency may, at its discretion, renew cost-effective contracts
3206 for choice counseling services once or more for such periods as
3207 the agency may decide. However, all such renewals may not
3208 combine to exceed a total period longer than the term of the
3209 original contract.
3210
3211 This subsection expires October 1, 2014.
3212 (3)(a) The agency shall establish quality-of-care
3213 standards for managed care plans. These standards shall be based
3214 upon, but are not limited to:
3215 1. Compliance with the accreditation requirements as
3216 provided in s. 641.512.
3217 2. Compliance with Early and Periodic Screening,
3218 Diagnosis, and Treatment screening requirements.
3219 3. The percentage of voluntary disenrollments.
3220 4. Immunization rates.

3221 5. Standards of the National Committee for Quality
3222 Assurance and other approved accrediting bodies.
3223 6. Recommendations of other authoritative bodies.
3224 7. Specific requirements of the Medicaid program, or
3225 standards designed to specifically assist the unique needs of
3226 Medicaid recipients.
3227 8. Compliance with the health quality improvement system
3228 as established by the agency, which incorporates standards and
3229 guidelines developed by the Medicaid Bureau of the Health Care
3230 Financing Administration as part of the quality assurance reform
3231 initiative.
3232 (b) For the MediPass program, the agency shall establish
3233 standards which are based upon, but are not limited to:
3234 1. Quality-of-care standards which are comparable to those
3235 required of managed care plans.
3236 2. Credentialing standards for MediPass providers.
3237 3. Compliance with Early and Periodic Screening,
3238 Diagnosis, and Treatment screening requirements.
3239 4. Immunization rates.
3240 5. Specific requirements of the Medicaid program, or
3241 standards designed to specifically assist the unique needs of
3242 Medicaid recipients.
3243
3244 This subsection expires October 1, 2014.
3245 (4)(a) Each female recipient may select as her primary
3246 care provider an obstetrician/gynecologist who has agreed to
3247 participate as a MediPass primary care case manager.
3248 (b) The agency shall establish a complaints and grievance

3249 process to assist Medicaid recipients enrolled in the MediPass
3250 program to resolve complaints and grievances. The agency shall
3251 investigate reports of quality-of-care grievances which remain
3252 unresolved to the satisfaction of the enrollee.
3253
3254 This subsection expires October 1, 2014.
3255 (5)(a) The agency shall work cooperatively with the Social
3256 Security Administration to identify beneficiaries who are
3257 jointly eligible for Medicare and Medicaid and shall develop
3258 cooperative programs to encourage these beneficiaries to enroll
3259 in a Medicare participating health maintenance organization or
3260 prepaid health plans.
3261 (b) The agency shall work cooperatively with the
3262 Department of Elderly Affairs to assess the potential cost-
3263 effectiveness of providing MediPass to beneficiaries who are
3264 jointly eligible for Medicare and Medicaid on a voluntary choice
3265 basis. If the agency determines that enrollment of these
3266 beneficiaries in MediPass has the potential for being cost-
3267 effective for the state, the agency shall offer MediPass to
3268 these beneficiaries on a voluntary choice basis in the counties
3269 where MediPass operates.
3270
3271 This subsection expires October 1, 2014.
3272 (6) MediPass enrolled recipients may receive up to 10
3273 visits of reimbursable services by participating Medicaid
3274 physicians licensed under chapter 460 and up to four visits of
3275 reimbursable services by participating Medicaid physicians
3276 licensed under chapter 461. Any further visits must be by prior

3277 authorization by the MediPass primary care provider. However,
3278 nothing in this subsection may be construed to increase the
3279 total number of visits or the total amount of dollars per year
3280 per person under current Medicaid rules, unless otherwise
3281 provided for in the General Appropriations Act. This subsection
3282 expires October 1, 2014.
3283 (7) The agency shall investigate the feasibility of
3284 developing managed care plan and MediPass options for the
3285 following groups of Medicaid recipients:
3286 (a) Pregnant women and infants.
3287 (b) Elderly and disabled recipients, especially those who
3288 are at risk of nursing home placement.
3289 (c) Persons with developmental disabilities.
3290 (d) Qualified Medicare beneficiaries.
3291 (e) Adults who have chronic, high-cost medical conditions.
3292 (f) Adults and children who have mental health problems.
3293 (g) Other recipients for whom managed care plans and
3294 MediPass offer the opportunity of more cost-effective care and
3295 greater access to qualified providers.
3296 (8)(a) The agency shall encourage the development of
3297 public and private partnerships to foster the growth of health
3298 maintenance organizations and prepaid health plans that will
3299 provide high-quality health care to Medicaid recipients.
3300 (b) Subject to the availability of moneys and any
3301 limitations established by the General Appropriations Act or
3302 chapter 216, the agency is authorized to enter into contracts
3303 with traditional providers of health care to low-income persons
3304 to assist such providers with the technical aspects of

3305 ~~cooperatively developing Medicaid prepaid health plans.~~
3306 ~~1. The agency may contract with disproportionate share~~
3307 ~~hospitals, county health departments, federally initiated or~~
3308 ~~federally funded community health centers, and counties that~~
3309 ~~operate either a hospital or a community clinic.~~
3310 ~~2. A contract may not be for more than $100,000 per year,~~
3311 ~~and no contract may be extended with any particular provider for~~
3312 ~~more than 2 years. The contract is intended only as seed or~~
3313 ~~development funding and requires a commitment from the~~
3314 ~~interested party.~~
3315 ~~3. A contract must require participation by at least one~~
3316 ~~community health clinic and one disproportionate share hospital.~~
3317 (7) ~~(9)~~(a) The agency shall develop and implement a
3318 comprehensive plan to ensure that recipients are adequately
3319 informed of their choices and rights under all Medicaid managed
3320 care programs and that Medicaid managed care programs meet
3321 acceptable standards of quality in patient care, patient
3322 satisfaction, and financial solvency.
3323 (b) The agency shall provide adequate means for informing
3324 patients of their choice and rights under a managed care plan at
3325 the time of eligibility determination.
3326 (c) The agency shall require managed care plans and
3327 MediPass providers to demonstrate and document plans and
3328 activities, as defined by rule, including outreach and followup,
3329 undertaken to ensure that Medicaid recipients receive the health
3330 care service to which they are entitled.
3331
3332 This subsection expires October 1, 2014.

