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1                                   A bill to be entitled  
2           An act relating to health and human services; amending  
3           s. 216.262, F.S.; providing that limitations on an  
4           agency's total number of positions does not apply to  
5           certain positions in the Department of Health;  
6           amending s. 393.063, F.S.; redefining the term  
7           "developmental disability" to include Down syndrome;  
8           defining the term "Down syndrome" as it relates to  
9           developmental disabilities; amending s. 393.0661,  
10          F.S.; conforming provisions to changes made by the  
11          act; amending s. 408.7057, F.S.; requiring that the  
12          dispute resolution program include a hearing in  
13          specified circumstances; providing that the dispute  
14          resolution program established to resolve claims  
15          disputes between providers and health plans does not  
16          provide an independent right of recovery; requiring  
17          that the conclusions of law in the written  
18          recommendation of the resolution organization identify  
19          certain information; providing a directive to the  
20          Division of Statutory Revision; amending s. 409.016,  
21          F.S.; conforming provisions to changes made by the  
22          act; creating s. 409.16713, F.S.; providing for  
23          medical assistance for children in out-of-home care  
24          and adopted children; specifying how those services  
25          will be funded under certain circumstances; providing  
26          legislative intent; providing a directive to the  
27          Division of Statutory Revision; transferring,  
28          renumbering, and amending s. 624.91, F.S.; decreasing  
29          the administrative cost and raising the minimum loss

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30 ratio for health plans; increasing compensation to the  
31 insurer or provider for dental contracts; requiring  
32 the Florida Healthy Kids Corporation to include use of  
33 the school breakfast and lunch application form in the  
34 corporation's plan for publicizing the program;  
35 conforming provisions to changes made by the act;  
36 amending ss. 409.813, 409.8132, 409.815, 409.818,  
37 154.503, and 408.915, F.S.; conforming provisions to  
38 changes made by the act; amending s. 1006.06, F.S.;  
39 requiring school districts to collaborate with the  
40 Florida Kidcare program to use the application form  
41 for the school breakfast and lunch programs to provide  
42 information about the Florida Kidcare program and to  
43 authorize data on the application form be shared with  
44 state agencies and the Florida Healthy Kids  
45 Corporation and its agents; authorizing each school  
46 district the option to share the data electronically;  
47 requiring interagency agreements to ensure that the  
48 data exchanged is protected from unauthorized  
49 disclosure and is used only for enrollment in the  
50 Florida Kidcare program; amending s. 409.901, F.S.;  
51 revising definitions relating to Medicaid; amending s.  
52 409.902, F.S.; revising provisions relating to the  
53 designation of the Agency for Health Care  
54 Administration as the state Medicaid agency;  
55 specifying that eligibility and state funds for  
56 medical services apply only to citizens and certain  
57 noncitizens; providing exceptions; providing a  
58 limitation on persons transferring assets in order to

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59           become eligible for Medicaid nursing facility  
60           services; amending s. 409.9021, F.S.; revising  
61           provisions relating to conditions for Medicaid  
62           eligibility; increasing the number of years a Medicaid  
63           applicant forfeits entitlements to the Medicaid  
64           program if he or she has committed fraud; providing  
65           for the payment of monthly premiums by Medicaid  
66           recipients; providing exemptions to the premium  
67           requirement; requiring applicants to agree to  
68           participate in certain health programs; prohibiting a  
69           recipient who has access to employer-sponsored health  
70           care from obtaining services reimbursed through the  
71           Medicaid fee-for-service system; requiring the agency  
72           to develop a process to allow the Medicaid premium  
73           that would have been received to be used to pay  
74           employer premiums; requiring that the agency allow  
75           opt-out opportunities for certain recipients; creating  
76           s. 409.9022, F.S.; specifying procedures to be  
77           implemented by a state agency if the Medicaid  
78           expenditures exceed appropriations; amending s.  
79           409.903, F.S.; conforming provisions to changes made  
80           by the act; deleting obsolete provisions; amending s.  
81           409.904, F.S.; conforming provisions to changes made  
82           by the act; renaming the "medically needy" program as  
83           the "Medicaid nonpoverty medical subsidy"; narrowing  
84           the subsidy to cover only certain services for a  
85           family, persons age 65 or older, or blind or disabled  
86           persons; revising the criteria for the agency's  
87           assessment of need for private duty nursing services;

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88           amending s. 409.905, F.S.; conforming provisions to  
89           changes made by the act; requiring prior authorization  
90           for home health services; amending s. 409.906, F.S.;  
91           providing for a parental fee based on family income to  
92           be assessed against the parents of children with  
93           developmental disabilities served by home and  
94           community-based waivers; prohibiting the agency from  
95           paying for certain psychotropic medications prescribed  
96           for a child; conforming provisions to changes made by  
97           the act; amending ss. 409.9062 and 409.907, F.S.;  
98           conforming provisions to changes made by the act;  
99           amending s. 409.908, F.S.; modifying the nursing home  
100          patient care per diem rate to include dental care and  
101          podiatric care; directing the agency to seek a waiver  
102          to treat a portion of the nursing home per diem as  
103          capital for self-insurance purposes; requiring primary  
104          physicians to be paid the Medicare fee-for-service  
105          rate by a certain date; deleting the requirement that  
106          the agency contract for transportation services with  
107          the community transportation system; authorizing  
108          qualified plans to contract for transportation  
109          services; deleting obsolete provisions; conforming  
110          provisions to changes made by the act; amending s.  
111          409.9081, F.S.; revising copayments for physician  
112          visits; requiring the agency to seek a waiver to allow  
113          the increase of copayments for nonemergency services  
114          furnished in a hospital emergency department; amending  
115          s. 409.912, F.S.; requiring Medicaid-eligible children  
116          who have open child welfare cases who reside in AHCA

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117 area 10 to be enrolled in specified capitated managed  
118 care plans; expanding the number of children eligible  
119 to receive behavioral health care services through a  
120 specialty prepaid plan; repealing provisions relating  
121 to a provider lock-in program; eliminating obsolete  
122 provisions and updating provisions; conforming cross-  
123 references; amending s. 409.915, F.S.; conforming  
124 provisions to changes made by the act; transferring,  
125 renumbering, and amending s. 409.9301, F.S.;  
126 conforming provisions to changes made by the act;  
127 amending s. 409.9126, F.S.; conforming a cross-  
128 reference; providing a directive to the Division of  
129 Statutory Revision; creating s. 409.961, F.S.;  
130 providing for statutory construction of provisions  
131 relating to Medicaid managed care; creating s.  
132 409.962, F.S.; providing definitions; creating s.  
133 409.963, F.S.; establishing the Medicaid managed care  
134 program as the statewide, integrated managed care  
135 program for medical assistance and long-term care  
136 services; directing the agency to apply for and  
137 implement waivers; providing for public notice and  
138 comment; providing for a limited managed care program  
139 if waivers are not approved; creating s. 409.964,  
140 F.S.; requiring all Medicaid recipients to be enrolled  
141 in Medicaid managed care; providing exemptions;  
142 prohibiting a recipient who has access to employer-  
143 sponsored health care from enrolling in Medicaid  
144 managed care; requiring the agency to develop a  
145 process to allow the Medicaid premium that would have

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146           been received to be used to pay employer premiums;  
147           requiring that the agency allow opt-out opportunities  
148           for certain recipients; providing for voluntary  
149           enrollment; creating s. 409.965, F.S.; providing  
150           requirements for qualified plans that provide services  
151           in the Medicaid managed care program; requiring the  
152           agency to issue an invitation to negotiate; requiring  
153           the agency to compile and publish certain information;  
154           establishing regions for separate procurement of  
155           plans; establishing selection criteria for plan  
156           selection; limiting the number of plans in a region;  
157           authorizing the agency to conduct negotiations if  
158           funding is insufficient; providing that the Children's  
159           Medical Service Network is a qualified plan; creating  
160           s. 409.966, F.S.; providing managed care plan contract  
161           requirements; establishing contract terms; providing  
162           for annual rate setting; providing for contract  
163           extension under certain circumstances; establishing  
164           access requirements; requiring the agency to  
165           establishing performance standards for plans;  
166           providing for program integrity; requiring plans to  
167           provide encounter data; providing penalties for  
168           failure to submit data; requiring plans to accept  
169           electronic claims; providing for prompt payment;  
170           providing for payments to noncontract emergency  
171           providers; requiring a surety bond; requiring plans to  
172           establish a grievance resolution process; requiring  
173           plan solvency; requiring guaranteed savings; providing  
174           costs and penalties for early termination of contracts

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175 or reduction in enrollment levels; requiring the  
176 agency to terminate qualified plans for noncompliance  
177 under certain circumstances; creating s. 409.967,  
178 F.S.; providing for managed care plan accountability;  
179 establishing a medical loss ratio; requiring that a  
180 plan pay back to the agency a specified amount in  
181 specified circumstances; authorizing plans to limit  
182 providers in networks; mandating that certain  
183 providers be offered contracts during the first year;  
184 authorizing plans to exclude certain providers in  
185 certain circumstances; requiring plans to monitor the  
186 quality and performance history of providers;  
187 requiring plans to hold primary care physicians  
188 responsible for certain activities; requiring plans to  
189 offer certain programs and procedures; requiring plans  
190 to pay primary care providers the same rate as  
191 Medicare by a certain date; providing for conflict  
192 resolution between plans and providers; creating s.  
193 409.968, F.S.; providing for managed care plan  
194 payments on a per-member, per-month basis; requiring  
195 the agency to establish a methodology to ensure the  
196 availability of certain types of payments to specified  
197 providers; requiring the development of rate cells;  
198 requiring that the amount paid to the plans for  
199 supplemental payments or enhanced rates be reconciled  
200 to the amount required to pay providers; requiring  
201 that plans make certain payments to providers within a  
202 certain time; creating s. 409.969, F.S.; authorizing  
203 Medicaid recipients to select any plan within a

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204 region; providing for automatic enrollment of  
205 recipients by the agency; providing criteria for  
206 automatic enrollment; authorizing disenrollment under  
207 certain circumstances; providing for a grievance  
208 process; defining the term "good cause" for purposes  
209 of disenrollment; requiring recipients to stay in  
210 plans for a specified time; providing for reenrollment  
211 of recipients who move out of a region; creating s.  
212 409.970, F.S.; requiring the agency to maintain an  
213 encounter data system; providing requirements for  
214 prepaid plans to submit data in a certain format;  
215 requiring the agency to analyze the data; requiring  
216 the agency to test the data for certain purposes by a  
217 certain date; creating s. 409.971, F.S.; providing for  
218 managed care medical assistance; providing deadlines  
219 for beginning and finalizing implementation; creating  
220 s. 409.972, F.S.; establishing minimum services for  
221 the managed medical assistance; providing for optional  
222 services; authorizing plans to customize benefit  
223 packages; creating s. 409.973, F.S.; providing for  
224 managed long-term care; providing deadlines for  
225 beginning and finalizing implementation; providing  
226 duties for the Department of Elderly Affairs relating  
227 to the program; creating s. 409.974, F.S.; providing  
228 recipient eligibility requirements for managed long-  
229 term care; listing programs for which certain  
230 recipients are eligible; specifying that an  
231 entitlement to home and community-based services is  
232 not created; creating s. 409.975, F.S.; establishing



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233 minimum services for managed long-term care; creating  
234 s. 409.976, F.S.; providing criteria for the selection  
235 of plans to provide managed long-term care; creating  
236 s. 409.977, F.S.; providing for managed long-term care  
237 plan accountability; requiring the agency to establish  
238 and plans to comply with standards for specified  
239 providers; creating s. 409.978, F.S.; requiring that  
240 the agency operate the Comprehensive Assessment and  
241 Review for Long-Term Care Services program through an  
242 interagency agreement with the Department of Elderly  
243 Affairs; providing duties of the program; requiring  
244 the program to assign plan enrollees to a level of  
245 care; providing for the evaluation of dually eligible  
246 nursing home residents; transferring, renumbering, and  
247 amending ss. 409.91207, 409.91211, 409.9122, F.S.;  
248 conforming provisions to changes made by the act;  
249 updating provisions and deleting obsolete provisions;  
250 transferring and renumbering ss. 409.9123 and  
251 409.9124, F.S.; amending s. 430.04, F.S.; eliminating  
252 outdated provisions; requiring the Department of  
253 Elderly Affairs to develop a transition plan for  
254 specified elders and disabled adults receiving long-  
255 term care Medicaid services if qualified plans become  
256 available; amending s. 430.2053, F.S.; eliminating  
257 outdated provisions; providing additional duties of  
258 aging resource centers; providing an additional  
259 exception to direct services that may not be provided  
260 by an aging resource center; providing for the  
261 cessation of specified payments by the department as

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262 qualified plans become available; eliminating  
263 provisions requiring reports; amending s. 39.407,  
264 F.S.; requiring a motion by the Department of Children  
265 and Family Services to provide psychotropic medication  
266 to a child 10 years of age or younger to include a  
267 review by a child psychiatrist; providing that a court  
268 may not authorize the administration of such  
269 medication absent a finding of compelling state  
270 interest based on the review; amending s. 400.023,  
271 F.S.; requiring the trial judge to conduct an  
272 evidentiary hearing to determine the sufficiency of  
273 evidence for claims against certain persons relating  
274 to a nursing home; limiting noneconomic damages in a  
275 wrongful death action against the nursing home;  
276 amending s. 400.0237, F.S.; revising provisions  
277 relating to punitive damages against a nursing home;  
278 authorizing a defendant to proffer admissible evidence  
279 to refute a claimant's proffer of evidence for  
280 punitive damages; requiring the trial judge to conduct  
281 an evidentiary hearing and the plaintiff to  
282 demonstrate that a reasonable basis exists for the  
283 recovery of punitive damages; prohibiting discovery of  
284 the defendant's financial worth until the judge  
285 approves the pleading on punitive damages; revising  
286 definitions; amending s. 409.1671, F.S.; modifying the  
287 amount and limits of general liability coverage,  
288 automobile coverage, and tort coverage that must be  
289 carried by eligible community lead agency providers  
290 and their subcontractors; providing that the

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291 Department of Children and Family Services is not  
292 liable for the acts or omissions of such lead agencies  
293 and that the agencies may not be required to indemnify  
294 the department; creating ss. 458.3167 and 459.0078,  
295 F.S.; providing for an expert witness certificate for  
296 allopathic and osteopathic physicians licensed in  
297 other states or Canada which authorizes such  
298 physicians to provide expert medical opinions in this  
299 state; providing application requirements and  
300 timeframes for approval or denial by the Board of  
301 Medicine and Board of Osteopathic Medicine,  
302 respectively; requiring the boards to adopt rules and  
303 set fees; providing for expiration of a certificate;  
304 amending ss. 458.331 and 459.015, F.S.; providing  
305 grounds for disciplinary action for providing  
306 misleading, deceptive, or fraudulent expert witness  
307 testimony relating to the practice of medicine and of  
308 osteopathic medicine, respectively; providing for  
309 construction with respect to the doctrine of  
310 incorporation by reference; amending s. 766.102, F.S.;  
311 providing that a physician who is an expert witness in  
312 a medical malpractice presuit action must meet certain  
313 requirements; amending s. 766.104, F.S.; requiring a  
314 good faith demonstration in a medical malpractice case  
315 that there has been a breach of the standard of care;  
316 amending s. 766.106, F.S.; clarifying that a physician  
317 acting as an expert witness is subject to disciplinary  
318 actions; amending s. 766.1115, F.S.; conforming  
319 provisions to changes made by the act; creating s.

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320 766.1183, F.S.; defining terms; providing for the  
321 recovery of civil damages by Medicaid recipients  
322 according to a modified standard of care; providing  
323 for recovery of certain excess judgments by act of the  
324 Legislature; requiring the Department of Children and  
325 Family Services to provide notice to program  
326 applicants; creating s. 766.1184, F.S.; defining  
327 terms; providing for the recovery of civil damages by  
328 certain recipients of primary care services at primary  
329 care clinics receiving specified low-income pool funds  
330 according to a modified standard of care; providing  
331 for recovery of certain excess judgments by act of the  
332 Legislature; providing requirements of health care  
333 providers receiving such funds in order for the  
334 liability provisions to apply; requiring notice to  
335 low-income pool recipients; amending s. 766.203, F.S.;  
336 requiring the presuit investigations conducted by the  
337 claimant and the prospective defendant in a medical  
338 malpractice action to provide grounds for a breach of  
339 the standard of care; amending s. 768.28, F.S.;  
340 revising a definition; providing that colleges and  
341 universities that own or operate an accredited medical  
342 school and their employees and agents providing  
343 patient services in a public teaching hospital  
344 pursuant to an affiliation agreement or contract with  
345 the teaching hospital are considered agents of the  
346 hospital for the purposes of the applicability of  
347 sovereign immunity; providing definitions; requiring  
348 patients of such hospitals to be provided with notice

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349 of their remedies under sovereign immunity; providing  
350 legislative findings and intent with respect to  
351 including colleges and universities and their  
352 employees and agents under sovereign immunity;  
353 providing a statement of public necessity; amending s.  
354 1004.41, F.S.; clarifying provisions relating to  
355 references to the corporation known as Shands Teaching  
356 Hospital and Clinics, Inc.; clarifying provisions  
357 regarding the purpose of the corporation; authorizing  
358 the corporation to create corporate subsidiaries and  
359 affiliates; providing that Shands Teaching Hospital  
360 and Clinics, Inc., Shands Jacksonville Medical Center,  
361 Inc., Shands Jacksonville Healthcare, Inc., and any  
362 not-for-profit subsidiary of such entities are  
363 instrumentalities of the state for purposes of  
364 sovereign immunity; repealing s. 409.9121, F.S.,  
365 relating to legislative intent concerning managed  
366 care; repealing s. 409.919, F.S., relating to rule  
367 authority; repealing s. 624.915, F.S., relating to the  
368 Florida Healthy Kids Corporation operating fund;  
369 renumbering and transferring ss. 409.942, 409.944,  
370 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.  
371 414.29, 163.464, 163.465, 163.466, 402.81, and 402.82,  
372 F.S., respectively; amending s. 443.111, F.S.;  
373 conforming a cross-reference; directing the Agency for  
374 Health Care Administration to submit a reorganization  
375 plan to the Legislature; providing for the state's  
376 withdrawal from the Medicaid program under certain  
377 circumstances; providing for severability; providing

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378 an effective date.

379

380 Be It Enacted by the Legislature of the State of Florida:

381

382 Section 1. Paragraph (a) of subsection (1) of section  
383 216.262, Florida Statutes, is amended to read:

384 216.262 Authorized positions.—

385 (1) (a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by  
386 law, the total number of authorized positions may not exceed the  
387 total provided in the appropriations acts. If a ~~In the event any~~  
388 state agency or entity of the judicial branch finds that the  
389 number of positions so provided is not sufficient to administer  
390 its authorized programs, it may file an application with the  
391 Executive Office of the Governor or the Chief Justice~~;~~ and, if  
392 the Executive Office of the Governor or Chief Justice certifies  
393 that there are no authorized positions available for addition,  
394 deletion, or transfer within the agency or entity as provided in  
395 paragraph (c), may recommend ~~and recommends~~ an increase in the  
396 number of positions.~~;~~

397 1. The Governor or the Chief Justice may recommend an  
398 increase in the number of positions for the following reasons  
399 only:

400 a.1.~~1.~~ To implement or provide for continuing federal grants  
401 or changes in grants not previously anticipated.

402 b.2.~~2.~~ To meet emergencies pursuant to s. 252.36.

403 c.3.~~3.~~ To satisfy new federal regulations or changes therein.

404 d.4.~~4.~~ To take advantage of opportunities to reduce operating  
405 expenditures or to increase the revenues of the state or local  
406 government.

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407 ~~e.5.~~ To authorize positions that were not fixed by the  
408 Legislature due to ~~through~~ error in drafting the appropriations  
409 acts.

410 2. Actions recommended pursuant to this paragraph are  
411 subject to approval by the Legislative Budget Commission. The  
412 certification and the final authorization shall be provided to  
413 the Legislative Budget Commission, the legislative  
414 appropriations committees, and the Auditor General.

415 3. The provisions of this paragraph do not apply to  
416 positions in the Department of Health which are funded by the  
417 County Health Department Trust Fund.

418 Section 2. Subsection (9) of section 393.063, Florida  
419 Statutes, is amended, present subsections (13) through (40) of  
420 that section are redesignated as subsections (14) through (41),  
421 respectively, and a new subsection (13) is added to that  
422 section, to read:

423 393.063 Definitions.—For the purposes of this chapter, the  
424 term:

425 (9) "Developmental disability" means a disorder or syndrome  
426 that is attributable to retardation, cerebral palsy, autism,  
427 spina bifida, Down syndrome, or Prader-Willi syndrome; that  
428 manifests before the age of 18; and that constitutes a  
429 substantial handicap that can reasonably be expected to continue  
430 indefinitely.

431 (13) "Down syndrome" means a disorder that is caused by the  
432 presence of an extra chromosome 21.

433 Section 3. Present subsections (7) and (8) of section  
434 393.0661, Florida Statutes, are redesignated as subsections (8)  
435 and (9), respectively, a new subsection (7) is added to that

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436 section, and present subsection (7) of that section is amended,  
437 to read:

438 393.0661 Home and community-based services delivery system;  
439 comprehensive redesign.—The Legislature finds that the home and  
440 community-based services delivery system for persons with  
441 developmental disabilities and the availability of appropriated  
442 funds are two of the critical elements in making services  
443 available. Therefore, it is the intent of the Legislature that  
444 the Agency for Persons with Disabilities shall develop and  
445 implement a comprehensive redesign of the system.

446 (7) The agency shall impose and collect the fee authorized  
447 by s. 409.906(13)(d) upon approval by the Centers for Medicare  
448 and Medicaid Services.

449 (8)~~(7)~~ ~~Nothing in This section or related in any~~  
450 ~~administrative rule does not shall be construed to prevent or~~  
451 limit the Agency for Health Care Administration, in consultation  
452 with the Agency for Persons with Disabilities, from adjusting  
453 fees, reimbursement rates, lengths of stay, number of visits, or  
454 number of services, or from limiting enrollment, or making any  
455 other adjustment necessary to comply with the availability of  
456 moneys and any limitations or directions provided ~~for~~ in the  
457 General Appropriations Act or pursuant to s. 409.9022.

458 Section 4. Subsections (3) and (4) of section 408.7057,  
459 Florida Statutes, are amended, subsection (7) of that section is  
460 redesignated as subsection (8), and a new subsection (7) is  
461 added to that section, to read:

462 408.7057 Statewide provider and health plan claim dispute  
463 resolution program.—

464 (3) The agency shall adopt rules to establish a process to



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465 be used by the resolution organization in considering claim  
466 disputes submitted by a provider or health plan which must  
467 include a hearing, if requested by the respondent, and the  
468 issuance by the resolution organization of a written  
469 recommendation, supported by findings of fact and conclusions of  
470 law, to the agency within 60 days after the requested  
471 information is received by the resolution organization within  
472 the timeframes specified by the resolution organization. ~~In no~~  
473 ~~event shall~~ The review time may not exceed 90 days following  
474 receipt of the initial claim dispute submission by the  
475 resolution organization.

476 (4) Within 30 days after receipt of the recommendation of  
477 the resolution organization, the agency shall adopt the  
478 recommendation as a final order subject to chapter 120.

479 (7) This section creates a procedure for dispute resolution  
480 and not an independent right of recovery. The conclusions of law  
481 contained in the written recommendation of the resolution  
482 organization must identify the provisions of law or contract  
483 which, under the particular facts and circumstances of the case,  
484 entitle the provider or health plan to the amount awarded, if  
485 any.

486 Section 5. The Division of Statutory Revision is requested  
487 to designate ss. 409.016-409.803, Florida Statutes, as part I of  
488 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC  
489 ASSISTANCE."

490 Section 6. Section 409.016, Florida Statutes, is amended to  
491 read:

492 409.016 Definitions.—As used in this part, the term  
493 ~~chapter~~:

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494 (1) "Department," ~~unless otherwise specified,~~ means the  
495 Department of Children and Family Services.

496 (2) "Secretary" means the Secretary of ~~the Department of~~  
497 Children and Family Services.

498 (3) "Social and economic services," ~~within the meaning of~~  
499 ~~this chapter,~~ means the providing of financial assistance as  
500 well as preventive and rehabilitative social services for  
501 children, adults, and families.

502 Section 7. Section 409.16713, Florida Statutes, is created  
503 to read:

504 409.16713 Medical assistance for children in out-of-home  
505 care and adopted children.-

506 (1) A child who is eligible under Title IV-E of the Social  
507 Security Act, as amended, for subsidized board payments, foster  
508 care, or adoption subsidies, and a child for whom the state has  
509 assumed temporary or permanent responsibility and who does not  
510 qualify for Title IV-E assistance but is in foster care, shelter  
511 or emergency shelter care, or subsidized adoption is eligible  
512 for medical assistance as provided in s. 409.903(4). This  
513 includes a young adult who is eligible to receive services under  
514 s. 409.1451(5) until the young adult reaches 21 years of age,  
515 and a person who was eligible, as a child, under Title IV-E for  
516 foster care or the state-provided foster care and who is a  
517 participant in the Road-to-Independence Program.

518 (2) If medical assistance under Title XIX of the Social  
519 Security Act, as amended, is not available due to the refusal of  
520 the federal Department of Health and Human Services to provide  
521 federal funds, a child or young adult described in subsection  
522 (1) is eligible for medical services under the Medicaid managed

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523 care program established in s. 409.963. Such medical assistance  
524 shall be obtained by the community-based care lead agencies  
525 established under s. 409.1671 and is subject to the availability  
526 of funds appropriated for such purpose in the General  
527 Appropriations Act.

528 (3) It is the intent of the Legislature that the provision  
529 of medical assistance meet the requirements of s. 471(a)(21) of  
530 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),  
531 related to eligibility for Title IV-E of the Social Security  
532 Act, and that compliance with such provisions meet the  
533 requirements of s. 402(a)(3) of the Social Security Act, as  
534 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary  
535 Assistance for Needy Families Block Grant Program.

536 Section 8. The Division of Statutory Revision is requested  
537 to designate ss. 409.810-409.821, Florida Statutes, as part II  
538 of chapter 409, Florida Statutes, entitled "KIDCARE."

539 Section 9. Section 624.91, Florida Statutes, is  
540 transferred, renumbered as section 409.8115, Florida Statutes,  
541 paragraph (b) of subsection (5) of that section is amended, and  
542 subsection (8) is added to that section, to read:

543 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.-

544 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.-

545 (b) The Florida Healthy Kids Corporation shall:

546 1. Arrange for the collection of any family, local  
547 contributions, or employer payment or premium, in an amount to  
548 be determined by the board of directors, to provide for payment  
549 of premiums for comprehensive insurance coverage and for the  
550 actual or estimated administrative expenses.

551 2. Arrange for the collection of any voluntary

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552 contributions ~~to provide~~ for payment of ~~Florida~~ Kidcare program  
553 premiums for children who are not eligible for medical  
554 assistance under Title XIX or Title XXI of the Social Security  
555 Act.

556 3. Subject to ~~the provisions of~~ s. 409.8134, accept  
557 voluntary supplemental local match contributions that comply  
558 with ~~the requirements of~~ Title XXI of the Social Security Act  
559 for the purpose of providing additional ~~Florida~~ Kidcare coverage  
560 in contributing counties under Title XXI.

561 4. Establish the administrative and accounting procedures  
562 for the operation of the corporation.

563 5. Establish, with consultation from appropriate  
564 professional organizations, standards for preventive health  
565 services and providers and comprehensive insurance benefits  
566 appropriate to children if, provided that such standards for  
567 rural areas do ~~shall~~ not limit primary care providers to board-  
568 certified pediatricians.

569 6. Determine eligibility for children seeking to  
570 participate in the Title XXI-funded components of the ~~Florida~~  
571 Kidcare program consistent with the requirements specified in s.  
572 409.814, as well as the non-Title-XXI-eligible children as  
573 provided in subsection (3).

574 7. Establish procedures under which providers of local  
575 match to, applicants to, and participants in the program may  
576 have grievances reviewed by an impartial body and reported to  
577 the board of directors of the corporation.

578 8. Establish participation criteria and, if appropriate,  
579 contract with an authorized insurer, health maintenance  
580 organization, or third-party administrator to provide

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581 administrative services to the corporation.

582 9. Establish enrollment criteria that include penalties or  
583 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage  
584 upon voluntary cancellation for nonpayment of family premiums.

585 10. Contract with authorized insurers or providers ~~any~~  
586 ~~provider~~ of health care services, who meet ~~meeting~~ standards  
587 established by the corporation, for the provision of  
588 comprehensive insurance coverage to participants. Such standards  
589 must ~~shall~~ include criteria under which the corporation may  
590 contract with more than one provider of health care services in  
591 program sites. Health plans shall be selected through a  
592 competitive bid process. The Florida Healthy Kids Corporation  
593 shall purchase goods and services in the most cost-effective  
594 manner consistent with the delivery of quality medical care. The  
595 maximum administrative cost for a Florida Healthy Kids  
596 Corporation contract shall be 10 ~~15~~ percent. For health care  
597 contracts, the minimum medical loss ratio for a Florida Healthy  
598 Kids Corporation contract shall be 90 ~~85~~ percent. For dental  
599 contracts, the remaining compensation to be paid to the  
600 authorized insurer or provider must be at least 90 ~~under a~~  
601 ~~Florida Healthy Kids Corporation contract shall be no less than~~  
602 ~~an amount which is 85 percent of the premium, and,~~ to the extent  
603 any contract provision does not provide for this minimum  
604 compensation, this section prevails ~~shall prevail~~. The health  
605 plan selection criteria and scoring system, and the scoring  
606 results, shall be available upon request for inspection after  
607 the bids have been awarded.

608 11. Establish disenrollment criteria if ~~in the event~~ local  
609 matching funds are insufficient to cover enrollments.

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610           12. Develop and implement a plan to publicize the Florida  
611 Kidcare program, the eligibility requirements of the program,  
612 and the procedures for enrollment in the program and to maintain  
613 public awareness of the corporation and the program. Such plan  
614 must include using the application form for the school lunch and  
615 breakfast programs as provided under s. 1006.06(7).

616           13. Secure staff necessary to properly administer the  
617 corporation. Staff costs shall be funded from state and local  
618 matching funds and such other private or public funds as become  
619 available. The board of directors shall determine the number of  
620 staff members necessary to administer the corporation.

621           14. In consultation with the partner agencies, provide an  
622 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the  
623 Governor, the Chief Financial Officer, the Commissioner of  
624 Education, the President of the Senate, the Speaker of the House  
625 of Representatives, and the Minority Leaders of the Senate and  
626 the House of Representatives.

627           15. Provide information on a quarterly basis to the  
628 Legislature and the Governor which compares the costs and  
629 utilization of the full-pay enrolled population and the Title  
630 XXI-subsidized enrolled population in the Florida Kidcare  
631 program. ~~The information,~~ At a minimum, the information must  
632 include:

633           a. The monthly enrollment and expenditure for full-pay  
634 enrollees in the Medikids and Florida Healthy Kids programs  
635 compared to the Title XXI-subsidized enrolled population; and

636           b. The costs and utilization by service of the full-pay  
637 enrollees in the Medikids and Florida Healthy Kids programs and  
638 the Title XXI-subsidized enrolled population.

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By February 1, 2010, the Florida Healthy Kids Corporation shall provide a study to the Legislature and the Governor on premium impacts to the subsidized portion of the program from the inclusion of the full-pay program, which must ~~shall~~ include recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

16. Establish benefit packages that conform to ~~the provisions of~~ the Florida Kidcare program, as created under this part in ss. 409.810-409.821.

(8) OPERATING FUND.—The Florida Healthy Kids Corporation may establish and manage an operating fund for the purposes of addressing the corporation’s unique cash-flow needs and facilitating the fiscal management of the corporation. At any given time, the corporation may accumulate and maintain in the operating fund a cash balance reserve equal to no more than 25 percent of its annualized operating expenses. Upon dissolution of the corporation, any remaining cash balances of state funds shall revert to the General Revenue Fund, or such other state funds consistent with the appropriated funding, as provided by law.

Section 10. Subsection (1) of section 409.813, Florida Statutes, is amended to read:

409.813 Health benefits coverage; program components; entitlement and nonentitlement.—

(1) The Florida Kidcare program includes health benefits coverage provided to children through the following program components, which shall be marketed as the Florida Kidcare program:

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668 (a) Medicaid.†  
669 (b) Medikids as created in s. 409.8132.†  
670 (c) The Florida Healthy Kids Corporation as created in s.  
671 409.8115. ~~624.91;~~  
672 (d) Employer-sponsored group health insurance plans  
673 approved under this part. ~~ss. 409.810-409.821;~~ and  
674 (e) The Children's Medical Services network ~~established in~~  
675 ~~chapter 391.~~  
676 Section 11. Subsection (4) of section 409.8132, Florida  
677 Statutes, is amended to read:  
678 409.8132 Medikids program component.—  
679 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The  
680 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,  
681 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,  
682 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,  
683 409.987, 409.988, and 409.989 apply to the administration of the  
684 Medikids program component of the Florida Kidcare program,  
685 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified  
686 by ~~the provisions of~~ subsection (7).  
687 Section 12. Subsection (1) of section 409.815, Florida  
688 Statutes, is amended to read:  
689 409.815 Health benefits coverage; limitations.—  
690 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare  
691 program, benefits available under Medicaid and Medikids include  
692 those goods and services provided under the medical assistance  
693 program authorized by Title XIX of the Social Security Act, and  
694 regulations thereunder, as administered in this state by the  
695 agency. This includes those mandatory Medicaid services  
696 authorized under s. 409.905 and optional Medicaid services



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697 authorized under s. 409.906, rendered on behalf of eligible  
698 individuals by qualified providers, in accordance with federal  
699 requirements ~~for Title XIX~~, subject to any limitations or  
700 directions provided ~~for~~ in the General Appropriations Act, ~~or~~  
701 chapter 216, or s. 409.9022, and according to methodologies and  
702 limitations set forth in agency rules and policy manuals and  
703 handbooks incorporated by reference ~~thereto~~.

704 Section 13. Subsection (5) of section 409.818, Florida  
705 Statutes, is amended to read:

706 409.818 Administration.—In order to implement ss. 409.810-  
707 409.821, the following agencies shall have the following duties:

708 (5) The Florida Healthy Kids Corporation shall retain its  
709 functions as authorized in s. 409.8115 ~~624.91~~, including  
710 eligibility determination for participation in the Healthy Kids  
711 program.

712 Section 14. Paragraph (e) of subsection (2) of section  
713 154.503, Florida Statutes, is amended to read:

714 154.503 Primary Care for Children and Families Challenge  
715 Grant Program; creation; administration.—

716 (2) The department shall:

717 (e) Coordinate with the primary care program developed  
718 pursuant to s. 154.011, the Florida Healthy Kids Corporation  
719 program created in s. 409.8115 ~~624.91~~, the school health  
720 services program created in ss. 381.0056 and 381.0057, the  
721 Healthy Communities, Healthy People Program created in s.  
722 381.734, and the volunteer health care provider program  
723 established ~~developed~~ pursuant to s. 766.1115.

724 Section 15. Paragraph (c) of subsection (4) of section  
725 408.915, Florida Statutes, is amended to read:

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726 408.915 Eligibility pilot project.—The Agency for Health  
727 Care Administration, in consultation with the steering committee  
728 established in s. 408.916, shall develop and implement a pilot  
729 project to integrate the determination of eligibility for health  
730 care services with information and referral services.

731 (4) The pilot project shall include eligibility  
732 determinations for the following programs:

733 (c) Florida Healthy Kids as described in s. 409.8115 ~~624.91~~  
734 and within eligibility guidelines provided in s. 409.814.

735 Section 16. Subsection (7) is added to section 1006.06,  
736 Florida Statutes, to read:

737 1006.06 School food service programs.—

738 (7) Each school district shall collaborate with the Florida  
739 Kidcare program created pursuant to ss. 409.810-409.821 to:

740 (a) At a minimum:

741 1. Provide application information about the Kidcare  
742 program or an application for Kidcare to students at the  
743 beginning of each school year.

744 2. Modify the school district's application form for the  
745 lunch program under subsection (4) and the breakfast program  
746 under subsection (5) to incorporate a provision that permits the  
747 school district to share data from the application form with the  
748 state agencies and the Florida Healthy Kids Corporation and its  
749 agents that administer the Kidcare program unless the child's  
750 parent or guardian opts out of the provision.

751 (b) At the option of the school district, share income and  
752 other demographic data through an electronic interchange with  
753 the Florida Healthy Kids Corporation and other state agencies in  
754 order to determine eligibility for the Kidcare program on a

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755 regular and periodic basis.

756 (c) Establish interagency agreements ensuring that data  
757 exchanged under this subsection is used only to enroll eligible  
758 children in the Florida Kidcare program and is protected from  
759 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).

760 Section 17. The Division of Statutory Revision is requested  
761 to designate ss. 409.901 through 409.9205, Florida Statutes, as  
762 part III of chapter 409, Florida Statutes, entitled "MEDICAID."

763 Section 18. Section 409.901, Florida Statutes, is amended  
764 to read:

765 409.901 Definitions; ~~ss. 409.901-409.920.~~ As used in this  
766 part and part IV ss. 409.901-409.920, except as otherwise  
767 specifically provided, the term:

768 (1) "Affiliate" or "affiliated person" means any person who  
769 directly or indirectly manages, controls, or oversees the  
770 operation of a corporation or other business entity that is a  
771 Medicaid provider, regardless of whether such person is a  
772 partner, shareholder, owner, officer, director, agent, or  
773 employee of the entity.

774 (2) "Agency" means the Agency for Health Care  
775 Administration. ~~The agency is the Medicaid agency for the state,~~  
776 ~~as provided under federal law.~~

777 (3) "Applicant" means an individual whose written  
778 application for medical assistance provided by Medicaid ~~under~~  
779 ~~ss. 409.903-409.906~~ has been submitted to the Department of  
780 Children and Family Services, or to the Social Security  
781 Administration if the application is for Supplemental Security  
782 Income, but has not received final action. The ~~This~~ term  
783 includes an individual, who need not be alive at the time of

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784 application, and whose application is submitted through a  
785 representative or a person acting for the individual.

786 (4) "Benefit" means any benefit, assistance, aid,  
787 obligation, promise, debt, liability, or the like, related to  
788 any covered injury, illness, or necessary medical care, goods,  
789 or services.

