By Senator Negron

28-01190B-11 20111972__

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

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30 option to share the data electronically; requiring
31 interagency agreements to ensure that the data
32 exchanged is protected from unauthorized disclosure
33 and is used only for enrollment in the Florida Kidcare
34 program; amending s. 409.901, F.S.; revising
35 definitions relating to Medicaid; amending s. 409.902,
36 F.S.; revising provisions relating to the designation
37 of the Agency for Health Care Administration as the
38 state Medicaid agency; specifying that eligibility and
39 state funds for medical services apply only to
40 citizens and certain noncitizens; providing
41 exceptions; providing a limitation on persons
42 transferring assets in order to become eligible for
43 certain services; amending s. 409.9021, F.S.; revising
44 provisions relating to conditions for Medicaid
45 eligibility; increasing the number of years a Medicaid
46 applicant forfeits entitlements to the Medicaid
47 program if he or she has committed fraud; providing
48 for the payment of monthly premiums by Medicaid
49 recipients; providing exemptions to the premium
50 requirement; requiring applicants to agree to
51 participate in certain health programs; prohibiting a
52 recipient who has access to employer-sponsored health
53 care from obtaining services reimbursed through the
54 Medicaid fee-for-service system; requiring the agency
55 to develop a process to allow the Medicaid premium
56 that would have been received to be used to pay
57 employer premiums; requiring that the agency allow
58 opt-out opportunities for certain recipients; creating

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59 s. 409.9022, F.S.; specifying procedures to be
60 implemented by a state agency if the Medicaid
61 expenditures exceed appropriations; amending s.
62 409.903, F.S.; conforming provisions to changes made
63 by the act; deleting obsolete provisions; amending s.
64 409.904, F.S.; conforming provisions to changes made
65 by the act; renaming the "medically needy" program as
66 the "Medicaid nonpoverty medical subsidy"; narrowing
67 the subsidy to cover only certain services for a
68 family, persons age 65 or older, or blind or disabled
69 persons; revising the criteria for the agency's
70 assessment of need for private duty nursing services;
71 amending s. 409.905, F.S.; conforming provisions to
72 changes made by the act; requiring prior authorization
73 for home health services; amending s. 409.906, F.S.;
74 providing for a parental fee based on family income to
75 be assessed against the parents of children with
76 developmental disabilities served by home and
77 community-based waivers; prohibiting the agency from
78 paying for certain psychotropic medications prescribed
79 for a child; conforming provisions to changes made by
80 the act; amending ss. 409.9062 and 409.907, F.S.;
81 conforming provisions to changes made by the act;
82 amending s. 409.908, F.S.; modifying the nursing home
83 patient care per diem rate to include dental care and
84 podiatric care; directing the agency to seek a waiver
85 to treat a portion of the nursing home per diem as
86 capital for self-insurance purposes; requiring primary
87 physicians to be paid the Medicare fee-for-service

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88 rate by a certain date; deleting the requirement that
89 the agency contract for transportation services with
90 the community transportation system; authorizing
91 qualified plans to contract for transportation
92 services; deleting obsolete provisions; conforming
93 provisions to changes made by the act; amending s.
94 409.9081, F.S.; revising copayments for physician
95 visits; requiring the agency to seek a waiver to allow
96 the increase of copayments for nonemergency services
97 furnished in a hospital emergency department; amending
98 s. 409.912, F.S.; requiring Medicaid-eligible children
99 who have open child welfare cases and who reside in
100 AHCA area 10 to be enrolled in specified capitated
101 managed care plans; expanding the number of children
102 eligible to receive behavioral health care services
103 through a specialty prepaid plan; repealing provisions
104 relating to a provider lock-in program; eliminating
105 obsolete provisions and updating provisions;
106 conforming cross-references; amending s. 409.915,
107 F.S.; conforming provisions to changes made by the
108 act; transferring, renumbering, and amending s.
109 409.9301, F.S.; conforming provisions to changes made
110 by the act; amending s. 409.9126, F.S.; conforming a
111 cross-reference; providing a directive to the Division
112 of Statutory Revision; creating s. 409.961, F.S.;
113 providing for statutory construction of provisions
114 relating to Medicaid managed care; creating s.
115 409.962, F.S.; providing definitions; creating s.
116 409.963, F.S.; establishing the Medicaid managed care