3333 (8) ~~(10)~~ The agency shall consult with Medicaid consumers
3334 and their representatives on an ongoing basis regarding
3335 measurements of patient satisfaction, procedures for resolving
3336 patient grievances, standards for ensuring quality of care,
3337 mechanisms for providing patient access to services, and
3338 policies affecting patient care. This subsection expires October
3339 1, 2014.
3340 (9) ~~(11)~~ The agency may extend eligibility for Medicaid
3341 recipients enrolled in licensed and accredited health
3342 maintenance organizations for the duration of the enrollment
3343 period or for 6 months, whichever is earlier, provided the
3344 agency certifies that such an offer will not increase state
3345 expenditures. This subsection expires October 1, 2013.
3346 (10) ~~(12)~~ A managed care plan that has a Medicaid contract
3347 shall at least annually review each primary care physician's
3348 active patient load and shall ensure that additional Medicaid
3349 recipients are not assigned to physicians who have a total
3350 active patient load of more than 3,000 patients. As used in this
3351 subsection, the term "active patient" means a patient who is
3352 seen by the same primary care physician, or by a physician
3353 assistant or advanced registered nurse practitioner under the
3354 supervision of the primary care physician, at least three times
3355 within a calendar year. Each primary care physician shall
3356 annually certify to the managed care plan whether or not his or
3357 her patient load exceeds the limits established under this
3358 subsection and the managed care plan shall accept such
3359 certification on face value as compliance with this subsection.
3360 The agency shall accept the managed care plan's representations

3361 that it is in compliance with this subsection based on the
3362 certification of its primary care physicians, unless the agency
3363 has an objective indication that access to primary care is being
3364 compromised, such as receiving complaints or grievances relating
3365 to access to care. If the agency determines that an objective
3366 indication exists that access to primary care is being
3367 compromised, it may verify the patient load certifications
3368 submitted by the managed care plan's primary care physicians and
3369 that the managed care plan is not assigning Medicaid recipients
3370 to primary care physicians who have an active patient load of
3371 more than 3,000 patients. This subsection expires October 1,
3372 2014.
3373 (11) ~~(13)~~ Effective July 1, 2003, the agency shall adjust
3374 the enrollee assignment process of Medicaid managed prepaid
3375 health plans for those Medicaid managed prepaid plans operating
3376 in Miami-Dade County which have executed a contract with the
3377 agency for a minimum of 8 consecutive years in order for the
3378 Medicaid managed prepaid plan to maintain a minimum enrollment
3379 level of 15,000 members per month. When assigning enrollees
3380 pursuant to this subsection, the agency shall give priority to
3381 providers that initially qualified under this subsection until
3382 such providers reach and maintain an enrollment level of 15,000
3383 members per month. A prepaid health plan that has a statewide
3384 Medicaid enrollment of 25,000 or more members is not eligible
3385 for enrollee assignments under this subsection. This subsection
3386 expires October 1, 2014.
3387 (12) ~~(14)~~ The agency shall include in its calculation of
3388 the hospital inpatient component of a Medicaid health

3389 maintenance organization's capitation rate any special payments,
3390 including, but not limited to, upper payment limit or
3391 disproportionate share hospital payments, made to qualifying
3392 hospitals through the fee-for-service program. The agency may
3393 seek federal waiver approval or state plan amendment as needed
3394 to implement this adjustment.
3395 (13) The agency shall develop a process to enable any
3396 recipient with access to employer-sponsored health care coverage
3397 to opt out of all eligible plans in the Medicaid program and to
3398 use Medicaid financial assistance to pay for the recipient's
3399 share of cost in any such employer-sponsored coverage.
3400 Contingent on federal approval, the agency shall also enable
3401 recipients with access to other insurance or related products
3402 that provide access to health care services created pursuant to
3403 state law, including any plan or product available pursuant to
3404 the Florida Health Choices Program or any health exchange, to
3405 opt out. The amount of financial assistance provided for each
3406 recipient may not exceed the amount of the Medicaid premium that
3407 would have been paid to a plan for that recipient.
3408 (14) The agency shall maintain and operate the Medicaid
3409 Encounter Data System to collect, process, store, and report on
3410 covered services provided to all Florida Medicaid recipients
3411 enrolled in prepaid managed care plans.
3412 (a) Prepaid managed care plans shall submit encounter data
3413 electronically in a format that complies with the Health
3414 Insurance Portability and Accountability Act provisions for
3415 electronic claims and in accordance with deadlines established
3416 by the agency. Prepaid managed care plans must certify that the

3417 data reported is accurate and complete.
3418 (b) The agency is responsible for validating the data
3419 submitted by the plans. The agency shall develop methods and
3420 protocols for ongoing analysis of the encounter data that
3421 adjusts for differences in characteristics of prepaid plan
3422 enrollees to allow comparison of service utilization among plans
3423 and against expected levels of use. The analysis shall be used
3424 to identify possible cases of systemic underutilization or
3425 denials of claims and inappropriate service utilization such as
3426 higher-than-expected emergency department encounters. The
3427 analysis shall provide periodic feedback to the plans and enable
3428 the agency to establish corrective action plans when necessary.
3429 One of the focus areas for the analysis shall be the use of
3430 prescription drugs.
3431 (15) The agency may establish a per-member, per-month
3432 payment for Medicare Advantage Special Needs members that are
3433 also eligible for Medicaid as a mechanism for meeting the
3434 state's cost-sharing obligation. The agency may also develop a
3435 per-member, per-month payment only for Medicaid-covered services
3436 for which the state is responsible. The agency shall develop a
3437 mechanism to ensure that such per-member, per-month payment
3438 enhances the value to the state and enrolled members by limiting
3439 cost sharing, enhances the scope of Medicare supplemental
3440 benefits that are equal to or greater than Medicaid coverage for
3441 select services, and improves care coordination.
3442 (16) The agency shall establish, and managed care plans
3443 shall use, a uniform method of accounting for and reporting
3444 medical and nonmedical costs.