790 (5) "Capitation" means a prospective per-member, per-month  
791 payment designed to represent, in the aggregate, an actuarially  
792 sound estimate of expenditures required for the management and  
793 provision of a specified set of medical services or long-term  
794 care services needed by members enrolled in a prepaid health  
795 plan.

796 ~~(6)~~~~(5)~~ "Change of ownership" has the same meaning as in s.  
797 408.803 and includes means:

798 ~~(a) An event in which the provider ownership changes to a~~  
799 ~~different individual entity as evidenced by a change in federal~~  
800 ~~employer identification number or taxpayer identification~~  
801 ~~number;~~

802 ~~(b) An event in which 51 percent or more of the ownership,~~  
803 ~~shares, membership, or controlling interest of a provider is in~~  
804 ~~any manner transferred or otherwise assigned. This paragraph~~  
805 ~~does not apply to a licensee that is publicly traded on a~~  
806 ~~recognized stock exchange; or~~

807 ~~(c) When the provider is licensed or registered by the~~  
808 ~~agency, an event considered a change of ownership under part II~~  
809 ~~of chapter 408 for licensure as defined in s. 408.803.~~

810

811 ~~A change solely in the management company or board of directors~~  
812 ~~is not a change of ownership.~~

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813           (7)~~(6)~~ "Claim" means any communication, whether written or  
814 electronic (electronic impulse or magnetic), which is used by  
815 any person to apply for payment from the Medicaid program, ~~or~~  
816 its fiscal agent, or a qualified plan under part IV of this  
817 chapter for each item or service purported ~~by any person~~ to have  
818 been provided ~~by a person~~ to a ~~any~~ Medicaid recipient.

819           (8)~~(7)~~ "Collateral" means:

820           (a) Any and all causes of action, suits, claims,  
821 counterclaims, and demands that accrue to a ~~the~~ recipient or to  
822 a ~~the~~ recipient's legal representative, related to any covered  
823 injury, illness, or necessary medical care, goods, or services  
824 that resulted in ~~necessitated that~~ Medicaid providing ~~provide~~  
825 medical assistance.

826           (b) All judgments, settlements, and settlement agreements  
827 rendered or entered into and related to ~~such~~ causes of action,  
828 suits, claims, counterclaims, demands, or judgments.

829           (c) Proceeds, as defined in this section.

830           (9)~~(8)~~ "Convicted" or "conviction" means a finding of  
831 guilt, with or without an adjudication of guilt, in any federal  
832 or state trial court ~~of record relating to charges brought by~~  
833 ~~indictment or information~~, as a result of a jury verdict,  
834 nonjury trial, or entry of a plea of guilty or nolo contendere,  
835 regardless of whether an appeal from judgment is pending.

836           (10)~~(9)~~ "Covered injury or illness" means any sickness,  
837 injury, disease, disability, deformity, abnormality disease,  
838 necessary medical care, pregnancy, or death for which a third  
839 party is, may be, could be, should be, or has been liable, and  
840 for which Medicaid is, or may be, obligated to provide, or has  
841 provided, medical assistance.

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842 (11)~~(10)~~ "Emergency medical condition" has the same meaning  
843 as in s. 395.002. ~~means:~~

844 ~~(a) A medical condition manifesting itself by acute~~  
845 ~~symptoms of sufficient severity, which may include severe pain~~  
846 ~~or other acute symptoms, such that the absence of immediate~~  
847 ~~medical attention could reasonably be expected to result in any~~  
848 ~~of the following:~~

849 ~~1. Serious jeopardy to the health of a patient, including a~~  
850 ~~pregnant woman or a fetus.~~

851 ~~2. Serious impairment to bodily functions.~~

852 ~~3. Serious dysfunction of any bodily organ or part.~~

853 ~~(b) With respect to a pregnant woman:~~

854 ~~1. That there is inadequate time to effect safe transfer to~~  
855 ~~another hospital prior to delivery.~~

856 ~~2. That a transfer may pose a threat to the health and~~  
857 ~~safety of the patient or fetus.~~

858 ~~3. That there is evidence of the onset and persistence of~~  
859 ~~uterine contractions or rupture of the membranes.~~

860 (12)~~(11)~~ "Emergency services and care" has the same meaning  
861 as in s. 395.002 ~~means medical screening, examination, and~~  
862 ~~evaluation by a physician, or, to the extent permitted by~~  
863 ~~applicable laws, by other appropriate personnel under the~~  
864 ~~supervision of a physician, to determine whether an emergency~~  
865 ~~medical condition exists and, if it does, the care, treatment,~~  
866 ~~or surgery for a covered service by a physician which is~~  
867 ~~necessary to relieve or eliminate the emergency medical~~  
868 ~~condition, within the service capability of a hospital.~~

869 (13)~~(12)~~ "Legal representative" means a guardian,  
870 conservator, survivor, or personal representative of a recipient

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871 or applicant, or of the property or estate of a recipient or  
872 applicant.

873 (14)~~(13)~~ "Managed care plan" means a health insurer  
874 authorized under chapter 624, an exclusive provider organization  
875 authorized under chapter 627, a health maintenance organization  
876 authorized under chapter 641, a provider service network  
877 authorized under s. 409.912(4)(d), or an accountable care  
878 organization authorized under federal law ~~health maintenance~~  
879 ~~organization authorized pursuant to chapter 641 or a prepaid~~  
880 ~~health plan authorized pursuant to s. 409.912.~~

881 (15)~~(14)~~ "Medicaid" or Medicaid program means the medical  
882 assistance program authorized by Title XIX of the Social  
883 Security Act, 42 U.S.C. s. 1396 et seq., and regulations  
884 thereunder, as administered in this state by the agency.

885 ~~(15) "Medicaid agency" or "agency" means the single state~~  
886 ~~agency that administers or supervises the administration of the~~  
887 ~~state Medicaid plan under federal law.~~

888 ~~(16) "Medicaid program" means the program authorized under~~  
889 ~~Title XIX of the federal Social Security Act which provides for~~  
890 ~~payments for medical items or services, or both, on behalf of~~  
891 ~~any person who is determined by the Department of Children and~~  
892 ~~Family Services, or, for Supplemental Security Income, by the~~  
893 ~~Social Security Administration, to be eligible on the date of~~  
894 ~~service for Medicaid assistance.~~

895 (16)~~(17)~~ "Medicaid provider" or "provider" means a person  
896 or entity that has a Medicaid provider agreement in effect with  
897 the agency and is in good standing with the agency. The term  
898 also includes a person or entity that provides medical services  
899 to a Medicaid recipient under the Medicaid managed care program

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900 in part IV of this chapter.

901 (17)~~(18)~~ "Medicaid provider agreement" or "provider  
902 agreement" means a contract between the agency and a provider  
903 for the provision of services or goods, or both, to Medicaid  
904 recipients pursuant to Medicaid.

905 (18)~~(19)~~ "Medicaid recipient" or "recipient" means an  
906 individual whom the Department of Children and Family Services,  
907 or, for Supplemental Security Income, ~~by~~ the Social Security  
908 Administration, determines is eligible, pursuant to federal and  
909 state law, to receive medical assistance and related services  
910 for which the agency may make payments under the Medicaid  
911 program. For the purposes of determining third-party liability,  
912 the term includes an individual formerly determined to be  
913 eligible for Medicaid, an individual who has received medical  
914 assistance under ~~the Medicaid program~~, or an individual on whose  
915 behalf Medicaid has become obligated.

916 (19)~~(20)~~ "Medicaid-related records" means records that  
917 relate to the provider's business or profession and to a  
918 Medicaid recipient. The term includes ~~Medicaid related records~~  
919 ~~include~~ records related to non-Medicaid customers, clients, or  
920 patients but only to the extent that the documentation is shown  
921 by the agency to be necessary for determining ~~to determine~~ a  
922 provider's entitlement to payments under the Medicaid program.

923 (20)~~(21)~~ "Medical assistance" means any provision of,  
924 payment for, or liability for medical services or care by  
925 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.

926 (21)~~(22)~~ "Medical services" or "medical care" means medical  
927 or medically related institutional or noninstitutional care,  
928 goods, or services covered by the Medicaid program. The term



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929 includes any services authorized and funded in the General  
930 Appropriations Act.

931 ~~(22)(23)~~ "MediPass" means a primary care case management  
932 program operated by the agency.

933 ~~(23)(24)~~ "Minority physician network" means a network of  
934 primary care physicians with experience in managing Medicaid or  
935 Medicare recipients which ~~that~~ is predominantly owned by  
936 minorities, as defined in s. 288.703, and which may have a  
937 collaborative partnership with a public college or university  
938 and a tax-exempt charitable corporation.

939 ~~(24)(25)~~ "Payment," as it relates to third-party benefits,  
940 means performance of a duty, promise, or obligation, or  
941 discharge of a debt or liability, by the delivery, provision, or  
942 transfer of third-party benefits for medical services. To "pay"  
943 means to do any of the acts set forth in this subsection.

944 ~~(25)(26)~~ "Proceeds" means whatever is received upon the  
945 sale, exchange, collection, or other disposition of the  
946 collateral or proceeds thereon and includes insurance payable by  
947 reason of loss or damage to the collateral or proceeds. Money,  
948 checks, deposit accounts, and the like are "cash proceeds." All  
949 other proceeds are "noncash proceeds."

950 ~~(26)(27)~~ "Third party" means an individual, entity, or  
951 program, excluding Medicaid, that is, may be, could be, should  
952 be, or has been liable for all or part of the cost of medical  
953 services related to any medical assistance covered by Medicaid.  
954 A third party includes a third-party administrator or a pharmacy  
955 benefits manager.

956 ~~(27)(28)~~ "Third-party benefit" means any benefit that is or  
957 may be available at any time through contract, court award,

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958 judgment, settlement, agreement, or any arrangement between a  
959 third party and any person or entity, including, without  
960 limitation, a Medicaid recipient, a provider, another third  
961 party, an insurer, or the agency, for any Medicaid-covered  
962 injury, illness, goods, or services, including costs of medical  
963 services related thereto, for personal injury or for death of  
964 the recipient, but specifically excluding policies of life  
965 insurance on the recipient, unless available under terms of the  
966 policy to pay medical expenses prior to death. The term  
967 includes, without limitation, collateral, as defined in this  
968 section, health insurance, any benefit under a health  
969 maintenance organization, a preferred provider arrangement, a  
970 prepaid health clinic, liability insurance, uninsured motorist  
971 insurance or personal injury protection coverage, medical  
972 benefits under workers' compensation, and any obligation under  
973 law or equity to provide medical support.

974 Section 19. Section 409.902, Florida Statutes, is amended  
975 to read:

976 409.902 Designated single state agency; eligibility  
977 determinations; rules payment requirements; program title;  
978 ~~release of medical records.-~~

979 (1) The agency ~~for Health Care Administration~~ is designated  
980 as the single state agency authorized to administer the Medicaid  
981 state plan and to make payments for medical assistance and  
982 related services under Title XIX of the Social Security Act.  
983 These payments shall be made, subject to any limitations or  
984 directions provided for in the General Appropriations Act, only  
985 for services included in the Medicaid program, ~~shall be made~~  
986 only on behalf of eligible individuals, and ~~shall be made~~ only

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987 to qualified providers in accordance with federal requirements  
988 under ~~for~~ Title XIX of the Social Security Act and ~~the~~  
989 ~~provisions of~~ state law.

990 (a) The agency must notify the Legislature before seeking  
991 an amendment to the state plan for purposes of implementing  
992 provisions authorized by the Deficit Reduction Act of 2005.

993 (b) The agency shall adopt any rules necessary to carry out  
994 its statutory duties under this subsection and any other  
995 statutory provisions related to its responsibility for the  
996 Medicaid program and state compliance with federal Medicaid  
997 requirements, including the Medicaid managed care program. This  
998 ~~program of medical assistance is designated the "Medicaid~~  
999 ~~program."~~

1000 (2) The Department of Children and Family Services is  
1001 responsible for determining Medicaid eligibility determinations,  
1002 including, but not limited to, policy, rules, and the agreement  
1003 with the Social Security Administration for Medicaid eligibility  
1004 determinations for Supplemental Security Income recipients, as  
1005 well as the actual determination of eligibility. As a condition  
1006 of Medicaid eligibility, subject to federal approval, the agency  
1007 for Health Care Administration and the Department of Children  
1008 and Family Services shall ensure that each recipient of Medicaid  
1009 consents to the release of her or his medical records to the  
1010 agency for Health Care Administration and the Medicaid Fraud  
1011 Control Unit of the Department of Legal Affairs.

1012 (a) Eligibility is restricted to United States citizens and  
1013 to lawfully admitted noncitizens who meet the criteria provided  
1014 in s. 414.095(3).

1015 1. Citizenship or immigration status must be verified. For

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1016 noncitizens, this includes verification of the validity of  
1017 documents with the United States Citizenship and Immigration  
1018 Services using the federal SAVE verification process.

1019 2. State funds may not be used to provide medical services  
1020 to individuals who do not meet the requirements of this  
1021 paragraph unless the services are necessary to treat an  
1022 emergency medical condition or are for pregnant women. Such  
1023 services are authorized only to the extent provided under  
1024 federal law and in accordance with federal regulations as  
1025 provided in 42 C.F.R. s. 440.255.

1026 (b) In determining eligibility for nursing facility  
1027 services, including institutional hospice services and home and  
1028 community-based waiver programs under the Medicaid program,  
1029 individuals who enter into a personal services contract with a  
1030 relative on or after October 1, 2011, are considered to have  
1031 transferred assets without fair compensation in order to qualify  
1032 for Medicaid unless the following criteria are met:

1033 1. The contracted services do not duplicate services  
1034 available through other sources or providers, such as Medicaid,  
1035 Medicare, private insurance, or another legally obligated third  
1036 party;

1037 2. The contracted services directly benefit the individual  
1038 and are not services normally provided out of love and  
1039 consideration for the individual;

1040 3. The actual cost to deliver services is computed in a  
1041 manner that clearly reflects the actual number of hours to be  
1042 expended, and the contract clearly identifies each specific  
1043 service and the average number of hours of each service to be  
1044 delivered each month;

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1045 4. The hourly rate for each contracted service is equal to  
1046 or less than the amount normally charged by a professional who  
1047 traditionally provides the same or similar services;

1048 5. The contracted services are provided on a prospective  
1049 basis only and not for services provided in the past; and

1050 6. The contract provides fair compensation to the  
1051 individual in his or her lifetime as set forth in life  
1052 expectancy tables adopted in rule 65A-1.716, Florida  
1053 Administrative Code.

1054 (c) The department shall adopt any rules necessary to carry  
1055 out its statutory duties under this subsection for receiving and  
1056 processing Medicaid applications and determining Medicaid  
1057 eligibility, and any other statutory provisions related to  
1058 responsibility for the determination of Medicaid eligibility.

1059 Section 20. Section 409.9021, Florida Statutes, is amended  
1060 to read:

1061 409.9021 Conditions for Medicaid ~~Forfeiture of eligibility~~  
1062 ~~agreement.~~—As a condition of Medicaid eligibility, subject to  
1063 federal regulation and approval:~~7~~

1064 (1) A Medicaid applicant must consent ~~shall agree~~ in  
1065 writing to:

1066 (a) Have her or his medical records released to the agency  
1067 and the Medicaid Fraud Control Unit of the Department of Legal  
1068 Affairs.

1069 (b) Forfeit all entitlements to any goods or services  
1070 provided through the Medicaid program for the next 10 years if  
1071 he or she has been found to have committed Medicaid fraud,~~7~~  
1072 through judicial or administrative determination,~~7 two times in a~~  
1073 ~~period of 5 years.~~ This provision applies only to the Medicaid

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1074 recipient found to have committed or participated in Medicaid  
1075 ~~the~~ fraud and does not apply to any family member of the  
1076 recipient who was not involved in the fraud.

1077 (2) A Medicaid applicant must pay a \$10 monthly premium  
1078 that covers all Medicaid-eligible recipients in the applicant's  
1079 family. However, an individual who is eligible for the  
1080 Supplemental Security Income related Medicaid and is receiving  
1081 institutional care payments is exempt from this requirement. The  
1082 agency shall seek a federal waiver to authorize the imposition  
1083 and collection of this premium effective December 31, 2011. Upon  
1084 approval, the agency shall establish by rule procedures for  
1085 collecting premiums from recipients, advance notice of  
1086 cancellation, and waiting periods for reinstatement of coverage  
1087 upon voluntary cancellation for nonpayment of premiums.

1088 (3) A Medicaid applicant must participate, in good faith,  
1089 in:

1090 (a) A medically approved smoking cessation program if the  
1091 applicant smokes.

1092 (b) A medically directed weight loss program if the  
1093 applicant is or becomes morbidly obese.

1094 (c) A medically approved alcohol or substance abuse  
1095 recovery program if the applicant is or becomes diagnosed as a  
1096 substance abuser.

1097  
1098 The agency shall seek a federal waiver to authorize the  
1099 implementation of this subsection in order to assist the  
1100 recipient in mitigating lifestyle choices and avoiding behaviors  
1101 associated with the use of high-cost medical services.

1102 (4) A person who is eligible for Medicaid services and who

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1103 has access to health care coverage through an employer-sponsored  
1104 health plan may not receive Medicaid services reimbursed under  
1105 s. 409.908, s. 409.912, or s. 409.986, but may use Medicaid  
1106 financial assistance to pay the cost of premiums for the  
1107 employer-sponsored health plan for the eligible person and his  
1108 or her Medicaid-eligible family members.

1109 (5) A Medicaid recipient who has access to other insurance  
1110 or coverage created pursuant to state or federal law may opt out  
1111 of the Medicaid services provided under s. 409.908, s. 409.912,  
1112 or s. 409.986 and use Medicaid financial assistance to pay the  
1113 cost of premiums for the recipient and the recipient's Medicaid  
1114 eligible family members.

1115 (6) Subsections (4) and (5) shall be administered by the  
1116 agency in accordance with s. 409.964(1)(h). The maximum amount  
1117 available for the Medicaid financial assistance shall be  
1118 calculated based on the Medicaid capitated rate as if the  
1119 Medicaid recipient and the recipient's eligible family members  
1120 participated in a qualified plan for Medicaid managed care under  
1121 part IV of this chapter.

1122 Section 21. Section 409.9022, Florida Statutes, is created  
1123 to read:

1124 409.9022 Limitations on Medicaid expenditures.-

1125 (1) Except as specifically authorized in this section, a  
1126 state agency may not obligate or expend funds for the Medicaid  
1127 program in excess of the amount appropriated in the General  
1128 Appropriations Act.

1129 (2) If, at any time during the fiscal year, a state agency  
1130 determines that Medicaid expenditures may exceed the amount  
1131 appropriated during the fiscal year, the state agency shall

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1132 notify the Social Services Estimating Conference, which shall  
1133 meet to estimate Medicaid expenditures for the remainder of the  
1134 fiscal year. If, pursuant to this paragraph or for any other  
1135 purpose, the conference determines that Medicaid expenditures  
1136 will exceed appropriations for the fiscal year, the state agency  
1137 shall develop and submit a plan for revising Medicaid  
1138 expenditures in order to remain within the annual appropriation.  
1139 The plan must include cost-mitigating strategies to negate the  
1140 projected deficit for the remainder of the fiscal year and shall  
1141 be submitted in the form of a budget amendment to the  
1142 Legislative Budget Commission. The conference shall also  
1143 estimate the amount of savings which will result from such cost-  
1144 mitigating strategies proposed by the state agency as well as  
1145 any other strategies the conference may consider and recommend.

1146 (3) In preparing the budget amendment to revise Medicaid  
1147 expenditures in order to remain within appropriations, a state  
1148 agency shall include the following revisions to the Medicaid  
1149 state plan, in the priority order listed below:

1150 (a) Reduction in administrative costs.

1151 (b) Elimination of optional benefits.

1152 (c) Elimination of optional eligibility groups.

1153 (d) Reduction to institutional and provider reimbursement  
1154 rates.

1155 (e) Reduction in the amount, duration, and scope of  
1156 mandatory benefits.

1157  
1158 The state agency may not implement any of these cost-containment  
1159 measures until the amendment is approved by the Legislative  
1160 Budget Commission.



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1161       (4) In order to remedy a projected expenditure in excess of  
1162 the amount appropriated in a specific appropriation within the  
1163 Medicaid budget, a state agency may, consistent with chapter  
1164 216:

1165       (a) Submit a budget amendment to transfer budget authority  
1166 between appropriation categories;

1167       (b) Submit a budget amendment to increase federal trust  
1168 authority or grants and donations trust authority if additional  
1169 federal or local funds are available; or

1170       (c) Submit any other budget amendment consistent with  
1171 chapter 216.

1172       (5) The agency shall amend the Medicaid state plan to  
1173 incorporate the provisions of this section.

1174       (6) Chapter 216 does not permit the transfer of funds from  
1175 any other program into the Medicaid program or the transfer of  
1176 funds out of the Medicaid program into any other program.

1177       Section 22. Section 409.903, Florida Statutes, is amended  
1178 to read:

1179       409.903 Mandatory payments for eligible persons.—The agency  
1180 shall make payments for medical assistance and related services  
1181 on behalf of the following categories of persons who the  
1182 Department of Children and Family Services, or the Social  
1183 Security Administration by contract with the department ~~of~~  
1184 ~~Children and Family Services~~, determines to be eligible for  
1185 Medicaid, subject to the income, assets, and categorical  
1186 eligibility tests set forth in federal and state law. Payment on  
1187 behalf of these recipients ~~Medicaid eligible persons~~ is subject  
1188 to the availability of moneys and any limitations established by  
1189 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

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1190 (1) Low-income families with children if ~~are eligible for~~  
1191 ~~Medicaid provided~~ they meet the following requirements:

1192 (a) The family includes a dependent child who is living  
1193 with a caretaker relative.

1194 (b) The family's income does not exceed the gross income  
1195 test limit.

1196 (c) The family's countable income and resources do not  
1197 exceed the applicable Aid to Families with Dependent Children  
1198 (AFDC) income and resource standards under the AFDC state plan  
1199 in effect on ~~in~~ July 1996, except as amended in the Medicaid  
1200 state plan to conform as closely as possible to the requirements  
1201 of the welfare transition program, to the extent permitted by  
1202 federal law.

1203 (2) A person who receives payments from, who is determined  
1204 eligible for, or who was eligible for but lost cash benefits  
1205 from the federal program known as the Supplemental Security  
1206 Income program (SSI). This ~~category~~ includes a low-income person  
1207 age 65 or over and a low-income person under age 65 considered  
1208 to be permanently and totally disabled.

1209 (3) A child under age 21 living in a low-income, two-parent  
1210 family, and a child under age 7 living with a nonrelative, ~~if~~  
1211 the income and assets of the family or child, as applicable, do  
1212 not exceed the resource limits under the Temporary Cash  
1213 Assistance Program.

1214 (4) A child who is eligible under Title IV-E of the Social  
1215 Security Act for subsidized board payments, foster care, or  
1216 adoption subsidies, and a child for whom the state has assumed  
1217 temporary or permanent responsibility and who does not qualify  
1218 for Title IV-E assistance but is in foster care, shelter or

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1219 emergency shelter care, or subsidized adoption. This ~~category~~  
1220 includes a young adult who is eligible to receive services under  
1221 s. 409.1451(5), until the young adult reaches 21 years of age,  
1222 without regard to any income, resource, or categorical  
1223 eligibility test that is otherwise required. This ~~category~~ also  
1224 includes a person who as a child was eligible under Title IV-E  
1225 of the Social Security Act for foster care or the state-provided  
1226 foster care and who is a participant in the Road-to-Independence  
1227 Program.

1228 (5) A pregnant woman for the duration of her pregnancy and  
1229 for the postpartum period as defined in federal law and rule, or  
1230 a child under age 1, if either is living in a family that has an  
1231 income which is at or below ~~150 percent of the most current~~  
1232 ~~federal poverty level, or, effective January 1, 1992, that has~~  
1233 ~~an income which is at or below~~ 185 percent of the most current  
1234 federal poverty level. Such a person is not subject to an assets  
1235 test. ~~Further,~~ A pregnant woman who applies for eligibility for  
1236 the Medicaid program through a qualified Medicaid provider must  
1237 be offered the opportunity, subject to federal rules, to be made  
1238 presumptively eligible for the Medicaid program.

1239 (6) A child ~~born after September 30, 1983,~~ living in a  
1240 family that has an income which is at or below 100 percent of  
1241 the current federal poverty level, who has attained the age of  
1242 6, but has not attained the age of 19. In determining the  
1243 eligibility of such a child, an assets test is not required. A  
1244 child who is eligible ~~for Medicaid~~ under this subsection must be  
1245 offered the opportunity, subject to federal rules, to be made  
1246 presumptively eligible. A child who has been deemed  
1247 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in

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1248 a managed care plan until the child's full eligibility  
1249 ~~determination~~ for Medicaid has been determined ~~completed~~.

1250 (7) A child living in a family that has an income that  
1251 ~~which~~ is at or below 133 percent of the current federal poverty  
1252 level, who has attained the age of 1, but has not attained the  
1253 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an  
1254 assets test is not required. A child who is eligible ~~for~~  
1255 ~~Medicaid~~ under this subsection must be offered the opportunity,  
1256 subject to federal rules, to be made presumptively eligible. A  
1257 child who has been deemed presumptively eligible may ~~for~~  
1258 ~~Medicaid shall~~ not be enrolled in a managed care plan until the  
1259 child's full eligibility ~~determination~~ for Medicaid has been  
1260 determined ~~completed~~.

1261 (8) A person who is age 65 or over or is determined by the  
1262 agency to be disabled, whose income is at or below 100 percent  
1263 of the most current federal poverty level and whose assets do  
1264 not exceed limitations established by the agency. However, the  
1265 agency may only pay for premiums, coinsurance, and deductibles,  
1266 as required by federal law, unless additional coverage is  
1267 provided for any or all members of this group under ~~by~~ s.  
1268 409.904(1).

1269 Section 23. Section 409.904, Florida Statutes, is amended  
1270 to read:

1271 409.904 Optional payments for eligible persons.—The agency  
1272 may make payments for medical assistance and related services on  
1273 behalf of the following categories of persons who are determined  
1274 to be eligible for Medicaid, subject to the income, assets, and  
1275 categorical eligibility tests set forth in federal and state  
1276 law. Payment on behalf of these ~~Medicaid-eligible~~ persons is

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1277 subject to the availability of moneys and any limitations  
1278 established by the General Appropriations Act, ~~or~~ chapter 216,  
1279 or s. 409.9022.

1280 (1) ~~Effective January 1, 2006, and~~ Subject to federal  
1281 waiver approval, a person who is age 65 or older or is  
1282 determined to be disabled, whose income is at or below 88  
1283 percent of the federal poverty level, whose assets do not exceed  
1284 established limitations, and who is not eligible for Medicare  
1285 or, if eligible for Medicare, is also eligible for and receiving  
1286 Medicaid-covered institutional care services, hospice services,  
1287 or home and community-based services. The agency shall seek  
1288 federal authorization through a waiver to provide this coverage.  
1289 This subsection expires June 30, 2011.

1290 (2) The following persons who are eligible for the Medicaid  
1291 nonpoverty medical subsidy, which includes the same services as  
1292 those provided to other Medicaid recipients, with the exception  
1293 of services in skilled nursing facilities and intermediate care  
1294 facilities for the developmentally disabled:

1295 (a) A family, a pregnant woman, a child under age 21, a  
1296 person age 65 or over, or a blind or disabled person, who would  
1297 be eligible under any group listed in s. 409.903(1), (2), or  
1298 (3), except that the income or assets of such family or person  
1299 exceed established limitations. For a family or person in one of  
1300 these coverage groups, medical expenses are deductible from  
1301 income in accordance with federal requirements in order to make  
1302 a determination of eligibility. ~~A family or person eligible~~  
1303 ~~under the coverage known as the "medically needy," is eligible~~  
1304 ~~to receive the same services as other Medicaid recipients, with~~  
1305 ~~the exception of services in skilled nursing facilities and~~

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1306 ~~intermediate care facilities for the developmentally disabled.~~  
1307 This paragraph expires June 30, 2011.

1308 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a  
1309 child younger than 21 years of age who would be eligible under  
1310 any group listed in s. 409.903, except that the income or assets  
1311 of such group exceed established limitations. For a person in  
1312 one of these coverage groups, medical expenses are deductible  
1313 from income in accordance with federal requirements in order to  
1314 make a determination of eligibility. ~~A person eligible under the~~  
1315 ~~coverage known as the "medically needy" is eligible to receive~~  
1316 ~~the same services as other Medicaid recipients, with the~~  
1317 ~~exception of services in skilled nursing facilities and~~  
1318 ~~intermediate care facilities for the developmentally disabled.~~

1319 (c) A family, a person age 65 or older, or a blind or  
1320 disabled person, who would be eligible under any group listed in  
1321 s. 409.903(1), (2), or (3), except that the income or assets of  
1322 such family or person exceed established limitations. For a  
1323 family or person in one of these coverage groups, medical  
1324 expenses are deductible from income in accordance with federal  
1325 requirements in order to make a determination of eligibility. A  
1326 family, a person age 65 or older, or a blind or disabled person,  
1327 covered under the Medicaid nonpoverty medical subsidy, is  
1328 eligible to receive physician services only.

1329 (3) A person who is in need of the services of a licensed  
1330 nursing facility, a licensed intermediate care facility for the  
1331 developmentally disabled, or a state mental hospital, whose  
1332 income does not exceed 300 percent of the SSI income standard,  
1333 and who meets the assets standards established under federal and  
1334 state law. In determining the person's responsibility for the

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1335 cost of care, the following amounts must be deducted from the  
1336 person's income:

1337 (a) The monthly personal allowance for residents as set  
1338 based on appropriations.

1339 (b) The reasonable costs of medically necessary services  
1340 and supplies that are not reimbursable by the Medicaid program.

1341 (c) The cost of premiums, copayments, coinsurance, and  
1342 deductibles for supplemental health insurance.

1343 (4) A low-income person who meets all other requirements  
1344 for Medicaid eligibility except citizenship and who is in need  
1345 of emergency medical services. The eligibility of such a  
1346 recipient is limited to the period of the emergency, in  
1347 accordance with federal regulations.

1348 (5) Subject to specific federal authorization, a woman  
1349 living in a family that has an income that is at or below 185  
1350 percent of the most current federal poverty level. Coverage is  
1351 limited to ~~is eligible for~~ family planning services as specified  
1352 in s. 409.905(3) for a period of up to 24 months following a  
1353 loss of Medicaid benefits.

1354 (6) A child who has not attained the age of 19 who has been  
1355 determined eligible for the Medicaid program is deemed to be  
1356 eligible for a total of 6 months, regardless of changes in  
1357 circumstances other than attainment of the maximum age.

1358 ~~Effective January 1, 1999,~~ A child who has not attained the age  
1359 of 5 and who has been determined eligible for the Medicaid  
1360 program is deemed to be eligible for a total of 12 months  
1361 regardless of changes in circumstances other than attainment of  
1362 the maximum age.

1363 (7) A child under 1 year of age who lives in a family that

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1364 has an income above 185 percent of the most recently published  
1365 federal poverty level, but which is at or below 200 percent of  
1366 such poverty level. In determining the eligibility ~~of such~~  
1367 ~~child~~, an assets test is not required. A child who is eligible  
1368 ~~for Medicaid~~ under this subsection must be offered the  
1369 opportunity, subject to federal rules, to be made presumptively  
1370 eligible.

1371 (8) An eligible person ~~A Medicaid-eligible individual~~ for  
1372 the individual's health insurance premiums, if the agency  
1373 determines that such payments are cost-effective.

1374 (9) Eligible women with incomes at or below 200 percent of  
1375 the federal poverty level and under age 65, for cancer treatment  
1376 pursuant to the federal Breast and Cervical Cancer Prevention  
1377 and Treatment Act of 2000, screened through the Mary Brogan  
1378 Breast and Cervical Cancer Early Detection Program established  
1379 under s. 381.93.

1380 Section 24. Section 409.905, Florida Statutes, is amended  
1381 to read:

1382 409.905 Mandatory Medicaid services.—The agency shall ~~may~~  
1383 make payments for the following services, which are required ~~of~~  
1384 ~~the state~~ by Title XIX of the Social Security Act, furnished by  
1385 Medicaid providers to recipients who are ~~determined to be~~  
1386 eligible on the dates on which the services were provided. Any  
1387 service under this section shall be provided only when medically  
1388 necessary and in accordance with state and federal law.  
1389 Mandatory services rendered by providers in mobile units to  
1390 Medicaid recipients may be restricted by the agency. This  
1391 section does not ~~Nothing in this section shall be construed to~~  
1392 prevent or limit the agency from adjusting fees, reimbursement



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1393 rates, lengths of stay, number of visits, number of services, or  
1394 any other adjustments necessary to comply with the availability  
1395 of moneys and any limitations or directions provided ~~for~~ in the  
1396 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

1397 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The  
1398 agency shall pay for services provided to a recipient by a  
1399 licensed advanced registered nurse practitioner who has a valid  
1400 collaboration agreement with a licensed physician on file with  
1401 the Department of Health or who provides anesthesia services in  
1402 accordance with established protocol required by state law and  
1403 approved by the medical staff of the facility in which the  
1404 ~~anesthetic~~ service is performed. Reimbursement for such services  
1405 must be provided in an amount that equals at least ~~not less than~~  
1406 80 percent of the reimbursement to a physician who provides the  
1407 same services, unless otherwise provided ~~for~~ in the General  
1408 Appropriations Act.

1409 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT  
1410 SERVICES.—The agency shall pay for early and periodic screening  
1411 and diagnosis of a recipient under age 21 to ascertain physical  
1412 and mental problems and conditions and ~~provide treatment to~~  
1413 ~~correct or ameliorate these problems and conditions. These~~  
1414 ~~services include~~ all services determined by the agency to be  
1415 medically necessary for the treatment, correction, or  
1416 amelioration of these problems and conditions, including  
1417 personal care, private duty nursing, durable medical equipment,  
1418 physical therapy, occupational therapy, speech therapy,  
1419 respiratory therapy, and immunizations.

1420 (3) FAMILY PLANNING SERVICES.—The agency shall pay for  
1421 services necessary to enable a recipient voluntarily to plan

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1422 family size or to space children. These services include  
1423 information; education; counseling regarding the availability,  
1424 benefits, and risks of each method of pregnancy prevention;  
1425 drugs and supplies; and necessary medical care and followup.  
1426 Each recipient participating in ~~the~~ family planning ~~portion of~~  
1427 ~~the Medicaid program~~ must be provided the choice of freedom to  
1428 ~~choose~~ any alternative method of family planning, as required by  
1429 federal law.

1430 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for  
1431 nursing and home health aide services, supplies, appliances, and  
1432 durable medical equipment, necessary to assist a recipient  
1433 living at home. An entity that provides such services must  
1434 ~~pursuant to this subsection shall~~ be licensed under part III of  
1435 chapter 400. These services, equipment, and supplies, or  
1436 reimbursement therefor, may be limited as provided in the  
1437 General Appropriations Act and do not include services,  
1438 equipment, or supplies provided to a person residing in a  
1439 hospital or nursing facility.

1440 (a) ~~In providing home health care services,~~ The agency  
1441 shall may require prior authorization of home health services  
1442 ~~are~~ based on diagnosis, utilization rates, and ~~or~~ billing  
1443 rates. ~~The agency shall require prior authorization for visits~~  
1444 ~~for home health services that are not associated with a skilled~~  
1445 ~~nursing visit when the home health agency billing rates exceed~~  
1446 ~~the state average by 50 percent or more.~~ The home health agency  
1447 must submit the recipient's plan of care and documentation that  
1448 supports the recipient's diagnosis to the agency when requesting  
1449 prior authorization.

1450 (b) The agency shall implement a comprehensive utilization

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1451 management program ~~that requires prior authorization~~ of all  
1452 private duty nursing services, an individualized treatment plan  
1453 that includes information about medication and treatment orders,  
1454 treatment goals, methods of care to be used, and plans for care  
1455 coordination by nurses and other health professionals. The  
1456 utilization management program must ~~shall~~ also include a process  
1457 for periodically reviewing the ongoing use of private duty  
1458 nursing services. The assessment of need shall be based on a  
1459 child's condition; family support and care supplements; ~~;~~ a  
1460 family's ability to provide care; ~~;~~ and a family's and child's  
1461 schedule regarding work, school, sleep, and care for other  
1462 family dependents; and a determination of the medical necessity  
1463 for private duty nursing instead of other more cost-effective  
1464 in-home services. When implemented, the private duty nursing  
1465 utilization management program shall replace the current  
1466 authorization program used by the agency ~~for Health Care~~  
1467 ~~Administration~~ and the Children's Medical Services program of  
1468 the Department of Health. The agency may competitively bid ~~on~~ a  
1469 contract to select a qualified organization to provide  
1470 utilization management of private duty nursing services. The  
1471 agency may ~~is authorized to~~ seek federal waivers to implement  
1472 this initiative.

1473 (c) The agency may not pay for home health services unless  
1474 the services are medically necessary and:

- 1475 1. The services are ordered by a physician.
- 1476 2. The written prescription for the services is signed and  
1477 dated by the recipient's physician before the development of a  
1478 plan of care and before any request requiring prior  
1479 authorization.

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1480           3. The physician ordering the services is not employed,  
1481 under contract with, or otherwise affiliated with the home  
1482 health agency rendering the services. However, this subparagraph  
1483 does not apply to a home health agency affiliated with a  
1484 retirement community, of which the parent corporation or a  
1485 related legal entity owns a rural health clinic certified under  
1486 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed  
1487 under part II of chapter 400, or an apartment or single-family  
1488 home for independent living. For purposes of this subparagraph,  
1489 the agency may, on a case-by-case basis, provide an exception  
1490 for medically fragile children who are younger than 21 years of  
1491 age.

1492           4. The physician ordering the services has examined the  
1493 recipient within the 30 days preceding the initial request for  
1494 the services and biannually thereafter.

1495           5. The written prescription for the services includes the  
1496 recipient's acute or chronic medical condition or diagnosis, the  
1497 home health service required, and, for skilled nursing services,  
1498 the frequency and duration of the services.

1499           6. The national provider identifier, Medicaid  
1500 identification number, or medical practitioner license number of  
1501 the physician ordering the services is listed on the written  
1502 prescription for the services, the claim for home health  
1503 reimbursement, and the prior authorization request.