3445 (a) Managed care plans shall submit financial data
3446 electronically in a format that complies with the uniform
3447 accounting procedures established by the agency. Managed care
3448 plans must certify that the data reported is accurate and
3449 complete.
3450 (b) The agency is responsible for validating the financial
3451 data submitted by the plans. The agency shall develop methods
3452 and protocols for ongoing analysis of data that adjusts for
3453 differences in characteristics of plan enrollees to allow
3454 comparison among plans and against expected levels of
3455 expenditures. The analysis shall be used to identify possible
3456 cases of overspending on administrative costs or under spending
3457 on medical services.
3458 (17) The agency shall establish and maintain an
3459 information system to make encounter data, financial data, and
3460 other measures of plan performance to the public and any
3461 interested party.
3462 (a) Information submitted by the managed care plans shall
3463 be available online as well as in other formats.
3464 (b) Periodic agency reports shall be published that
3465 include provide summary as well as plan specific measures of
3466 financial performance and service utilization.
3467 (c) Any release of the financial and encounter data
3468 submitted by managed care plans shall ensure the confidentiality
3469 of personal health information.
3470 (18) The agency may, on a case-by-case basis, exempt a
3471 recipient from mandatory enrollment in a managed care plan when
3472 the recipient has a unique, time-limited disease or condition-

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

3473 related circumstance and managed care enrollment will interfere
3474 with ongoing care because the recipient's provider does not
3475 participate in the managed care plans available in the
3476 recipient's area.
3477 (19) The agency shall contract with a single provider
3478 service network to function as a managing entity for the
3479 MediPass program in all counties with fewer than two prepaid
3480 plans. The contractor shall be responsible for implementing
3481 preauthorization procedures, case management programs, and
3482 utilization management initiatives in order to improve care
3483 coordination and patient outcomes while reducing costs. The
3484 contractor may earn an administrative fee, if the fee is less
3485 than any savings determined by the reconciliation process
3486 pursuant to s. 409.912(4)(d)1. This subsection expires October
3487 1, 2014, or upon full implementation of the managed medical
3488 assistance program, whichever is sooner.
3489 (20) Subject to federal approval, the agency shall
3490 contract with a single provider service network to function as a
3491 third-party administrator and managing entity for the Medically
3492 Needy program in all counties. The contractor shall provide care
3493 coordination and utilization management in order to achieve more
3494 cost-effective services for Medically Needy enrollees. To
3495 facilitate the care management functions of the provider service
3496 network, enrollment in the network shall be for a continuous 6-
3497 month period or until the end of the contract between the
3498 provider service network and the agency, whichever is sooner.
3499 Beginning the second month after the determination of
3500 eligibility, the contractor may collect a monthly premium from

3501 each Medically Needy recipient provided the premium does not
3502 exceed the enrollee's share of cost as determined by the
3503 Department of Children and Family Services. The contractor must
3504 provide a 90-day grace period before disenrolling a Medically
3505 Needy recipient for failure to pay premiums. The contractor may
3506 earn an administrative fee, if the fee is less than any savings
3507 determined by the reconciliation process pursuant to s.
3508 409.912(4)(d)1. Premium revenue collected from the recipients
3509 shall be deducted from the contractor's earned savings. This
3510 subsection expires October 1, 2014, or upon full implementation
3511 of the managed medical assistance program, whichever is sooner.
3512 Section 22. Subsection (15) of section 430.04, Florida
3513 Statutes, is amended to read:
3514 430.04 Duties and responsibilities of the Department of
3515 Elderly Affairs.—The Department of Elderly Affairs shall:
3516 (15) Administer all Medicaid waivers and programs relating
3517 to elders and their appropriations. The waivers include, but are
3518 not limited to:
3519 (a) The Alzheimer's Dementia-Specific Medicaid Waiver as
3520 established in s. 430.502(7), (8), and (9).
3521 (a)(b) The Assisted Living for the Frail Elderly Waiver.
3522 (b)(c) The Aged and Disabled Adult Waiver.
3523 (c)(d) The Adult Day Health Care Waiver.
3524 (d)(e) The Consumer-Directed Care Plus Program as defined
3525 in s. 409.221.
3526 (e)(f) The Program of All-inclusive Care for the Elderly.
3527 (f)(g) The Long-Term Care Community-Based Diversion Pilot
3528 Project as described in s. 430.705.

3529 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
3530
3531 The department shall develop a transition plan for recipients
3532 receiving services in long-term care Medicaid waivers for elders
3533 or disabled adults on the date eligible plans become available
3534 in each recipient's region defined in s. 409.981(2) to enroll
3535 those recipients in eligible plans. This subsection expires
3536 October 1, 2014.
3537 Section 23. Section 430.2053, Florida Statutes, is amended
3538 to read:
3539 430.2053 Aging resource centers.—
3540 (1) The department, in consultation with the Agency for
3541 Health Care Administration and the Department of Children and
3542 Family Services, shall develop pilot projects for aging resource
3543 centers. ~~By October 31, 2004, the department, in consultation~~
3544 ~~with the agency and the Department of Children and Family~~
3545 ~~Services, shall develop an implementation plan for aging~~
3546 ~~resource centers and submit the plan to the Governor, the~~
3547 ~~President of the Senate, and the Speaker of the House of~~
3548 ~~Representatives. The plan must include qualifications for~~
3549 ~~designation as a center, the functions to be performed by each~~
3550 ~~center, and a process for determining that a current area agency~~
3551 ~~on aging is ready to assume the functions of an aging resource~~
3552 ~~center.~~
3553 ~~(2) Each area agency on aging shall develop, in~~
3554 ~~consultation with the existing community care for the elderly~~
3555 ~~lead agencies within their planning and service areas, a~~
3556 ~~proposal that describes the process the area agency on aging~~