1504           (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for  
1505 all covered services provided for the medical care and treatment  
1506 of a recipient who is admitted as an inpatient by a licensed  
1507 physician or dentist to a hospital licensed under part I of  
1508 chapter 395. However, the agency shall limit the payment for

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1509 inpatient hospital services for a Medicaid recipient 21 years of  
1510 age or older to 45 days or the number of days necessary to  
1511 comply with the General Appropriations Act.

1512 (a) The agency may ~~is authorized to~~ implement reimbursement  
1513 and utilization management reforms in order to comply with any  
1514 limitations or directions in the General Appropriations Act,  
1515 which may include, but are not limited to: prior authorization  
1516 for inpatient psychiatric days; prior authorization for  
1517 nonemergency hospital inpatient admissions for individuals 21  
1518 years of age and older; authorization of emergency and urgent-  
1519 care admissions within 24 hours after admission; enhanced  
1520 utilization and concurrent review programs for highly utilized  
1521 services; reduction or elimination of covered days of service;  
1522 adjusting reimbursement ceilings for variable costs; adjusting  
1523 reimbursement ceilings for fixed and property costs; and  
1524 implementing target rates of increase. The agency may limit  
1525 prior authorization for hospital inpatient services to selected  
1526 diagnosis-related groups, based on an analysis of the cost and  
1527 potential for unnecessary hospitalizations represented by  
1528 certain diagnoses. Admissions for normal delivery and newborns  
1529 are exempt from requirements for prior authorization. In  
1530 implementing the provisions of this section related to prior  
1531 authorization, the agency must ~~shall~~ ensure that the process for  
1532 authorization is accessible 24 hours per day, 7 days per week  
1533 and that authorization is automatically granted if ~~when~~ not  
1534 denied within 4 hours after the request. Authorization  
1535 procedures must include steps for reviewing ~~review of~~ denials.  
1536 Upon implementing the prior authorization program for hospital  
1537 inpatient services, the agency shall discontinue its hospital

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1538 retrospective review program.

1539 (b) A licensed hospital maintained primarily for the care  
1540 and treatment of patients having mental disorders or mental  
1541 diseases may ~~is not eligible to~~ participate in the hospital  
1542 inpatient portion of the Medicaid program except as provided in  
1543 federal law. However, the Department of Children and Family  
1544 Services shall apply for a waiver, ~~within 9 months after June 5,~~  
1545 ~~1991,~~ designed to provide hospitalization services for mental  
1546 health reasons to children and adults in the most cost-effective  
1547 and lowest cost setting possible. Such waiver shall include a  
1548 request for the opportunity to pay for care in hospitals known  
1549 under federal law as "institutions for mental disease" or  
1550 "IMD's." The waiver proposal shall propose no additional  
1551 aggregate cost to the state or Federal Government, and shall be  
1552 conducted in Hillsborough County, Highlands County, Hardee  
1553 County, Manatee County, and Polk County. The waiver proposal may  
1554 incorporate competitive bidding for hospital services,  
1555 comprehensive brokering, prepaid capitated arrangements, or  
1556 other mechanisms deemed by the department to show promise in  
1557 reducing the cost of acute care and increasing the effectiveness  
1558 of preventive care. When developing the waiver proposal, the  
1559 department shall take into account price, quality,  
1560 accessibility, linkages of the hospital to community services  
1561 and family support programs, plans of the hospital to ensure the  
1562 earliest discharge possible, and the comprehensiveness of the  
1563 mental health and other health care services offered by  
1564 participating providers.

1565 (c) The agency shall adjust a hospital's current inpatient  
1566 per diem rate to reflect the cost of serving the Medicaid

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1567 population at that institution if:

1568 1. The hospital experiences an increase in Medicaid  
1569 caseload by more than 25 percent in any year, primarily  
1570 resulting from the closure of a hospital in the same service  
1571 area occurring after July 1, 1995;

1572 2. The hospital's Medicaid per diem rate is at least 25  
1573 percent below the Medicaid per patient cost for that year; or

1574 3. The hospital is located in a county that has six or  
1575 fewer general acute care hospitals, began offering obstetrical  
1576 services on or after September 1999, and has submitted a request  
1577 in writing to the agency for a rate adjustment after July 1,  
1578 2000, but before September 30, 2000, in which case such  
1579 hospital's Medicaid inpatient per diem rate shall be adjusted to  
1580 cost, effective July 1, 2002. By October 1 of each year, the  
1581 agency must provide estimated costs for any adjustment in a  
1582 hospital inpatient per diem rate to the Executive Office of the  
1583 Governor, the House of Representatives General Appropriations  
1584 Committee, and the Senate Appropriations Committee. Before the  
1585 agency implements a change in a hospital's inpatient per diem  
1586 rate pursuant to this paragraph, the Legislature must have  
1587 specifically appropriated sufficient funds in the General  
1588 Appropriations Act to support the increase in cost as estimated  
1589 by the agency.

1590 (d) The agency shall implement a hospitalist program in  
1591 nonteaching hospitals, select counties, or statewide. The  
1592 program shall require hospitalists to manage Medicaid  
1593 recipients' hospital admissions and lengths of stay. Individuals  
1594 who are dually eligible for Medicare and Medicaid are exempted  
1595 from this requirement. Medicaid participating physicians and

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1596 other practitioners with hospital admitting privileges shall  
1597 coordinate and review admissions of Medicaid recipients with the  
1598 hospitalist. The agency may competitively bid a contract for  
1599 selection of a single qualified organization to provide  
1600 hospitalist services. The agency may procure hospitalist  
1601 services by individual county or may combine counties in a  
1602 single procurement. The qualified organization shall contract  
1603 with or employ board-eligible physicians in Miami-Dade, Palm  
1604 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency  
1605 may ~~is authorized to~~ seek federal waivers to implement this  
1606 program.

1607 (e) The agency shall implement a comprehensive utilization  
1608 management program for hospital neonatal intensive care stays in  
1609 certain high-volume participating hospitals, select counties, or  
1610 statewide, and shall replace existing hospital inpatient  
1611 utilization management programs for neonatal intensive care  
1612 admissions. The program shall be designed to manage the lengths  
1613 of stay for children being treated in neonatal intensive care  
1614 units and must seek the earliest medically appropriate discharge  
1615 to the child's home or other less costly treatment setting. The  
1616 agency may competitively bid a contract for selection of a  
1617 qualified organization to provide neonatal intensive care  
1618 utilization management services. The agency may ~~is authorized to~~  
1619 seek any federal waivers to implement this initiative.

1620 (f) The agency may develop and implement a program to  
1621 reduce the number of hospital readmissions among the non-  
1622 Medicare population eligible in areas 9, 10, and 11.

1623 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for  
1624 preventive, diagnostic, therapeutic, or palliative care and



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1625 other services provided to a recipient in the outpatient portion  
1626 of a hospital licensed under part I of chapter 395, and provided  
1627 under the direction of a licensed physician or licensed dentist,  
1628 except that payment for such care and services is limited to  
1629 \$1,500 per state fiscal year per recipient, unless an exception  
1630 has been made by the agency, and with the exception of a  
1631 Medicaid recipient under age 21, in which case the only  
1632 limitation is medical necessity.

1633 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay  
1634 for medically necessary diagnostic laboratory procedures ordered  
1635 by a licensed physician or other licensed health care  
1636 practitioner ~~of the healing arts~~ which are provided for a  
1637 recipient in a laboratory that meets the requirements for  
1638 Medicare participation and is licensed under chapter 483, if  
1639 required.

1640 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-  
1641 hour-a-day nursing and rehabilitative services for a recipient  
1642 in a nursing facility licensed under part II of chapter 400 or  
1643 in a rural hospital, as defined in s. 395.602, or in a Medicare  
1644 certified skilled nursing facility operated by a general  
1645 hospital, as defined in ~~by~~ s. 395.002(10), which ~~that~~ is  
1646 licensed under part I of chapter 395, and in accordance with  
1647 ~~provisions set forth in~~ s. 409.908(2)(a), which services are  
1648 ordered by and provided under the direction of a licensed  
1649 physician. However, if a nursing facility has been destroyed or  
1650 otherwise made uninhabitable by natural disaster or other  
1651 emergency and another nursing facility is not available, the  
1652 agency must pay for similar services temporarily in a hospital  
1653 licensed under part I of chapter 395 provided federal funding is

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1654 approved and available. The agency shall pay only for bed-hold  
1655 days if the facility has an occupancy rate of 95 percent or  
1656 greater. The agency is authorized to seek any federal waivers to  
1657 implement this policy.

1658 (9) PHYSICIAN SERVICES.—The agency shall pay for covered  
1659 services and procedures rendered to a Medicaid recipient by, or  
1660 under the personal supervision of, a person licensed under state  
1661 law to practice medicine or osteopathic medicine. These services  
1662 may be furnished in the physician's office, the ~~Medicaid~~  
1663 recipient's home, a hospital, a nursing facility, or elsewhere,  
1664 but must ~~shall~~ be medically necessary for the treatment of a  
1665 covered ~~an~~ injury or, ~~illness, or disease~~ within the scope of  
1666 the practice of medicine or osteopathic medicine as defined by  
1667 state law. The agency may ~~shall~~ not pay for services that are  
1668 clinically unproven, experimental, or for purely cosmetic  
1669 purposes.

1670 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for  
1671 professional and technical portable radiological services  
1672 ordered by a licensed physician or other licensed health care  
1673 practitioner ~~of the healing arts~~ which are provided by a  
1674 licensed professional in a setting other than a hospital,  
1675 clinic, or office of a physician or practitioner ~~of the healing~~  
1676 ~~arts~~, on behalf of a recipient.

1677 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for  
1678 outpatient primary ~~health~~ care services for a recipient provided  
1679 by a clinic certified by and participating in the Medicare  
1680 program which is located in a federally designated, rural,  
1681 medically underserved area and has on its staff one or more  
1682 licensed primary care nurse practitioners or physician

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1683 assistants, and a licensed staff supervising physician or a  
1684 consulting supervising physician.

1685 (12) TRANSPORTATION SERVICES.—The agency shall ensure that  
1686 appropriate transportation services are available for a Medicaid  
1687 recipient in need of transport to a qualified Medicaid provider  
1688 for medically necessary ~~and Medicaid-compensable~~ services, if  
1689 the recipient's ~~provided a client's~~ ability to choose a specific  
1690 transportation provider is ~~shall be~~ limited to those options  
1691 resulting from policies established by the agency to meet the  
1692 fiscal limitations of the General Appropriations Act. The agency  
1693 may pay for necessary transportation and other related travel  
1694 expenses ~~as necessary~~ only if these services are not otherwise  
1695 available.

1696 Section 25. Section 409.906, Florida Statutes, is amended  
1697 to read:

1698 409.906 Optional Medicaid services.—Subject to specific  
1699 appropriations, the agency may make payments for services which  
1700 are optional to the state under Title XIX of the Social Security  
1701 Act and are furnished by Medicaid providers to recipients who  
1702 are determined to be eligible on the dates on which the services  
1703 were provided. Any optional service that is provided shall be  
1704 provided only when medically necessary and in accordance with  
1705 state and federal law. Optional services rendered by providers  
1706 in mobile units to Medicaid recipients may be restricted or  
1707 prohibited by the agency. ~~Nothing in~~ This section does not ~~shall~~  
1708 ~~be construed to~~ prevent or limit the agency from adjusting fees,  
1709 reimbursement rates, lengths of stay, number of visits, or  
1710 number of services, or making any other adjustments necessary to  
1711 comply with the availability of moneys and any limitations or

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1712 directions provided for in the General Appropriations Act, ~~or~~  
1713 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~  
1714 ~~state's systems of providing services to elderly and disabled~~  
1715 ~~persons and subject to the notice and review provisions of s.~~  
1716 ~~216.177, the Governor may direct the Agency for Health Care~~  
1717 ~~Administration to amend the Medicaid state plan to delete the~~  
1718 ~~optional Medicaid service known as "Intermediate Care Facilities~~  
1719 ~~for the Developmentally Disabled."~~ Optional services may  
1720 include:

1721 (1) ADULT DENTAL SERVICES. For a recipient who is 21 years  
1722 of age or older:

1723 (a) The agency may pay for medically necessary, emergency  
1724 dental procedures to alleviate pain or infection. Emergency  
1725 dental care is ~~shall be~~ limited to emergency oral examinations,  
1726 necessary radiographs, extractions, and incision and drainage of  
1727 abscess, ~~for a recipient who is 21 years of age or older.~~

1728 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or  
1729 partial dentures, the procedures required to seat full or  
1730 partial dentures, and the repair and reline of full or partial  
1731 dentures, provided by or under the direction of a licensed  
1732 dentist, ~~for a recipient who is 21 years of age or older.~~

1733 (c) ~~However,~~ Medicaid will not provide reimbursement for  
1734 dental services provided in a mobile dental unit, except for a  
1735 mobile dental unit:

1736 1. Owned by, operated by, or having a contractual agreement  
1737 with the Department of Health and complying with Medicaid's  
1738 county health department clinic services program specifications  
1739 as a county health department clinic services provider.

1740 2. Owned by, operated by, or having a contractual

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1741 arrangement with a federally qualified health center and  
1742 complying with Medicaid's federally qualified health center  
1743 specifications as a federally qualified health center provider.

1744 3. Rendering dental services to Medicaid recipients, 21  
1745 years of age and older, at nursing facilities.

1746 4. Owned by, operated by, or having a contractual agreement  
1747 with a state-approved dental educational institution.

1748 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for  
1749 an annual routine physical examination, conducted by or under  
1750 the direction of a licensed physician, for a recipient age 21 or  
1751 older, without regard to medical necessity, in order to detect  
1752 and prevent disease, disability, or other health condition or  
1753 its progression.

1754 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay  
1755 for services provided to a recipient in an ambulatory surgical  
1756 center licensed under part I of chapter 395, by or under the  
1757 direction of a licensed physician or dentist.

1758 (4) BIRTH CENTER SERVICES.—The agency may pay for  
1759 examinations and delivery, recovery, ~~and~~ newborn assessment, and  
1760 related services, provided in a licensed birth center staffed  
1761 with licensed physicians, certified nurse midwives, and midwives  
1762 licensed in accordance with chapter 467, to a recipient expected  
1763 to experience a low-risk pregnancy and delivery.

1764 (5) CASE MANAGEMENT SERVICES.—The agency may pay for  
1765 primary care case management services rendered to a recipient  
1766 pursuant to a federally approved waiver, ~~and~~ targeted case  
1767 management services for specific groups of targeted recipients,  
1768 for which funding has been provided and which are rendered  
1769 pursuant to federal guidelines. The agency may ~~is authorized to~~

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1770 limit reimbursement for targeted case management services in  
1771 order to comply with any limitations or directions provided for  
1772 in the General Appropriations Act.

1773 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for  
1774 diagnostic, preventive, or corrective procedures, including  
1775 orthodontia in severe cases, provided to a recipient under age  
1776 21, by or under the supervision of a licensed dentist. Services  
1777 ~~provided under this program~~ include treatment of the teeth and  
1778 associated structures of the oral cavity, as well as treatment  
1779 of disease, injury, or impairment that may affect the oral or  
1780 general health of the individual. However, Medicaid may ~~will~~ not  
1781 provide reimbursement for dental services provided in a mobile  
1782 dental unit, except for a mobile dental unit:

1783 (a) Owned by, operated by, or having a contractual  
1784 agreement with the Department of Health and complying with  
1785 Medicaid's county health department clinic services program  
1786 specifications as a county health department clinic services  
1787 provider.

1788 (b) Owned by, operated by, or having a contractual  
1789 arrangement with a federally qualified health center and  
1790 complying with Medicaid's federally qualified health center  
1791 specifications as a federally qualified health center provider.

1792 (c) Rendering dental services to Medicaid recipients, 21  
1793 years of age and older, at nursing facilities.

1794 (d) Owned by, operated by, or having a contractual  
1795 agreement with a state-approved dental educational institution.

1796 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual  
1797 manipulation of the spine and initial services, screening, and X  
1798 rays provided to a recipient by a licensed chiropractic

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1799 physician.

1800 (8) COMMUNITY MENTAL HEALTH SERVICES.-

1801 ~~(a)~~ The agency may pay for rehabilitative services provided  
1802 to a recipient by a mental health or substance abuse provider  
1803 under contract with the agency or the Department of Children and  
1804 Family Services to provide such services. ~~These Services~~ that  
1805 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or  
1806 recommended by a psychiatrist, and ~~these services~~ that ~~which~~ are  
1807 medical in nature must ~~shall~~ be rendered or recommended by a  
1808 physician or psychiatrist.

1809 (a) The agency shall ~~must~~ develop a provider enrollment  
1810 process for community mental health providers which bases  
1811 provider enrollment on an assessment of service need. The  
1812 provider enrollment process shall be designed to control costs,  
1813 prevent fraud and abuse, consider provider expertise and  
1814 capacity, and assess provider success in managing utilization of  
1815 care and measuring treatment outcomes. Providers must ~~will~~ be  
1816 selected through a competitive procurement or selective  
1817 contracting process. In addition ~~to other community mental~~  
1818 ~~health providers,~~ the agency shall consider enrolling ~~for~~  
1819 ~~enrollment~~ mental health programs licensed under chapter 395 and  
1820 group practices licensed under chapter 458, chapter 459, chapter  
1821 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~  
1822 continue the operation of its behavioral health utilization  
1823 management program and ~~may~~ develop new services, ~~if these~~  
1824 ~~actions are necessary,~~ to ensure savings from the implementation  
1825 of the utilization management system. The agency shall  
1826 coordinate the implementation of this enrollment process with  
1827 the Department of Children and Family Services and the

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1828 Department of Juvenile Justice. The agency may use ~~is authorized~~  
1829 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,  
1830 ~~to~~ preauthorize certain high-cost or highly utilized services,  
1831 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make  
1832 any other adjustments necessary to comply with any limitations  
1833 or directions provided for in the General Appropriations Act.

1834 (b) The agency may ~~is authorized to~~ implement reimbursement  
1835 and use management reforms in order to comply with any  
1836 limitations or directions in the General Appropriations Act,  
1837 which may include, but are not limited to: prior authorization  
1838 of treatment and service plans; prior authorization of services;  
1839 enhanced use review programs for highly used services; and  
1840 limits on services for recipients ~~those~~ determined to be abusing  
1841 their benefit coverages.

1842 (9) DIALYSIS FACILITY SERVICES.—Subject to specific  
1843 appropriations being provided for this purpose, the agency may  
1844 pay a dialysis facility that is approved as a dialysis facility  
1845 in accordance with Title XVIII of the Social Security Act, for  
1846 dialysis services that are provided to a Medicaid recipient  
1847 under the direction of a physician licensed to practice medicine  
1848 or osteopathic medicine in this state, including dialysis  
1849 services provided in the recipient's home by a hospital-based or  
1850 freestanding dialysis facility.

1851 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize  
1852 and pay for certain durable medical equipment and supplies  
1853 provided to a Medicaid recipient as medically necessary.

1854 (11) HEALTHY START SERVICES.—The agency may pay for a  
1855 continuum of risk-appropriate medical and psychosocial services  
1856 for the Healthy Start program in accordance with a federal



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1857 waiver. The agency may not implement the federal waiver unless  
1858 the waiver permits the state to limit enrollment or the amount,  
1859 duration, and scope of services to ensure that expenditures will  
1860 not exceed funds appropriated by the Legislature or available  
1861 from local sources. If ~~the Health Care Financing Administration~~  
1862 ~~does not approve~~ a federal waiver for Healthy Start services is  
1863 not approved, the agency, in consultation with the Department of  
1864 Health and the Florida Association of Healthy Start Coalitions,  
1865 may ~~is authorized to~~ establish a Medicaid certified-match  
1866 program for Healthy Start services. Participation in the Healthy  
1867 Start certified-match program is ~~shall be~~ voluntary, and  
1868 reimbursement is ~~shall be~~ limited to the federal Medicaid share  
1869 provided to Medicaid-enrolled Healthy Start coalitions for  
1870 services provided to Medicaid recipients. The agency may not  
1871 ~~shall~~ take ~~no~~ action to implement a certified-match program  
1872 without ensuring that the amendment and review requirements of  
1873 ss. 216.177 and 216.181 have been met.

1874 (12) HEARING SERVICES.—The agency may pay for hearing and  
1875 related services, including hearing evaluations, hearing aid  
1876 devices, dispensing of the hearing aid, and related repairs, ~~if~~  
1877 provided to a recipient by a licensed hearing aid specialist,  
1878 otolaryngologist, otologist, audiologist, or physician.

1879 (13) HOME AND COMMUNITY-BASED SERVICES.—

1880 (a) The agency may pay for home-based or community-based  
1881 services that are rendered to a recipient in accordance with a  
1882 federally approved waiver program. The agency may limit or  
1883 eliminate coverage for certain services, preauthorize high-cost  
1884 or highly utilized services, or make any other adjustments  
1885 necessary to comply with any limitations or directions provided

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1886 ~~for~~ in the General Appropriations Act.

1887 (b) The agency may consolidate types of services offered in  
1888 the Aged and Disabled Waiver, the Channeling Waiver, the Project  
1889 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury  
1890 Waiver programs in order to group similar services under a  
1891 single service, or continue a service upon evidence of the need  
1892 for including a particular service type in a particular waiver.  
1893 The agency may ~~is authorized to~~ seek a Medicaid state plan  
1894 amendment or federal waiver approval to implement this policy.

1895 (c) The agency may implement a utilization management  
1896 program designed to prior-authorize home and community-based  
1897 service plans which ~~and~~ includes, but is not limited to,  
1898 assessing proposed quantity and duration of services and  
1899 monitoring ongoing service use by participants in the program.  
1900 The agency may ~~is authorized to~~ competitively procure a  
1901 qualified organization to provide utilization management of home  
1902 and community-based services. The agency may ~~is authorized to~~  
1903 seek any federal waivers to implement this initiative.

1904 (d) The agency shall assess a fee against the parents of a  
1905 child who is being served by a waiver under this subsection if  
1906 the adjusted household income is greater than 100 percent of the  
1907 federal poverty level. The amount of the fee shall be calculated  
1908 using a sliding scale based on the size of the family, the  
1909 amount of the parent's adjusted gross income, and the federal  
1910 poverty guidelines. The agency shall seek a federal waiver to  
1911 implement this provision.

1912 (14) HOSPICE CARE SERVICES.—The agency may pay for all  
1913 reasonable and necessary services for the palliation or  
1914 management of a recipient's terminal illness, if the services

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1915 are provided by a hospice that is licensed under part IV of  
1916 chapter 400 and meets Medicare certification requirements.

1917 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY  
1918 DISABLED SERVICES.—The agency may pay for health-related care  
1919 and services provided on a 24-hour-a-day basis by a facility  
1920 licensed and certified as a Medicaid Intermediate Care Facility  
1921 for the Developmentally Disabled, for a recipient who needs such  
1922 care because of a developmental disability. Payment may ~~shall~~  
1923 not include bed-hold days except in facilities with occupancy  
1924 rates of 95 percent or greater. The agency may ~~is authorized to~~  
1925 seek any federal waiver approvals to implement this policy. If  
1926 necessary to safeguard the state's systems of providing services  
1927 to elderly and disabled persons and subject to notice and review  
1928 under s. 216.177, the Governor may direct the agency to amend  
1929 the Medicaid state plan to delete these services.

1930 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-  
1931 hour-a-day intermediate care nursing and rehabilitation services  
1932 rendered to a recipient in a nursing facility licensed under  
1933 part II of chapter 400, if the services are ordered by and  
1934 provided under the direction of a physician.

1935 (17) OPTOMETRIC SERVICES.—The agency may pay for services  
1936 provided to a recipient, including examination, diagnosis,  
1937 treatment, and management, related to ocular pathology, if the  
1938 services are provided by a licensed optometrist or physician.

1939 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for  
1940 all services provided to a recipient by a physician assistant  
1941 licensed under s. 458.347 or s. 459.022. Reimbursement for such  
1942 services must be at least ~~not less than~~ 80 percent of the  
1943 reimbursement that would be paid to a physician who provided the

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1944 same services.

1945 (19) PODIATRIC SERVICES.—The agency may pay for services,  
1946 including diagnosis and medical, surgical, palliative, and  
1947 mechanical treatment, related to ailments of the human foot and  
1948 lower leg, if provided to a recipient by a podiatric physician  
1949 licensed under state law.

1950 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for  
1951 medications that are prescribed for a recipient by a physician  
1952 or other licensed health care practitioner ~~of the healing arts~~  
1953 authorized to prescribe medications and that are dispensed to  
1954 the recipient by a licensed pharmacist or physician in  
1955 accordance with applicable state and federal law. However, the  
1956 agency may not pay for any psychotropic medication prescribed  
1957 for a child younger than the age for which the federal Food and  
1958 Drug Administration has approved its use.

1959 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency  
1960 may pay for all services provided to a recipient by a registered  
1961 nurse first assistant as described in s. 464.027. Reimbursement  
1962 for such services must be at least ~~may not be less than~~ 80  
1963 percent of the reimbursement that would be paid to a physician  
1964 providing the same services.

1965 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-  
1966 inclusive psychiatric inpatient hospital care provided to a  
1967 recipient age 65 or older in a state mental hospital.

1968 (23) VISUAL SERVICES.—The agency may pay for visual  
1969 examinations, eyeglasses, and eyeglass repairs for a recipient  
1970 if they are prescribed by a licensed physician specializing in  
1971 diseases of the eye or by a licensed optometrist. Eyeglass  
1972 frames for adult recipients are ~~shall be~~ limited to one pair per

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1973 recipient every 2 years, except a second pair may be provided  
1974 ~~during that period~~ after prior authorization. Eyeglass lenses  
1975 for adult recipients are ~~shall be~~ limited to one pair per year  
1976 except a second pair may be provided ~~during that period~~ after  
1977 prior authorization.

1978 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~  
1979 ~~Health Care Administration~~, in consultation with the Department  
1980 of Children and Family Services, may establish a targeted case-  
1981 management project in those counties identified by the  
1982 department ~~of Children and Family Services~~ and for all counties  
1983 with a community-based child welfare project, as authorized  
1984 under s. 409.1671, which have been specifically approved by the  
1985 department. The covered group that is ~~of individuals who are~~  
1986 eligible for ~~to receive~~ targeted case management include  
1987 children who are eligible for Medicaid; who are between the ages  
1988 of birth through 21; and who are under protective supervision or  
1989 postplacement supervision, under foster-care supervision, or in  
1990 shelter care or foster care. The number of eligible children  
1991 ~~individuals who are eligible to receive targeted case management~~  
1992 is limited to the number for whom the department ~~of Children and~~  
1993 ~~Family Services~~ has matching funds to cover the costs. The  
1994 general revenue funds required to match the funds for services  
1995 provided by the community-based child welfare projects are  
1996 limited to funds available for services described under s.  
1997 409.1671. The department ~~of Children and Family Services~~ may  
1998 transfer the general revenue matching funds as billed by the  
1999 agency ~~for Health Care Administration~~.

2000 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for  
2001 assistive-care services provided to recipients with functional

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2002 or cognitive impairments residing in assisted living facilities,  
2003 adult family-care homes, or residential treatment facilities.  
2004 These services may include health support, assistance with the  
2005 activities of daily living and the instrumental acts of daily  
2006 living, assistance with medication administration, and  
2007 arrangements for health care.

2008 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM  
2009 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~  
2010 ~~authorized to~~ seek federal approval through a Medicaid waiver or  
2011 a state plan amendment for the provision of occupational  
2012 therapy, speech therapy, physical therapy, behavior analysis,  
2013 and behavior assistant services to individuals who are 5 years  
2014 of age and under and have a diagnosed developmental disability  
2015 as defined in s. 393.063, or autism spectrum disorder as defined  
2016 in s. 627.6686, ~~or Down syndrome, a genetic disorder caused by~~  
2017 ~~the presence of extra-chromosomal material on chromosome 21.~~  
2018 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~  
2019 ~~Robertsonian Translocation, and other duplications of a portion~~  
2020 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited  
2021 to \$36,000 annually and may not exceed \$108,000 in total  
2022 lifetime benefits. The agency shall submit an annual report  
2023 beginning ~~on~~ January 1, 2009, to the President of the Senate,  
2024 the Speaker of the House of Representatives, and the relevant  
2025 committees of the Senate and the House of Representatives  
2026 regarding progress on obtaining federal approval and  
2027 recommendations for the implementation of these home and  
2028 community-based services. The agency may not implement this  
2029 subsection without prior legislative approval.

2030 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may

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2031 pay for all services provided to a recipient by an  
2032 anesthesiologist assistant licensed under s. 458.3475 or s.  
2033 459.023. Reimbursement for such services must be at least ~~not~~  
2034 ~~less than~~ 80 percent of the reimbursement that would be paid to  
2035 a physician who provided the same services.

2036 Section 26. Section 409.9062, Florida Statutes, is amended  
2037 to read:

2038 409.9062 Lung transplant services for Medicaid recipients.-  
2039 Subject to the availability of funds and ~~subject to~~ any  
2040 limitations or directions provided ~~for~~ in the General  
2041 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~  
2042 ~~for Health Care Administration~~ Medicaid program shall pay for  
2043 medically necessary lung transplant services for Medicaid  
2044 recipients. These payments must be used to reimburse approved  
2045 lung transplant facilities a global fee for providing lung  
2046 transplant services to Medicaid recipients.

2047 Section 27. Paragraph (h) of subsection (3) of section  
2048 409.907, Florida Statutes, is amended to read:

2049 409.907 Medicaid provider agreements.-The agency may make  
2050 payments for medical assistance and related services rendered to  
2051 Medicaid recipients only to an individual or entity who has a  
2052 provider agreement in effect with the agency, who is performing  
2053 services or supplying goods in accordance with federal, state,  
2054 and local law, and who agrees that no person shall, on the  
2055 grounds of handicap, race, color, or national origin, or for any  
2056 other reason, be subjected to discrimination under any program  
2057 or activity for which the provider receives payment from the  
2058 agency.

2059 (3) The provider agreement developed by the agency, in

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2060 addition to the requirements specified in subsections (1) and  
2061 (2), shall require the provider to:

2062 (h) Be liable for and indemnify, defend, and hold the  
2063 agency harmless from all claims, suits, judgments, or damages,  
2064 including court costs and attorney's fees, arising out of the  
2065 negligence or omissions of the provider in the course of  
2066 providing services to a recipient or a person believed to be a  
2067 recipient, subject to s. 766.1183 or s. 766.1184.

2068 Section 28. Section 409.908, Florida Statutes, is amended  
2069 to read:

2070 409.908 Reimbursement of Medicaid providers.—Subject to  
2071 specific appropriations, the agency shall reimburse Medicaid  
2072 providers, in accordance with state and federal law, according  
2073 to methodologies set forth in the rules of the agency and in  
2074 policy manuals and handbooks incorporated by reference therein.  
2075 These methodologies may include fee schedules, reimbursement  
2076 methods based on cost reporting, negotiated fees, competitive  
2077 bidding pursuant to s. 287.057, and other mechanisms the agency  
2078 considers efficient and effective for purchasing services or  
2079 goods on behalf of recipients. ~~If a provider is reimbursed based  
2080 on cost reporting and submits a cost report late and that cost  
2081 report would have been used to set a lower reimbursement rate  
2082 for a rate semester, then the provider's rate for that semester  
2083 shall be retroactively calculated using the new cost report, and  
2084 full payment at the recalculated rate shall be effected  
2085 retroactively. Medicare granted extensions for filing cost  
2086 reports, if applicable, shall also apply to Medicaid cost  
2087 reports.~~ Payment for Medicaid compensable services made on  
2088 behalf of Medicaid eligible persons is subject to the



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2089 availability of moneys and any limitations or directions  
2090 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,  
2091 or s. 409.9022. ~~Further, nothing in~~ This section does not shall  
2092 ~~be construed to~~ prevent or limit the agency from adjusting fees,  
2093 reimbursement rates, lengths of stay, number of visits, or  
2094 number of services, or making any other adjustments necessary to  
2095 comply with the availability of moneys and any limitations or  
2096 directions provided ~~for~~ in the General Appropriations Act if,  
2097 ~~provided~~ the adjustment is consistent with legislative intent.

2098 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed  
2099 under part I of chapter 395 must be made prospectively or on the  
2100 basis of negotiation.

2101 (a) Inpatient care.—

2102 1. Reimbursement for inpatient care is limited as provided  
2103 ~~for~~ in s. 409.905(5), except for:

2104 a.1. ~~The raising of rate reimbursement caps, excluding~~  
2105 rural hospitals.

2106 b.2. ~~Recognition of the costs of graduate medical~~  
2107 education.

2108 c.3. ~~Other methodologies recognized in the General~~  
2109 Appropriations Act.

2110 2. ~~If During the years~~ funds are transferred from the  
2111 Department of Health, any reimbursement supported by such funds  
2112 is shall be subject to certification by the Department of Health  
2113 that the hospital has complied with s. 381.0403. The agency may  
2114 ~~is authorized to~~ receive funds from state entities, including,  
2115 but not limited to, the Department of Health, local governments,  
2116 and other local political subdivisions, for the purpose of  
2117 making special exception payments, including federal matching

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2118 funds, through the Medicaid inpatient reimbursement  
2119 methodologies. Funds received from state entities or local  
2120 governments for this purpose shall be separately accounted for  
2121 and may ~~shall~~ not be commingled with other state or local funds  
2122 in any manner. The agency may certify all local governmental  
2123 funds used as state match under Title XIX of the Social Security  
2124 Act, to the extent that the identified local health care  
2125 provider that is otherwise entitled to and is contracted to  
2126 receive such local funds is the benefactor under the state's  
2127 Medicaid program as determined under the General Appropriations  
2128 Act and pursuant to an agreement between the agency ~~for Health~~  
2129 ~~Care Administration~~ and the local governmental entity. The local  
2130 governmental entity shall use a certification form prescribed by  
2131 the agency. At a minimum, the certification form must ~~shall~~  
2132 identify the amount being certified and describe the  
2133 relationship between the certifying local governmental entity  
2134 and the local health care provider. The agency shall prepare an  
2135 annual statement of impact which documents the specific  
2136 activities undertaken during the previous fiscal year pursuant  
2137 to this paragraph, to be submitted to the Legislature annually  
2138 by no later than January 1, ~~annually.~~

2139 (b) Outpatient care.—

2140 1. Reimbursement for hospital outpatient care is limited to  
2141 \$1,500 per state fiscal year per recipient, except for:

2142 a.1. ~~Such~~ Care provided to a Medicaid recipient under age  
2143 21, in which case the only limitation is medical necessity.

2144 b.2. Renal dialysis services.

2145 c.3. Other exceptions made by the agency.

2146 2. The agency may ~~is authorized to~~ receive funds from state

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2147 entities, including, but not limited to, the Department of  
2148 Health, the Board of Governors of the State University System,  
2149 local governments, and other local political subdivisions, for  
2150 the purpose of making payments, including federal matching  
2151 funds, through the Medicaid outpatient reimbursement  
2152 methodologies. Funds received ~~from state entities and local~~  
2153 ~~governments~~ for this purpose shall be separately accounted for  
2154 and may ~~shall~~ not be commingled with other state or local funds  
2155 ~~in any manner.~~

2156 3. The agency may limit inflationary increases for  
2157 outpatient hospital services as directed by the General  
2158 Appropriations Act.

2159 (c) Disproportionate share.—Hospitals that provide services  
2160 to a disproportionate share of low-income Medicaid recipients,  
2161 ~~or~~ that participate in the regional perinatal intensive care  
2162 center program under chapter 383, or that participate in the  
2163 statutory teaching hospital disproportionate share program may  
2164 receive additional reimbursement. The total amount of payment  
2165 for disproportionate share hospitals shall be fixed by the  
2166 General Appropriations Act. The computation of these payments  
2167 must comply ~~be made in compliance~~ with all federal regulations  
2168 and the methodologies described in ss. 409.911, 409.9112, and  
2169 409.9113.

2170 ~~(d) The agency is authorized to limit inflationary~~  
2171 ~~increases for outpatient hospital services as directed by the~~  
2172 ~~General Appropriations Act.~~

2173 (2) NURSING HOME CARE.—

2174 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II  
2175 of chapter 400 and state-owned-and-operated intermediate care

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2176 facilities for the developmentally disabled licensed under part  
2177 VIII of chapter 400 must be made prospectively.

2178 (a)2. Unless otherwise limited or directed in the General  
2179 Appropriations Act, reimbursement to hospitals licensed under  
2180 part I of chapter 395 for ~~the provision of~~ swing-bed nursing  
2181 home services must based ~~be made on the basis of~~ the average  
2182 statewide nursing home payment, and reimbursement to a hospital  
2183 ~~licensed under part I of chapter 395 for the provision of~~  
2184 skilled nursing services must be based ~~made on the basis of~~ the  
2185 average nursing home payment for those services in the county in  
2186 which the hospital is located. If ~~When~~ a hospital is located in  
2187 a county that does not have any community nursing homes,  
2188 reimbursement shall be determined by averaging the nursing home  
2189 payments in counties that surround the county in which the  
2190 hospital is located. Reimbursement to hospitals, including  
2191 Medicaid payment of Medicare copayments, for skilled nursing  
2192 services is ~~shall be~~ limited to 30 days, unless a prior  
2193 authorization has been obtained from the agency. Medicaid  
2194 reimbursement may be extended by the agency beyond 30 days, and  
2195 approval must be based upon verification by the patient's  
2196 physician that the patient requires short-term rehabilitative  
2197 and recuperative services only, in which case an extension of no  
2198 more than 15 days may be approved. Reimbursement to a hospital  
2199 ~~licensed under part I of chapter 395 for the temporary provision~~  
2200 of skilled nursing services to nursing home residents who have  
2201 been displaced as the result of a natural disaster or other  
2202 emergency may not exceed the average county nursing home payment  
2203 for those services in the county in which the hospital is  
2204 located and is limited to the period of time which the agency

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2205 considers necessary for continued placement of the nursing home  
2206 residents in the hospital.

2207 (b) Subject to any limitations or directions provided ~~for~~  
2208 in the General Appropriations Act, the agency shall establish  
2209 and implement a Florida Title XIX Long-Term Care Reimbursement  
2210 Plan (Medicaid) for nursing home care in order to provide care  
2211 and services that conform to ~~in conformance with the~~ applicable  
2212 state and federal laws, rules, regulations, and quality and  
2213 safety standards and to ensure that individuals eligible for  
2214 medical assistance have reasonable geographic access to such  
2215 care.