3557 ~~intends to undertake to transition to an aging resource center~~
3558 ~~prior to July 1, 2005, and that describes the area agency's~~
3559 ~~compliance with the requirements of this section. The proposals~~
3560 ~~must be submitted to the department prior to December 31, 2004.~~
3561 ~~The department shall evaluate all proposals for readiness and,~~
3562 ~~prior to March 1, 2005, shall select three area agencies on~~
3563 ~~aging which meet the requirements of this section to begin the~~
3564 ~~transition to aging resource centers. Those area agencies on~~
3565 ~~aging which are not selected to begin the transition to aging~~
3566 ~~resource centers shall, in consultation with the department and~~
3567 ~~the existing community care for the elderly lead agencies within~~
3568 ~~their planning and service areas, amend their proposals as~~
3569 ~~necessary and resubmit them to the department prior to July 1,~~
3570 ~~2005. The department may transition additional area agencies to~~
3571 ~~aging resource centers as it determines that area agencies are~~
3572 ~~in compliance with the requirements of this section.~~
3573 ~~(3) The Auditor General and the Office of Program Policy~~
3574 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
3575 ~~review and assess the department's process for determining an~~
3576 ~~area agency's readiness to transition to an aging resource~~
3577 ~~center.~~
3578 ~~(a) The review must, at a minimum, address the~~
3579 ~~appropriateness of the department's criteria for selection of an~~
3580 ~~area agency to transition to an aging resource center, the~~
3581 ~~instruments applied, the degree to which the department~~
3582 ~~accurately determined each area agency's compliance with the~~
3583 ~~readiness criteria, the quality of the technical assistance~~
3584 ~~provided by the department to an area agency in correcting any~~

3585 ~~weaknesses identified in the readiness assessment, and the~~
3586 ~~degree to which each area agency overcame any identified~~
3587 ~~weaknesses.~~
3588 ~~(b) Reports of these reviews must be submitted to the~~
3589 ~~appropriate substantive and appropriations committees in the~~
3590 ~~Senate and the House of Representatives on March 1 and September~~
3591 ~~1 of each year until full transition to aging resource centers~~
3592 ~~has been accomplished statewide, except that the first report~~
3593 ~~must be submitted by February 1, 2005, and must address all~~
3594 ~~readiness activities undertaken through December 31, 2004. The~~
3595 ~~perspectives of all participants in this review process must be~~
3596 ~~included in each report.~~
3597 (2) ~~(4)~~ The purposes of an aging resource center shall be:
3598 (a) To provide Florida's elders and their families with a
3599 locally focused, coordinated approach to integrating information
3600 and referral for all available services for elders with the
3601 eligibility determination entities for state and federally
3602 funded long-term-care services.
3603 (b) To provide for easier access to long-term-care
3604 services by Florida's elders and their families by creating
3605 multiple access points to the long-term-care network that flow
3606 through one established entity with wide community recognition.
3607 (3) ~~(5)~~ The duties of an aging resource center are to:
3608 (a) Develop referral agreements with local community
3609 service organizations, such as senior centers, existing elder
3610 service providers, volunteer associations, and other similar
3611 organizations, to better assist clients who do not need or do
3612 not wish to enroll in programs funded by the department or the

3613 agency. The referral agreements must also include a protocol,
3614 developed and approved by the department, which provides
3615 specific actions that an aging resource center and local
3616 community service organizations must take when an elder or an
3617 elder's representative seeking information on long-term-care
3618 services contacts a local community service organization prior
3619 to contacting the aging resource center. The protocol shall be
3620 designed to ensure that elders and their families are able to
3621 access information and services in the most efficient and least
3622 cumbersome manner possible.

3623 (b) Provide an initial screening of all clients who
3624 request long-term-care services to determine whether the person
3625 would be most appropriately served through any combination of
3626 federally funded programs, state-funded programs, locally funded
3627 or community volunteer programs, or private funding for
3628 services.

3629 (c) Determine eligibility for the programs and services
3630 listed in subsection (9) ~~(11)~~ for persons residing within the
3631 geographic area served by the aging resource center and
3632 determine a priority ranking for services which is based upon
3633 the potential recipient's frailty level and likelihood of
3634 institutional placement without such services.

3635 (d) Manage the availability of financial resources for the
3636 programs and services listed in subsection (9) ~~(11)~~ for persons
3637 residing within the geographic area served by the aging resource
3638 center.

3639 (e) When financial resources become available, refer a
3640 client to the most appropriate entity to begin receiving

3641 services. The aging resource center shall make referrals to lead
3642 agencies for service provision that ensure that individuals who
3643 are vulnerable adults in need of services pursuant to s.
3644 415.104(3)(b), or who are victims of abuse, neglect, or
3645 exploitation in need of immediate services to prevent further
3646 harm and are referred by the adult protective services program,
3647 are given primary consideration for receiving community-care-
3648 for-the-elderly services in compliance with the requirements of
3649 s. 430.205(5)(a) and that other referrals for services are in
3650 compliance with s. 430.205(5)(b).
3651 (f) Convene a work group to advise in the planning,
3652 implementation, and evaluation of the aging resource center. The
3653 work group shall be comprised of representatives of local
3654 service providers, Alzheimer's Association chapters, housing
3655 authorities, social service organizations, advocacy groups,
3656 representatives of clients receiving services through the aging
3657 resource center, and any other persons or groups as determined
3658 by the department. The aging resource center, in consultation
3659 with the work group, must develop annual program improvement
3660 plans that shall be submitted to the department for
3661 consideration. The department shall review each annual
3662 improvement plan and make recommendations on how to implement
3663 the components of the plan.
3664 (g) Enhance the existing area agency on aging in each
3665 planning and service area by integrating, either physically or
3666 virtually, the staff and services of the area agency on aging
3667 with the staff of the department's local CARES Medicaid ~~nursing~~
3668 ~~home~~ preadmission screening unit and a sufficient number of

3669 staff from the Department of Children and Family Services'
3670 Economic Self-Sufficiency Unit necessary to determine the
3671 financial eligibility for all persons age 60 and older residing
3672 within the area served by the aging resource center that are
3673 seeking Medicaid services, Supplemental Security Income, and
3674 food assistance.
3675 (h) Assist clients who request long-term care services in
3676 being evaluated for eligibility for enrollment in the Medicaid
3677 long-term care managed care program as eligible plans become
3678 available in each of the regions pursuant to s. 409.981(2).
3679 (i) Provide enrollment and coverage information to
3680 Medicaid managed long-term care enrollees as qualified plans
3681 become available in each of the regions pursuant to s.
3682 409.981(2).
3683 (j) Assist Medicaid recipients enrolled in the Medicaid
3684 long-term care managed care program with informally resolving
3685 grievances with a managed care network and assist Medicaid
3686 recipients in accessing the managed care network's formal
3687 grievance process as eligible plans become available in each of
3688 the regions defined in s. 409.981(2).
3689 (4) ~~(6)~~ The department shall select the entities to become
3690 aging resource centers based on each entity's readiness and
3691 ability to perform the duties listed in subsection (3) ~~(5)~~ and
3692 the entity's:
3693 (a) Expertise in the needs of each target population the
3694 center proposes to serve and a thorough knowledge of the
3695 providers that serve these populations.
3696 (b) Strong connections to service providers, volunteer

3697 agencies, and community institutions.
3698 (c) Expertise in information and referral activities.
3699 (d) Knowledge of long-term-care resources, including
3700 resources designed to provide services in the least restrictive
3701 setting.
3702 (e) Financial solvency and stability.
3703 (f) Ability to collect, monitor, and analyze data in a
3704 timely and accurate manner, along with systems that meet the
3705 department's standards.
3706 (g) Commitment to adequate staffing by qualified personnel
3707 to effectively perform all functions.
3708 (h) Ability to meet all performance standards established
3709 by the department.
3710 (5)~~(7)~~ The aging resource center shall have a governing
3711 body which shall be the same entity described in s. 20.41(7),
3712 and an executive director who may be the same person as
3713 described in s. 20.41(7). The governing body shall annually
3714 evaluate the performance of the executive director.
3715 (6)~~(8)~~ The aging resource center may not be a provider of
3716 direct services other than information and referral services,
3717 and screening.
3718 (7)~~(9)~~ The aging resource center must agree to allow the
3719 department to review any financial information the department
3720 determines is necessary for monitoring or reporting purposes,
3721 including financial relationships.
3722 (8)~~(10)~~ The duties and responsibilities of the community
3723 care for the elderly lead agencies within each area served by an
3724 aging resource center shall be to:

3725 (a) Develop strong community partnerships to maximize the
3726 use of community resources for the purpose of assisting elders
3727 to remain in their community settings for as long as it is
3728 safely possible.
3729 (b) Conduct comprehensive assessments of clients that have
3730 been determined eligible and develop a care plan consistent with
3731 established protocols that ensures that the unique needs of each
3732 client are met.
3733 (9) ~~(11)~~ The services to be administered through the aging
3734 resource center shall include those funded by the following
3735 programs:
3736 (a) Community care for the elderly.
3737 (b) Home care for the elderly.
3738 (c) Contracted services.
3739 (d) Alzheimer's disease initiative.
3740 (e) Aged and disabled adult Medicaid waiver. This
3741 paragraph expires October 1, 2013.
3742 (f) Assisted living for the frail elderly Medicaid waiver.
3743 This paragraph expires October 1, 2013.
3744 (g) Older Americans Act.
3745 (10) ~~(12)~~ The department shall, prior to designation of an
3746 aging resource center, develop by rule operational and quality
3747 assurance standards and outcome measures to ensure that clients
3748 receiving services through all long-term-care programs
3749 administered through an aging resource center are receiving the
3750 appropriate care they require and that contractors and
3751 subcontractors are adhering to the terms of their contracts and
3752 are acting in the best interests of the clients they are

3753 serving, consistent with the intent of the Legislature to reduce
3754 the use of and cost of nursing home care. The department shall
3755 by rule provide operating procedures for aging resource centers,
3756 which shall include:
3757 (a) Minimum standards for financial operation, including
3758 audit procedures.
3759 (b) Procedures for monitoring and sanctioning of service
3760 providers.
3761 (c) Minimum standards for technology utilized by the aging
3762 resource center.
3763 (d) Minimum staff requirements which shall ensure that the
3764 aging resource center employs sufficient quality and quantity of
3765 staff to adequately meet the needs of the elders residing within
3766 the area served by the aging resource center.
3767 (e) Minimum accessibility standards, including hours of
3768 operation.
3769 (f) Minimum oversight standards for the governing body of
3770 the aging resource center to ensure its continuous involvement
3771 in, and accountability for, all matters related to the
3772 development, implementation, staffing, administration, and
3773 operations of the aging resource center.
3774 (g) Minimum education and experience requirements for
3775 executive directors and other executive staff positions of aging
3776 resource centers.
3777 (h) Minimum requirements regarding any executive staff
3778 positions that the aging resource center must employ and minimum
3779 requirements that a candidate must meet in order to be eligible
3780 for appointment to such positions.

3781 (11) ~~(13)~~ In an area in which the department has designated
3782 an area agency on aging as an aging resource center, the
3783 department and the agency shall not make payments for the
3784 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
3785 Community Diversion Project for such persons who were not
3786 screened and enrolled through the aging resource center. The
3787 department shall cease making payments for recipients in
3788 eligible plans as eligible plans become available in each of the
3789 regions defined in s. 409.981(2).
3790 (12) ~~(14)~~ Each aging resource center shall enter into a
3791 memorandum of understanding with the department for
3792 collaboration with the CARES unit staff. The memorandum of
3793 understanding shall outline the staff person responsible for
3794 each function and shall provide the staffing levels necessary to
3795 carry out the functions of the aging resource center.
3796 (13) ~~(15)~~ Each aging resource center shall enter into a
3797 memorandum of understanding with the Department of Children and
3798 Family Services for collaboration with the Economic Self-
3799 Sufficiency Unit staff. The memorandum of understanding shall
3800 outline which staff persons are responsible for which functions
3801 and shall provide the staffing levels necessary to carry out the
3802 functions of the aging resource center.
3803 (14) ~~(16)~~ If any of the state activities described in this
3804 section are outsourced, either in part or in whole, the contract
3805 executing the outsourcing shall mandate that the contractor or
3806 its subcontractors shall, either physically or virtually,
3807 execute the provisions of the memorandum of understanding
3808 instead of the state entity whose function the contractor or