2216 1. The agency shall amend the long-term care reimbursement  
2217 plan and cost reporting system to create direct care and  
2218 indirect care subcomponents of the patient care component of the  
2219 per diem rate. These two subcomponents together must ~~shall~~ equal  
2220 the patient care component of the per diem rate. Separate cost-  
2221 based ceilings shall be calculated for each patient care  
2222 subcomponent. The direct care subcomponent of the per diem rate  
2223 is ~~shall be~~ limited by the cost-based class ceiling, and the  
2224 indirect care subcomponent may be limited by the lower of the  
2225 cost-based class ceiling, the target rate class ceiling, or the  
2226 individual provider target.

2227 2. The direct care subcomponent includes ~~shall include~~  
2228 salaries and benefits of direct care staff providing nursing  
2229 services, including registered nurses, licensed practical  
2230 nurses, and certified nursing assistants who deliver care  
2231 directly to residents in the nursing home facility. This  
2232 excludes nursing administration, minimum data set, and care plan  
2233 coordinators, staff development, and the staffing coordinator.

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2234 The direct care subcomponent also includes medically necessary  
2235 dental care or podiatric care.

2236 3. All other patient care costs are ~~shall be~~ included in  
2237 the indirect care cost subcomponent of the patient care per diem  
2238 rate. ~~There shall be no~~ Costs may not be directly or indirectly  
2239 allocated to the direct care subcomponent from a home office or  
2240 management company.

2241 4. On July 1 of each year, the agency shall report to the  
2242 Legislature direct and indirect care costs, including average  
2243 direct and indirect care costs per resident per facility and  
2244 direct care and indirect care salaries and benefits per category  
2245 of staff member per facility.

2246 5. In order to offset the cost of general and professional  
2247 liability insurance, the agency shall amend the plan to allow  
2248 for interim rate adjustments to reflect increases in the cost of  
2249 general or professional liability insurance for nursing homes.  
2250 This provision shall be implemented to the extent existing  
2251 appropriations are available.

2252  
2253 It is the intent of the Legislature that the reimbursement plan  
2254 achieve the goal of providing access to health care for nursing  
2255 home residents who require large amounts of care while  
2256 encouraging diversion services as an alternative to nursing home  
2257 care for residents who can be served within the community. The  
2258 agency shall base the establishment of any maximum rate of  
2259 payment, whether overall or component, on the available moneys  
2260 ~~as provided for~~ in the General Appropriations Act. The agency  
2261 may base the maximum rate of payment on the results of  
2262 scientifically valid analysis and conclusions derived from

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2263 objective statistical data pertinent to the particular maximum  
2264 rate of payment.

2265 (c) The agency shall request and implement Medicaid waivers  
2266 approved by the federal Centers for Medicare and Medicaid  
2267 Services to advance and treat a portion of the Medicaid nursing  
2268 home per diem as capital for creating and operating a risk-  
2269 retention group for self-insurance purposes, consistent with  
2270 federal and state laws and rules.

2271 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any  
2272 limitations or directions provided ~~for~~ in the General  
2273 Appropriations Act, the following Medicaid services and goods  
2274 may be reimbursed on a fee-for-service basis. For each allowable  
2275 service or goods furnished in accordance with Medicaid rules,  
2276 policy manuals, handbooks, and state and federal law, the  
2277 payment shall be the amount billed by the provider, the  
2278 provider's usual and customary charge, or the maximum allowable  
2279 fee established by the agency, whichever amount is less, with  
2280 the exception of those services or goods for which the agency  
2281 makes payment using a methodology based on capitation rates,  
2282 average costs, or negotiated fees.

2283 (a) Advanced registered nurse practitioner services.

2284 (b) Birth center services.

2285 (c) Chiropractic services.

2286 (d) Community mental health services.

2287 (e) Dental services, including oral and maxillofacial  
2288 surgery.

2289 (f) Durable medical equipment.

2290 (g) Hearing services.

2291 (h) Occupational therapy for Medicaid recipients under age

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- 2292 21.
- 2293 (i) Optometric services.
- 2294 (j) Orthodontic services.
- 2295 (k) Personal care for Medicaid recipients under age 21.
- 2296 (l) Physical therapy for Medicaid recipients under age 21.
- 2297 (m) Physician assistant services.
- 2298 (n) Podiatric services.
- 2299 (o) Portable X-ray services.
- 2300 (p) Private-duty nursing for Medicaid recipients under age
- 2301 21.
- 2302 (q) Registered nurse first assistant services.
- 2303 (r) Respiratory therapy for Medicaid recipients under age
- 2304 21.
- 2305 (s) Speech therapy for Medicaid recipients under age 21.
- 2306 (t) Visual services.
- 2307 (4) MANAGED CARE SERVICES.—Subject to any limitations or
- 2308 directions provided ~~for~~ in the General Appropriations Act,
- 2309 alternative health plans, health maintenance organizations, and
- 2310 prepaid health plans shall be reimbursed a fixed, prepaid amount
- 2311 negotiated, or competitively bid pursuant to s. 287.057, by the
- 2312 agency and prospectively paid to the provider monthly for each
- 2313 Medicaid recipient enrolled. The amount may not exceed the
- 2314 average amount the agency determines it would have paid, based
- 2315 on claims experience, for recipients in the same or similar
- 2316 category of eligibility. The agency shall calculate capitation
- 2317 rates on a regional basis and, ~~beginning September 1, 1995,~~
- 2318 ~~shall~~ include age-band differentials in such calculations.
- 2319 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical
- 2320 center shall be reimbursed the lesser of the amount billed by



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2321 the provider or the Medicare-established allowable amount for  
2322 the facility.

2323 (6) EPSDT SERVICES.—A provider of early and periodic  
2324 screening, diagnosis, and treatment services to Medicaid  
2325 recipients who are ~~children~~ under age 21 shall be reimbursed  
2326 using an all-inclusive rate stipulated in a fee schedule  
2327 established by the agency. A provider of the visual, dental, and  
2328 hearing components of such services shall be reimbursed the  
2329 lesser of the amount billed by the provider or the Medicaid  
2330 maximum allowable fee established by the agency.

2331 (7) FAMILY PLANNING SERVICES.—A provider of family planning  
2332 services shall be reimbursed the lesser of the amount billed by  
2333 the provider or an all-inclusive amount per type of visit for  
2334 physicians and advanced registered nurse practitioners, as  
2335 established by the agency in a fee schedule.

2336 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-  
2337 based or community-based services rendered pursuant to a  
2338 federally approved waiver shall be reimbursed based on an  
2339 established or negotiated rate for each service. These rates  
2340 shall be established according to an analysis of the expenditure  
2341 history and prospective budget developed by each contract  
2342 provider participating in the waiver program, or under any other  
2343 methodology adopted by the agency and approved by the Federal  
2344 Government in accordance with the waiver. Privately owned and  
2345 operated community-based residential facilities that ~~which~~ meet  
2346 agency requirements and ~~which~~ formerly received Medicaid  
2347 reimbursement for the optional intermediate care facility for  
2348 the mentally retarded service may participate in the  
2349 developmental services waiver as part of a home-and-community-

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2350 based continuum of care for Medicaid recipients who receive  
2351 waiver services.

2352 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider  
2353 of home health care services or of medical supplies and  
2354 appliances shall be reimbursed on the basis of competitive  
2355 bidding or for the lesser of the amount billed by the provider  
2356 or the agency's established maximum allowable amount, except  
2357 that, ~~in the case of the rental of durable medical equipment,~~  
2358 the total rental payments for durable medical equipment may not  
2359 exceed the purchase price of the equipment over its expected  
2360 useful life or the agency's established maximum allowable  
2361 amount, whichever amount is less.

2362 (10) HOSPICE.—A hospice shall be reimbursed through a  
2363 prospective system for each Medicaid hospice patient at Medicaid  
2364 rates using the methodology established for hospice  
2365 reimbursement pursuant to Title XVIII of the federal Social  
2366 Security Act.

2367 (11) LABORATORY SERVICES.—A provider of independent  
2368 laboratory services shall be reimbursed on the basis of  
2369 competitive bidding or for the least of the amount billed by the  
2370 provider, the provider's usual and customary charge, or the  
2371 Medicaid maximum allowable fee established by the agency.

2372 (12) PHYSICIAN SERVICES.—

2373 (a) A physician shall be reimbursed the lesser of the  
2374 amount billed by the provider or the Medicaid maximum allowable  
2375 fee established by the agency.

2376 (b) The agency shall adopt a fee schedule, subject to any  
2377 limitations or directions provided ~~for~~ in the General  
2378 Appropriations Act, based on a resource-based relative value

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2379 scale for pricing Medicaid physician services. Under the ~~this~~  
2380 fee schedule, physicians shall be paid a dollar amount for each  
2381 service based on the average resources required to provide the  
2382 service, including, but not limited to, estimates of average  
2383 physician time and effort, practice expense, and the costs of  
2384 professional liability insurance. The fee schedule must ~~shall~~  
2385 provide increased reimbursement for preventive and primary care  
2386 services and lowered reimbursement for specialty services by  
2387 using at least two conversion factors, one for cognitive  
2388 services and another for procedural services. The fee schedule  
2389 may ~~shall~~ not increase total Medicaid physician expenditures  
2390 unless moneys are available. The agency ~~for Health Care~~  
2391 ~~Administration~~ shall seek the advice of a 16-member advisory  
2392 panel in formulating and adopting the fee schedule. The panel  
2393 shall consist of Medicaid physicians licensed under chapters 458  
2394 and 459 and ~~shall~~ be composed of 50 percent primary care  
2395 physicians and 50 percent specialty care physicians.

2396 (c) Notwithstanding paragraph (b), reimbursement fees to  
2397 physicians for providing total obstetrical services to Medicaid  
2398 recipients, which include prenatal, delivery, and postpartum  
2399 care, must ~~shall~~ be at least \$1,500 per delivery for a pregnant  
2400 woman with low medical risk and at least \$2,000 per delivery for  
2401 a pregnant woman with high medical risk. However, reimbursement  
2402 to physicians working in regional perinatal intensive care  
2403 centers designated pursuant to chapter 383, for services to  
2404 ~~certain~~ pregnant Medicaid recipients with a high medical risk,  
2405 may be made according to obstetrical care and neonatal care  
2406 groupings and rates established by the agency. Nurse midwives  
2407 licensed under part I of chapter 464 or midwives licensed under

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2408 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent  
2409 of the low medical risk fee. The agency shall by rule determine,  
2410 for the purpose of this paragraph, what constitutes a high or  
2411 low medical risk pregnant woman and may ~~shall~~ not pay more based  
2412 solely on the fact that a caesarean section was performed,  
2413 rather than a vaginal delivery. The agency shall by rule  
2414 determine a prorated payment for obstetrical services ~~in cases~~  
2415 where only part of the total prenatal, delivery, or postpartum  
2416 care was performed. The Department of Health shall adopt rules  
2417 for appropriate insurance coverage for midwives licensed under  
2418 chapter 467. Before issuing and renewing ~~Prior to the issuance~~  
2419 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~  
2420 ~~of~~ an inactive license for midwives licensed under chapter 467,  
2421 such licensees must ~~shall~~ submit proof of coverage with each  
2422 application.

2423 (d) Effective January 1, 2013, Medicaid fee-for-service  
2424 payments to primary care physicians for primary care services  
2425 must be at least 100 percent of the Medicare payment rate for  
2426 such services.

2427 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for  
2428 persons eligible for both Medicare and Medicaid coverage shall  
2429 be paid at the rates established by Title XVIII of the Social  
2430 Security Act. For Medicare services rendered to Medicaid-  
2431 eligible persons, Medicaid shall pay Medicare deductibles and  
2432 coinsurance as follows:

2433 (a) Medicaid's financial obligation for deductibles and  
2434 coinsurance payments shall be based on Medicare allowable fees,  
2435 not on a provider's billed charges.

2436 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare

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2437 deductibles and coinsurance if ~~when~~ payment that Medicare has  
2438 made for the service equals or exceeds what Medicaid would have  
2439 paid if it had been the sole payor. The combined payment of  
2440 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid  
2441 would have paid had it been the sole payor. The Legislature  
2442 finds that there has been confusion regarding the reimbursement  
2443 for services rendered to dually eligible Medicare beneficiaries.  
2444 Accordingly, the Legislature clarifies that it has always been  
2445 the intent of the Legislature before and after 1991 that, in  
2446 reimbursing in accordance with fees established by Title XVIII  
2447 for premiums, deductibles, and coinsurance for Medicare services  
2448 rendered by physicians to Medicaid eligible persons, physicians  
2449 be reimbursed at the lesser of the amount billed by the  
2450 physician or the Medicaid maximum allowable fee established by  
2451 the agency ~~for Health Care Administration~~, as is permitted by  
2452 federal law. It has never been the intent of the Legislature  
2453 ~~with regard to such services rendered by physicians that~~  
2454 Medicaid be required to provide any payment for deductibles,  
2455 coinsurance, or copayments for Medicare cost sharing, or any  
2456 expenses incurred relating thereto, in excess of the payment  
2457 amount provided for under the State Medicaid plan for physician  
2458 services ~~such service~~. This payment methodology is applicable  
2459 even in those situations in which the payment for Medicare cost  
2460 sharing for a qualified Medicare beneficiary with respect to an  
2461 item or service is reduced or eliminated. This expression of the  
2462 Legislature clarifies ~~is in clarification of~~ existing law and  
2463 applies ~~shall apply~~ to payment for, and with respect to provider  
2464 agreements with respect to, items or services furnished on or  
2465 after July 1, 2000 ~~the effective date of this act~~. This

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2466 paragraph applies to payment by Medicaid for items and services  
2467 furnished before July 1, 2000, ~~the effective date of this act~~ if  
2468 such payment is the subject of a lawsuit that is based on ~~the~~  
2469 ~~provisions of~~ this section, and that is pending as of, or is  
2470 initiated after that date, ~~the effective date of this act~~.

2471 (c) Notwithstanding paragraphs (a) and (b):

2472 1. Medicaid payments for Nursing Home Medicare part A  
2473 coinsurance are limited to the Medicaid nursing home per diem  
2474 rate less any amounts paid by Medicare, but only up to the  
2475 amount of Medicare coinsurance. The Medicaid per diem rate is  
2476 ~~shall be~~ the rate in effect for the dates of service of the  
2477 crossover claims and may not be subsequently adjusted due to  
2478 subsequent per diem rate adjustments.

2479 2. Medicaid shall pay all deductibles and coinsurance for  
2480 Medicare-eligible recipients receiving freestanding end stage  
2481 renal dialysis center services.

2482 3. Medicaid payments for general and specialty hospital  
2483 inpatient services are limited to the Medicare deductible and  
2484 coinsurance per spell of illness. Medicaid payments for hospital  
2485 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid  
2486 hospital per diem rate less any amounts paid by Medicare, but  
2487 only up to the amount of Medicare coinsurance. Medicaid payments  
2488 for coinsurance are ~~shall be~~ limited to the Medicaid per diem  
2489 rate in effect for the dates of service of the crossover claims  
2490 and may not be subsequently adjusted due to subsequent per diem  
2491 adjustments.

2492 4. Medicaid shall pay all deductibles and coinsurance for  
2493 Medicare emergency transportation services provided by  
2494 ambulances licensed pursuant to chapter 401.

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2495 5. Medicaid shall pay all deductibles and coinsurance for  
2496 portable X-ray Medicare Part B services provided in a nursing  
2497 home.

2498 (14) PRESCRIBED DRUGS.-A provider of prescribed drugs shall  
2499 be reimbursed the least of the amount billed by the provider,  
2500 the provider's usual and customary charge, or the Medicaid  
2501 maximum allowable fee established by the agency, plus a  
2502 dispensing fee. The Medicaid maximum allowable fee for  
2503 ingredient cost must ~~will~~ be based on the lower of the ~~the~~ average  
2504 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition  
2505 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the  
2506 state maximum allowable cost (SMAC), or the usual and customary  
2507 (UAC) charge billed by the provider.

2508 (a) Medicaid providers must ~~are required to~~ dispense  
2509 generic drugs if available at lower cost and the agency has not  
2510 determined that the branded product is more cost-effective,  
2511 unless the prescriber has requested and received approval to  
2512 require the branded product.

2513 (b) The agency shall ~~is directed to~~ implement a variable  
2514 dispensing fee for ~~payments for~~ prescribed medicines while  
2515 ensuring continued access for Medicaid recipients. The variable  
2516 dispensing fee may be based upon, but not limited to, either or  
2517 both the volume of prescriptions dispensed by a specific  
2518 pharmacy provider, the volume of prescriptions dispensed to an  
2519 individual recipient, and dispensing of preferred-drug-list  
2520 products.

2521 (c) The agency may increase the pharmacy dispensing fee  
2522 authorized by statute and in the ~~annual~~ General Appropriations  
2523 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-

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2524 list product and reduce the pharmacy dispensing fee by \$0.50 for  
2525 the dispensing of a Medicaid product that is not included on the  
2526 preferred drug list.

2527 (d) The agency may establish a supplemental pharmaceutical  
2528 dispensing fee to be paid to providers returning unused unit-  
2529 dose packaged medications to stock and crediting the Medicaid  
2530 program for the ingredient cost of those medications if the  
2531 ingredient costs to be credited exceed the value of the  
2532 supplemental dispensing fee.

2533 (e) The agency may ~~is authorized to~~ limit reimbursement for  
2534 prescribed medicine in order to comply with any limitations or  
2535 directions provided ~~for~~ in the General Appropriations Act, which  
2536 may include implementing a prospective or concurrent utilization  
2537 review program.

2538 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary  
2539 care case management services rendered pursuant to a federally  
2540 approved waiver shall be reimbursed by payment of a fixed,  
2541 prepaid monthly sum for each Medicaid recipient enrolled with  
2542 the provider.

2543 (16) RURAL HEALTH CLINICS.—A provider of rural health  
2544 clinic services and federally qualified health center services  
2545 shall be reimbursed a rate per visit based on total reasonable  
2546 costs of the clinic, as determined by the agency in accordance  
2547 with federal regulations.

2548 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case  
2549 management services shall be reimbursed pursuant to an  
2550 established fee, except where the Federal Government requires a  
2551 public provider be reimbursed on the basis of average actual  
2552 costs.



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2553           (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the  
2554 General Appropriations Act, a provider of transportation  
2555 services shall be reimbursed the lesser of the amount billed by  
2556 the provider or the Medicaid maximum allowable fee established  
2557 by the agency, except if ~~when~~ the agency has entered into a  
2558 direct contract with the provider, or with a community  
2559 transportation coordinator, for the provision of an all-  
2560 inclusive service, or if ~~when~~ services are provided pursuant to  
2561 an agreement negotiated between the agency and the provider. ~~The~~  
2562 ~~agency, as provided for in s. 427.0135, shall purchase~~  
2563 ~~transportation services through the community coordinated~~  
2564 ~~transportation system, if available, unless the agency, after~~  
2565 ~~consultation with the commission, determines that it cannot~~  
2566 ~~reach mutually acceptable contract terms with the commission.~~  
2567 ~~The agency may then contract for the same transportation~~  
2568 ~~services provided in a more cost effective manner and of~~  
2569 ~~comparable or higher quality and standards. Nothing in~~

2570           (a) This subsection does not ~~shall be construed to~~ limit or  
2571 preclude the agency from contracting for services using a  
2572 prepaid capitation rate or from establishing maximum fee  
2573 schedules, individualized reimbursement policies by provider  
2574 type, negotiated fees, prior authorization, competitive bidding,  
2575 increased use of mass transit, or any other mechanism that the  
2576 agency considers efficient and effective for the purchase of  
2577 services on behalf of Medicaid clients, including implementing a  
2578 transportation eligibility process.

2579           (b) The agency may ~~shall~~ not ~~be required to~~ contract with  
2580 any community transportation coordinator or transportation  
2581 operator that has been determined by the agency, the Department

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2582 of Legal Affairs Medicaid Fraud Control Unit, or any other state  
2583 or federal agency to have engaged in any abusive or fraudulent  
2584 billing activities.

2585 (c) The agency shall ~~is authorized to~~ competitively procure  
2586 transportation services or make other changes necessary to  
2587 secure approval of federal waivers needed to permit federal  
2588 financing of Medicaid transportation services at the service  
2589 matching rate rather than the administrative matching rate.  
2590 ~~Notwithstanding chapter 427, the agency is authorized to~~  
2591 ~~continue contracting for Medicaid nonemergency transportation~~  
2592 ~~services in agency service area 11 with managed care plans that~~  
2593 ~~were under contract for those services before July 1, 2004.~~

2594 (d) Transportation to access covered services provided by a  
2595 qualified plan pursuant to part IV of this chapter shall be  
2596 contracted for by the plan. A qualified plan is not required to  
2597 purchase such services through a coordinated transportation  
2598 system established pursuant to part I of chapter 427.

2599 (19) COUNTY HEALTH DEPARTMENTS.—County health department  
2600 services shall be reimbursed a rate per visit based on total  
2601 reasonable costs of the clinic, as determined by the agency in  
2602 accordance with federal regulations under the authority of 42  
2603 C.F.R. s. 431.615.

2604 (20) DIALYSIS.—A renal dialysis facility that provides  
2605 dialysis services under s. 409.906(9) must be reimbursed the  
2606 lesser of the amount billed by the provider, the provider's  
2607 usual and customary charge, or the maximum allowable fee  
2608 established by the agency, whichever ~~amount~~ is less.

2609 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse  
2610 school districts that ~~which~~ certify the state match pursuant to

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2611 ss. 409.9071 and 1011.70 for the federal portion of the school  
2612 district's allowable costs to deliver the services, based on the  
2613 reimbursement schedule. The school district shall determine the  
2614 costs for delivering services as authorized in ss. 409.9071 and  
2615 1011.70 for which the state match will be certified.

2616 Reimbursement of school-based providers is contingent on such  
2617 providers being enrolled as Medicaid providers and meeting the  
2618 qualifications contained in 42 C.F.R. s. 440.110, unless  
2619 otherwise waived by the federal Centers for Medicare and  
2620 Medicaid Services Health Care Financing Administration. Speech  
2621 therapy providers who are certified through the Department of  
2622 Education pursuant to rule 6A-4.0176, Florida Administrative  
2623 Code, are eligible for reimbursement for services that are  
2624 provided on school premises. Any employee of the school district  
2625 who has been fingerprinted and has received a criminal  
2626 background check in accordance with Department of Education  
2627 rules and guidelines is ~~shall be~~ exempt from any agency  
2628 requirements relating to criminal background checks.

2629 ~~(22) The agency shall request and implement Medicaid~~  
2630 ~~waivers from the federal Health Care Financing Administration to~~  
2631 ~~advance and treat a portion of the Medicaid nursing home per~~  
2632 ~~diem as capital for creating and operating a risk retention~~  
2633 ~~group for self insurance purposes, consistent with federal and~~  
2634 ~~state laws and rules.~~

2635 (22)(23)(a) LIMITATION ON REIMBURSEMENT RATES.—The agency  
2636 shall establish rates at a level that ensures no increase in  
2637 statewide expenditures resulting from a change in unit costs for  
2638 2 fiscal years effective July 1, 2009. Reimbursement rates for  
2639 the 2 fiscal years shall be as provided in the General

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2640 Appropriations Act.

2641 (a)~~(b)~~ This subsection applies to the following provider  
2642 types:

- 2643 1. Inpatient hospitals.
- 2644 2. Outpatient hospitals.
- 2645 3. Nursing homes.
- 2646 4. County health departments.
- 2647 5. Community intermediate care facilities for the  
2648 developmentally disabled.
- 2649 6. Prepaid health plans.

2650 (b) The agency shall apply ~~the effect of~~ this subsection to  
2651 the reimbursement rates for nursing home diversion programs.

2652 ~~(c) The agency shall create a workgroup on hospital  
2653 reimbursement, a workgroup on nursing facility reimbursement,  
2654 and a workgroup on managed care plan payment. The workgroups  
2655 shall evaluate alternative reimbursement and payment  
2656 methodologies for hospitals, nursing facilities, and managed  
2657 care plans, including prospective payment methodologies for  
2658 hospitals and nursing facilities. The nursing facility workgroup  
2659 shall also consider price-based methodologies for indirect care  
2660 and acuity adjustments for direct care. The agency shall submit  
2661 a report on the evaluated alternative reimbursement  
2662 methodologies to the relevant committees of the Senate and the  
2663 House of Representatives by November 1, 2009.~~

2664 (c)~~(d)~~ This subsection expires June 30, 2011.

2665 (23) PAYMENT METHODOLOGIES.-If a provider is reimbursed  
2666 based on cost reporting and submits a cost report late and that  
2667 cost report would have been used to set a lower reimbursement  
2668 rate for a rate semester, the provider's rate for that semester

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2669 shall be retroactively calculated using the new cost report, and  
2670 full payment at the recalculated rate shall be applied  
2671 retroactively. Medicare-granted extensions for filing cost  
2672 reports, if applicable, also apply to Medicaid cost reports.

2673 (24) RETURN OF PAYMENTS.—If a provider fails to notify the  
2674 agency within 5 business days after suspension or disenrollment  
2675 from Medicare, sanctions may be imposed pursuant to this  
2676 chapter, and the provider may be required to return funds paid  
2677 to the provider during the period of time that the provider was  
2678 suspended or disenrolled ~~as a Medicare provider.~~

2679 Section 29. Subsection (1) of section 409.9081, Florida  
2680 Statutes, is amended to read:

2681 409.9081 Copayments.—

2682 (1) ~~The agency shall require,~~ Subject to federal  
2683 regulations and limitations, each Medicaid recipient must ~~to~~ pay  
2684 at the time of service a nominal copayment for the following  
2685 Medicaid services:

2686 (a) Hospital outpatient services: up to \$3 for each  
2687 hospital outpatient visit.

2688 (b) Physician services: up to \$2 copayment for each visit  
2689 with a primary care physician and up to \$3 copayment for each  
2690 visit with a specialty care physician licensed under chapter  
2691 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463.~~

2692 (c) Hospital emergency department visits for nonemergency  
2693 care: 5 percent of up to the first \$300 of the Medicaid payment  
2694 for emergency room services, not to exceed \$15. The agency shall  
2695 seek a federal waiver of the requirement that cost-sharing  
2696 amounts for nonemergency services and care furnished in a  
2697 hospital emergency department be nominal. Upon waiver approval,

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2698 a Medicaid recipient who requests such services and care, must  
2699 pay a \$100 copayment to the hospital for the nonemergency  
2700 services and care provided in the hospital emergency department.

2701 (d) Prescription drugs: a coinsurance equal to 2.5 percent  
2702 of the Medicaid cost of the prescription drug at the time of  
2703 purchase. The maximum coinsurance is ~~shall be~~ \$7.50 per  
2704 prescription drug purchased.

2705 Section 30. Paragraph (b) and (d) of subsection (4) and  
2706 subsections (8), (34), (44), (47), and (53) of section 409.912,  
2707 Florida Statutes, are amended, and subsections (48) through (52)  
2708 of that section are renumbered as subsections (47) through (51)  
2709 respectively, to read:

2710 409.912 Cost-effective purchasing of health care.—The  
2711 agency shall purchase goods and services for Medicaid recipients  
2712 in the most cost-effective manner consistent with the delivery  
2713 of quality medical care. To ensure that medical services are  
2714 effectively utilized, the agency may, in any case, require a  
2715 confirmation or second physician's opinion of the correct  
2716 diagnosis for purposes of authorizing future services under the  
2717 Medicaid program. This section does not restrict access to  
2718 emergency services or poststabilization care services as defined  
2719 in 42 C.F.R. part 438.114. Such confirmation or second opinion  
2720 shall be rendered in a manner approved by the agency. The agency  
2721 shall maximize the use of prepaid per capita and prepaid  
2722 aggregate fixed-sum basis services when appropriate and other  
2723 alternative service delivery and reimbursement methodologies,  
2724 including competitive bidding pursuant to s. 287.057, designed  
2725 to facilitate the cost-effective purchase of a case-managed  
2726 continuum of care. The agency shall also require providers to

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2727 minimize the exposure of recipients to the need for acute  
2728 inpatient, custodial, and other institutional care and the  
2729 inappropriate or unnecessary use of high-cost services. The  
2730 agency shall contract with a vendor to monitor and evaluate the  
2731 clinical practice patterns of providers in order to identify  
2732 trends that are outside the normal practice patterns of a  
2733 provider's professional peers or the national guidelines of a  
2734 provider's professional association. The vendor must be able to  
2735 provide information and counseling to a provider whose practice  
2736 patterns are outside the norms, in consultation with the agency,  
2737 to improve patient care and reduce inappropriate utilization.  
2738 The agency may mandate prior authorization, drug therapy  
2739 management, or disease management participation for certain  
2740 populations of Medicaid beneficiaries, certain drug classes, or  
2741 particular drugs to prevent fraud, abuse, overuse, and possible  
2742 dangerous drug interactions. The Pharmaceutical and Therapeutics  
2743 Committee shall make recommendations to the agency on drugs for  
2744 which prior authorization is required. The agency shall inform  
2745 the Pharmaceutical and Therapeutics Committee of its decisions  
2746 regarding drugs subject to prior authorization. The agency is  
2747 authorized to limit the entities it contracts with or enrolls as  
2748 Medicaid providers by developing a provider network through  
2749 provider credentialing. The agency may competitively bid single-  
2750 source-provider contracts if procurement of goods or services  
2751 results in demonstrated cost savings to the state without  
2752 limiting access to care. The agency may limit its network based  
2753 on the assessment of beneficiary access to care, provider  
2754 availability, provider quality standards, time and distance  
2755 standards for access to care, the cultural competence of the

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2756 provider network, demographic characteristics of Medicaid  
2757 beneficiaries, practice and provider-to-beneficiary standards,  
2758 appointment wait times, beneficiary use of services, provider  
2759 turnover, provider profiling, provider licensure history,  
2760 previous program integrity investigations and findings, peer  
2761 review, provider Medicaid policy and billing compliance records,  
2762 clinical and medical record audits, and other factors. Providers  
2763 shall not be entitled to enrollment in the Medicaid provider  
2764 network. The agency shall determine instances in which allowing  
2765 Medicaid beneficiaries to purchase durable medical equipment and  
2766 other goods is less expensive to the Medicaid program than long-  
2767 term rental of the equipment or goods. The agency may establish  
2768 rules to facilitate purchases in lieu of long-term rentals in  
2769 order to protect against fraud and abuse in the Medicaid program  
2770 as defined in s. 409.913. The agency may seek federal waivers  
2771 necessary to administer these policies.

2772 (4) The agency may contract with:

2773 (b) An entity that is providing comprehensive behavioral  
2774 health care services to ~~certain~~ Medicaid recipients through a  
2775 capitated, prepaid arrangement pursuant to the federal waiver  
2776 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.  
2777 Such entity must be licensed under chapter 624, chapter 636, or  
2778 chapter 641, or authorized under paragraph (c) or paragraph (d),  
2779 and must possess the clinical systems and operational competence  
2780 to manage risk and provide comprehensive behavioral health care  
2781 to Medicaid recipients. As used in this paragraph, the term  
2782 "comprehensive behavioral health care services" means covered  
2783 mental health and substance abuse treatment services that are  
2784 available to Medicaid recipients. The Secretary ~~of the~~



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2785 Department of Children and Family Services must ~~shall~~ approve  
2786 ~~provisions of~~ procurements related to children in the  
2787 department's care or custody before enrolling such children in a  
2788 prepaid behavioral health plan. Any contract awarded under this  
2789 paragraph must be competitively procured. ~~In developing~~ The  
2790 behavioral health care prepaid plan procurement document must  
2791 require, ~~the agency shall ensure that the procurement document~~  
2792 ~~requires~~ the contractor to develop and implement a plan to  
2793 ensure compliance with s. 394.4574 related to services provided  
2794 to residents of licensed assisted living facilities that hold a  
2795 limited mental health license. Except as provided in  
2796 subparagraph 5. 8., and except in counties where the Medicaid  
2797 managed care pilot program is authorized pursuant to s. 409.986  
2798 ~~409.91211~~, the agency shall seek federal approval to contract  
2799 with a single entity ~~meeting these requirements~~ to provide  
2800 comprehensive behavioral health care services to all Medicaid  
2801 recipients not enrolled in a Medicaid managed care plan  
2802 authorized under s. 409.986 ~~409.91211~~, a provider service  
2803 network authorized under paragraph (d), or a Medicaid health  
2804 maintenance organization in an AHCA area. In an AHCA area where  
2805 the Medicaid managed care pilot program is authorized pursuant  
2806 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may  
2807 procure a contract with a single entity to serve the remaining  
2808 counties as an AHCA area or the remaining counties may be  
2809 included with an adjacent AHCA area and are subject to this  
2810 paragraph. Each entity must offer a ~~sufficient~~ choice of  
2811 providers in its network to ensure recipient access to care and  
2812 the opportunity to select a provider with whom they are  
2813 satisfied. The network shall include all public mental health

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2814 hospitals. To ensure unimpaired access to behavioral health care  
2815 services by Medicaid recipients, all contracts issued pursuant  
2816 to this paragraph must require that 90 ~~80~~ percent of the  
2817 capitation paid to the managed care plan, including health  
2818 maintenance organizations and capitated provider service  
2819 networks, ~~to~~ be expended for the provision of behavioral health  
2820 care services. If the managed care plan expends less than 90 ~~80~~  
2821 percent ~~of the capitation paid~~ for the provision of behavioral  
2822 health care services, the difference shall be returned to the  
2823 agency. The agency shall provide the plan with a certification  
2824 letter indicating the amount of capitation paid during each  
2825 calendar year for behavioral health care services pursuant to  
2826 this section. The agency may reimburse ~~for~~ substance abuse  
2827 treatment services on a fee-for-service basis until the agency  
2828 finds that adequate funds are available for capitated, prepaid  
2829 arrangements.

2830 1. ~~By January 1, 2001,~~ The agency shall modify the  
2831 contracts with the entities providing comprehensive inpatient  
2832 and outpatient mental health care services to Medicaid  
2833 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk  
2834 Counties, to include substance abuse treatment services.

2835 2. ~~By July 1, 2003, the agency and the Department of~~  
2836 ~~Children and Family Services shall execute a written agreement~~  
2837 ~~that requires collaboration and joint development of all policy,~~  
2838 ~~budgets, procurement documents, contracts, and monitoring plans~~  
2839 ~~that have an impact on the state and Medicaid community mental~~  
2840 ~~health and targeted case management programs.~~

2841 2.3. Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~  
2842 ~~2006,~~ the agency and the Department of Children and Family

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2843 Services shall contract with managed care entities in each AHCA  
2844 area ~~except area 6~~ or arrange to provide comprehensive inpatient  
2845 and outpatient mental health and substance abuse services  
2846 through capitated prepaid arrangements to all Medicaid  
2847 recipients who are eligible to participate in such plans under  
2848 federal law and regulation. In AHCA areas where there are fewer  
2849 than 150,000 eligible individuals ~~number less than 150,000~~, the  
2850 agency shall contract with a single managed care plan to provide  
2851 comprehensive behavioral health services to all recipients who  
2852 are not enrolled in a Medicaid health maintenance organization,  
2853 a provider service network authorized under paragraph (d), or a  
2854 Medicaid capitated managed care plan authorized under s. 409.986  
2855 ~~409.91211~~. The agency may contract with more than one  
2856 comprehensive behavioral health provider to provide care to  
2857 recipients who are not enrolled in a Medicaid capitated managed  
2858 care plan authorized under s. 409.986 ~~409.91211~~, a provider  
2859 service network authorized under paragraph (d), or a Medicaid  
2860 health maintenance organization in AHCA areas where the eligible  
2861 population exceeds 150,000. In an AHCA area where the Medicaid  
2862 managed care pilot program is authorized pursuant to s. 409.986  
2863 ~~409.91211~~ in one or more counties, the agency may procure a  
2864 contract with a single entity to serve the remaining counties as  
2865 an AHCA area or the remaining counties may be included with an  
2866 adjacent AHCA area and shall be subject to this paragraph.  
2867 Contracts for comprehensive behavioral health providers awarded  
2868 pursuant to this section must ~~shall~~ be competitively procured.  
2869 Both for-profit and not-for-profit corporations are eligible to  
2870 compete. Managed care plans contracting with the agency under  
2871 subsection (3) or paragraph (d), shall provide and receive

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2872 payment for the same comprehensive behavioral health benefits as  
2873 provided in AHCA rules, including handbooks incorporated by  
2874 reference. In AHCA area 11, the agency shall contract with at  
2875 least two comprehensive behavioral health care providers to  
2876 provide behavioral health care to recipients ~~in that area~~ who  
2877 are enrolled in, or assigned to, the MediPass program. One of  
2878 the ~~behavioral health care~~ contracts must be with the existing  
2879 provider service network pilot project, as described in  
2880 paragraph (d), for the purpose of demonstrating the cost-  
2881 effectiveness of the provision of quality mental health services  
2882 through a public hospital-operated managed care model. Payment  
2883 shall be at an agreed-upon capitated rate to ensure cost  
2884 savings. Of the recipients in area 11 who are assigned to  
2885 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those  
2886 MediPass-enrolled recipients shall be assigned to the existing  
2887 provider service network in area 11 for their behavioral care.

2888 ~~4. By October 1, 2003, the agency and the department shall~~  
2889 ~~submit a plan to the Governor, the President of the Senate, and~~  
2890 ~~the Speaker of the House of Representatives which provides for~~  
2891 ~~the full implementation of capitated prepaid behavioral health~~  
2892 ~~care in all areas of the state.~~

2893 ~~a. Implementation shall begin in 2003 in those AHCA areas~~  
2894 ~~of the state where the agency is able to establish sufficient~~  
2895 ~~capitation rates.~~

2896 ~~b. If the agency determines that the proposed capitation~~  
2897 ~~rate in any area is insufficient to provide appropriate~~  
2898 ~~services, the agency may adjust the capitation rate to ensure~~  
2899 ~~that care will be available. The agency and the department may~~  
2900 ~~use existing general revenue to address any additional required~~

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2901 ~~match but may not over obligate existing funds on an annualized~~  
2902 ~~basis.~~

2903 ~~e. Subject to any limitations provided in the General~~  
2904 ~~Appropriations Act, the agency, in compliance with appropriate~~  
2905 ~~federal authorization, shall develop policies and procedures~~  
2906 ~~that allow for certification of local and state funds.~~

2907 3.5. Children residing in a statewide inpatient psychiatric  
2908 program, or in a Department of Juvenile Justice or a Department  
2909 of Children and Family Services residential program approved as  
2910 a Medicaid behavioral health overlay services provider may not  
2911 be included in a behavioral health care prepaid health plan or  
2912 any other Medicaid managed care plan pursuant to this paragraph.