3809 subcontractor now performs.
3810 (15) ~~(17)~~ In order to be eligible to begin transitioning to
3811 an aging resource center, an area agency on aging board must
3812 ensure that the area agency on aging which it oversees meets all
3813 of the minimum requirements set by law and in rule.
3814 ~~(18) The department shall monitor the three initial~~
3815 ~~projects for aging resource centers and report on the progress~~
3816 ~~of those projects to the Governor, the President of the Senate,~~
3817 ~~and the Speaker of the House of Representatives by June 30,~~
3818 ~~2005. The report must include an evaluation of the~~
3819 ~~implementation process.~~
3820 (16) ~~(19)~~(a) Once an aging resource center is operational,
3821 the department, in consultation with the agency, may develop
3822 capitation rates for any of the programs administered through
3823 the aging resource center. Capitation rates for programs shall
3824 be based on the historical cost experience of the state in
3825 providing those same services to the population age 60 or older
3826 residing within each area served by an aging resource center.
3827 Each capitated rate may vary by geographic area as determined by
3828 the department.
3829 (b) The department and the agency may determine for each
3830 area served by an aging resource center whether it is
3831 appropriate, consistent with federal and state laws and
3832 regulations, to develop and pay separate capitated rates for
3833 each program administered through the aging resource center or
3834 to develop and pay capitated rates for service packages which
3835 include more than one program or service administered through
3836 the aging resource center.

3837 (c) Once capitation rates have been developed and
3838 certified as actuarially sound, the department and the agency
3839 may pay service providers the capitated rates for services when
3840 appropriate.
3841 (d) The department, in consultation with the agency, shall
3842 annually reevaluate and recertify the capitation rates,
3843 adjusting forward to account for inflation, programmatic
3844 changes.
3845 ~~(20) The department, in consultation with the agency,~~
3846 ~~shall submit to the Governor, the President of the Senate, and~~
3847 ~~the Speaker of the House of Representatives, by December 1,~~
3848 ~~2006, a report addressing the feasibility of administering the~~
3849 ~~following services through aging resource centers beginning July~~
3850 ~~1, 2007:~~
3851 ~~(a) Medicaid nursing home services.~~
3852 ~~(b) Medicaid transportation services.~~
3853 ~~(c) Medicaid hospice care services.~~
3854 ~~(d) Medicaid intermediate care services.~~
3855 ~~(e) Medicaid prescribed drug services.~~
3856 ~~(f) Medicaid assistive care services.~~
3857 ~~(g) Any other long-term-care program or Medicaid service.~~
3858 (17) ~~(21)~~ This section shall not be construed to allow an
3859 aging resource center to restrict, manage, or impede the local
3860 fundraising activities of service providers.
3861 Section 24. Effective October 1, 2013, sections 430.701,
3862 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,
3863 430.708, and 430.709, Florida Statutes, are repealed.
3864 Section 25. Sections 409.9301, 409.942, 409.944, 409.945,

3865 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered
3866 as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
3867 402.87, Florida Statutes, respectively.
3868 Section 26. Paragraph (a) of subsection (1) of section
3869 443.111, Florida Statutes, is amended to read:
3870 443.111 Payment of benefits.—
3871 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
3872 in accordance with rules adopted by the Agency for Workforce
3873 Innovation, subject to the following requirements:
3874 (a) Benefits are payable by mail or electronically.
3875 Notwithstanding s. 402.82(4) ~~s. 409.942(4)~~, the agency may
3876 develop a system for the payment of benefits by electronic funds
3877 transfer, including, but not limited to, debit cards, electronic
3878 payment cards, or any other means of electronic payment that the
3879 agency deems to be commercially viable or cost-effective.
3880 Commodities or services related to the development of such a
3881 system shall be procured by competitive solicitation, unless
3882 they are purchased from a state term contract pursuant to s.
3883 287.056. The agency shall adopt rules necessary to administer
3884 the system.
3885 Section 27. Subsection (4) of section 641.386, Florida
3886 Statutes, is amended to read:
3887 641.386 Agent licensing and appointment required;
3888 exceptions.—
3889 (4) All agents and health maintenance organizations shall
3890 comply with and be subject to the applicable provisions of ss.
3891 641.309 and 409.912(20) ~~(21)~~, and all companies and entities
3892 appointing agents shall comply with s. 626.451, when marketing

3893 for any health maintenance organization licensed pursuant to
3894 this part, including those organizations under contract with the
3895 Agency for Health Care Administration to provide health care
3896 services to Medicaid recipients or any private entity providing
3897 health care services to Medicaid recipients pursuant to a
3898 prepaid health plan contract with the Agency for Health Care
3899 Administration.
3900 Section 28. Subsections (6) and (7) of section 766.118,
3901 Florida Statutes, are renumbered as subsections (7) and (8),
3902 respectively, and a new subsection (6) is added to that section,
3903 to read:
3904 766.118 Determination of noneconomic damages.—
3905 (6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A
3906 PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID
3907 RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with
3908 respect to a cause of action for personal injury or wrongful
3909 death arising from medical negligence of a practitioner
3910 committed in the course of providing medical services and
3911 medical care to a Medicaid recipient, regardless of the number
3912 of such practitioner defendants providing the services and care,
3913 noneconomic damages may not exceed $300,000 per claimant, unless
3914 the claimant pleads and proves, by clear and convincing
3915 evidence, that the practitioner acted in a wrongful manner. A
3916 practitioner providing medical services and medical care to a
3917 Medicaid recipient is not liable for more than $200,000 in
3918 noneconomic damages, regardless of the number of claimants,
3919 unless the claimant pleads and proves, by clear and convincing
3920 evidence, that the practitioner acted in a wrongful manner. The