2913 ~~6. In converting to a prepaid system of delivery, the~~  
2914 ~~agency shall in its procurement document require an entity~~  
2915 ~~providing only comprehensive behavioral health care services to~~  
2916 ~~prevent the displacement of indigent care patients by enrollees~~  
2917 ~~in the Medicaid prepaid health plan providing behavioral health~~  
2918 ~~care services from facilities receiving state funding to provide~~  
2919 ~~indigent behavioral health care, to facilities licensed under~~  
2920 ~~chapter 395 which do not receive state funding for indigent~~  
2921 ~~behavioral health care, or reimburse the unsubsidized facility~~  
2922 ~~for the cost of behavioral health care provided to the displaced~~  
2923 ~~indigent care patient.~~

2924 4.7. Traditional community mental health providers under  
2925 contract with the Department of Children and Family Services  
2926 pursuant to part IV of chapter 394, ~~child welfare providers~~  
2927 ~~under contract with the Department of Children and Family~~  
2928 ~~Services in areas 1 and 6,~~ and inpatient mental health providers  
2929 licensed pursuant to chapter 395 must be offered an opportunity

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2930 to accept or decline a contract to participate in any provider  
2931 network for prepaid behavioral health services.

2932 ~~5.8.~~ All Medicaid-eligible children, except children in  
2933 area 1 and children in ~~Highlands County, Hardee County, Polk~~  
2934 ~~County, or Manatee County~~ in ~~of~~ area 6, whose cases ~~that~~ are  
2935 open for child welfare services in the statewide automated child  
2936 welfare information HomeSafeNet system, shall receive their  
2937 behavioral health care services through a specialty prepaid plan  
2938 operated by community-based lead agencies through a single  
2939 agency or formal agreements among several agencies. The  
2940 specialty prepaid plan must result in savings to the state  
2941 comparable to savings achieved in other Medicaid managed care  
2942 and prepaid programs. Such plan must provide mechanisms to  
2943 maximize state and local revenues. The specialty prepaid plan  
2944 shall be developed by the agency and the Department of Children  
2945 and Family Services. The agency may seek federal waivers to  
2946 implement this initiative. Medicaid-eligible children whose  
2947 cases are open for child welfare services in the statewide  
2948 automated child welfare information HomeSafeNet system and who  
2949 reside in AHCA area 10 shall be enrolled in capitated managed  
2950 care plans that, in coordination with available community-based  
2951 care providers specified in s. 409.1671, provide sufficient  
2952 medical, developmental, behavioral, and emotional services to  
2953 meet the needs of these children, subject to funding as provided  
2954 in the General Appropriations Act ~~are exempt from the specialty~~  
2955 ~~prepaid plan upon the development of a service delivery~~  
2956 ~~mechanism for children who reside in area 10 as specified in s.~~  
2957 ~~409.91211(3)(dd).~~

2958 (d) A provider service network, which may be reimbursed on

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2959 a fee-for-service or prepaid basis.

2960 1. A provider service network that ~~which~~ is reimbursed by  
2961 the agency on a prepaid basis is ~~shall be~~ exempt from parts I  
2962 and III of chapter 641, but must comply with the solvency  
2963 requirements in s. 641.2261(2) and meet appropriate financial  
2964 reserve, quality assurance, and patient rights requirements ~~as~~  
2965 established by the agency.

2966 2. ~~Medicaid recipients assigned to a provider service~~  
2967 ~~network shall be chosen equally from those who would otherwise~~  
2968 ~~have been assigned to prepaid plans and MediPass. The agency may~~  
2969 ~~is authorized to seek federal Medicaid waivers as necessary to~~  
2970 ~~implement the provisions of this section. Any contract~~  
2971 ~~previously awarded to a provider service network operated by a~~  
2972 ~~hospital pursuant to this subsection shall remain in effect for~~  
2973 ~~a period of 3 years following the current contract expiration~~  
2974 ~~date, regardless of any contractual provisions to the contrary.~~

2975 3. A provider service network is a network established or  
2976 organized and operated by a health care provider, or group of  
2977 affiliated health care providers, including minority physician  
2978 networks and emergency room diversion programs that meet the  
2979 requirements of s. 409.986 ~~409.91211~~, which provides a  
2980 substantial proportion of the health care items and services  
2981 under a contract directly through the provider or affiliated  
2982 group of providers and may make arrangements with physicians or  
2983 other health care professionals, health care institutions, or  
2984 any combination of such individuals or institutions to assume  
2985 all or part of the financial risk on a prospective basis for the  
2986 provision of basic health services by the physicians, by other  
2987 health professionals, or through the institutions. The health

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2988 care providers must have a controlling interest in the governing  
2989 body of the provider service network organization.

2990 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum  
2991 basis with an exclusive provider organization to provide health  
2992 care services to Medicaid recipients if provided that the  
2993 exclusive provider organization meets applicable managed care  
2994 plan requirements in this section, ss. 409.987, 409.988  
2995 ~~409.9122, 409.9123,~~ 409.9128, and 627.6472, and other applicable  
2996 provisions of law.

2997 ~~(b) For a period of no longer than 24 months after the~~  
2998 ~~effective date of this paragraph, when a member of an exclusive~~  
2999 ~~provider organization that is contracted by the agency to~~  
3000 ~~provide health care services to Medicaid recipients in rural~~  
3001 ~~areas without a health maintenance organization obtains services~~  
3002 ~~from a provider that participates in the Medicaid program in~~  
3003 ~~this state, the provider shall be paid in accordance with the~~  
3004 ~~appropriate fee schedule for services provided to eligible~~  
3005 ~~Medicaid recipients. The agency may seek waiver authority to~~  
3006 ~~implement this paragraph.~~

3007 (34) The agency and entities that contract with the agency  
3008 to provide health care services to Medicaid recipients under  
3009 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~  
3010 must comply with the provisions of s. 641.513 in providing  
3011 emergency services and care to Medicaid recipients and MediPass  
3012 recipients. Where feasible, safe, and cost-effective, the agency  
3013 shall encourage hospitals, emergency medical services providers,  
3014 and other public and private health care providers to work  
3015 together in their local communities to enter into agreements or  
3016 arrangements to ensure access to alternatives to emergency



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3017 services and care for those Medicaid recipients who need  
3018 nonemergent care. The agency shall coordinate with hospitals,  
3019 emergency medical services providers, private health plans,  
3020 capitated managed care networks as established in s. 409.986  
3021 ~~409.91211~~, and other public and private health care providers to  
3022 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),  
3023 627.6405, and 641.31097 to develop and implement emergency  
3024 department diversion programs for Medicaid recipients.

3025 (44) The agency ~~for Health Care Administration~~ shall ensure  
3026 that any Medicaid managed care plan as defined in s.  
3027 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis  
3028 or a shared savings basis, is cost-effective. For purposes of  
3029 this subsection, the term "cost-effective" means that a  
3030 network's per-member, per-month costs to the state, including,  
3031 but not limited to, fee-for-service costs, administrative costs,  
3032 and case-management fees, if any, must be no greater than the  
3033 state's costs associated with contracts for Medicaid services  
3034 established under subsection (3), which may be adjusted for  
3035 health status. The agency shall conduct actuarially sound  
3036 adjustments for health status in order to ensure such cost-  
3037 effectiveness and shall annually publish the results on its  
3038 Internet website. Contracts established pursuant to this  
3039 subsection which are not cost-effective may not be renewed.

3040 ~~(47) The agency shall conduct a study of available~~  
3041 ~~electronic systems for the purpose of verifying the identity and~~  
3042 ~~eligibility of a Medicaid recipient. The agency shall recommend~~  
3043 ~~to the Legislature a plan to implement an electronic~~  
3044 ~~verification system for Medicaid recipients by January 31, 2005.~~

3045 ~~(53) Before seeking an amendment to the state plan for~~

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3046 ~~purposes of implementing programs authorized by the Deficit~~  
3047 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~

3048 Section 31. Paragraph (a) of subsection (1) of section  
3049 409.915, Florida Statutes, is amended to read:

3050 409.915 County contributions to Medicaid.—Although the  
3051 state is responsible for the full portion of the state share of  
3052 the matching funds required for the Medicaid program, in order  
3053 to acquire a certain portion of these funds, the state shall  
3054 charge the counties for certain items of care and service as  
3055 provided in this section.

3056 (1) Each county shall participate in the following items of  
3057 care and service:

3058 (a) For both health maintenance members and fee-for-service  
3059 beneficiaries, payments for inpatient hospitalization in excess  
3060 of 10 days, but not in excess of 45 days, with the exception of  
3061 pregnant women and children whose income is greater than ~~in~~  
3062 ~~excess of~~ the federal poverty level and who do not receive a  
3063 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~  
3064 ~~medically needy Program~~, and for adult lung transplant services.

3065 Section 32. Section 409.9301, Florida Statutes, is  
3066 transferred, renumbered as section 409.9067, Florida Statutes,  
3067 and subsections (1) and (2) of that section are amended, to  
3068 read:

3069 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—

3070 (1) PROGRAM ESTABLISHED.—A program is established in the  
3071 agency ~~for Health Care Administration~~ to provide pharmaceutical  
3072 expense assistance to individuals diagnosed with cancer or  
3073 individuals who have obtained ~~received~~ organ transplants who  
3074 received a Medicaid nonpoverty medical subsidy before ~~were~~

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3075 ~~medically needy recipients prior to~~ January 1, 2006.

3076 (2) ELIGIBILITY.—Eligibility for the program is limited to  
3077 an individual who:

3078 (a) Is a resident of this state;

3079 (b) Was a Medicaid recipient who received a nonpoverty  
3080 medical subsidy before ~~under the Florida Medicaid medically~~  
3081 ~~needy program prior to~~ January 1, 2006;

3082 (c) Is eligible for Medicare;

3083 (d) Is a cancer patient or an organ transplant recipient;

3084 and

3085 (e) Requests to be enrolled in the program.

3086 Section 33. Subsection (1) of section 409.9126, Florida  
3087 Statutes, is amended to read:

3088 409.9126 Children with special health care needs.—

3089 (1) Except as provided in subsection (4), children eligible  
3090 for Children's Medical Services who receive Medicaid benefits,  
3091 and other Medicaid-eligible children with special health care  
3092 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987  
3093 ~~409.9122~~ and shall be served through the Children's Medical  
3094 Services network established in chapter 391.

3095 Section 34. The Division of Statutory Revision is requested  
3096 to create part IV of chapter 409, Florida Statutes, consisting  
3097 of sections 409.961-409.978, Florida Statutes, entitled  
3098 "MEDICAID MANAGED CARE."

3099 Section 35. Section 409.961, Florida Statutes, is created  
3100 to read:

3101 409.961 Construction; applicability.—It is the intent of  
3102 the Legislature that if any conflict exists between ss. 409.961-  
3103 409.978 and other parts or sections of this chapter, the

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3104 provisions in ss. 409.961-409.978 control. Sections 409.961-  
3105 409.978 apply only to the Medicaid managed care program, as  
3106 provided in this part.

3107 Section 36. Section 409.962, Florida Statutes, is created  
3108 to read:

3109 409.962 Definitions.—As used in this part, and including  
3110 the terms defined in s. 409.901, the term:

3111 (1) "Direct care management" means care management  
3112 activities that involve direct interaction between providers and  
3113 patients.

3114 (2) "Medicaid managed care program" means the integrated,  
3115 statewide Medicaid program created in this part, which includes  
3116 the provision of managed care medical assistance services  
3117 described in ss. 409.971 and 409.972 and managed long-term care  
3118 services described in ss. 409.973-409.978.

3119 (3) "Provider service network" means an entity of which a  
3120 controlling interest is owned by a health care provider, a group  
3121 of affiliated providers, or a public agency or entity that  
3122 delivers health services. Health care providers include Florida-  
3123 licensed health care professionals or licensed health care  
3124 facilities, federally qualified health care centers, and home  
3125 health care agencies.

3126 (4) "Qualified plan" means a managed care plan that is  
3127 determined eligible to participate in the Medicaid managed care  
3128 program pursuant to s. 409.965.

3129 (5) "Specialty plan" means a qualified plan that serves  
3130 Medicaid recipients who meet specified criteria based on age,  
3131 medical condition, or diagnosis.

3132 Section 37. Section 409.963, Florida Statutes, is created

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3133 to read:

3134 409.963 Medicaid managed care program.-The Medicaid managed  
3135 care program is established as a statewide, integrated managed  
3136 care program for all covered medical assistance services and  
3137 long-term care services as provided under this part. Pursuant to  
3138 s. 409.902, the program shall be administered by the agency, and  
3139 eligibility for the program shall be determined by the  
3140 Department of Children and Family Services.

3141 (1) The agency shall submit amendments to the Medicaid  
3142 state plan or to existing waivers, or submit new waiver requests  
3143 under section 1115 or other applicable sections of the Social  
3144 Security Act, by August 1, 2011, as needed to implement the  
3145 managed care program. At a minimum, the waiver requests must  
3146 include a waiver that allows home and community-based services  
3147 to be preferred over nursing home services for persons who can  
3148 be safely managed in the home and community, and a waiver that  
3149 requires dually eligible recipients to participate in the  
3150 Medicaid managed care program. The waiver requests must also  
3151 include provisions authorizing the state to limit enrollment in  
3152 managed long-term care, establish waiting lists, and limit the  
3153 amount, duration, and scope of home and community-based services  
3154 to ensure that expenditures for persons eligible for managed  
3155 long-term care services do not exceed funds provided in the  
3156 General Appropriations Act.

3157 (a) The agency shall initiate any necessary procurements  
3158 required to implement the managed care program as soon as  
3159 practicable, but no later than July 1, 2011, in anticipation of  
3160 prompt approval of the waivers needed for the managed care  
3161 program by the United States Department of Health and Human

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3162 Services.

3163 (b) In submitting waivers, the agency shall work with the  
3164 federal Centers for Medicare and Medicaid Services to accomplish  
3165 approval of all waivers by December 1, 2011, in order to begin  
3166 implementation of the managed care program by December 31, 2011.

3167 (c) Before seeking a waiver, the agency shall provide  
3168 public notice and the opportunity for public comment and include  
3169 public feedback in the waiver application.

3170 (2) The agency shall begin implementation of the Medicaid  
3171 managed care program on December 31, 2011. If waiver approval is  
3172 obtained, the program shall be implemented in accordance with  
3173 the terms and conditions of the waiver. If necessary waivers  
3174 have not been timely received, the agency shall notify the  
3175 Centers for Medicare and Medicaid Services of the state's  
3176 implementation of the managed care program and request the  
3177 federal agency to continue providing federal funds equivalent to  
3178 the funding level provided under the Federal Medical Assistance  
3179 Percentage in order to implement the managed care program.

3180 (a) If the Centers for Medicare and Medicaid Services  
3181 refuses to continue providing federal funds, the managed care  
3182 program shall be implemented as a state-only funded program to  
3183 the extent state funds are available.

3184 (b) If implemented as a state-only funded program, priority  
3185 shall be given to providing:

3186 1. Nursing home services to persons eligible for nursing  
3187 home care.

3188 2. Medical services to persons served by the Agency for  
3189 Persons with Disabilities.

3190 3. Medical services to pregnant women.

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3191 4. Physician and hospital services to persons who are  
3192 determined to be eligible for Medicaid subject to the income,  
3193 assets, and categorical eligibility tests set forth in federal  
3194 and state law.

3195 5. Services provided under the Healthy Start waiver.

3196 6. Medical services provided to persons in the Nursing Home  
3197 Diversion waiver.

3198 7. Medical services provided to persons in intermediate  
3199 care facilities for the developmentally disabled.

3200 8. Services to children in the child welfare system whose  
3201 medical care is provided in accordance with s. 409.16713, as  
3202 authorized by the General Appropriations Act.

3203 (c) If implemented as a state-only funded program pursuant  
3204 to paragraph (b), provisions related to the eligibility  
3205 standards of the state and federally funded Medicaid program  
3206 remain in effect, except as otherwise provided under the managed  
3207 care program.

3208 (d) If implemented as a state-only funded program pursuant  
3209 to paragraph (a), provider agreements and other contracts that  
3210 provide for Medicaid services to recipients identified in  
3211 paragraph (b) continue in effect.

3212 Section 38. Section 409.964, Florida Statutes, is created  
3213 to read:

3214 409.964 Enrollment.—All Medicaid recipients shall receive  
3215 medical services through the Medicaid managed care program  
3216 established under this part unless excluded under this section.

3217 (1) The following recipients are excluded from  
3218 participation in the Medicaid managed care program:

3219 (a) Women who are eligible only for family planning

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- 3220 services.
- 3221 (b) Women who are eligible only for breast and cervical
- 3222 cancer services.
- 3223 (c) Persons who have a developmental disability as defined
- 3224 in s. 393.063.
- 3225 (d) Persons who are eligible for a Medicaid nonpoverty
- 3226 medical subsidy.
- 3227 (e) Persons who receive eligible services under emergency
- 3228 Medicaid for aliens.
- 3229 (f) Persons who are residing in a nursing home facility or
- 3230 are considered residents under the nursing home's bed-hold
- 3231 policy on or before July 1, 2011.
- 3232 (g) Persons who are eligible for and receiving prescribed
- 3233 pediatric extended care.
- 3234 (h) A person who is eligible for services under the
- 3235 Medicaid program who has access to health care coverage through
- 3236 an employer-sponsored health plan. Such person may not receive
- 3237 Medicaid services under the fee-for-service program but may use
- 3238 Medicaid financial assistance to pay the cost of premiums for
- 3239 the employer-sponsored health plan. For purposes of this
- 3240 paragraph, access to health care coverage through an employer-
- 3241 sponsored health plan means that the Medicaid financial
- 3242 assistance available to the person is sufficient to pay the
- 3243 premium for the employer-sponsored health plan for the eligible
- 3244 person and his or her Medicaid eligible family members.
- 3245 1. The agency shall develop a process that allows a
- 3246 recipient who has access to employer-sponsored health coverage
- 3247 to use Medicaid financial assistance to pay the cost of the
- 3248 premium for the recipient and the recipient's Medicaid-eligible



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3249 family members for such coverage. The amount of financial  
3250 assistance may not exceed the Medicaid capitated rate that would  
3251 have been paid to a qualified plan for that recipient and the  
3252 recipient's family members.

3253 2. Contingent upon federal approval, the agency shall also  
3254 allow recipients who have access to other insurance or coverage  
3255 created pursuant to state or federal law to opt out of Medicaid  
3256 managed care and apply the Medicaid capitated rate that would  
3257 have been paid to a qualified plan for that recipient and the  
3258 recipient's family to pay for the other insurance product.

3259 (2) The following Medicaid recipients are exempt from  
3260 mandatory enrollment in the managed care program but may  
3261 volunteer to participate in the program:

3262 (a) Recipients residing in residential commitment  
3263 facilities operated through the Department of Juvenile Justice,  
3264 group care facilities operated by the Department of Children and  
3265 Family Services, or treatment facilities funded through the  
3266 substance abuse and mental health program of the Department of  
3267 Children and Family Services.

3268 (b) Persons eligible for refugee assistance.

3269 (3) Medicaid recipients who are exempt from mandatory  
3270 participation under this section and who do not choose to enroll  
3271 in the Medicaid managed care program shall be served through the  
3272 Medicaid fee-for-service program as provided under part III of  
3273 this chapter.

3274 Section 39. Section 409.965, Florida Statutes, is created  
3275 to read:

3276 409.965 Qualified plans; regions; selection criteria.-  
3277 Services in the Medicaid managed care program shall be provided

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3278 by qualified plans.

3279 (1) The agency shall select qualified plans to participate  
3280 in the Medicaid managed care program using an invitation to  
3281 negotiate issued pursuant to s. 287.057.

3282 (a) The agency shall notice separate invitations to  
3283 negotiate for the managed medical assistance component and the  
3284 managed long-term care component of the managed care program.

3285 (b) At least 30 days before noticing the invitation to  
3286 negotiate and annually thereafter, the agency shall compile and  
3287 publish a databook consisting of a comprehensive set of  
3288 utilization and spending data for the 3 most recent contract  
3289 years, consistent with the rate-setting periods for all Medicaid  
3290 recipients by region and county. Pursuant to s. 409.970, the  
3291 source of the data must include both historic fee-for-service  
3292 claims and validated data from the Medicaid Encounter Data  
3293 System. The report shall be made available electronically and  
3294 must delineate utilization by age, gender, eligibility group,  
3295 geographic area, and acuity level.

3296 (2) Separate and simultaneous procurements shall be  
3297 conducted in each of the following regions:

3298 (a) Region 1, which consists of Escambia, Okaloosa, Santa  
3299 Rosa, and Walton counties.

3300 (b) Region 2, which consists of Franklin, Gadsden,  
3301 Jefferson, Leon, Liberty, and Wakulla counties.

3302 (c) Region 3, which consists of Columbia, Dixie, Hamilton,  
3303 Lafayette, Madison, Suwannee, and Taylor counties.

3304 (d) Region 4, which consists of Baker, Clay, Duval, and  
3305 Nassau counties.

3306 (e) Region 5, which consists of Citrus, Hernando, Lake,

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- 3307 Marion, and Sumter counties.
- 3308 (f) Region 6, which consists of Pasco and Pinellas
- 3309 counties.
- 3310 (g) Region 7, which consists of Flagler, Putnam, St. Johns,
- 3311 and Volusia counties.
- 3312 (h) Region 8, which consists of Alachua, Bradford,
- 3313 Gilchrist, Levy, and Union counties.
- 3314 (i) Region 9, which consists of Orange and Osceola
- 3315 counties.
- 3316 (j) Region 10, which consists of Hardee, Highlands, and
- 3317 Polk counties.
- 3318 (k) Region 11, which consists of Miami-Dade and Monroe
- 3319 counties.
- 3320 (l) Region 12, which consists of DeSoto, Manatee, and
- 3321 Sarasota counties.
- 3322 (m) Region 13, which consists of Hillsborough County.
- 3323 (n) Region 14, which consists of Bay, Calhoun, Gulf,
- 3324 Holmes, Jackson, and Washington counties.
- 3325 (o) Region 15, which consists of Palm Beach County.
- 3326 (p) Region 16, which consists of Broward County.
- 3327 (q) Region 17, which consists of Brevard and Seminole
- 3328 counties.
- 3329 (r) Region 18, which consists of Indian River, Martin,
- 3330 Okeechobee, and St. Lucie counties.
- 3331 (s) Region 19, which consists of Charlotte, Collier,
- 3332 Glades, Hendry, and Lee counties.
- 3333 (3) The invitation to negotiate must specify the criteria
- 3334 and the relative weight of the criteria to be used for
- 3335 determining the acceptability of a reply and guiding the

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3336 selection of qualified plans with which the agency shall  
3337 contract. In addition to other criteria developed by the agency,  
3338 the agency shall give preference to the following factors in  
3339 selecting qualified plans:

3340 (a) Accreditation by the National Committee for Quality  
3341 Assurance or another nationally recognized accrediting body.

3342 (b) Experience serving similar populations, including the  
3343 organization's record in achieving specific quality standards  
3344 for similar populations.

3345 (c) Availability and accessibility of primary care and  
3346 specialty physicians in the provider network.

3347 (d) Establishment of partnerships with community providers  
3348 that provide community-based services.

3349 (e) The organization's commitment to quality improvement  
3350 and documentation of achievements in specific quality-  
3351 improvement projects, including active involvement by the  
3352 organization's leadership.

3353 (f) Provision of additional benefits, particularly dental  
3354 care for all recipients, disease management, and other programs  
3355 offering additional benefits.

3356 (g) Establishment of incentive programs that reward  
3357 specific behaviors with health-related benefits not otherwise  
3358 covered by the organizations' benefit plan. Such behaviors may  
3359 include participation in smoking-cessation programs, weight-loss  
3360 programs, or other activities designed to mitigate lifestyle  
3361 choices and avoid behaviors associated with the use of high-cost  
3362 medical services.

3363 (h) Organizations without a history of voluntary or  
3364 involuntary withdrawal from any state Medicaid program or

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3365 program area.

3366 (i) Evidence that an organization has written agreements or  
3367 signed contracts or has made substantial progress in  
3368 establishing relationships with providers before the  
3369 organization submits a reply. The agency shall evaluate such  
3370 evidence based on the following factors:

3371 1. Contracts with primary care and specialty physicians in  
3372 sufficient numbers to meet the specific standards established in  
3373 s. 409.966(2)(b).

3374 2. Specific arrangements that provide evidence that the  
3375 compensation offered by the plan is sufficient to retain primary  
3376 care and specialty physicians in sufficient numbers to comply  
3377 with the standards established in s. 409.966(2) throughout the  
3378 5-year contract term. The agency shall give preference to plans  
3379 that provide evidence that primary care physicians within the  
3380 plan's provider network will be compensated for primary care  
3381 services with payments equivalent to or greater than payments  
3382 for such services under the Medicare program, whether  
3383 compensation is made on a fee-for-service basis or by sub-  
3384 capitation.

3385 3. Contracts with community pharmacies located in rural  
3386 areas; contracts with community pharmacies serving specialty  
3387 disease populations, including, but not limited to, HIV/AIDS  
3388 patients, hemophiliacs, patients suffering from end-stage renal  
3389 disease, diabetes, or cancer; community pharmacies located  
3390 within distinct cultural communities that reflect the unique  
3391 cultural dynamics of such communities, including, but not  
3392 limited to, languages spoken, ethnicities served, unique disease  
3393 states serviced, and geographic location within the neighborhood

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3394 of a culturally distinct populations; and community pharmacies  
3395 providing value-added services to patients, such as free  
3396 delivery, immunizations, disease management, diabetes education,  
3397 and medication utilization review.

3398 (j) The capitated rates provided in the reply to the  
3399 invitation to negotiate.

3400 (k) Establishment of a claims payment process to ensure  
3401 that claims that are not contested or denied will be paid within  
3402 20 days after receipt.

3403 (l) For long-term care plans, additional criteria as  
3404 specified in s. 409.976(3).

3405 (4) Acceptable replies to the invitation to negotiate for  
3406 each region shall be ranked, and the agency shall select the  
3407 number of qualified plans with which to contract in each region.

3408 (a) The agency may not select more than one plan per 20,000  
3409 Medicaid recipients residing in the region who are subject to  
3410 mandatory managed care enrollment, except that, in addition to  
3411 the Children's Medical Services Network, a region may not have  
3412 more than 10 qualified plans for the managed medical assistance  
3413 or the managed long-term care components of the program.

3414 (b) If the funding available in the General Appropriations  
3415 Act is not adequate to meet the proposed statewide requirement  
3416 under the Medicaid managed care program, the agency shall enter  
3417 into negotiations with qualified plans that responded to the  
3418 invitation to negotiate. The negotiation process may alter the  
3419 rank of a qualified plan. If negotiations are conducted, the  
3420 agency shall select qualified plans that are responsive and  
3421 provide the best value to the state.

3422 (5) The Children's Medical Services Network authorized

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3423 under chapter 391 is a qualified plan for purposes of the  
3424 managed care medical assistance component of the Medicaid  
3425 managed care program. Participation by the network shall be  
3426 pursuant to a single statewide contract with the agency which is  
3427 not subject to the procurement requirements of this section. The  
3428 network must meet all other plan requirements for the managed  
3429 care medical assistance component of the program.

3430 Section 40. Section 409.966, Florida Statutes, is created  
3431 to read:

3432 409.966 Plan contracts.-

3433 (1) The agency shall execute a 5-year contract with each  
3434 qualified plan selected through the procurement process  
3435 described in s. 409.965. A contract between the agency and the  
3436 qualified plan may be amended annually, or as needed, to reflect  
3437 capitated rate adjustments due to funding availability pursuant  
3438 to the General Appropriations Act and ss. 409.9022, 409.972, and  
3439 409.975(2).

3440 (a) A plan contract may not be renewed; however, the agency  
3441 may extend the term of a contract, keeping intact all  
3442 operational provisions in the contract, including capitation  
3443 rates, to cover any delays in transitioning to a new plan.

3444 (b) If a plan applies for a rate increase that is not the  
3445 result of a solicitation from the agency and the application for  
3446 rate increase is not timely withdrawn, the plan will be deemed  
3447 to have submitted a notice of intent to leave the region before  
3448 the end of the contract term.

3449 (2) The agency shall establish such contract requirements  
3450 as are necessary for the operation of the Medicaid managed care  
3451 program. In addition to any other provisions the agency may deem

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3452 necessary, the contract must require:

3453 (a) Access.—The agency shall establish specific standards  
3454 for the number, type, and regional distribution of providers in  
3455 plan networks in order to ensure access to care. Each qualified  
3456 plan shall:

3457 1. Maintain a network of providers in sufficient numbers to  
3458 meet the access standards for specified services for all  
3459 recipients enrolled in the plan.

3460 2. Establish and maintain an accurate and complete  
3461 electronic database of contracted providers, including  
3462 information about licensure or registration, locations and hours  
3463 of operation, specialty credentials and other certifications,  
3464 specific performance indicators, and such other information as  
3465 the agency deems necessary. The provider database must be  
3466 available online to both the agency and the public and allow  
3467 comparison of the availability of providers to network adequacy  
3468 standards, and accept and display feedback from each provider's  
3469 patients.

3470 3. Provide for reasonable and adequate hours of operation,  
3471 including 24-hour availability of information, referral, and  
3472 treatment for emergency medical conditions.

3473 4. Assign each new enrollee to a primary care provider and  
3474 ensure that an appointment with that provider has been scheduled  
3475 within 30 days after the enrollment in the plan.

3476 5. Submit quarterly reports to the agency identifying the  
3477 number of enrollees assigned to each primary care provider.

3478 (b) Performance standards.—The agency shall establish  
3479 specific performance standards and expected milestones or  
3480 timelines for improving plan performance over the term of the



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3481 contract.

3482 1. Each plan shall establish an internal health care  
3483 quality improvement system that includes enrollee satisfaction  
3484 and disenrollment surveys and incentives and disincentives for  
3485 network providers.

3486 2. A qualified plan that is not accredited when the  
3487 contract is executed with the agency must become accredited or  
3488 have initiated the accreditation process within 1 year after the  
3489 contract is executed. If the plan is not accredited within 18  
3490 months after executing the contract, the plan shall be suspended  
3491 from automated enrollments pursuant to s. 409.969(2).

3492 3. In addition to agency standards, a qualified plan must  
3493 ensure that the agency is notified of the impending birth of a  
3494 child to an enrollee or as soon as practicable after the child's  
3495 birth. Upon the birth, the child is deemed enrolled with the  
3496 qualified plan, regardless of the administrative enrollment  
3497 procedures, and the qualified plan is responsible for providing  
3498 Medicaid services to the child on a capitated basis.

3499 (c) Program integrity.—Each plan shall establish program  
3500 integrity functions and activities in order to reduce the  
3501 incidence of fraud and abuse, including, at a minimum:

3502 1. A provider credentialing system and ongoing provider  
3503 monitoring. Each plan must verify at least annually that all  
3504 providers have a valid and unencumbered license or permit to  
3505 provide services to Medicaid recipients, and shall establish a  
3506 procedure for providers to notify the plan when the provider has  
3507 been notified by a licensing or regulatory agency that the  
3508 provider's license or permit is to be revoked or suspended, or  
3509 when an event has occurred which would prevent the provider from

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3510 renewing its license or permit. The provider must also notify  
3511 the plan if the license or permit is revoked or suspended, if  
3512 renewal of the license or permit is denied or expires by  
3513 operation of law, or if the provider requests that the license  
3514 or permit be inactivated. The plan must immediately exclude a  
3515 provider from the plan's provider network if the provider's  
3516 license is suspended or invalid;

3517 2. An effective prepayment and postpayment review process  
3518 that includes, at a minimum, data analysis, system editing, and  
3519 auditing of network providers;

3520 3. Procedures for reporting instances of fraud and abuse  
3521 pursuant to s. 409.91212;

3522 4. The establishment of an anti-fraud plan pursuant to s.  
3523 409.91212; and

3524 5. Designation of a program integrity compliance officer.

3525 (d) Encounter data.—Each plan must comply with the agency's  
3526 reporting requirements for the Medicaid Encounter Data System  
3527 under s. 409.970. The agency shall assess a fine of \$5,000 per  
3528 day against a qualified plan for failing to comply with this  
3529 requirement. If a plan fails to comply for more than 30 days,  
3530 the agency shall assess a fine of \$10,000 per day beginning on  
3531 the 31st day. If a plan is fined \$300,000 or more for failing to  
3532 comply, in addition to paying the fine, the plan shall be  
3533 disqualified from the Medicaid managed care program for 3 years.  
3534 If the plan is disqualified, the plan shall be deemed to have  
3535 terminated its contract before the scheduled end date and shall  
3536 also be subject to applicable penalties under paragraph (1).  
3537 However, the agency may waive or reduce the fine upon a showing  
3538 of good cause for the failure to comply.

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3539       (e) *Electronic claims.*—Plans shall accept electronic claims  
3540 that are in compliance with federal standards.

3541       (f) *Prompt payment.*—All qualified plans must comply with  
3542 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay  
3543 nursing homes by the 10th day of the month for enrollees who are  
3544 residing in the nursing home on the 1st day of the month.  
3545 Payment for the month in which an enrollee initiates residency  
3546 in a nursing home shall be in accordance with s. 641.3155. On an  
3547 annual basis, qualified plans shall submit a report certifying  
3548 compliance with the prompt payment requirements for the plan  
3549 year.

3550       (g) *Emergency services.*—Qualified plans must pay for  
3551 emergency services and care required under ss. 395.1041 and  
3552 401.45 and rendered by a noncontracted provider in accordance  
3553 with the prompt payment standards established in s. 641.3155.  
3554 The payment rate shall be the fee-for-service rate the agency  
3555 would pay the noncontracted provider for such services.

3556       (h) *Surety bond.*—A qualified plan shall post and maintain a  
3557 surety bond with the agency, payable to the agency, in the  
3558 amount of \$1.5 million. In lieu of a surety bond, the qualified  
3559 plan may establish and maintain an irrevocable letter of credit  
3560 or a deposit in a trust account in a financial institution,  
3561 payable to the agency, for \$1.5 million. The purpose of the  
3562 surety bond, letter of credit, or trust account is to protect  
3563 the agency if the entity terminates its contract with the agency  
3564 before the scheduled end date for the contract, the plan fails  
3565 to comply with the terms of the contract, including, but not  
3566 limited to, the timely submission of encounter data, the agency  
3567 imposes fines or penalties for noncompliance, or the plan fails

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3568 to achieve the guaranteed savings. If the contract is terminated  
3569 by the plan for any reason, the agency imposes fines or  
3570 penalties for noncompliance, or the guaranteed savings are not  
3571 achieved, the agency shall first request payment from the  
3572 qualified plan. If the qualified plan has not paid all costs,  
3573 fines, penalties, or the differential in the guaranteed savings  
3574 in full within 30 days, the agency shall pursue a claim against  
3575 the surety bond, letter of credit, or trust account for all  
3576 applicable moneys and the legal and administrative costs  
3577 associated with claiming under the surety bond, letter of  
3578 credit, or trust account.

3579 (i) Grievance resolution.—Each plan shall establish and the  
3580 agency shall approve an internal process for reviewing and  
3581 responding to grievances from enrollees consistent with s.  
3582 641.511. Each plan shall submit quarterly reports to the agency  
3583 on the number, description, and outcome of grievances filed by  
3584 enrollees.

3585 (j) Solvency.—A qualified plan must meet and maintain the  
3586 surplus and solvency requirements under s. 409.912(17) and (18).  
3587 A provider service network may satisfy the surplus and solvency  
3588 requirements if the network's performance and financial  
3589 obligations are guaranteed in writing by an entity licensed by  
3590 the Office of Insurance Regulation which meets the surplus and  
3591 solvency requirements of s. 624.408 or s. 641.225.

3592 (k) Guaranteed savings.—During the first contract period, a  
3593 qualified plan must agree to provide a guaranteed minimum  
3594 savings of 7 percent to the state. The agency shall conduct a  
3595 cost reconciliation to determine the amount of cost savings  
3596 achieved by the qualified plan compared with the reimbursements

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3597 the agency would have incurred under fee-for-service provisions.

3598 (1) Costs and penalties.—Plans that reduce enrollment  
3599 levels or leave a region before the end of the contract term  
3600 must reimburse the agency for the cost of enrollment changes and  
3601 other transition activities. If more than one plan leaves a  
3602 region at the same time, costs shall be shared by the departing  
3603 plans proportionate to their enrollment. In addition to the  
3604 payment of costs, departing plans must pay a penalty of 1  
3605 month's payment calculated as an average of the past 12 months  
3606 of payments, or since inception if the plan has not contracted  
3607 with the agency for 12 months, plus the differential of the  
3608 guaranteed savings based on the original contract term and the  
3609 corresponding termination date. Plans must provide the agency  
3610 with at least 180 days' notice before withdrawing from a region.

3611 (3) If the agency terminates more than one regional  
3612 contract with a qualified plan due to the plan's noncompliance  
3613 with one or more requirements of this section, the agency shall  
3614 terminate all regional contracts with the plan under the  
3615 Medicaid managed care program, as well as any other contracts or  
3616 agreements for other programs or services, and the plan may not  
3617 be awarded new contracts for 3 years.

3618 Section 41. Section 409.967, Florida Statutes, is created  
3619 to read:

3620 409.967 Plan accountability.—In addition to the contract  
3621 requirements of s. 409.966, plans and providers participating in  
3622 the Medicaid managed care program must comply with this section.

3623 (1) The agency shall require qualified plans to use a  
3624 uniform method of reporting and accounting for medical, direct  
3625 care management, and nonmedical costs. The agency shall evaluate

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3626 plan spending patterns after the plan completes 2 full years of  
3627 operation and at least annually thereafter. The agency shall  
3628 implement the following thresholds and consequences of various  
3629 spending patterns for qualified plans under the managed medical  
3630 assistance component of the Medicaid managed care program:

3631 (a) The minimum medical loss ratio shall be 90 percent.

3632 (b) A plan that spends less than 90 percent of its Medicaid  
3633 capitation revenue on medical services and direct care  
3634 management, as determined by the agency, must pay back to the  
3635 agency a share of the dollar difference between the plan's  
3636 actual medical loss ratio and the minimum medical loss ratio, as  
3637 follows:

3638 1. If the plan's actual medical loss ratio is not lower  
3639 than 87 percent, the plan must pay back 50 percent of the dollar  
3640 difference between the actual medical loss ratio and the minimum  
3641 medical loss ratio of 90 percent.