3921 fact that a claimant proves that a practitioner acted in a
3922 wrongful manner does not preclude the application of the
3923 limitation on noneconomic damages prescribed elsewhere in this
3924 section. For purposes of this subsection:
3925 (a) The terms "medical services," "medical care," and
3926 "Medicaid recipient" have the same meaning as provided in s.
3927 409.901.
3928 (b) The term "practitioner," in addition to the meaning
3929 prescribed in subsection (1), includes any hospital, ambulatory
3930 surgical center, or mobile surgical facility as defined and
3931 licensed under chapter 395.
3932 (c) The term "wrongful manner" means in bad faith or with
3933 malicious purpose or in a manner exhibiting wanton and willful
3934 disregard of human rights, safety, or property, and shall be
3935 construed in conformity with the standard set forth in s.
3936 768.28(9)(a).
3937 Section 29. The Agency for Health Care Administration
3938 shall develop a plan for implementing a plan for medically needy
3939 Medicaid enrollees pursuant to s. 409.975(8), Florida Statutes,
3940 as created in HB 7107 or similar legislation that is adopted in
3941 the same legislative session or an extension thereof and becomes
3942 law, and shall immediately seek federal approval to implement
3943 that subsection. The plan shall include a preliminary
3944 calculation of actuarially sound rates and estimated fiscal
3945 impact.
3946 Section 30. The Agency for Health Care Administration
3947 shall develop a reorganization plan for realignment of
3948 administrative resources of the Medicaid program to respond to

3949 changes in functional responsibilities and priorities necessary
3950 for implementation of HB 7107 or similar legislation that is
3951 adopted in the same legislative session or an extension thereof
3952 and becomes law. The plan shall assess the agency's current
3953 capabilities, identify shifts in staffing and other resources
3954 necessary to strengthen procurement and contract monitoring
3955 functions, and establish an implementation timeline. The plan
3956 shall be submitted to the Governor, the Speaker of the House of
3957 Representatives, and the President of the Senate by August 1,
3958 2011.
3959 Section 31. Subsection (1) of section 393.0662, Florida
3960 Statutes, is amended to read:
3961 393.0662 Individual budgets for delivery of home and
3962 community-based services; iBudget system established.—The
3963 Legislature finds that improved financial management of the
3964 existing home and community-based Medicaid waiver program is
3965 necessary to avoid deficits that impede the provision of
3966 services to individuals who are on the waiting list for
3967 enrollment in the program. The Legislature further finds that
3968 clients and their families should have greater flexibility to
3969 choose the services that best allow them to live in their
3970 community within the limits of an established budget. Therefore,
3971 the Legislature intends that the agency, in consultation with
3972 the Agency for Health Care Administration, develop and implement
3973 a comprehensive redesign of the service delivery system using
3974 individual budgets as the basis for allocating the funds
3975 appropriated for the home and community-based services Medicaid
3976 waiver program among eligible enrolled clients. The service

3977 delivery system that uses individual budgets shall be called the
3978 iBudget system.
3979 (1) The agency shall establish an individual budget,
3980 referred to as an iBudget, for each individual served by the
3981 home and community-based services Medicaid waiver program. The
3982 funds appropriated to the agency shall be allocated through the
3983 iBudget system to eligible, Medicaid-enrolled clients. For the
3984 iBudget system, eligible clients shall include individuals with
3985 a diagnosis of Down syndrome or a developmental disability as
3986 defined in s. 393.063. The iBudget system shall be designed to
3987 provide for: enhanced client choice within a specified service
3988 package; appropriate assessment strategies; an efficient
3989 consumer budgeting and billing process that includes
3990 reconciliation and monitoring components; a redefined role for
3991 support coordinators that avoids potential conflicts of
3992 interest; a flexible and streamlined service review process; and
3993 a methodology and process that ensures the equitable allocation
3994 of available funds to each client based on the client's level of
3995 need, as determined by the variables in the allocation
3996 algorithm.
3997 (a) In developing each client's iBudget, the agency shall
3998 use an allocation algorithm and methodology. The algorithm shall
3999 use variables that have been determined by the agency to have a
4000 statistically validated relationship to the client's level of
4001 need for services provided through the home and community-based
4002 services Medicaid waiver program. The algorithm and methodology
4003 may consider individual characteristics, including, but not
4004 limited to, a client's age and living situation, information

4005 from a formal assessment instrument that the agency determines
4006 is valid and reliable, and information from other assessment
4007 processes.
4008 (b) The allocation methodology shall provide the algorithm
4009 that determines the amount of funds allocated to a client's
4010 iBudget. The agency may approve an increase in the amount of
4011 funds allocated, as determined by the algorithm, based on the
4012 client having one or more of the following needs that cannot be
4013 accommodated within the funding as determined by the algorithm
4014 and having no other resources, supports, or services available
4015 to meet the need:
4016 1. An extraordinary need that would place the health and
4017 safety of the client, the client's caregiver, or the public in
4018 immediate, serious jeopardy unless the increase is approved. An
4019 extraordinary need may include, but is not limited to:
4020 a. A documented history of significant, potentially life-
4021 threatening behaviors, such as recent attempts at suicide,
4022 arson, nonconsensual sexual behavior, or self-injurious behavior
4023 requiring medical attention;
4024 b. A complex medical condition that requires active
4025 intervention by a licensed nurse on an ongoing basis that cannot
4026 be taught or delegated to a nonlicensed person;
4027 c. A chronic comorbid condition. As used in this
4028 subparagraph, the term "comorbid condition" means a medical
4029 condition existing simultaneously but independently with another
4030 medical condition in a patient; or
4031 d. A need for total physical assistance with activities
4032 such as eating, bathing, toileting, grooming, and personal