3642 2. If the plan's actual medical loss ratio is lower than 87  
3643 percent, the plan must pay back 50 percent of the dollar  
3644 difference between a medical loss ratio of 87 percent and the  
3645 minimum medical loss ratio of 90 percent, plus 100 percent of  
3646 the dollar difference between the actual medical loss ratio and  
3647 a medical loss ratio of 87 percent.

3648 (c) To administer this subsection, the agency shall adopt  
3649 rules that specify a methodology for calculating medical loss  
3650 ratios and the requirements for plans to annually report  
3651 information related to medical loss ratios. Repayments required  
3652 by this subsection must be made annually.

3653 (2) Plans may limit the providers in their networks.

3654 (a) However, during the first year in which a qualified

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3655 plan is operating in a region after the initial plan procurement  
3656 for that region, the plan must offer a network contract to the  
3657 following providers in the region:

3658 1. Federally qualified health centers.

3659 2. Nursing homes if the plan is providing managed long-term  
3660 care services.

3661 3. Aging network service providers that have previously  
3662 participated in home and community-based waivers serving elders,  
3663 or community-service programs administered by the Department of  
3664 Elderly Affairs if the plan is providing managed long-term care  
3665 services.

3666 (b) After 12 months of active participation in a plan's  
3667 network, the plan may exclude any of the providers listed in  
3668 paragraph (a) from the network while maintaining network  
3669 adequacy standards required under s. 409.966(2)(b). If the plan  
3670 excludes a nursing home that meets the standards for ongoing  
3671 Medicaid certification, the plan must provide an alternative  
3672 residence in that community for Medicaid recipients residing in  
3673 that nursing home. If a Medicaid recipient residing in an  
3674 excluded nursing home does not choose to change residence, the  
3675 plan must continue to pay for the recipient's care in that  
3676 nursing home. If the plan excludes a provider, the plan must  
3677 provide written notice to all enrollees who have chosen that  
3678 provider for care. Notice to excluded providers must be  
3679 delivered at least 30 days before the effective date of the  
3680 exclusion.

3681 (c) Qualified plans and providers shall engage in good  
3682 faith negotiations to reach contract terms.

3683 1. If a qualified plan seeks to develop a provider network

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3684 in a county or region that, as of June 30, 2011, does not have a  
3685 capitated managed care plan providing comprehensive acute care  
3686 for Medicaid recipients, and the qualified plan has made at  
3687 least three documented, unsuccessful, good faith attempts to  
3688 contract with a specific provider, the plan may request the  
3689 agency to examine the negotiation process. During the  
3690 examination, the agency shall consider similar counties or  
3691 regions in which qualified plans have contracted with providers  
3692 under similar circumstances, as well as the contracted rates  
3693 between qualified plans and that provider and similar providers  
3694 in the same region. If the agency determines that the plan has  
3695 made three good faith attempts to contract with the provider,  
3696 the agency shall consider that provider to be part of the  
3697 qualified plan's provider network for the purpose of determining  
3698 network adequacy, and the plan shall pay the provider for  
3699 services to Medicaid recipients on a noncontracted basis at a  
3700 rate or rates determined by the agency to be the average of  
3701 rates for corresponding services paid by the qualified plan and  
3702 other qualified plans in the region and in similar counties or  
3703 regions under similar circumstances.

3704 2. The agency may continue to calculate Medicaid hospital  
3705 inpatient per diem rates and outpatient rates. However, these  
3706 rates may not be the basis for contract negotiations between a  
3707 managed care plan and a hospital.

3708 (3) Each qualified plan shall monitor the quality and  
3709 performance of each provider within its network based on metrics  
3710 established by the agency for evaluating and documenting  
3711 provider performance and determining continued participation in  
3712 the network. The agency shall establish requirements for



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3713 qualified plans to report, at least annually, provider  
3714 performance data compiled under this subsection. If a plan uses  
3715 additional metrics to evaluate the provider's performance and to  
3716 determine continued participation in the network, the plan must  
3717 notify the network providers of these metrics at the beginning  
3718 of the contract period.

3719 (a) At a minimum, a qualified plan shall hold primary care  
3720 physicians responsible for the following activities:

3721 1. Supervision, coordination, and provision of care to each  
3722 assigned enrollee.

3723 2. Initiation of referrals for medically necessary  
3724 specialty care and other services.

3725 3. Maintaining continuity of care for each assigned  
3726 enrollee.

3727 4. Maintaining the enrollee's medical record, including  
3728 documentation of all medical services provided to the enrollee  
3729 by the primary care physician, as well as any specialty or  
3730 referral services.

3731 (b) Qualified plans shall establish and implement policies  
3732 and procedures to monitor primary care physician activities and  
3733 ensure that primary care physicians are adequately notified and  
3734 receive documentation of specialty and referral services  
3735 provided to enrollees by specialty physicians and other health  
3736 care providers within the plan's provider network.

3737 (4) Each qualified plan shall establish specific programs  
3738 and procedures to improve pregnancy outcomes and infant health,  
3739 including, but not limited to, coordination with the Healthy  
3740 Start program, immunization programs, and referral to the  
3741 Special Supplemental Nutrition Program for Women, Infants, and

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3742 Children, and the Children's Medical Services Program for  
3743 children with special health care needs.

3744 (a) Qualified plans must ensure that primary care  
3745 physicians who provide obstetrical care are available to  
3746 pregnant recipients and that an obstetrical care provider is  
3747 assigned to each pregnant recipient for the duration of her  
3748 pregnancy and postpartum care, by referral of the recipient's  
3749 primary care physician if necessary.

3750 (b) Qualified plans within the managed long-term care  
3751 component are exempt from this subsection.

3752 (5) Each qualified plan shall achieve an annual screening  
3753 rate for early and periodic screening, diagnosis, and treatment  
3754 services of at least 80 percent of those recipients continuously  
3755 enrolled for at least 8 months. Qualified plans within the  
3756 managed long-term care component are exempt from this  
3757 requirement.

3758 (6) Effective January 1, 2013, qualified plans must  
3759 compensate primary care physicians for primary care services at  
3760 payment rates that are equivalent to or greater than payments  
3761 under the federal Medicare program, whether compensation is made  
3762 on a fee-for-service basis or by sub-capitation.

3763 (7) In order to protect the continued operation of the  
3764 Medicaid managed care program, unresolved disputes, including  
3765 claim and other types of disputes, between a qualified plan and  
3766 a provider shall proceed in accordance with s. 408.7057. This  
3767 process may not be used to review or reverse a decision by a  
3768 qualified plan to exclude a provider from its network if the  
3769 decision does not conflict with s. 409.967(2).

3770 Section 42. Section 409.968, Florida Statutes, is created

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3771 to read:

3772 409.968 Plan payment.-Payments for managed medical  
3773 assistance and managed long-term care services under this part  
3774 shall be made in accordance with a capitated managed care model.  
3775 Qualified plans shall receive per-member, per-month payments  
3776 pursuant to the procurements described in s. 409.965 and annual  
3777 adjustments as described in s. 409.966(1). Payment rates must be  
3778 based on the acuity level for each member pursuant to ss.  
3779 409.972 and 409.978. Payment rates for managed long-term care  
3780 plans shall be combined with rates for managed medical  
3781 assistance plans.

3782 (1) The agency shall develop a methodology and request a  
3783 waiver that ensures the availability of intergovernmental  
3784 transfers in the Medicaid managed care program to support  
3785 providers that have historically served Medicaid recipients.  
3786 Such providers include, but are not limited to, safety net  
3787 providers, trauma hospitals, children's hospitals, statutory  
3788 teaching hospitals, and medical and osteopathic physicians  
3789 employed by or under contract with a medical school in this  
3790 state. The agency may develop a supplemental capitation rate,  
3791 risk pool, or incentive payment for plans that contract with  
3792 these providers. A plan is eligible for a supplemental payment  
3793 only if there are sufficient intergovernmental transfers  
3794 available from allowable sources.

3795 (2) The agency shall evaluate the development of the rate  
3796 cell to accurately reflect the underlying utilization to the  
3797 maximum extent possible. This methodology may include interim  
3798 rate adjustments as permitted under federal regulations. Any  
3799 such methodology must preserve federal funding to these entities

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3800 and be actuarially sound. In the absence of federal approval of  
3801 the methodology, the agency may set an enhanced rate and require  
3802 that plans pay the rate if the agency determines the enhanced  
3803 rate is necessary to ensure access to care by the providers  
3804 described in this subsection.

3805 (3) The amount paid to the plans to make supplemental  
3806 payments or to enhance provider rates pursuant to this  
3807 subsection must be reconciled to the exact amounts the plans are  
3808 required to pay providers. The plans shall make the designated  
3809 payments to providers within 15 business days after notification  
3810 by the agency regarding provider-specific distributions.

3811 Section 43. Section 409.969, Florida Statutes, is created  
3812 to read:

3813 409.969 Enrollment; disenrollment; grievance procedure.—

3814 (1) Each Medicaid recipient may choose any available plan  
3815 within the region in which the recipient resides unless that  
3816 plan is a specialty plan for which the recipient does not  
3817 qualify. The agency may not provide or contract for choice  
3818 counseling services for persons enrolling in the Medicaid  
3819 managed care program.

3820 (2) If a recipient has not made a choice of plans within 30  
3821 days after having been notified to choose a plan, the agency  
3822 shall assign the recipient to a plan in accordance with the  
3823 following:

3824 (a) A recipient who was previously enrolled in a plan  
3825 within the preceding 90 days shall be automatically enrolled in  
3826 the same plan, if available. Newborns of eligible mothers  
3827 enrolled in a plan at the time of the child's birth shall be  
3828 enrolled in the mother's plan; however, the mother may choose

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3829 another plan for the newborn within 90 days after the child's  
3830 birth. Other recipients shall be enrolled into a qualified plan  
3831 in accordance with an auto-assignment enrollment algorithm that  
3832 the agency develops by rule. The algorithm must heavily weigh  
3833 family continuity.

3834 (b) The agency shall automatically enroll recipients in  
3835 plans that meet or exceed the performance or quality standards  
3836 established pursuant to s. 409.967, and may not automatically  
3837 enroll recipients in a plan that is not meeting those standards.  
3838 Except as provided by law or rule, the agency may not engage in  
3839 practices that favor one qualified plan over another.

3840 (c) Automatic enrollment of recipients in plans must be  
3841 based on the following criteria:

3842 1. Whether the plan has sufficient network capacity to meet  
3843 the needs of recipients.

3844 2. Whether the recipient has previously received services  
3845 from one of the plan's primary care providers.

3846 3. Whether primary care providers in one plan are more  
3847 geographically accessible to the recipient's residence than  
3848 those providers in other plans.

3849 4. If a recipient is eligible for long-term care services,  
3850 whether the recipient has previously received services from one  
3851 of the plan's home and community-based service providers.

3852 5. If a recipient is eligible for long-term care services,  
3853 whether the home and community-based providers in one plan are  
3854 more geographically accessible to the recipient's residence than  
3855 those providers in other plans.

3856 (3) After a recipient has enrolled in a qualified plan, the  
3857 enrollee shall have 90 days to voluntarily disenroll and select

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3858 another plan. After 90 days, no further changes may be made  
3859 except for good cause. Good cause includes, but is not limited  
3860 to, poor quality of care, lack of access to necessary specialty  
3861 services, an unreasonable delay or denial of service, or  
3862 fraudulent enrollment. The agency shall determine whether good  
3863 cause exists. The agency may require an enrollee to use the  
3864 plan's grievance process before the agency makes a determination  
3865 of good cause, unless an immediate risk of permanent damage to  
3866 the enrollee's health is alleged.

3867 (a) If used, the qualified plan's internal grievance  
3868 process must be completed in time to allow the enrollee to  
3869 disenroll by the first day of the second month after the month  
3870 the disenrollment request was made. If the grievance process  
3871 approves an enrollee's request to disenroll, the agency is not  
3872 required to make a determination of good cause.

3873 (b) The agency must make a determination of good cause and  
3874 take final action on an enrollee's request so that disenrollment  
3875 occurs by the first day of the second month after the month the  
3876 request was made. If the agency fails to act within this  
3877 timeframe, the enrollee's request to disenroll is deemed  
3878 approved as of the date agency action was required. Enrollees  
3879 who disagree with the agency's finding that good cause for  
3880 disenrollment does not exist shall be advised of their right to  
3881 pursue a Medicaid fair hearing to dispute the agency's finding.

3882 (c) Medicaid recipients enrolled in a qualified plan after  
3883 the 90-day period must remain in the plan for the remainder of  
3884 the 12-month period. After 12 months, the enrollee may select  
3885 another plan. However, if a recipient is referred for hospice  
3886 services, the recipient shall have 30 days to enroll in another

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3887 plan in order to access the hospice provider of the recipient's  
3888 choice. An enrollee may change primary care providers within the  
3889 plan at any time.

3890 (d) On the first day of the next month after receiving  
3891 notice from a recipient that the recipient has moved to another  
3892 region, the agency shall automatically disenroll the recipient  
3893 from the plan the recipient is currently enrolled in and treat  
3894 the recipient as if the recipient is a new enrollee. At that  
3895 time, the recipient may choose another plan pursuant to the  
3896 enrollment process established in this section.

3897 Section 44. Section 409.970, Florida Statutes, is created  
3898 to read:

3899 409.970 Medicaid Encounter Data System.—The agency shall  
3900 maintain and operate the Medicaid Encounter Data System to  
3901 collect, process, and report on covered services provided to all  
3902 Medicaid recipients enrolled in qualified plans.

3903 (1) Qualified plans shall submit encounter data  
3904 electronically in a format that complies with provisions of the  
3905 federal Health Insurance Portability and Accountability Act for  
3906 electronic claims and in accordance with deadlines established  
3907 by the agency. Plans must certify that the data reported is  
3908 accurate and complete. The agency is responsible for validating  
3909 the data submitted by the plans.

3910 (2) The agency shall develop methods and protocols for  
3911 ongoing analysis of the encounter data, which must adjust for  
3912 differences in the characteristics of enrollees in order to  
3913 allow for the comparison of service utilization among plans. The  
3914 analysis shall be used to identify possible cases of systemic  
3915 overutilization, underutilization, inappropriate denials of

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3916 claims, and inappropriate utilization of covered services, such  
3917 as higher than expected emergency department and pharmacy  
3918 encounters. One of the primary focus areas for the analysis  
3919 shall be the use of prescription drugs.

3920 (3) The agency shall provide periodic feedback to the plans  
3921 based on the analysis and establish corrective action plans if  
3922 necessary.

3923 (4) The agency shall make encounter data available to plans  
3924 accepting enrollees who are reassigned to them from other plans  
3925 leaving a region.

3926 (5) Beginning July 1, 2011, the agency shall conduct  
3927 appropriate tests and establish specific criteria for  
3928 determining whether the Medicaid Encounter Data System has  
3929 valid, complete, and sound data for a sufficient period of time  
3930 to provide qualified plans with a reliable basis for determining  
3931 and proposing actuarially sound payment rates.

3932 Section 45. Section 409.971, Florida Statutes, is created  
3933 to read:

3934 409.971 Managed care medical assistance.—Pursuant to s.  
3935 409.902, the agency shall administer the managed care medical  
3936 assistance component of the Medicaid managed care program  
3937 described in this section and s. 409.972. Unless otherwise  
3938 specified, the provisions of ss. 409.961-409.970 apply to the  
3939 provision of managed care medical assistance. By December 31,  
3940 2011, the agency shall begin implementation of managed care  
3941 medical assistance, and full implementation in all regions must  
3942 be completed by December 31, 2012.

3943 Section 46. Section 409.972, Florida Statutes, is created  
3944 to read:



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- 3945       409.972 Managed care medical assistance services.-  
3946       (1) Qualified plans providing managed care medical  
3947 assistance must, at a minimum, cover the following services:  
3948       (a) Ambulatory patient services.  
3949       (b) Dental services for a recipient who is under age 21.  
3950       (c) Dental services as provided in s. 627.419(7) for a  
3951 recipient who is 21 years of age or older.  
3952       (d) Dialysis services.  
3953       (e) Durable medical equipment and supplies.  
3954       (f) Early periodic screening diagnosis and treatment  
3955 services, hearing services and hearing aids, and vision services  
3956 and eyeglasses for enrollees under age 21.  
3957       (g) Emergency services.  
3958       (h) Family planning services.  
3959       (i) Hearing services for a recipient who is under age 21.  
3960       (j) Hearing services that are medically indicated for a  
3961 recipient who is 21 years of age or older.  
3962       (k) Home health services.  
3963       (l) Hospice services.  
3964       (m) Hospital inpatient services.  
3965       (n) Hospital outpatient services.  
3966       (o) Laboratory and imaging services.  
3967       (p) Maternity and newborn care and birth center services.  
3968       (q) Mental health services, substance abuse disorder  
3969 services, and behavioral health treatment.  
3970       (r) Prescription drugs.  
3971       (s) Primary care service, referred specialty care services,  
3972 preventive services, and wellness services.  
3973       (t) Skilled nursing facility or inpatient rehabilitation

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3974 facility services.  
3975 (u) Transplant services.  
3976 (v) Transportation to access covered services.  
3977 (w) Vision services for a recipient who is under age 21.  
3978 (x) Vision services that are medically indicated for a  
3979 recipient who is 21 years of age or older.  
3980 (2) Subject to specific appropriations, the agency may make  
3981 payments for services that are optional.  
3982 (3) Qualified plans may customize benefit packages for  
3983 nonpregnant adults, vary cost-sharing provisions, and provide  
3984 coverage for additional services. The agency shall evaluate the  
3985 proposed benefit packages to ensure that services are sufficient  
3986 to meet the needs of the plans' enrollees and to verify  
3987 actuarial equivalence.  
3988 (4) Managed care medical assistance services provided under  
3989 this section must be medically necessary and provided in  
3990 accordance with state and federal law. This section does not  
3991 prevent the agency from adjusting fees, reimbursement rates,  
3992 lengths of stay, number of visits, or number of services, or  
3993 from making any other adjustments necessary to comply with the  
3994 availability of funding and any limitations or directions  
3995 provided in the General Appropriations Act, chapter 216, or s.  
3996 409.9022.  
3997 Section 47. Section 409.973, Florida Statutes, is created  
3998 to read:  
3999 409.973 Managed long-term care.-  
4000 (1) Qualified plans providing managed care medical  
4001 assistance may also participate in the managed long-term care  
4002 component of the Medicaid managed care program. Unless otherwise

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4003 specified, the provisions of ss. 409.961-409.970 apply to the  
4004 managed long-term care component of the managed care program.

4005 (2) Pursuant to s. 409.902, the agency shall administer the  
4006 managed long-term care component described in this section and  
4007 ss. 409.974-409.978, but may delegate specific duties and  
4008 responsibilities to the Department of Elderly Affairs and other  
4009 state agencies. By March 31, 2012, the agency shall begin  
4010 implementation of the managed long-term care component, with  
4011 full implementation in all regions by March 31, 2013.

4012 (3) The Department of Elderly Affairs shall assist the  
4013 agency in developing specifications for use in the invitation to  
4014 negotiate and the model contract, determining clinical  
4015 eligibility for enrollment in managed long-term care plans,  
4016 monitoring plan performance and measuring quality of service  
4017 delivery, assisting clients and families in order to address  
4018 complaints with the plans, facilitating working relationships  
4019 between plans and providers serving elders and disabled adults,  
4020 and performing other functions specified in a memorandum of  
4021 agreement.

4022 Section 48. Section 409.974, Florida Statutes, is created  
4023 to read:

4024 409.974 Recipient eligibility for managed long-term care.-

4025 (1) Medicaid recipients shall receive covered long-term  
4026 care services through the managed long-term care component  
4027 unless excluded pursuant to s. 409.964. In order to receive  
4028 Medicaid long-term care services, Medicaid recipients who meet  
4029 all of the following criteria may participate in the managed  
4030 long-term care. The recipient must be:

4031 (a) Sixty-five years of age or older or eligible for

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4032 Medicaid by reason of a disability.

4033 (b) Determined by the Comprehensive Assessment Review and  
4034 Evaluation for Long-Term Care Services (CARES) Program to meet  
4035 the criteria for nursing facility care.

4036 (2) Medicaid recipients who are residing in a nursing home  
4037 facility or enrolled in one of the following long-term care  
4038 Medicaid waiver programs on the date managed long-term care  
4039 plans becomes available in the recipient's region are eligible  
4040 for the following long-term care programs if the programs are  
4041 operational on that date:

4042 (a) The Assisted Living for the Frail Elderly Waiver.

4043 (b) The Aged and Disabled Adult Waiver.

4044 (c) The Adult Day Health Care Waiver.

4045 (d) The Consumer-Directed Care Program as described in s.  
4046 409.221.

4047 (e) The Program of All-inclusive Care for the Elderly.

4048 (f) The Long-Term Care Community-Based Diversion Pilot  
4049 Project as described in s. 430.705.

4050 (g) The Channeling Services Waiver for Frail Elders.

4051 (3) This part does not create an entitlement to any home  
4052 and community-based services provided under the managed long-  
4053 term care component.

4054 Section 49. Section 409.975, Florida Statutes, is created  
4055 to read:

4056 409.975 Managed long-term care services.-

4057 (1) Qualified plans participating in the managed long-term  
4058 care component of the Medicaid managed care program, at a  
4059 minimum, shall cover the following services:

4060 (a) The services listed in s. 409.972.

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4061       (b) Nursing facility services.  
4062       (c) Home and community-based services, including, but not  
4063 limited to, assisted living facility services.  
4064       (2) Services provided under this section must be medically  
4065 necessary and provided in accordance with state and federal law.  
4066 This section does not prevent the agency from adjusting fees,  
4067 reimbursement rates, lengths of stay, number of visits, or  
4068 number of services, or from making any other adjustments  
4069 necessary to comply with the availability of funding and any  
4070 limitations or directions provided in the General Appropriations  
4071 Act, chapter 216, or s. 409.9022.  
4072       Section 50. Section 409.976, Florida Statutes, is created  
4073 to read:  
4074       409.976 Qualified managed long-term care plans.-  
4075       (1) For purposes of managed long-term care, qualified plans  
4076 also include:  
4077       (a) Entities who are qualified under 42 C.F.R. part 422 as  
4078 Medicare Advantage Preferred Provider Organizations, Medicare  
4079 Advantage Provider-sponsored Organizations, and Medicare  
4080 Advantage Special Needs Plans. Such plans may participate in the  
4081 managed long-term care component.  
4082       (b) The Program of All-inclusive Care for the Elderly  
4083 (PACE). Participation by PACE shall be pursuant to a contract  
4084 with the agency and is not subject to the procurement  
4085 requirements of this section. PACE plans may continue to provide  
4086 services to recipients at such levels and enrollment caps as  
4087 authorized by the General Appropriations Act.  
4088       (2) The agency shall select qualified plans through the  
4089 procurement described in s. 409.965. The agency shall notice the

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4090 invitation to negotiate by November 14, 2011.

4091 (3) In addition to the criteria established in s. 409.965,  
4092 the agency shall give preference to the following factors in  
4093 selecting qualified plans:

4094 (a) The plan's employment of executive managers having  
4095 expertise and experience in serving aged and disabled persons  
4096 who require long-term care.

4097 (b) The plan's establishment of a network of service  
4098 providers dispersed throughout the region and in sufficient  
4099 numbers to meet specific service standards established by the  
4100 agency for a continuum of care, beginning from the provision of  
4101 assistance with the activities of daily living at a recipient's  
4102 home and the provision of other home and community-based care  
4103 through the provision of nursing home care. These providers  
4104 include:

- 4105 1. Adult day centers.
- 4106 2. Adult family care homes.
- 4107 3. Assisted living facilities.
- 4108 4. Health care services pools.
- 4109 5. Home health agencies.
- 4110 6. Homemaker and companion services.
- 4111 7. Community Care for the Elderly lead agencies.
- 4112 8. Nurse registries.
- 4113 9. Nursing homes.

4114

4115 All providers are not required to be located within the region;  
4116 however, the provider network must be sufficient to ensure that  
4117 services are available throughout the region.

4118 (c) Whether a plan offers consumer-directed care services

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4119 to enrollees pursuant to s. 409.221 or includes attendant care  
4120 or paid family caregivers in the benefit package. Consumer-  
4121 directed care services must provide a flexible budget, which is  
4122 managed by enrollees and their families or representatives, and  
4123 allows them to choose service providers, determine provider  
4124 rates of payment, and direct the delivery of services to best  
4125 meet their special long-term care needs. If all other factors  
4126 are equal among competing qualified plans, the agency shall give  
4127 preference to such plans.

4128 (d) Evidence that a qualified plan has written agreements  
4129 or signed contracts or has made substantial progress in  
4130 establishing relationships with providers before the plan  
4131 submits a response.

4132 (e) The availability and accessibility of case managers in  
4133 the plan and provider network.

4134 Section 51. Section 409.977, Florida Statutes, is created  
4135 to read:

4136 409.977 Managed long-term plan and provider  
4137 accountability.—In addition to the requirements of ss. 409.966  
4138 and 409.967, plans and providers participating in managed long-  
4139 term care must comply with specific standards established by the  
4140 agency for the number, type, and regional distribution of the  
4141 following providers in the plan's network, which must include:

- 4142 (1) Adult day centers.  
4143 (2) Adult family care homes.  
4144 (3) Assisted living facilities.  
4145 (4) Health care services pools.  
4146 (5) Home health agencies.  
4147 (6) Homemaker and companion services.

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4148       (7) Community Care for the Elderly lead agencies.

4149       (8) Nurse registries.

4150       (9) Nursing homes.

4151       Section 52. Section 409.978, Florida Statutes, is created  
4152 to read:

4153       409.978 CARES program screening; levels of care.—

4154       (1) The agency shall operate the Comprehensive Assessment  
4155 and Review for Long-Term Care Services (CARES) preadmission  
4156 screening program to ensure that only recipients whose  
4157 conditions require long-term care services are enrolled in  
4158 managed long-term care plans.

4159       (2) The agency shall operate the CARES program through an  
4160 interagency agreement with the Department of Elderly Affairs.  
4161 The agency, in consultation with the department, may contract  
4162 for any function or activity of the CARES program, including any  
4163 function or activity required by 42 C.F.R. part 483.20, relating  
4164 to preadmission screening and review.

4165       (3) The CARES program shall determine if a recipient  
4166 requires nursing facility care and, if so, assign the recipient  
4167 to one of the following levels of care:

4168       (a) Level of care 1 consists of enrollees who require the  
4169 constant availability of routine medical and nursing treatment  
4170 and care, have a limited need for health-related care and  
4171 services, are mildly medically or physically incapacitated, and  
4172 cannot be managed at home due to inadequacy of home-based  
4173 services.

4174       (b) Level of care 2 consists of enrollees who require the  
4175 constant availability of routine medical and nursing treatment  
4176 and care, and require extensive health-related care and services



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4177 because of mental or physical incapacitation. Current enrollees  
4178 in home and community-based waiver programs for persons who are  
4179 elderly or adults with physical disability, or both, who remain  
4180 financially eligible for Medicaid are not required to meet new  
4181 level-of-care criteria except for immediate placement in a  
4182 nursing home.

4183 (c) Level of care 3 consists of enrollees residing in  
4184 nursing homes, or needing immediate placement in a nursing home,  
4185 and who have a priority score of 5 or above as determined by  
4186 CARES.

4187 (4) For recipients whose nursing home stay is initially  
4188 funded by Medicare and Medicare coverage is being terminated for  
4189 lack of progress towards rehabilitation, CARES staff shall  
4190 consult with the person determining the recipient's progress  
4191 toward rehabilitation in order to ensure that the recipient is  
4192 not being inappropriately disqualified from Medicare coverage.  
4193 If, in their professional judgment, CARES staff believes that a  
4194 Medicare beneficiary is still making progress, they may assist  
4195 the Medicare beneficiary with appealing the disqualification  
4196 from Medicare coverage. The CARES teams may review Medicare  
4197 denials for coverage under this section only if it is determined  
4198 that such reviews qualify for federal matching funds through  
4199 Medicaid. The agency shall seek or amend federal waivers as  
4200 necessary to implement this section.

4201 Section 53. Section 409.91207, Florida Statutes, is  
4202 transferred, renumbered as section 409.985, Florida Statutes,  
4203 and subsection (1) of that section is amended to read:

4204 409.985 ~~409.91207~~ Medical home pilot project.—

4205 (1) The agency shall develop a plan to implement a medical

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4206 home pilot project that uses ~~utilizes~~ primary care case  
4207 management enhanced by medical home networks to provide  
4208 coordinated and cost-effective care that is reimbursed on a fee-  
4209 for-service basis and to compare the performance of the medical  
4210 home networks with other existing Medicaid managed care models.  
4211 The agency may ~~is authorized to~~ seek a federal Medicaid waiver  
4212 or an amendment to any existing Medicaid waiver, except for the  
4213 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,  
4214 as needed, to develop the pilot project created in this section  
4215 but must obtain approval of the Legislature before ~~prior to~~  
4216 implementing the pilot project.

4217 Section 54. Section 409.91211, Florida Statutes, is  
4218 transferred, renumbered as section 409.986, Florida Statutes,  
4219 and paragraph (aa) of subsection (3) and paragraph (a) of  
4220 subsection (4) of that section are amended, to read:

4221 409.986 ~~409.91211~~ Medicaid managed care pilot program.—

4222 (3) The agency shall have the following powers, duties, and  
4223 responsibilities with respect to the pilot program:

4224 (aa) To implement a mechanism whereby Medicaid recipients  
4225 who are already enrolled in a managed care plan or the MediPass  
4226 program in the pilot areas are ~~shall be~~ offered the opportunity  
4227 to change to capitated managed care plans on a staggered basis,  
4228 as defined by the agency. All Medicaid recipients shall have 30  
4229 days in which to make a choice of capitated managed care plans.  
4230 Those Medicaid recipients who do not make a choice shall be  
4231 assigned to a capitated managed care plan in accordance with  
4232 paragraph (4)(a) and shall be exempt from s. 409.987 ~~409.9122~~.  
4233 To facilitate continuity of care for a Medicaid recipient who is  
4234 also a recipient of Supplemental Security Income (SSI), prior to

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4235 assigning the SSI recipient to a capitated managed care plan,  
4236 the agency shall determine whether the SSI recipient has an  
4237 ongoing relationship with a provider or capitated managed care  
4238 plan, and, if so, the agency shall assign the SSI recipient to  
4239 that provider or capitated managed care plan where feasible.  
4240 Those SSI recipients who do not have such a provider  
4241 relationship shall be assigned to a capitated managed care plan  
4242 provider in accordance with paragraph (4)(a) and shall be exempt  
4243 from s. 409.987 ~~409.9122~~.

4244 (4)(a) A Medicaid recipient in the pilot area who is not  
4245 currently enrolled in a capitated managed care plan upon  
4246 implementation is not eligible for services as specified in ss.  
4247 409.905 and 409.906, for the amount of time that the recipient  
4248 does not enroll in a capitated managed care network. If a  
4249 Medicaid recipient has not enrolled in a capitated managed care  
4250 plan within 30 days after eligibility, the agency shall assign  
4251 the Medicaid recipient to a capitated managed care plan based on  
4252 the assessed needs of the recipient as determined by the agency  
4253 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When  
4254 making assignments, the agency shall take into account the  
4255 following criteria:

4256 1. A capitated managed care network has sufficient network  
4257 capacity to meet the needs of members.

4258 2. The capitated managed care network has previously  
4259 enrolled the recipient as a member, or one of the capitated  
4260 managed care network's primary care providers has previously  
4261 provided health care to the recipient.

4262 3. The agency has knowledge that the member has previously  
4263 expressed a preference for a particular capitated managed care

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4264 network as indicated by Medicaid fee-for-service claims data,  
4265 but has failed to make a choice.

4266 4. The capitated managed care network's primary care  
4267 providers are geographically accessible to the recipient's  
4268 residence.

4269 Section 55. Section 409.9122, Florida Statutes, is  
4270 transferred, renumbered as section 409.987, and paragraph (a) of  
4271 subsection (2) of that section is amended to read:

4272 409.987 ~~409.9122~~ Mandatory Medicaid managed care  
4273 enrollment; programs and procedures.-

4274 (2)(a) The agency shall enroll all Medicaid recipients in a  
4275 managed care plan or MediPass ~~all Medicaid recipients~~, except  
4276 ~~those Medicaid recipients who are~~ in an institution, receiving  
4277 a Medicaid nonpoverty medical subsidy, ~~enrolled in the Medicaid~~  
4278 ~~medically needy Program~~; or eligible for both Medicaid and  
4279 Medicare. Upon enrollment, recipients may ~~individuals will be~~  
4280 ~~able to~~ change their managed care option during the 90-day opt  
4281 out period required by federal Medicaid regulations. The agency  
4282 may ~~is authorized to~~ seek the necessary Medicaid state plan  
4283 amendment to implement this policy. ~~However, to the extent~~

4284 1. ~~If~~ permitted by federal law, the agency may enroll ~~in a~~  
4285 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt  
4286 from mandatory managed care enrollment in a managed care plan or  
4287 MediPass if, ~~provided that~~:

4288 a.1. ~~The~~ recipient's decision to enroll in a managed care  
4289 plan or MediPass is voluntary;

4290 b.2. ~~If~~ The recipient chooses to enroll in a managed care  
4291 plan, the agency has determined that the ~~managed care plan~~  
4292 provides specific programs and services that ~~which~~ address the

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4293 special health needs of the recipient; and  
4294 ~~c.3.~~ The agency receives the ~~any~~ necessary waivers from the  
4295 federal Centers for Medicare and Medicaid Services.

4296 2. The agency shall develop rules to establish policies by  
4297 which exceptions to the mandatory managed care enrollment  
4298 requirement may be made on a case-by-case basis. The rules must  
4299 ~~shall~~ include the specific criteria to be applied when  
4300 determining ~~making a determination as to~~ whether to exempt a  
4301 recipient from mandatory enrollment ~~in a managed care plan or~~  
4302 ~~MediPass.~~

4303 3. School districts participating in the certified school  
4304 match program pursuant to ss. 409.908(21) and 1011.70 shall be  
4305 reimbursed by Medicaid, subject to the limitations of s.  
4306 1011.70(1), for a Medicaid-eligible child participating in the  
4307 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.  
4308 409.9071, regardless of whether the child is enrolled in  
4309 MediPass or a managed care plan. Managed care plans must ~~shall~~  
4310 make a good faith effort to execute agreements with school  
4311 districts regarding the coordinated provision of services  
4312 authorized under s. 1011.70.

4313 4. County health departments delivering school-based  
4314 services pursuant to ss. 381.0056 and 381.0057 shall be  
4315 reimbursed by Medicaid for the federal share for a Medicaid-  
4316 eligible child who receives Medicaid-covered services in a  
4317 school setting, regardless of whether the child is enrolled in  
4318 MediPass or a managed care plan. Managed care plans shall make a  
4319 good faith effort to execute agreements with county health  
4320 departments that coordinate the ~~regarding the coordinated~~  
4321 provision of services to a Medicaid-eligible child. To ensure

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4322 continuity of care for Medicaid patients, the agency, the  
4323 Department of Health, and the Department of Education shall  
4324 develop procedures for ensuring that a student's managed care  
4325 plan or MediPass provider receives information relating to  
4326 services provided in accordance with ss. 381.0056, 381.0057,  
4327 409.9071, and 1011.70.

4328 Section 56. Section 409.9123, Florida Statutes, is  
4329 transferred and renumbered as section 409.988, Florida Statutes.

4330 Section 57. Section 409.9124, Florida Statutes, is  
4331 transferred and renumbered as section 409.989.

4332 Section 58. Subsection (15) of section 430.04, Florida  
4333 Statutes, is amended to read:

4334 430.04 Duties and responsibilities of the Department of  
4335 Elderly Affairs.—The Department of Elderly Affairs shall:

4336 (15) Administer all Medicaid waivers and programs relating  
4337 to elders and their appropriations. The waivers include, but are  
4338 not limited to:

4339 ~~(a) The Alzheimer's Dementia Specific Medicaid Waiver as~~  
4340 ~~established in s. 430.502(7), (8), and (9).~~

4341 (a)~~(b)~~ The Assisted Living for the Frail Elderly Waiver.

4342 (b)~~(c)~~ The Aged and Disabled Adult Waiver.

4343 (c)~~(d)~~ The Adult Day Health Care Waiver.

4344 (d)~~(e)~~ The Consumer-Directed Care Plus Program as defined  
4345 in s. 409.221.

4346 (e)~~(f)~~ The Program of All-inclusive Care for the Elderly.

4347 (f)~~(g)~~ The Long-Term Care Community-Based Diversion Pilot  
4348 Project as described in s. 430.705.

4349 (g)~~(h)~~ The Channeling Services Waiver for Frail Elders.

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4351 The department shall develop a transition plan for recipients  
4352 receiving services under long-term care Medicaid waivers for  
4353 elders or disabled adults on the date qualified plans become  
4354 available in each recipient's region pursuant to s. 409.973(2)  
4355 in order to enroll those recipients in qualified plans.

4356 Section 59. Section 430.2053, Florida Statutes, is amended  
4357 to read:

4358 430.2053 Aging resource centers.-

4359 (1) The department, in consultation with the Agency for  
4360 Health Care Administration and the Department of Children and  
4361 Family Services, shall develop pilot projects for aging resource  
4362 centers. ~~By October 31, 2004, the department, in consultation~~  
4363 ~~with the agency and the Department of Children and Family~~  
4364 ~~Services, shall develop an implementation plan for aging~~  
4365 ~~resource centers and submit the plan to the Governor, the~~  
4366 ~~President of the Senate, and the Speaker of the House of~~  
4367 ~~Representatives. The plan must include qualifications for~~  
4368 ~~designation as a center, the functions to be performed by each~~  
4369 ~~center, and a process for determining that a current area agency~~  
4370 ~~on aging is ready to assume the functions of an aging resource~~  
4371 ~~center.~~

4372 ~~(2) Each area agency on aging shall develop, in~~  
4373 ~~consultation with the existing community care for the elderly~~  
4374 ~~lead agencies within their planning and service areas, a~~  
4375 ~~proposal that describes the process the area agency on aging~~  
4376 ~~intends to undertake to transition to an aging resource center~~  
4377 ~~prior to July 1, 2005, and that describes the area agency's~~  
4378 ~~compliance with the requirements of this section. The proposals~~  
4379 ~~must be submitted to the department prior to December 31, 2004.~~

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4380 ~~The department shall evaluate all proposals for readiness and,~~  
4381 ~~prior to March 1, 2005, shall select three area agencies on~~  
4382 ~~aging which meet the requirements of this section to begin the~~  
4383 ~~transition to aging resource centers. Those area agencies on~~  
4384 ~~aging which are not selected to begin the transition to aging~~  
4385 ~~resource centers shall, in consultation with the department and~~  
4386 ~~the existing community care for the elderly lead agencies within~~  
4387 ~~their planning and service areas, amend their proposals as~~  
4388 ~~necessary and resubmit them to the department prior to July 1,~~  
4389 ~~2005. The department may transition additional area agencies to~~  
4390 ~~aging resource centers as it determines that area agencies are~~  
4391 ~~in compliance with the requirements of this section.~~

4392 ~~(3) The Auditor General and the Office of Program Policy~~  
4393 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~  
4394 ~~review and assess the department's process for determining an~~  
4395 ~~area agency's readiness to transition to an aging resource~~  
4396 ~~center.~~

4397 ~~(a) The review must, at a minimum, address the~~  
4398 ~~appropriateness of the department's criteria for selection of an~~  
4399 ~~area agency to transition to an aging resource center, the~~  
4400 ~~instruments applied, the degree to which the department~~  
4401 ~~accurately determined each area agency's compliance with the~~  
4402 ~~readiness criteria, the quality of the technical assistance~~  
4403 ~~provided by the department to an area agency in correcting any~~  
4404 ~~weaknesses identified in the readiness assessment, and the~~  
4405 ~~degree to which each area agency overcame any identified~~  
4406 ~~weaknesses.~~

4407 ~~(b) Reports of these reviews must be submitted to the~~  
4408 ~~appropriate substantive and appropriations committees in the~~



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4409 ~~Senate and the House of Representatives on March 1 and September~~  
4410 ~~1 of each year until full transition to aging resource centers~~  
4411 ~~has been accomplished statewide, except that the first report~~  
4412 ~~must be submitted by February 1, 2005, and must address all~~  
4413 ~~readiness activities undertaken through December 31, 2004. The~~  
4414 ~~perspectives of all participants in this review process must be~~  
4415 ~~included in each report.~~

4416 (2)~~(4)~~ The purposes of an aging resource center are ~~shall~~  
4417 ~~be:~~

4418 (a) To provide Florida's elders and their families with a  
4419 locally focused, coordinated approach to integrating information  
4420 and referral for all available services for elders with the  
4421 eligibility determination entities for state and federally  
4422 funded long-term-care services.

4423 (b) To provide for easier access to long-term-care services  
4424 by Florida's elders and their families by creating multiple  
4425 access points to the long-term-care network that flow through  
4426 one established entity with wide community recognition.

4427 (3)~~(5)~~ The duties of an aging resource center are to:

4428 (a) Develop referral agreements with local community  
4429 service organizations, such as senior centers, existing elder  
4430 service providers, volunteer associations, and other similar  
4431 organizations, to better assist clients who do not need or do  
4432 not wish to enroll in programs funded by the department or the  
4433 agency. The referral agreements must also include a protocol,  
4434 developed and approved by the department, which provides  
4435 specific actions that an aging resource center and local  
4436 community service organizations must take when an elder or an  
4437 elder's representative seeking information on long-term-care

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4438 services contacts a local community service organization prior  
4439 to contacting the aging resource center. The protocol shall be  
4440 designed to ensure that elders and their families are able to  
4441 access information and services in the most efficient and least  
4442 cumbersome manner possible.

4443 (b) Provide an initial screening of all clients who request  
4444 long-term-care services to determine whether the person would be  
4445 most appropriately served through any combination of federally  
4446 funded programs, state-funded programs, locally funded or  
4447 community volunteer programs, or private funding for services.

4448 (c) Determine eligibility for the programs and services  
4449 listed in subsection (9) ~~(11)~~ for persons residing within the  
4450 geographic area served by the aging resource center and  
4451 determine a priority ranking for services which is based upon  
4452 the potential recipient's frailty level and likelihood of  
4453 institutional placement without such services.

4454 (d) Manage the availability of financial resources for the  
4455 programs and services listed in subsection (9) ~~(11)~~ for persons  
4456 residing within the geographic area served by the aging resource  
4457 center.

4458 (e) If ~~When~~ financial resources become available, refer a  
4459 client to the most appropriate entity to begin receiving  
4460 services. The aging resource center shall make referrals to lead  
4461 agencies for service provision that ensure that individuals who  
4462 are vulnerable adults in need of services pursuant to s.  
4463 415.104(3)(b), or who are victims of abuse, neglect, or  
4464 exploitation in need of immediate services to prevent further  
4465 harm and are referred by the adult protective services program,  
4466 are given primary consideration for receiving community-care-

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4467 for-the-elderly services in compliance with the requirements of  
4468 s. 430.205(5)(a) and that other referrals for services are in  
4469 compliance with s. 430.205(5)(b).

4470 (f) Convene a work group to advise in the planning,  
4471 implementation, and evaluation of the aging resource center. The  
4472 work group shall be composed ~~comprised~~ of representatives of  
4473 local service providers, Alzheimer's Association chapters,  
4474 housing authorities, social service organizations, advocacy  
4475 groups, representatives of clients receiving services through  
4476 the aging resource center, and ~~any~~ other persons or groups as  
4477 determined by the department. The aging resource center, in  
4478 consultation with the work group, must develop annual program  
4479 improvement plans that shall be submitted to the department for  
4480 consideration. The department shall review each annual  
4481 improvement plan and make recommendations on how to implement  
4482 the components of the plan.

4483 (g) Enhance the existing area agency on aging in each  
4484 planning and service area by integrating, ~~either~~ physically or  
4485 virtually, the staff and services of the area agency on aging  
4486 with the staff of the department's local CARES Medicaid ~~nursing~~  
4487 ~~home~~ preadmission screening unit and a sufficient number of  
4488 staff from the Department of Children and Family Services'  
4489 Economic Self-Sufficiency Unit necessary to determine the  
4490 financial eligibility for all persons age 60 and older residing  
4491 within the area served by the aging resource center who ~~that~~ are  
4492 seeking Medicaid services, Supplemental Security Income, and  
4493 food assistance.

4494 (h) Assist clients who request long-term care services in  
4495 being evaluated for eligibility for the long-term care managed

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4496 care component of the Medicaid managed care program as qualified  
4497 plans become available in each of the regions pursuant to s.  
4498 409.973(2).

4499 (i) Provide enrollment and coverage information to Medicaid  
4500 managed long-term care enrollees as qualified plans become  
4501 available in each of the regions pursuant to s. 409.973(2).

4502 (j) Assist enrollees in the Medicaid long-term care managed  
4503 care program with informally resolving grievances with a managed  
4504 care network and in accessing the managed care network's formal  
4505 grievance process as qualified plans become available in each of  
4506 the regions pursuant to s. 409.973(2).

4507 (4)~~(6)~~ The department shall select the entities to become  
4508 aging resource centers based on each entity's readiness and  
4509 ability to perform the duties listed in subsection (3) ~~(5)~~ and  
4510 the entity's:

4511 (a) Expertise in the needs of each target population the  
4512 center proposes to serve and a thorough knowledge of the  
4513 providers that serve these populations.

4514 (b) Strong connections to service providers, volunteer  
4515 agencies, and community institutions.

4516 (c) Expertise in information and referral activities.

4517 (d) Knowledge of long-term-care resources, including  
4518 resources designed to provide services in the least restrictive  
4519 setting.

4520 (e) Financial solvency and stability.

4521 (f) Ability to collect, monitor, and analyze data in a  
4522 timely and accurate manner, along with systems that meet the  
4523 department's standards.

4524 (g) Commitment to adequate staffing by qualified personnel

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4525 to effectively perform all functions.

4526 (h) Ability to meet all performance standards established  
4527 by the department.

4528 (5)~~(7)~~ The aging resource center shall have a governing  
4529 body which shall be the same entity described in s. 20.41(7),  
4530 and an executive director who may be the same person as  
4531 described in s. 20.41(7). The governing body shall annually  
4532 evaluate the performance of the executive director.

4533 (6)~~(8)~~ The aging resource center may not be a provider of  
4534 direct services other than information and referral services,  
4535 and screening.

4536 (7)~~(9)~~ The aging resource center must agree to allow the  
4537 department to review any financial information the department  
4538 determines is necessary for monitoring or reporting purposes,  
4539 including financial relationships.

4540 (8)~~(10)~~ The duties and responsibilities of the community  
4541 care for the elderly lead agencies within each area served by an  
4542 aging resource center shall be to:

4543 (a) Develop strong community partnerships to maximize the  
4544 use of community resources for the purpose of assisting elders  
4545 to remain in their community settings for as long as it is  
4546 safely possible.

4547 (b) Conduct comprehensive assessments of clients that have  
4548 been determined eligible and develop a care plan consistent with  
4549 established protocols that ensures that the unique needs of each  
4550 client are met.

4551 (9)~~(11)~~ The services to be administered through the aging  
4552 resource center shall include those funded by the following  
4553 programs:

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- 4554 (a) Community care for the elderly.  
4555 (b) Home care for the elderly.  
4556 (c) Contracted services.  
4557 (d) Alzheimer's disease initiative.  
4558 (e) Aged and disabled adult Medicaid waiver.  
4559 (f) Assisted living for the frail elderly Medicaid waiver.  
4560 (g) Older Americans Act.  
4561 (10)~~(12)~~ The department shall, prior to designation of an  
4562 aging resource center, develop by rule operational and quality  
4563 assurance standards and outcome measures to ensure that clients  
4564 receiving services through all long-term-care programs  
4565 administered through an aging resource center are receiving the  
4566 appropriate care they require and that contractors and  
4567 subcontractors are adhering to the terms of their contracts and  
4568 are acting in the best interests of the clients they are  
4569 serving, consistent with the intent of the Legislature to reduce  
4570 the use of and cost of nursing home care. The department shall  
4571 by rule provide operating procedures for aging resource centers,  
4572 which shall include:  
4573 (a) Minimum standards for financial operation, including  
4574 audit procedures.  
4575 (b) Procedures for monitoring and sanctioning of service  
4576 providers.  
4577 (c) Minimum standards for technology utilized by the aging  
4578 resource center.  
4579 (d) Minimum staff requirements which shall ensure that the  
4580 aging resource center employs sufficient quality and quantity of  
4581 staff to adequately meet the needs of the elders residing within  
4582 the area served by the aging resource center.

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4583 (e) Minimum accessibility standards, including hours of  
4584 operation.

4585 (f) Minimum oversight standards for the governing body of  
4586 the aging resource center to ensure its continuous involvement  
4587 in, and accountability for, all matters related to the  
4588 development, implementation, staffing, administration, and  
4589 operations of the aging resource center.

4590 (g) Minimum education and experience requirements for  
4591 executive directors and other executive staff positions of aging  
4592 resource centers.

4593 (h) Minimum requirements regarding any executive staff  
4594 positions that the aging resource center must employ and minimum  
4595 requirements that a candidate must meet in order to be eligible  
4596 for appointment to such positions.

4597 (11)~~(13)~~ In an area in which the department has designated  
4598 an area agency on aging as an aging resource center, the  
4599 department and the agency may ~~shall~~ not make payments for the  
4600 services listed in subsection (9) ~~(11)~~ and the Long-Term Care  
4601 Community Diversion Project for ~~such~~ persons who were not  
4602 screened and enrolled through the aging resource center. The  
4603 department shall cease making these payments for enrollees in  
4604 qualified plans as qualified plans become available in each of  
4605 the regions pursuant to s. 409.973(2).

4606 (12)~~(14)~~ Each aging resource center shall enter into a  
4607 memorandum of understanding with the department for  
4608 collaboration with the CARES unit staff. The memorandum of  
4609 understanding must ~~shall~~ outline the staff person responsible  
4610 for each function and ~~shall~~ provide the staffing levels  
4611 necessary to carry out the functions of the aging resource

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4612 center.

4613 (13)~~(15)~~ Each aging resource center shall enter into a  
4614 memorandum of understanding with the Department of Children and  
4615 Family Services for collaboration with the Economic Self-  
4616 Sufficiency Unit staff. The memorandum of understanding must  
4617 ~~shall~~ outline which staff persons are responsible for which  
4618 functions and ~~shall~~ provide the staffing levels necessary to  
4619 carry out the functions of the aging resource center.

4620 (14)~~(16)~~ If any of the state activities described in this  
4621 section are outsourced, ~~either~~ in part or in whole, the contract  
4622 executing the outsourcing must ~~shall~~ mandate that the contractor  
4623 or its subcontractors shall, ~~either~~ physically or virtually,  
4624 execute the provisions of the memorandum of understanding  
4625 instead of the state entity whose function the contractor or  
4626 subcontractor now performs.

4627 (15)~~(17)~~ In order to be eligible to begin transitioning to  
4628 an aging resource center, an area agency on aging board must  
4629 ensure that the area agency on aging which it oversees meets all  
4630 of the minimum requirements set by law and in rule.

4631 ~~(18) The department shall monitor the three initial~~  
4632 ~~projects for aging resource centers and report on the progress~~  
4633 ~~of those projects to the Governor, the President of the Senate,~~  
4634 ~~and the Speaker of the House of Representatives by June 30,~~  
4635 ~~2005. The report must include an evaluation of the~~  
4636 ~~implementation process.~~

4637 (16)~~(19)~~(a) Once an aging resource center is operational,  
4638 the department, in consultation with the agency, may develop  
4639 capitation rates for any of the programs administered through  
4640 the aging resource center. Capitation rates for programs must



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4641 shall be based on the historical cost experience of the state in  
4642 providing those same services to the population age 60 or older  
4643 residing within each area served by an aging resource center.  
4644 Each capitated rate may vary by geographic area as determined by  
4645 the department.

4646 (b) The department and the agency may determine for each  
4647 area served by an aging resource center whether it is  
4648 appropriate, consistent with federal and state laws and  
4649 regulations, to develop and pay separate capitated rates for  
4650 each program administered through the aging resource center or  
4651 to develop and pay capitated rates for service packages which  
4652 include more than one program or service administered through  
4653 the aging resource center.

4654 (c) Once capitation rates have been developed and certified  
4655 as actuarially sound, the department and the agency may pay  
4656 service providers the capitated rates for services if ~~when~~  
4657 appropriate.

4658 (d) The department, in consultation with the agency, shall  
4659 annually reevaluate and recertify the capitation rates,  
4660 adjusting forward to account for inflation, programmatic  
4661 changes.

4662 ~~(20) The department, in consultation with the agency, shall~~  
4663 ~~submit to the Governor, the President of the Senate, and the~~  
4664 ~~Speaker of the House of Representatives, by December 1, 2006, a~~  
4665 ~~report addressing the feasibility of administering the following~~  
4666 ~~services through aging resource centers beginning July 1, 2007:~~

- 4667 ~~(a) Medicaid nursing home services.~~  
4668 ~~(b) Medicaid transportation services.~~  
4669 ~~(c) Medicaid hospice care services.~~

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4670           ~~(d) Medicaid intermediate care services.~~  
4671           ~~(e) Medicaid prescribed drug services.~~  
4672           ~~(f) Medicaid assistive care services.~~  
4673           ~~(g) Any other long term care program or Medicaid service.~~  
4674           (17)~~(21)~~ This section does ~~shall~~ not be construed to allow  
4675 an aging resource center to restrict, manage, or impede the  
4676 local fundraising activities of service providers.

4677           Section 60. Paragraphs (c) and (d) of subsection (3) of  
4678 section 39.407, Florida Statutes, are amended to read:

4679           39.407 Medical, psychiatric, and psychological examination  
4680 and treatment of child; physical, mental, or substance abuse  
4681 examination of person with or requesting child custody.—

4682           (3)

4683           (c) Except as provided in paragraphs (b) and (e), the  
4684 department must file a motion seeking the court's authorization  
4685 to initially provide or continue to provide psychotropic  
4686 medication to a child in its legal custody. The motion must be  
4687 supported by a written report prepared by the department which  
4688 describes the efforts made to enable the prescribing physician  
4689 to obtain express and informed consent to provide ~~for providing~~  
4690 the medication to the child and other treatments considered or  
4691 recommended for the child. ~~In addition,~~ The motion must also be  
4692 supported by the prescribing physician's signed medical report  
4693 providing:

4694           1. The name of the child, the name and range of the dosage  
4695 of the psychotropic medication, and the ~~that there is a~~ need to  
4696 prescribe psychotropic medication to the child based upon a  
4697 diagnosed condition for which such medication is being  
4698 prescribed.

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4699           2. A statement indicating that the physician has reviewed  
4700 all medical information concerning the child which has been  
4701 provided.

4702           3. A statement indicating that the psychotropic medication,  
4703 at its prescribed dosage, is appropriate for treating the  
4704 child's diagnosed medical condition, as well as the behaviors  
4705 and symptoms the medication, at its prescribed dosage, is  
4706 expected to address.

4707           4. An explanation of the nature and purpose of the  
4708 treatment; the recognized side effects, risks, and  
4709 contraindications of the medication; drug-interaction  
4710 precautions; the possible effects of stopping the medication;  
4711 and how the treatment will be monitored, followed by a statement  
4712 indicating that this explanation was provided to the child if  
4713 age appropriate and to the child's caregiver.

4714           5. Documentation addressing whether the psychotropic  
4715 medication will replace or supplement any other currently  
4716 prescribed medications or treatments; the length of time the  
4717 child is expected to be taking the medication; and any  
4718 additional medical, mental health, behavioral, counseling, or  
4719 other services that the prescribing physician recommends.

4720           6. For a child 10 years of age or younger who is in an out-  
4721 of-home placement, the results of a review of the administration  
4722 of the medication by a child psychiatrist who is licensed under  
4723 chapter 458 or chapter 459. The review must be provided to the  
4724 child and the parent or legal guardian before final express and  
4725 informed consent is given. The review must include a  
4726 determination of the following:

4727           a. The presence of a genetic psychiatric disorder or a

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4728 family history of a psychiatric disorder;  
4729 b. Whether the cause of a psychiatric disorder is organic  
4730 or environmental; and

4731 c. The likelihood of the child being an imminent danger to  
4732 self or others.

4733 (d)~~1~~. The department must notify all parties of the  
4734 proposed action taken under paragraph (c) in writing or by  
4735 whatever other method best ensures that all parties receive  
4736 notification of the proposed action within 48 hours after the  
4737 motion is filed. If any party objects to the department's  
4738 motion, that party shall file the objection within 2 working  
4739 days after being notified of the department's motion. If any  
4740 party files an objection to the authorization of the proposed  
4741 psychotropic medication, the court shall hold a hearing as soon  
4742 as possible before authorizing the department to initially  
4743 provide or to continue providing psychotropic medication to a  
4744 child in the legal custody of the department.

4745 1. At such hearing and notwithstanding s. 90.803, the  
4746 medical report described in paragraph (c) is admissible in  
4747 evidence. The prescribing physician need not attend the hearing  
4748 or testify unless the court specifically orders such attendance  
4749 or testimony, or a party subpoenas the physician to attend the  
4750 hearing or provide testimony.

4751 2. If, after considering any testimony received, the court  
4752 finds that the department's motion and the physician's medical  
4753 report meet the requirements of this subsection and that it is  
4754 in the child's best interests, the court may order that the  
4755 department provide or continue to provide the psychotropic  
4756 medication to the child without additional testimony or

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4757 evidence.

4758 3. At any hearing held under this paragraph, the court  
4759 shall ~~further~~ inquire of the department as to whether additional  
4760 medical, mental health, behavioral, counseling, or other  
4761 services are being provided to the child by the department which  
4762 the prescribing physician considers to be necessary or  
4763 beneficial in treating the child's medical condition and which  
4764 the physician recommends or expects to provide to the child in  
4765 concert with the medication. The court may order additional  
4766 medical consultation, including consultation with the MedConsult  
4767 line at the University of Florida, if available, or require the  
4768 department to obtain a second opinion within a reasonable  
4769 timeframe as established by the court, not to exceed 21 calendar  
4770 days, ~~after such order~~ based upon consideration of the best  
4771 interests of the child. The department must make a referral for  
4772 an appointment for a second opinion with a physician within 1  
4773 working day.

4774 4. The court may not order the discontinuation of  
4775 prescribed psychotropic medication if such order is contrary to  
4776 the decision of the prescribing physician unless the court first  
4777 obtains an opinion from a licensed psychiatrist, if available,  
4778 or, if not available, a physician licensed under chapter 458 or  
4779 chapter 459, stating that more likely than not, discontinuing  
4780 the medication would not cause significant harm to the child.  
4781 If, however, the prescribing psychiatrist specializes in mental  
4782 health care for children and adolescents, the court may not  
4783 order the discontinuation of prescribed psychotropic medication  
4784 unless the required opinion is also from a psychiatrist who  
4785 specializes in mental health care for children and adolescents.

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4786 The court may also order the discontinuation of prescribed  
4787 psychotropic medication if a child's treating physician,  
4788 licensed under chapter 458 or chapter 459, states that  
4789 continuing the prescribed psychotropic medication would cause  
4790 significant harm to the child due to a diagnosed nonpsychiatric  
4791 medical condition.

4792 5. If a child who is in out-of-home placement is 10 years  
4793 of age or younger, psychotropic medication may not be authorized  
4794 by the court absent a finding of a compelling governmental  
4795 interest. In making such finding, the court shall review the  
4796 psychiatric review described in subparagraph (c)6.

4797 6.2. The burden of proof at any hearing held under this  
4798 paragraph shall be by a preponderance of the evidence.

4799 Section 61. Section 400.023, Florida Statutes, is reordered  
4800 and amended to read:

4801 400.023 Civil enforcement.-

4802 (1) A Any resident who whose alleges negligence or a  
4803 violation of rights as specified in this part has are violated  
4804 shall have a cause of action against the licensee or its  
4805 management company, as identified in the state application for  
4806 nursing home licensure. However, the cause of action may not be  
4807 asserted individually against an officer, director, owner,  
4808 including an owner designated as having a controlling interest  
4809 on the state application for nursing home licensure, or agent of  
4810 a licensee or management company unless, following an  
4811 evidentiary hearing, the court determines there is sufficient  
4812 evidence in the record or proffered by the claimant which  
4813 establishes a reasonable basis for finding that the person or  
4814 entity breached, failed to perform, or acted outside the scope

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4815 of duties as an officer, director, owner, or agent, and that the  
4816 breach, failure to perform, or action outside the scope of  
4817 duties is a legal cause of actual loss, injury, death, or damage  
4818 to the resident.

4819 (2) The action may be brought by the resident or his or her  
4820 guardian, by a person or organization acting on behalf of a  
4821 resident with the consent of the resident or his or her  
4822 guardian, or by the personal representative of the estate of a  
4823 deceased resident regardless of the cause of death.

4824 (5) If the action alleges a claim for the resident's rights  
4825 or for negligence that:

4826 (a) Caused the death of the resident, the claimant must  
4827 ~~shall be required to~~ elect ~~either~~ survival damages pursuant to  
4828 s. 46.021 or wrongful death damages pursuant to s. 768.21. If  
4829 the claimant elects wrongful death damages, total noneconomic  
4830 damages may not exceed \$250,000, regardless of the number of  
4831 claimants.

4832 ~~(b) If the action alleges a claim for the resident's rights~~  
4833 ~~or for negligence that~~ Did not cause the death of the resident,  
4834 the personal representative of the estate may recover damages  
4835 for the negligence that caused injury to the resident.

4836 (3) The action may be brought in any court of competent  
4837 jurisdiction to enforce such rights and to recover actual and  
4838 punitive damages for any violation of the rights of a resident  
4839 or for negligence.

4840 (10) Any resident who prevails in seeking injunctive relief  
4841 or a claim for an administrative remedy may ~~is entitled to~~  
4842 recover the costs of the action, and a reasonable attorney's fee  
4843 assessed against the defendant not to exceed \$25,000. Fees shall

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4844 be awarded solely for the injunctive or administrative relief  
4845 and not for any claim or action for damages whether such claim  
4846 or action is brought together with a request for an injunction  
4847 or administrative relief or as a separate action, except as  
4848 provided under s. 768.79 or the Florida Rules of Civil  
4849 Procedure. Sections 400.023-400.0238 provide the exclusive  
4850 remedy for a cause of action for recovery of damages for the  
4851 personal injury or death of a nursing home resident arising out  
4852 of negligence or a violation of rights specified in s. 400.022.  
4853 This section does not preclude theories of recovery not arising  
4854 out of negligence or s. 400.022 which are available to a  
4855 resident or to the agency. The provisions of chapter 766 do not  
4856 apply to any cause of action brought under ss. 400.023-400.0238.

4857 (6)(2) ~~If the In any~~ claim brought pursuant to this part  
4858 alleges ~~alleging~~ a violation of resident's rights or negligence  
4859 causing injury to or the death of a resident, the claimant shall  
4860 have the burden of proving, by a preponderance of the evidence,  
4861 that:

4862 (a) The defendant owed a duty to the resident;

4863 (b) The defendant breached the duty to the resident;

4864 (c) The breach of the duty is a legal cause of loss,  
4865 injury, death, or damage to the resident; and

4866 (d) The resident sustained loss, injury, death, or damage  
4867 as a result of the breach.

4868 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~  
4869 create strict liability. A violation of the rights set forth in  
4870 s. 400.022 or in any other standard or guidelines specified in  
4871 this part or in any applicable administrative standard or  
4872 guidelines of this state or a federal regulatory agency is ~~shall~~



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4873 ~~be~~ evidence of negligence but may ~~shall~~ not be considered  
4874 negligence per se.

4875 (7)~~(3)~~ In any claim brought pursuant to this section, a  
4876 licensee, person, or entity has ~~shall have~~ a duty to exercise  
4877 reasonable care. Reasonable care is that degree of care which a  
4878 reasonably careful licensee, person, or entity would use under  
4879 like circumstances.

4880 (9)~~(4)~~ In any claim for resident's rights violation or  
4881 negligence by a nurse licensed under part I of chapter 464, such  
4882 nurse has a ~~shall have the~~ duty to exercise care consistent with  
4883 the prevailing professional standard of care for a nurse. The  
4884 prevailing professional standard of care for a nurse is ~~shall be~~  
4885 that level of care, skill, and treatment which, in light of all  
4886 relevant surrounding circumstances, is recognized as acceptable  
4887 and appropriate by reasonably prudent similar nurses.

4888 (8)~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical  
4889 negligence of any physician rendering care or treatment to the  
4890 resident except for the administrative services of a medical  
4891 director as required in this part. ~~Nothing in~~ This subsection  
4892 does not ~~shall be construed to~~ protect a licensee, person, or  
4893 entity from liability for failure to provide a resident with  
4894 appropriate observation, assessment, nursing diagnosis,  
4895 planning, intervention, and evaluation of care by nursing staff.

4896 (4)~~(6)~~ The resident or the resident's legal representative  
4897 shall serve a copy of any complaint alleging in whole or in part  
4898 a violation of any rights specified in this part to the agency  
4899 ~~for Health Care Administration~~ at the time of filing the initial  
4900 complaint with the clerk of the court for the county in which  
4901 the action is pursued. ~~The requirement of~~ Providing a copy of

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4902 the complaint to the agency does not impair the resident's legal  
4903 rights or ability to seek relief for his or her claim.

4904 ~~(11)(7)~~ An action under this part for a violation of rights  
4905 or negligence ~~recognized herein~~ is not a claim for medical  
4906 malpractice, and the provisions of s. 768.21(8) do not apply to  
4907 a claim alleging death of the resident.

4908 Section 62. Subsections (1), (2), and (3) of section  
4909 400.0237, Florida Statutes, are amended to read:

4910 400.0237 Punitive damages; pleading; burden of proof.—

4911 (1) In any action ~~for damages~~ brought under this part, a ~~no~~  
4912 claim for punitive damages is not shall be permitted unless,  
4913 based on admissible ~~there is a reasonable showing by evidence in~~  
4914 ~~the record or~~ proffered by the claimant, which would provide a  
4915 reasonable basis for recovery of such damages is demonstrated  
4916 upon applying the criteria set forth in this section. The  
4917 defendant may proffer admissible evidence to refute the  
4918 claimant's proffer of evidence to recover punitive damages. The  
4919 trial judge shall conduct an evidentiary hearing and weigh the  
4920 admissible evidence proffered by the claimant and the defendant  
4921 to ensure that there is a reasonable basis to believe that the  
4922 claimant, at trial, will be able to demonstrate by clear and  
4923 convincing evidence that the recovery of such damages is  
4924 warranted. The claimant may move to amend her or his complaint  
4925 to assert a claim for punitive damages as allowed by the rules  
4926 of civil procedure. ~~The rules of civil procedure shall be~~  
4927 ~~liberally construed so as to allow the claimant discovery of~~  
4928 ~~evidence which appears reasonably calculated to lead to~~  
4929 ~~admissible evidence on the issue of punitive damages. No~~  
4930 Discovery of financial worth may not shall proceed until after

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4931 the trial judge approves the pleading on concerning punitive  
4932 damages ~~is permitted~~.

4933 (2) A defendant, including the licensee or management  
4934 company, against whom punitive damages is sought may be held  
4935 liable for punitive damages only if the trier of fact, based on  
4936 clear and convincing evidence, finds that a specific individual  
4937 or corporate defendant actively and knowingly participated in  
4938 intentional misconduct, or engaged in conduct that constituted  
4939 gross negligence, and that conduct contributed to the loss,  
4940 damages, or injury suffered by the claimant ~~the defendant was~~  
4941 ~~personally guilty of intentional misconduct or gross negligence.~~  
4942 As used in this section, the term:

4943 (a) "Intentional misconduct" means that the defendant  
4944 against whom a claim for punitive damages is sought had actual  
4945 knowledge of the wrongfulness of the conduct and the high  
4946 probability that injury or damage to the claimant would result  
4947 and, despite that knowledge, intentionally pursued that course  
4948 of conduct, resulting in injury or damage.

4949 (b) "Gross negligence" means that the defendant's conduct  
4950 was so reckless or wanting in care that it constituted a  
4951 conscious disregard or indifference to the life, safety, or  
4952 rights of persons exposed to such conduct.

4953 (3) In the case of vicarious liability of an employer,  
4954 principal, corporation, or other legal entity, punitive damages  
4955 may not be imposed for the conduct of an identified employee or  
4956 agent unless ~~only if~~ the conduct of the employee or agent meets  
4957 the criteria specified in subsection (2) and officers,  
4958 directors, or managers of the actual employer corporation or  
4959 legal entity condoned, ratified, or consented to the specific

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4960 conduct as alleged by the claimant in subsection (2).~~+~~

4961 ~~(a) The employer, principal, corporation, or other legal~~  
4962 ~~entity actively and knowingly participated in such conduct;~~

4963 ~~(b) The officers, directors, or managers of the employer,~~  
4964 ~~principal, corporation, or other legal entity condoned,~~  
4965 ~~ratified, or consented to such conduct; or~~

4966 ~~(c) The employer, principal, corporation, or other legal~~  
4967 ~~entity engaged in conduct that constituted gross negligence and~~  
4968 ~~that contributed to the loss, damages, or injury suffered by the~~  
4969 ~~claimant.~~

4970 Section 63. Paragraphs (f), (h), (j), and (l) of subsection  
4971 (1) and subsection (2) of section 409.1671, Florida Statutes,  
4972 are amended to read:

4973 409.1671 Foster care and related services; outsourcing.—

4974 (1)

4975 (f)~~1~~. The Legislature finds that the state has  
4976 traditionally provided foster care services to children who are  
4977 ~~have been~~ the responsibility of the state. As such, foster  
4978 children have not had the right to recover for injuries beyond  
4979 the limitations specified in s. 768.28. The Legislature has also  
4980 determined that foster care and related services need to be  
4981 outsourced ~~pursuant to this section~~ and that the provision of  
4982 such services is of paramount importance to the state. The  
4983 purpose for such outsourcing is to increase the level of safety,  
4984 security, and stability of children who are or become the  
4985 responsibility of the state.

4986 1. One of the components necessary to secure a safe and  
4987 stable environment for such children is for ~~that~~ private  
4988 providers to maintain adequate liability insurance. ~~As Such,~~

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4989 insurance needs to be available and remain available to  
4990 nongovernmental foster care and related services providers  
4991 without the resources of such providers being significantly  
4992 reduced by the cost of maintaining such insurance. To ensure  
4993 that these resources are not significantly reduced, specified  
4994 limits of liability are necessary for eligible lead community-  
4995 based providers and subcontractors engaged in the provision of  
4996 services previously performed by the department.

4997 2. The Legislature further finds that, by requiring the  
4998 following minimum levels of insurance, children in outsourced  
4999 foster care and related services will gain increased protection  
5000 ~~and rights of recovery in the event of injury than provided for~~  
5001 ~~in s. 768.28.~~

5002 (h) Other than an entity to which s. 768.28 applies, an any  
5003 eligible lead community-based provider, ~~as defined in paragraph~~  
5004 ~~(e),~~ or its employees or officers, except as otherwise provided  
5005 in paragraph (i), must, as a part of its contract, obtain  
5006 general liability coverage for a minimum of \$200,000 per claim  
5007 or \$300,000 per incident ~~a minimum of \$1 million per claim/\$3~~  
5008 ~~million per incident in general liability insurance coverage.~~

5009 1. The eligible lead community-based provider must also  
5010 require ~~that~~ staff who transport client children and families in  
5011 their personal automobiles in order to carry out their job  
5012 responsibilities to obtain minimum bodily injury liability  
5013 insurance on their personal automobiles in the amount of  
5014 \$100,000 per claim or, \$300,000 per incident, ~~on their personal~~  
5015 ~~automobiles.~~ In lieu of personal motor vehicle insurance, the  
5016 lead community-based provider's casualty, liability, or motor  
5017 vehicle insurance carrier may provide nonowned automobile

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5018 liability coverage. ~~This insurance provides liability insurance~~  
5019 for automobiles that the provider uses in connection with the  
5020 provider's business but does not own, lease, rent, or borrow.  
5021 This coverage includes automobiles owned by the employees of the  
5022 provider or a member of the employee's household ~~but only~~ while  
5023 the automobiles are used in connection with the provider's  
5024 business. The nonowned automobile coverage ~~for the provider~~  
5025 applies as excess coverage over any other collectible insurance.  
5026 The personal automobile policy for the employee of the provider  
5027 shall be primary insurance, and the nonowned automobile coverage  
5028 of the provider acts as excess insurance to the primary  
5029 insurance. The provider shall provide a minimum limit of \$1  
5030 million in nonowned automobile coverage.

5031 2. In any tort action brought against ~~such~~ an eligible lead  
5032 community-based provider or employee, net economic damages are  
5033 ~~shall be~~ limited to \$200,000 ~~\$1 million~~ per liability claim,  
5034 \$300,000 per liability incident, and \$100,000 per automobile  
5035 claim, including, but not limited to, past and future medical  
5036 expenses, wage loss, and loss of earning capacity, offset by any  
5037 collateral source payment paid or payable. In any tort action  
5038 brought against an eligible lead community-based provider, the  
5039 total economic damages recoverable by all claimants is limited  
5040 to \$500,000 in the aggregate. In any tort action brought against  
5041 such an eligible lead community-based provider, noneconomic  
5042 damages are ~~shall be~~ limited to \$200,000 per claim and \$300,000  
5043 per incident. In any tort action brought against an eligible  
5044 lead community-based provider, the total noneconomic damages  
5045 recoverable by all claimants are limited to \$500,000 in the  
5046 aggregate.

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5047           3. A claims bill may be brought on behalf of a claimant  
5048 pursuant to s. 768.28 for any amount exceeding the limits  
5049 specified in this paragraph. Any offset of collateral source  
5050 payments made as of the date of the settlement or judgment shall  
5051 be in accordance with s. 768.76. The lead community-based  
5052 provider is ~~shall~~ not be liable in tort for the acts or  
5053 omissions of its subcontractors or the officers, agents, or  
5054 employees of its subcontractors.

5055           (j) Any subcontractor of an eligible lead community-based  
5056 provider, ~~as defined in paragraph (e),~~ which is a direct  
5057 provider of foster care and related services to children and  
5058 families, and its employees or officers, except as otherwise  
5059 provided in paragraph (i), must, as a part of its contract,  
5060 obtain general liability insurance coverage for a minimum of  
5061 \$200,000 per claim or \$300,000 ~~\$1 million per claim/\$3 million~~  
5062 ~~per incident in general liability insurance coverage.~~

5063           1. The subcontractor of an eligible lead community-based  
5064 provider must also require that staff who transport client  
5065 children and families in their personal automobiles in order to  
5066 carry out their job responsibilities obtain minimum bodily  
5067 injury liability insurance in the amount of \$100,000 per claim,  
5068 \$300,000 per incident, on their personal automobiles. In lieu of  
5069 personal motor vehicle insurance, the subcontractor's casualty,  
5070 liability, or motor vehicle insurance carrier may provide  
5071 nonowned automobile liability coverage. This insurance provides  
5072 liability insurance for automobiles that the subcontractor uses  
5073 in connection with the subcontractor's business but does not  
5074 own, lease, rent, or borrow. This coverage includes automobiles  
5075 owned by the employees of the subcontractor or a member of the

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5076 employee's household but only while the automobiles are used in  
5077 connection with the subcontractor's business. The nonowned  
5078 automobile coverage for the subcontractor applies as excess  
5079 coverage over any other collectible insurance. The personal  
5080 automobile policy for the employee of the subcontractor ~~is shall~~  
5081 ~~be~~ primary insurance, and the nonowned automobile coverage of  
5082 the subcontractor acts as excess insurance to the primary  
5083 insurance. The subcontractor shall provide a minimum limit of \$1  
5084 million in nonowned automobile coverage.

5085 2. In any tort action brought against such subcontractor or  
5086 employee, net economic damages shall be limited to \$200,000 ~~\$1~~  
5087 ~~million~~ per liability claim, \$300,000 per liability incident,  
5088 and \$100,000 per automobile claim, including, but not limited  
5089 to, past and future medical expenses, wage loss, and loss of  
5090 earning capacity, offset by any collateral source payment paid  
5091 or payable. In any tort action brought against such  
5092 subcontractor or employee, the total economic damages  
5093 recoverable by all claimants is limited to \$500,000 in the  
5094 aggregate. In any tort action brought against such  
5095 subcontractor, noneconomic damages shall be limited to \$200,000  
5096 per claim and \$300,000 per incident. In any tort action brought  
5097 against such subcontractor or employee, the total noneconomic  
5098 damages recoverable by all claimants is limited to \$500,000 in  
5099 the aggregate.