4033 hygiene.
4034
4035 However, the presence of an extraordinary need alone does not
4036 warrant an increase in the amount of funds allocated to a
4037 client's iBudget as determined by the algorithm.
4038 2. A significant need for one-time or temporary support or
4039 services that, if not provided, would place the health and
4040 safety of the client, the client's caregiver, or the public in
4041 serious jeopardy, unless the increase is approved. A significant
4042 need may include, but is not limited to, the provision of
4043 environmental modifications, durable medical equipment, services
4044 to address the temporary loss of support from a caregiver, or
4045 special services or treatment for a serious temporary condition
4046 when the service or treatment is expected to ameliorate the
4047 underlying condition. As used in this subparagraph, the term
4048 "temporary" means a period of fewer than 12 continuous months.
4049 However, the presence of such significant need for one-time or
4050 temporary supports or services alone does not warrant an
4051 increase in the amount of funds allocated to a client's iBudget
4052 as determined by the algorithm.
4053 3. A significant increase in the need for services after
4054 the beginning of the service plan year that would place the
4055 health and safety of the client, the client's caregiver, or the
4056 public in serious jeopardy because of substantial changes in the
4057 client's circumstances, including, but not limited to, permanent
4058 or long-term loss or incapacity of a caregiver, loss of services
4059 authorized under the state Medicaid plan due to a change in age,
4060 or a significant change in medical or functional status which

4061 requires the provision of additional services on a permanent or
4062 long-term basis that cannot be accommodated within the client's
4063 current iBudget. As used in this subparagraph, the term "long-
4064 term" means a period of 12 or more continuous months. However,
4065 such significant increase in need for services of a permanent or
4066 long-term nature alone does not warrant an increase in the
4067 amount of funds allocated to a client's iBudget as determined by
4068 the algorithm.
4069
4070 The agency shall reserve portions of the appropriation for the
4071 home and community-based services Medicaid waiver program for
4072 adjustments required pursuant to this paragraph and may use the
4073 services of an independent actuary in determining the amount of
4074 the portions to be reserved.
4075 (c) A client's iBudget shall be the total of the amount
4076 determined by the algorithm and any additional funding provided
4077 pursuant to paragraph (b). A client's annual expenditures for
4078 home and community-based services Medicaid waiver services may
4079 not exceed the limits of his or her iBudget. The total of all
4080 clients' projected annual iBudget expenditures may not exceed
4081 the agency's appropriation for waiver services.
4082 Section 32. Section 409.902, Florida Statutes, is amended
4083 to read:
4084 409.902 Designated single state agency; payment
4085 requirements; program title; release of medical records.—
4086 (1) The Agency for Health Care Administration is
4087 designated as the single state agency authorized to make
4088 payments for medical assistance and related services under Title

4089 XIX of the Social Security Act. These payments shall be made,
4090 subject to any limitations or directions provided for in the
4091 General Appropriations Act, only for services included in the
4092 program, shall be made only on behalf of eligible individuals,
4093 and shall be made only to qualified providers in accordance with
4094 federal requirements for Title XIX of the Social Security Act
4095 and the provisions of state law. This program of medical
4096 assistance is designated the "Medicaid program." The Department
4097 of Children and Family Services is responsible for Medicaid
4098 eligibility determinations, including, but not limited to,
4099 policy, rules, and the agreement with the Social Security
4100 Administration for Medicaid eligibility determinations for
4101 Supplemental Security Income recipients, as well as the actual
4102 determination of eligibility. As a condition of Medicaid
4103 eligibility, subject to federal approval, the Agency for Health
4104 Care Administration and the Department of Children and Family
4105 Services shall ensure that each recipient of Medicaid consents
4106 to the release of her or his medical records to the Agency for
4107 Health Care Administration and the Medicaid Fraud Control Unit
4108 of the Department of Legal Affairs.
4109 (2) Eligibility is restricted to United States citizens
4110 and to lawfully admitted noncitizens who meet the criteria
4111 provided in s. 414.095(3).
4112 (a) Citizenship or immigration status must be verified.
4113 For noncitizens, this includes verification of the validity of
4114 documents with the United States Citizenship and Immigration
4115 Services using the federal SAVE verification process.
4116 (b) State funds may not be used to provide medical

4117 services to individuals who do not meet the requirements of this
4118 subsection unless the services are necessary to treat an
4119 emergency medical condition or are for pregnant women. Such
4120 services are authorized only to the extent provided under
4121 federal law and in accordance with federal regulations as
4122 provided in 42 C.F.R. s. 440.255.
4123 Section 33. Subsection (22) is added to section 641.19,
4124 Florida Statutes, to read:
4125 641.19 Definitions.—As used in this part, the term:
4126 (22) "Provider service network" means a network authorized
4127 under s. 409.912(4)(d), reimbursed on a prepaid basis, operated
4128 by a health care provider or group of affiliated health care
4129 providers, and which directly provides health care services
4130 under a Medicare, Medicaid, or Healthy Kids contract.
4131 Section 34. Section 641.2019, Florida Statutes, is created
4132 to read:
4133 641.2019 Provider service network certificate of
4134 authority.—A prepaid provider service network that applies for
4135 and obtains a health care provider certificate pursuant to part
4136 III of this chapter, meets the surplus requirements of s.
4137 641.225, and meets all other applicable requirements of this
4138 part may obtain a certificate of authority under s. 641.21. A
4139 certified provider service network has the same rights and
4140 responsibilities as a health maintenance organization certified
4141 under this part.
4142 Section 35. Subsection (2) of section 641.2261, Florida
4143 Statutes, is amended to read:
4144 641.2261 Application of solvency requirements to provider-

4145 sponsored organizations and Medicaid provider service networks.—
4146 (2) Except for a provider service network seeking to
4147 obtain a certificate of authority under s. 641.2019, the
4148 solvency requirements in 42 C.F.R. s. 422.350, subpart H, and
4149 the solvency requirements established in approved federal
4150 waivers pursuant to chapter 409 apply to a Medicaid provider
4151 service network rather than the solvency requirements of this
4152 part.
4153 Section 36. If any provision of this act or its
4154 application to any person or circumstance is held invalid, the
4155 invalidity does not affect other provisions or applications of
4156 the act which can be given effect without the invalid provision
4157 or application, and to this end the provisions of this act are
4158 severable.
4159 Section 37. Except as otherwise expressly provided in this
4160 act, this act shall take effect July 1, 2011, if HB 7107 or
4161 similar legislation is adopted in the same legislative session
4162 or an extension thereof and becomes law.