5100 3. A claims bill may be brought on behalf of a claimant  
5101 pursuant to s. 768.28 for any amount exceeding the limits  
5102 specified in this paragraph. Any offset of collateral source  
5103 payments made as of the date of the settlement or judgment shall  
5104 be in accordance with s. 768.76.



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5105           ~~(1) The Legislature is cognizant of the increasing costs of~~  
5106 ~~goods and services each year and recognizes that fixing a set~~  
5107 ~~amount of compensation actually has the effect of a reduction in~~  
5108 ~~compensation each year. Accordingly, the conditional limitations~~  
5109 ~~on damages in this section shall be increased at the rate of 5~~  
5110 ~~percent each year, prorated from the effective date of this~~  
5111 ~~paragraph to the date at which damages subject to such~~  
5112 ~~limitations are awarded by final judgment or settlement.~~

5113           (2) ~~(a)~~ The department may contract for the delivery,  
5114 administration, or management of protective services, the  
5115 services specified in subsection (1) relating to foster care,  
5116 and other related services or programs, as appropriate.

5117           (a) The department shall use diligent efforts to ensure  
5118 that retain responsibility for the quality of contracted  
5119 services and programs and shall ensure that services are of high  
5120 quality and delivered in accordance with applicable federal and  
5121 state statutes and regulations. However, the department is not  
5122 liable in tort for the acts or omissions of eligible lead  
5123 community-based providers or their officers, agents, or  
5124 employees, or liable in tort for the acts or omissions of the  
5125 subcontractors of eligible lead community-based care providers  
5126 or their officers, agents, or employees. Further, the department  
5127 may not require eligible lead community-based providers or their  
5128 subcontractors to indemnify the department for the department's  
5129 acts or omissions or require eligible lead-based community  
5130 providers or their subcontractors to include the department as  
5131 an additional insured on an insurance policy.

5132           (b) The department shall ~~must~~ adopt written policies and  
5133 procedures for monitoring the contract for the delivery of

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5134 services by lead community-based providers. These policies and  
5135 procedures must, at a minimum, address the evaluation of fiscal  
5136 accountability and program operations, including provider  
5137 achievement of performance standards, provider monitoring of  
5138 subcontractors, and timely followup of corrective actions for  
5139 significant monitoring findings related to providers and  
5140 subcontractors. The ~~These~~ policies and procedures must also  
5141 include provisions for reducing the duplication of the  
5142 department's program monitoring activities both internally and  
5143 with other agencies, to the extent possible. The department's  
5144 written procedures must ensure that the written findings,  
5145 conclusions, and recommendations from monitoring the contract  
5146 ~~for services of lead community based providers~~ are communicated  
5147 to the director of the provider agency as expeditiously as  
5148 possible.

5149 (c) ~~(b)~~ Persons employed by the department in the provision  
5150 of foster care and related services whose positions are being  
5151 outsourced under this statute shall be given hiring preference  
5152 by the provider, if provider qualifications are met.

5153 Section 64. Section 458.3167, Florida Statutes, is created  
5154 to read:

5155 458.3167 Expert witness certificate.-

5156 (1) A physician who holds an active and valid license to  
5157 practice allopathic medicine in any other state or in Canada,  
5158 who submits an application form prescribed by the board to  
5159 obtain a certificate to provide expert testimony and pays the  
5160 application fee, and who has not had a previous expert witness  
5161 certificate revoked by the board shall be issued a certificate  
5162 to provide expert testimony.

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5163       (2) A physician possessing an expert witness certificate  
5164 may use the certificate only to give a verified written medical  
5165 expert opinion as provided in s. 766.203 and to provide expert  
5166 testimony concerning the prevailing professional standard of  
5167 care for medical negligence litigation pending in this state  
5168 against a physician licensed under this chapter or chapter 459.

5169       (3) An application for an expert witness certificate must  
5170 be approved or denied within 5 business days after receipt of a  
5171 completed application. An application that is not approved or  
5172 denied within the required time period is deemed approved. An  
5173 applicant seeking to claim certification by default shall notify  
5174 the board, in writing, of the intent to rely on the default  
5175 certification provision of this subsection. In such case, s.  
5176 458.327 does not apply, and the applicant may provide expert  
5177 testimony as provided in subsection (2).

5178       (4) All licensure fees, other than the initial certificate  
5179 application fee, including the neurological injury compensation  
5180 assessment, are waived for those persons obtaining an expert  
5181 witness certificate. The possession of an expert witness  
5182 certificate alone does not entitle the physician to engage in  
5183 the practice of medicine as defined in s. 458.305.

5184       (5) The board shall adopt rules to administer this section,  
5185 including rules setting the amount of the expert witness  
5186 certificate application fee, which may not exceed \$50. An expert  
5187 witness certificate expires 2 years after the date of issuance.

5188       Section 65. Subsection (11) is added to section 458.331,  
5189 Florida Statutes, present paragraphs (oo) through (qq) of  
5190 subsection (1) of that section are redesignated as paragraphs  
5191 (pp) through (rr), respectively, and a new paragraph (oo) is

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5192 added to that subsection, to read:

5193 458.331 Grounds for disciplinary action; action by the  
5194 board and department.-

5195 (1) The following acts constitute grounds for denial of a  
5196 license or disciplinary action, as specified in s. 456.072(2):

5197 (oo) Providing misleading, deceptive, or fraudulent expert  
5198 witness testimony related to the practice of medicine.

5199 (11) The purpose of this section is to facilitate uniform  
5200 discipline for those acts made punishable under this section  
5201 and, to this end, a reference to this section constitutes a  
5202 general reference under the doctrine of incorporation by  
5203 reference.

5204 Section 66. Section 459.0078, Florida Statutes, is created  
5205 to read:

5206 459.0078 Expert witness certificate.-

5207 (1) A physician who holds an active and valid license to  
5208 practice osteopathic medicine in any other state or in Canada,  
5209 who submits an application form prescribed by the board to  
5210 obtain a certificate to provide expert testimony and pays the  
5211 application fee, and who has not had a previous expert witness  
5212 certificate revoked by the board shall be issued a certificate  
5213 to provide expert testimony.

5214 (2) A physician possessing an expert witness certificate  
5215 may use the certificate only to give a verified written medical  
5216 expert opinion as provided in s. 766.203 and to provide expert  
5217 testimony concerning the prevailing professional standard of  
5218 care for medical negligence litigation pending in this state  
5219 against a physician licensed under this chapter or chapter 458.

5220 (3) An application for an expert witness certificate must

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5221 be approved or denied within 5 business days after receipt of a  
5222 completed application. An application that is not approved or  
5223 denied within the required time period is deemed approved. An  
5224 applicant seeking to claim certification by default shall notify  
5225 the board, in writing, of the intent to rely on the default  
5226 certification provision of this subsection. In such case, s.  
5227 459.013 does not apply, and the applicant may provide expert  
5228 testimony as provided in subsection (2).

5229 (4) All licensure fees, other than the initial certificate  
5230 application fee, including the neurological injury compensation  
5231 assessment, are waived for those persons obtaining an expert  
5232 witness certificate. The possession of an expert witness  
5233 certificate alone does not entitle the physician to engage in  
5234 the practice of osteopathic medicine as defined in s. 459.003.

5235 (5) The board shall adopt rules to administer this section,  
5236 including rules setting the amount of the expert witness  
5237 certificate application fee, which may not exceed \$50. An expert  
5238 witness certificate expires 2 years after the date of issuance.

5239 Section 67. Subsection (11) is added to section 459.015,  
5240 Florida Statutes, present paragraphs (qq) through (ss) of  
5241 subsection (1) of that section are redesignated as paragraphs  
5242 (rr) through (tt), respectively, and a new paragraph (qq) is  
5243 added to that subsection, to read:

5244 459.015 Grounds for disciplinary action; action by the  
5245 board and department.—

5246 (1) The following acts constitute grounds for denial of a  
5247 license or disciplinary action, as specified in s. 456.072(2):

5248 (qq) Providing misleading, deceptive, or fraudulent expert  
5249 witness testimony related to the practice of osteopathic

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5250 medicine.

5251 (11) The purpose of this section is to facilitate uniform  
5252 discipline for those acts made punishable under this section  
5253 and, to this end, a reference to this section constitutes a  
5254 general reference under the doctrine of incorporation by  
5255 reference.

5256 Section 68. Present subsection (12) of section 766.102,  
5257 Florida Statutes, is redesignated as subsection (13), and a new  
5258 subsection (12) is added to that section, to read:

5259 766.102 Medical negligence; standards of recovery; expert  
5260 witness.—

5261 (12) If a physician licensed under chapter 458 or chapter  
5262 459 is a party against whom, or on whose behalf, expert  
5263 testimony about the prevailing professional standard of care is  
5264 offered, the expert witness must otherwise meet the requirements  
5265 of this section and be licensed as a physician under chapter 458  
5266 or chapter 459, or must possess a valid expert witness  
5267 certificate issued under s. 458.3167 or s. 459.0078.

5268 Section 69. Subsection (1) of section 766.104, Florida  
5269 Statutes, is amended to read:

5270 766.104 Pleading in medical negligence cases; claim for  
5271 punitive damages; authorization for release of records for  
5272 investigation.—

5273 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or  
5274 wrongful death arising out of medical negligence, whether in  
5275 tort or in contract, may not be filed unless the attorney filing  
5276 the action has made a reasonable investigation, as permitted by  
5277 the circumstances, to determine that there are grounds for a  
5278 good faith belief that there has been negligence in the care or

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5279 treatment of the claimant.

5280       (a) The complaint or initial pleading must ~~shall~~ contain a  
5281 certificate of counsel that such reasonable investigation gave  
5282 rise to a good faith belief that grounds exist for an action  
5283 against each named defendant. For purposes of this section, good  
5284 faith may be shown ~~to exist~~ if the claimant or his or her  
5285 counsel has received a written opinion, ~~which shall not be~~  
5286 subject to discovery by an opposing party, of an expert as  
5287 defined in s. 766.102 that there appears to be evidence of  
5288 medical negligence. If the court determines that the ~~such~~  
5289 certificate of counsel was not made in good faith and that no  
5290 justiciable issue was presented against a health care provider  
5291 that fully cooperated in providing informal discovery, the court  
5292 shall award attorney's fees and taxable costs against claimant's  
5293 counsel, ~~and shall~~ submit the matter to The Florida Bar for  
5294 disciplinary review of the attorney.

5295       (b) If the cause of action requires the plaintiff to  
5296 establish the breach of a standard of care other than negligence  
5297 in order to impose liability or secure specified damages arising  
5298 out of the rendering of, or the failure to render, medical care  
5299 or services, and the plaintiff intends to pursue such liability  
5300 or damages, the investigation and certification required by this  
5301 subsection must demonstrate grounds for a good faith belief that  
5302 the requirement is satisfied.

5303       Section 70. Subsection (5) of section 766.106, Florida  
5304 Statutes, is amended to read:

5305       766.106 Notice before filing action for medical negligence;  
5306 presuit screening period; offers for admission of liability and  
5307 for arbitration; informal discovery; review.-

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5308 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,  
5309 written document, report, or other work product generated by the  
5310 presuit screening process is discoverable or admissible in any  
5311 civil action for any purpose by the opposing party. All  
5312 participants, including, but not limited to, physicians,  
5313 investigators, witnesses, and employees or associates of the  
5314 defendant, are immune from civil liability arising from  
5315 participation in the presuit screening process. This subsection  
5316 does not prohibit a physician licensed under chapter 458 or  
5317 chapter 459, or a physician who holds a certificate to provide  
5318 expert testimony under s. 458.3167 or s. 459.0078, who submits a  
5319 verified written expert medical opinion from being subject to  
5320 disciplinary action pursuant to s. 456.073.

5321 Section 71. Subsection (11) of section 766.1115, Florida  
5322 Statutes, is amended to read:

5323 766.1115 Health care providers; creation of agency  
5324 relationship with governmental contractors.—

5325 (11) APPLICABILITY.—

5326 (a) This section applies to incidents occurring on or after  
5327 April 17, 1992.

5328 (b) This section does not apply to any health care contract  
5329 entered into by the Department of Corrections which is subject  
5330 to s. 768.28(10)(a).

5331 (c) This section does not apply to any affiliation  
5332 agreement or other contract subject to s. 768.28(10)(f).

5333 (d) ~~Nothing in~~ This section does not reduce or limit in any  
5334 ~~way reduces or limits~~ the rights of the state or any of its  
5335 agencies or subdivisions to any benefit currently provided under  
5336 s. 768.28.



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5337 Section 72. Section 766.1183, Florida Statutes, is created  
5338 to read:

5339 766.1183 Standard of care for Medicaid providers.-

5340 (1) As used in this section:

5341 (a) The terms "applicant," "medical assistance," "medical  
5342 services," and "Medicaid recipient" have the same meaning as in  
5343 s. 409.901.

5344 (b) The term "provider" means a health care provider as  
5345 defined in s. 766.202 or an entity that qualifies for an  
5346 exemption under s. 400.9905(4)(e). The term includes:

5347 1. Any person or entity for whom a provider is vicariously  
5348 liable; and

5349 2. Any person or entity whose liability is based solely on  
5350 such person or entity being vicariously liable for the actions  
5351 of a provider.

5352 (c) The term "wrongful manner" means in bad faith or with  
5353 malicious purpose or in a manner exhibiting wanton and willful  
5354 disregard of human rights, safety, or property, and shall be  
5355 construed in conformity with the standard set forth in s.  
5356 768.28(9)(a).

5357 (2) A provider is not liable in excess of \$200,000 per  
5358 claimant or \$300,000 per occurrence for any cause of action  
5359 arising out of the rendering of, or the failure to render,  
5360 medical services to a Medicaid recipient, except as provided  
5361 under subsection (3). However, a judgment may be claimed and  
5362 rendered in excess of the amounts set forth in this subsection.  
5363 That portion of the judgment that exceeds these amounts may be  
5364 reported to the Legislature, but may be paid in part or in whole  
5365 by the state only by further act of the Legislature.

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5366       (3) A provider may be liable for an amount in excess of  
5367 \$200,000 per claimant or \$300,000 per occurrence only if the  
5368 claimant pleads and proves, by clear and convincing evidence,  
5369 that the provider acted in a wrongful manner. If the claimant so  
5370 pleads, the court, after a reasonable opportunity for discovery,  
5371 shall conduct a hearing before trial to determine if there is a  
5372 reasonable basis in evidence to conclude that the provider acted  
5373 in a wrongful manner. A claim for wrongful conduct is not  
5374 permitted, to the extent it exceeds the amounts set forth in  
5375 subsection (2), unless the claimant makes the showing required  
5376 by this subsection.

5377       (4) At the time an application for medical assistance is  
5378 submitted, the Department of Children and Family Services shall  
5379 furnish the applicant with written notice of the provisions of  
5380 this section.

5381       (5) This section does not limit or exclude the application  
5382 of any law, including s. 766.118, which places limitations upon  
5383 the recovery of civil damages.

5384       (6) This section does not apply to any claim for damages to  
5385 which s. 768.28 applies.

5386       Section 73. Section 766.1184, Florida Statutes, is created  
5387 to read:

5388       766.1184 Standard of care; low-income pool recipient.—

5389       (1) As used in this section, the term:

5390       (a) "Low-income pool recipient" means a low-income  
5391 individual who is uninsured or underinsured and who receives  
5392 primary care services from a provider which are delivered  
5393 exclusively using funding received by that provider under  
5394 proviso language accompanying specific appropriation 191 of the

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5395 2010-2011 fiscal year General Appropriations Act to establish  
5396 new or expand existing primary care clinics for low-income  
5397 persons who are uninsured or underinsured.

5398 (b) "Provider" means a health care provider, as defined in  
5399 s. 766.202, which received funding under proviso language  
5400 accompanying specific appropriation 191 of the fiscal year 2010-  
5401 11 General Appropriations Act to establish new or expand  
5402 existing primary care clinics for low-income persons who are  
5403 uninsured or underinsured. The term includes:

5404 1. Any person or entity for whom the provider is  
5405 vicariously liable; and

5406 2. Any person or entity whose liability is based solely on  
5407 such person or entity being vicariously liable for the actions  
5408 of the provider.

5409 (c) "Wrongful manner" means in bad faith or with malicious  
5410 purpose or in a manner exhibiting wanton and willful disregard  
5411 of human rights, safety, or property, and shall be construed in  
5412 conformity with the standard set forth in s. 768.28(9)(a).

5413  
5414 The funding of the provider's primary care clinic must have been  
5415 awarded pursuant to a plan approved by the Legislative Budget  
5416 Commission, and must be the subject of an agreement between the  
5417 provider and the Agency for Health Care Administration,  
5418 following the competitive solicitation of proposals to use low-  
5419 income pool grant funds to provide primary care services in  
5420 general acute hospitals, county health departments, faith-based  
5421 and community clinics, and federally qualified health centers to  
5422 uninsured or underinsured persons.

5423 (2) A provider is not liable in excess of \$200,000 per

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5424 claimant or \$300,000 per occurrence for any cause of action  
5425 arising out of the rendering of, or the failure to render,  
5426 primary care services to a low-income pool recipient, except as  
5427 provided under subsection (3). However, a judgment may be  
5428 claimed and rendered in excess of the amounts set forth in this  
5429 subsection. That portion of the judgment that exceeds these  
5430 amounts may be reported to the Legislature, but may be paid in  
5431 part or in whole by the state only by further act of the  
5432 Legislature.

5433 (3) A provider may be liable for an amount in excess of  
5434 \$200,000 per claimant or \$300,000 per occurrence only if the  
5435 claimant pleads and proves, by clear and convincing evidence,  
5436 that the provider acted in a wrongful manner. If the claimant so  
5437 pleads, the court, after a reasonable opportunity for discovery,  
5438 shall conduct a hearing before trial to determine if there is a  
5439 reasonable basis in evidence to conclude that the provider acted  
5440 in a wrongful manner. A claim for wrongful conduct is not  
5441 permitted, to the extent it exceeds the amounts set forth in  
5442 subsection (2), unless the claimant makes the showing required  
5443 by this subsection.

5444 (4) In order for this section to apply, the provider must:

5445 (a) Develop, implement, and maintain policies and  
5446 procedures to:

5447 1. Ensure that funds described in subsection (1) are used  
5448 exclusively to serve low-income persons who are uninsured or  
5449 underinsured;

5450 2. Determine whether funds described in subsection (1) are  
5451 being used to provide primary care services to a particular  
5452 person; and

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5453 3. Identify whether an individual receiving primary care  
5454 services is a low-income pool recipient to whom the provisions  
5455 of this section apply.

5456 (b) Furnish a low-income pool recipient with written notice  
5457 of the provisions of this section before providing primary care  
5458 services to the recipient.

5459 (c) Be in compliance with the terms of any agreement  
5460 between the provider and the Agency for Health Care  
5461 Administration governing the receipt of the funds described in  
5462 subsection (1).

5463 (5) This section does not limit or exclude the application  
5464 of any law, including s. 766.118, which places limitations upon  
5465 the recovery of civil damages.

5466 (6) This section does not apply to any claim for damages to  
5467 which s. 768.28 applies.

5468 Section 74. Subsection (5) is added to section 766.203,  
5469 Florida Statutes, to read:

5470 766.203 Presuit investigation of medical negligence claims  
5471 and defenses by prospective parties.—

5472 (5) STANDARDS OF CARE.—If the cause of action that is the  
5473 basis for the litigation requires the plaintiff to establish the  
5474 breach of a standard of care other than negligence in order to  
5475 impose liability or secure specified damages arising out of the  
5476 rendering of, or the failure to render, medical care or  
5477 services, and the plaintiff intends to pursue such liability or  
5478 damages, the presuit investigations required of the claimant and  
5479 the prospective defendant by this section must ascertain that  
5480 there are reasonable grounds to believe that the requirement is  
5481 satisfied.

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5482 Section 75. Paragraph (b) of subsection (9) of section  
5483 768.28, Florida Statutes, is amended, and paragraph (f) is added  
5484 to subsection (10) of that section, to read:

5485 768.28 Waiver of sovereign immunity in tort actions;  
5486 recovery limits; limitation on attorney fees; statute of  
5487 limitations; exclusions; indemnification; risk management  
5488 programs.—

5489 (9)

5490 (b) As used in this subsection, the term:

5491 1. "Employee" includes any volunteer firefighter.

5492 2. "Officer, employee, or agent" includes, but is not  
5493 limited to, any health care provider when providing services  
5494 pursuant to s. 766.1115;~~;~~ any member of the Florida Health  
5495 Services Corps, as defined in s. 381.0302, who provides  
5496 uncompensated care to medically indigent persons referred by the  
5497 Department of Health; any state not-for-profit college or  
5498 university that owns or operates an accredited medical school  
5499 and its employees or agents when providing services pursuant to  
5500 paragraph (10) (f);~~;~~ and any public defender or her or his  
5501 employee or agent, including, among others, an assistant public  
5502 defender and an investigator.

5503 (10)

5504 (f) For purposes of this section, any state not-for-profit  
5505 college or university that owns or operates an accredited  
5506 medical school, or any of its employees or agents, and that has  
5507 agreed in an affiliation agreement or other contract to provide,  
5508 or permit its employees or agents to provide, patient services  
5509 as agents of a teaching hospital is considered an agent of the  
5510 teaching hospital while acting within the scope of and pursuant

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5511 to guidelines established in the contract. To the extent allowed  
5512 by law, the contract must provide for the indemnification of the  
5513 state, up to the limits set out in this chapter, by the agent  
5514 for any liability incurred which was caused by the negligence of  
5515 the college or university or its employees or agents.

5516 1. For purposes of this paragraph, the term:

5517 a. "Employee or agent" means an officer, employee, agent,  
5518 or servant of a state not-for-profit college or university that  
5519 owns or operates an accredited medical school, including, but  
5520 not limited to, the faculty of the medical school, any health  
5521 care practitioner or licensee as defined in s. 456.001 for which  
5522 the college or university is vicariously liable, and the staff  
5523 or administrator of the medical school.

5524 b. "Patient services" mean:

5525 (I) Comprehensive health care services as defined in s.  
5526 641.19, including any related administrative service, provided  
5527 to patients in a teaching hospital or in a health care facility  
5528 owned by a state not-for-profit college or university that owns  
5529 or operates an accredited medical school, pursuant to an  
5530 affiliation agreement or other contract with a teaching  
5531 hospital;

5532 (II) Training and supervision of interns, residents, and  
5533 fellows providing patient services in a teaching hospital or in  
5534 a health care facility owned by a state not-for-profit college  
5535 or university that owns or operates an accredited medical  
5536 school, pursuant to an affiliation agreement or other contract  
5537 with a teaching hospital;

5538 (III) Participation in medical research protocols; or

5539 (IV) Training and supervision of medical students in a

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5540 teaching hospital or in a health care facility owned by a state  
5541 not-for-profit college or university that owns or operates an  
5542 accredited medical school, pursuant to an affiliation agreement  
5543 or other contract with a teaching hospital.

5544 c. "Teaching hospital" means a teaching hospital as defined  
5545 in s. 408.07 which is owned or operated by the state, a county  
5546 or municipality, a public health trust, a special taxing  
5547 district, a governmental entity having health care  
5548 responsibilities, or a not-for-profit entity that operates such  
5549 facilities as an agent of the state or a political subdivision  
5550 of the state under a lease or other contract.

5551 2. The teaching hospital or the medical school, or its  
5552 employees or agents, must provide written notice to each  
5553 patient, or the patient's legal representative, receipt of which  
5554 must be acknowledged in writing, that the college or university  
5555 that owns or operates the medical school and the employees or  
5556 agents of that college or university are acting as agents of the  
5557 teaching hospital and that the exclusive remedy for injury or  
5558 damage suffered as the result of any act or omission of the  
5559 teaching hospital, the college or university that owns or  
5560 operates the medical school, or the employees or agents of the  
5561 college or university while acting within the scope of duties  
5562 pursuant to the affiliation agreement or other contract with a  
5563 teaching hospital is by commencement of an action pursuant to  
5564 the provisions of this section.

5565 3. This paragraph does not designate any employee providing  
5566 contracted patient services in a teaching hospital as an  
5567 employee or agent of the state for purposes of chapter 440.

5568 Section 76. Legislative findings and intent.-



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5569 (1) The Legislature finds that:

5570 (a) Access to high quality, comprehensive, and affordable  
5571 health care for all persons in this state is a necessary state  
5572 goal, and that teaching hospitals play an intrinsic and  
5573 essential role in providing that access.

5574 (b) Graduate medical education, provided by colleges and  
5575 universities that own or operate private medical schools, helps  
5576 provide the comprehensive specialty training needed by medical  
5577 school graduates to develop and refine the skills essential to  
5578 the provision of high quality health care for our state  
5579 residents. Much of that education and training is provided in  
5580 public teaching hospitals under the direct supervision of  
5581 medical faculty employees who provide guidance, training, and  
5582 oversight, and serve as role models to their students.

5583 (c) A large proportion of medical care is provided in large  
5584 public teaching hospitals that serve as safety nets for many  
5585 indigent and underserved patients who otherwise might not  
5586 receive the medical help they need. Resident physician training  
5587 that takes place in such hospitals provides much of the care  
5588 provided to this population. Medical faculty, supervising such  
5589 training and care, are a vital link between educating and  
5590 training resident physicians and ensuring the provision of  
5591 quality care for indigent and underserved residents. Physicians  
5592 that assume this role are often called upon to juggle the  
5593 demands of patient care, teaching, research, health policy, and  
5594 budgetary issues related to the programs they administer.

5595 (d) The employees or agents of private colleges and  
5596 universities that enter into affiliation agreements or contracts  
5597 with public teaching hospitals to provide patient services do

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5598 not have the same level of protection against liability claims  
5599 as public teaching hospitals and their employees and agents who  
5600 provide the same patient services to the same patients. Thus,  
5601 these private colleges and universities and their employees and  
5602 agents are disproportionately affected by claims arising out of  
5603 alleged medical malpractice and other allegedly negligent acts.  
5604 Given the recent growth in medical schools and medical education  
5605 programs and ongoing efforts to support, strengthen, and  
5606 increase physician residency training positions and medical  
5607 faculty in both existing and newly designated teaching  
5608 hospitals, this exposure and the consequent disparity in  
5609 liability exposure will continue to increase. The vulnerability  
5610 of these colleges and universities to claims of medical  
5611 malpractice will only add to the current physician workforce  
5612 crisis in Florida, and can only be alleviated through  
5613 legislative action.

5614 (e) Ensuring that the employees and agents of private  
5615 colleges and universities that own or operated medical schools  
5616 are able to continue to treat patients, provide graduate medical  
5617 education, supervise medical students, engage in research, and  
5618 provide administrative support and services in public teaching  
5619 hospitals is an overwhelming public necessity.

5620 (2) The Legislature intends that:

5621 (a) Employees and agents of private colleges and  
5622 universities that own or operate medical schools, who provide  
5623 patient services as agents of a public teaching hospital be  
5624 immune from lawsuits in the same manner and to the same extent  
5625 as employees and agents of public teaching hospitals in this  
5626 state under existing law, and that such colleges and

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5627 universities and their employees and agents not be held  
5628 personally liable in tort or named as a party defendant in an  
5629 action while providing patient services in a public teaching  
5630 hospital, unless such services are provided in bad faith, with  
5631 malicious purpose, or in a manner exhibiting wanton and willful  
5632 disregard of human rights, safety, or property.

5633 (b) Private colleges and universities that own or operate  
5634 medical schools and that permit their employees or agents to  
5635 provide patient services in public teaching hospitals pursuant  
5636 to an affiliation agreement or other contract, be afforded  
5637 sovereign immunity protections under s. 768.28, Florida  
5638 Statutes.

5639 (3) The Legislature declares that there is an overpowering  
5640 public necessity for extending the state's sovereign immunity to  
5641 private colleges and universities, and their employees or  
5642 agents, which own or operate medical schools and provide medical  
5643 services in public teaching hospitals, and that there is no  
5644 alternative method of meeting such public necessity.

5645 Section 77. Section 1004.41, Florida Statutes, is amended  
5646 to read:

5647 1004.41 University of Florida; J. Hillis Miller Health  
5648 Center.—

5649 (1) There is established the J. Hillis Miller Health Center  
5650 at the University of Florida, including campuses at Gainesville  
5651 and Jacksonville and affiliated teaching hospitals, which shall  
5652 include the following colleges:

5653 (a) College of Dentistry.

5654 (b) College of Public Health and Health Professions.

5655 (c) College of Medicine.

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5656 (d) College of Nursing.

5657 (e) College of Pharmacy.

5658 (f) College of Veterinary Medicine and related teaching  
5659 hospitals.

5660 (2) Each college of the health center shall be ~~se~~  
5661 maintained and operated so as to comply with the standards  
5662 approved by a nationally recognized association for  
5663 accreditation.

5664 (3)(a) The University of Florida Health Center Operations  
5665 and Maintenance Trust Fund shall be administered by the  
5666 University of Florida Board of Trustees. Funds shall be credited  
5667 to the trust fund from the sale of goods and services performed  
5668 by the University of Florida Veterinary Medicine Teaching  
5669 Hospital. The purpose of the trust fund is to support the  
5670 instruction, research, and service missions of the University of  
5671 Florida College of Veterinary Medicine.

5672 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and  
5673 pursuant to s. 216.351, any balance in the trust fund at the end  
5674 of any fiscal year shall remain in the trust fund and ~~shall~~ be  
5675 available for carrying out the purposes of the trust fund.

5676 (4)(a) The University of Florida Board of Trustees shall  
5677 lease the hospital facilities of the health center known as the  
5678 Shands Teaching Hospital and Clinics on the Gainesville campus  
5679 of the University of Florida and all furnishings, equipment, and  
5680 other chattels or choses in action used in the operation of the  
5681 hospital, to Shands Teaching Hospital and Clinics, Inc., a  
5682 private not-for-profit corporation organized ~~solely~~ for the  
5683 primary purpose of supporting operating the University of  
5684 Florida Board of Trustees' health affairs mission of community

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5685 service and patient care, education and training of health  
5686 professionals, and clinical research. In furtherance of that  
5687 purpose, Shands Teaching Hospital and Clinics, Inc., shall  
5688 operate the hospital and ancillary health care facilities as  
5689 deemed of the health center and other health care facilities and  
5690 programs determined to be necessary by the board of Shands  
5691 Teaching Hospital and Clinics, Inc. the nonprofit corporation.  
5692 The rental for the hospital facilities shall be an amount equal  
5693 to the debt service on bonds or revenue certificates issued  
5694 solely for capital improvements to the hospital facilities or as  
5695 otherwise provided by law.

5696 (b) The University of Florida Board of Trustees shall  
5697 provide in the lease or by separate contract or agreement with  
5698 Shands Teaching Hospital and Clinics, Inc., the not-for-profit  
5699 corporation for the following:

5700 1. Approval of the articles of incorporation of Shands  
5701 Teaching Hospital and Clinics, Inc., the not-for-profit  
5702 corporation by the University of Florida Board of Trustees and  
5703 the governance of that the not-for-profit corporation by a board  
5704 of directors appointed, subject to removal, and chaired by the  
5705 President of the University of Florida, or his or her designee,  
5706 and vice chaired by the Vice President for Health Affairs of the  
5707 University of Florida, or his or her designee.

5708 2. The use of hospital facilities and personnel in support  
5709 of community service and patient care, ~~the~~ research programs,  
5710 and ~~of the~~ teaching roles ~~role~~ of the health center.

5711 3. The continued recognition of the collective bargaining  
5712 units and collective bargaining agreements as currently composed  
5713 and recognition of the certified labor organizations

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5714 representing those units and agreements.

5715 4. The use of hospital facilities and personnel in  
5716 connection with research programs conducted by the health  
5717 center.

5718 5. Reimbursement to the hospital for indigent patients,  
5719 state-mandated programs, underfunded state programs, and costs  
5720 to the hospital for support of the teaching and research  
5721 programs of the health center. Such reimbursement shall be  
5722 appropriated to either the health center or the hospital each  
5723 year by the Legislature after review and approval of the request  
5724 for funds.

5725 (c) The University of Florida Board of Trustees may, with  
5726 the approval of the Legislature, increase the hospital  
5727 facilities or remodel or renovate them, provided that the rental  
5728 paid by the hospital for such new, remodeled, or renovated  
5729 facilities is sufficient to amortize the costs thereof over a  
5730 reasonable period of time or fund the debt service for any bonds  
5731 or revenue certificates issued to finance such improvements.

5732 (d) The University of Florida Board of Trustees is  
5733 authorized to provide to Shands Teaching Hospital and Clinics,  
5734 Inc., ~~the not-for-profit corporation leasing the hospital~~  
5735 ~~facilities~~ and its not-for-profit subsidiaries and affiliates  
5736 comprehensive general liability insurance including professional  
5737 liability from a self-insurance trust program established  
5738 pursuant to s. 1004.24.

5739 (e) Shands Teaching Hospital and Clinics, Inc., may, in  
5740 support of the health affairs mission of the University of  
5741 Florida Board of Trustees and with its prior approval, create  
5742 for-profit or not-for-profit corporate subsidiaries and

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5743 affiliates, or both. The University of Florida Board of  
5744 Trustees, which may act through the President of the University  
5745 of Florida or his or her designee, has the right to control  
5746 Shands Teaching Hospital and Clinics, Inc. Shands Teaching  
5747 Hospital and Clinics, Inc., and any not-for-profit subsidiaries  
5748 are conclusively deemed corporations primarily acting as  
5749 instrumentalities of the state, pursuant to s. 768.28(2), for  
5750 purposes of sovereign immunity.

5751 ~~(f)(e)~~ If In the event that the lease of the hospital  
5752 facilities to Shands Teaching Hospital and Clinics, Inc., the  
5753 ~~not-for-profit corporation~~ is terminated for any reason, the  
5754 University of Florida Board of Trustees shall resume management  
5755 and operation of the hospital facilities. In such event, the  
5756 University of Florida Board of Trustees is authorized to utilize  
5757 revenues generated from the operation of the hospital facilities  
5758 to pay the costs and expenses of operating the hospital facility  
5759 for the remainder of the fiscal year in which such termination  
5760 occurs.

5761 ~~(5)(f)~~ Shands Jacksonville Medical Center, Inc., and its  
5762 parent Shands Jacksonville Healthcare, Inc., are private not-  
5763 for-profit corporations organized primarily to support the  
5764 health affairs mission of the University of Florida Board of  
5765 Trustees in community service and patient care, education and  
5766 training of health affairs professionals, and clinical research.  
5767 Shands Jacksonville Medical Center, Inc., is a teaching hospital  
5768 affiliated with the University of Florida Board of Trustees,  
5769 located on the Jacksonville Campus of the University of Florida.  
5770 Shands Jacksonville Medical Center, Inc., and Shands  
5771 Jacksonville Healthcare, Inc., may, in support of the health

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5772 affairs mission of the University of Florida Board of Trustees  
5773 and with its prior approval, create for-profit or not-for-profit  
5774 corporate subsidiaries and affiliates, or both.

5775 (a) The University of Florida Board of Trustees, which may  
5776 act through the President of the University of Florida or his or  
5777 her designee, has the right to control Shands Jacksonville  
5778 Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.  
5779 Shands Jacksonville Medical Center, Inc., Shands Jacksonville  
5780 Healthcare, Inc., and any not-for-profit subsidiary of Shands  
5781 Jacksonville Medical Center, Inc., are conclusively deemed  
5782 corporations primarily acting as instrumentalities of the state,  
5783 pursuant to s. 768.28(2), for purposes of sovereign immunity.

5784 (b) The University of Florida Board of Trustees is  
5785 authorized to provide to Shands Jacksonville Healthcare, Inc.,  
5786 and its not-for-profit subsidiaries and affiliates and any  
5787 successor corporation that acts in support of the board of  
5788 trustees, comprehensive general liability coverage, including  
5789 professional liability, from the self-insurance programs  
5790 established pursuant to s. 1004.24.

5791 Section 78. Sections 409.9121, 409.919, and 624.915,  
5792 Florida Statutes, are repealed.

5793 Section 79. Section 409.942, Florida Statutes, is  
5794 transferred and renumbered as section 414.29, Florida Statutes.

5795 Section 80. Paragraph (a) of subsection (1) of section  
5796 443.111, Florida Statutes, is amended to read:

5797 443.111 Payment of benefits.—

5798 (1) MANNER OF PAYMENT.—Benefits are payable from the fund  
5799 in accordance with rules adopted by the Agency for Workforce  
5800 Innovation, subject to the following requirements:



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5801 (a) Benefits are payable by mail or electronically.  
5802 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a  
5803 system for the payment of benefits by electronic funds transfer,  
5804 including, but not limited to, debit cards, electronic payment  
5805 cards, or any other means of electronic payment that the agency  
5806 deems to be commercially viable or cost-effective. Commodities  
5807 or services related to the development of such a system shall be  
5808 procured by competitive solicitation, unless they are purchased  
5809 from a state term contract pursuant to s. 287.056. The agency  
5810 shall adopt rules necessary to administer the system.

5811 Section 81. Sections 409.944, 409.945, and 409.946, Florida  
5812 Statutes, are transferred and renumbered as sections 163.464,  
5813 163.465, and 163.466, Florida Statutes, respectively.

5814 Section 82. Sections 409.953 and 409.9531, Florida  
5815 Statutes, are transferred and renumbered as sections 402.81 and  
5816 402.82, Florida Statutes, respectively.

5817 Section 83. The Agency for Health Care administration shall  
5818 submit an reorganizational plan to the Governor, the Speaker of  
5819 the House of Representatives, and the President of the Senate by  
5820 January 1, 2012, which converts the agency from a check-writing  
5821 and fraud-chasing agency into a contract compliance and  
5822 monitoring agency.

5823 Section 84. Effective December 1, 2011, if the Legislature  
5824 has not received a letter from the Governor stating that the  
5825 federal Centers for Medicare and Medicaid has approved the  
5826 waivers necessary to implement the Medicaid managed care reforms  
5827 contained in this act, the State of Florida shall withdraw from  
5828 the Medicaid program effective December 31, 2011.

5829 Section 85. If any provision of this act or its application

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5830 to any person or circumstance is held invalid, the invalidity  
5831 does not affect other provisions or applications of the act  
5832 which can be given effect without the invalid provision or  
5833 application, and to this end the provisions of this act are  
5834 severable.

5835 Section 86. This act shall take effect upon becoming a law.