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117 program as the statewide, integrated managed care
118 program for medical assistance and long-term care
119 services; directing the agency to apply for and
120 implement waivers; providing for public notice and
121 comment; providing for a limited managed care program
122 if waivers are not approved; creating s. 409.964,
123 F.S.; requiring all Medicaid recipients to be enrolled
124 in Medicaid managed care; providing exemptions;
125 prohibiting a recipient who has access to employer-
126 sponsored health care from enrolling in Medicaid
127 managed care; requiring the agency to develop a
128 process to allow the Medicaid premium that would have
129 been received to be used to pay employer premiums;
130 requiring that the agency allow opt-out opportunities
131 for certain recipients; providing for voluntary
132 enrollment; creating s. 409.965, F.S.; providing
133 requirements for qualified plans that provide services
134 in the Medicaid managed care program; requiring the
135 agency to issue an invitation to negotiate; requiring
136 the agency to compile and publish certain information;
137 establishing regions for separate procurement of
138 plans; establishing selection criteria for plan
139 selection; limiting the number of plans in a region;
140 authorizing the agency to conduct negotiations if
141 funding is insufficient; specifying circumstances
142 under which the agency may issue a new invitation to
143 negotiate; providing that the Children’s Medical
144 Service Network is a qualified plan; directing the
145 agency to assign Medicaid provider agreements for a

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146 limited time to a provider services network
147 participating in the managed care program in a rural
148 area; creating s. 409.966, F.S.; providing managed
149 care plan contract requirements; establishing contract
150 terms; providing for annual rate setting; providing
151 for contract extension under certain circumstances;
152 establishing access requirements; requiring the agency
153 to establish performance standards for plans;
154 requiring each plan to publish specified measures on
155 the plan's website; providing for program integrity;
156 requiring plans to provide encounter data; providing
157 penalties for failure to submit data; requiring plans
158 to accept electronic claims; providing for prompt
159 payment; providing for payments to noncontract
160 emergency providers; requiring a qualified plan to
161 post a surety bond or establish a letter of credit or
162 a deposit in a trust account; requiring plans to
163 establish a grievance resolution process; requiring
164 plan solvency; requiring guaranteed savings; providing
165 costs and penalties for early termination of contracts
166 or reduction in enrollment levels; requiring the
167 agency to terminate qualified plans for noncompliance
168 under certain circumstances; creating s. 409.967,
169 F.S.; providing for managed care plan accountability;
170 requiring plans to use a uniform method of accounting
171 for medical costs; establishing a medical loss ratio;
172 requiring that a plan pay back to the agency a
173 specified amount in specified circumstances;
174 authorizing plans to limit providers in networks;

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

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204 of recipients who move out of a region; creating s.
205 409.970, F.S.; requiring the agency to maintain an
206 encounter data system; providing requirements for
207 prepaid plans to submit data in a certain format;
208 requiring the agency to analyze the data; requiring
209 the agency to test the data for certain purposes by a
210 certain date; creating s. 409.971, F.S.; providing for
211 managed care medical assistance; providing deadlines
212 for beginning and finalizing implementation; creating
213 s. 409.972, F.S.; establishing minimum services for
214 the managed medical assistance; providing for optional
215 services; authorizing plans to customize benefit
216 packages; requiring the agency to provide certain
217 services to hemophiliacs; creating s. 409.973, F.S.;
218 providing for managed long-term care; providing
219 deadlines for beginning and finalizing implementation;
220 providing duties for the Department of Elderly Affairs
221 relating to the program; creating s. 409.974, F.S.;
222 providing recipient eligibility requirements for
223 managed long-term care; listing programs for which
224 certain recipients are eligible; specifying that an
225 entitlement to home and community-based services is
226 not created; creating s. 409.975, F.S.; establishing
227 minimum services for managed long-term care; creating
228 s. 409.976, F.S.; providing criteria for the selection
229 of plans to provide managed long-term care; creating
230 s. 409.977, F.S.; providing for managed long-term care
231 plan accountability; requiring the agency to establish
232 standards for specified providers; creating s.

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233 409.978, F.S.; requiring that the agency operate the
234 Comprehensive Assessment and Review for Long-Term Care
235 Services program through an interagency agreement with
236 the Department of Elderly Affairs; providing duties of
237 the program; requiring the program to assign plan
238 enrollees to a level of care; providing for the
239 evaluation of dually eligible nursing home residents;
240 transferring, renumbering, and amending ss. 409.91207,
241 409.91211, 409.9122, F.S.; conforming provisions to
242 changes made by the act; updating provisions and
243 deleting obsolete provisions; transferring and
244 renumbering ss. 409.9123 and 409.9124, F.S.; amending
245 s. 430.04, F.S.; eliminating outdated provisions;
246 requiring the Department of Elderly Affairs to develop
247 a transition plan for specified elders and disabled
248 adults receiving long-term care Medicaid services if
249 qualified plans become available; amending s.
250 430.2053, F.S.; eliminating outdated provisions;
251 providing additional duties of aging resource centers;
252 providing an additional exception to direct services
253 that may not be provided by an aging resource center;
254 providing for the cessation of specified payments by
255 the department as qualified plans become available;
256 eliminating provisions requiring reports; amending s.
257 39.407, F.S.; requiring a motion by the Department of
258 Children and Family Services to provide psychotropic
259 medication to a child 10 years of age or younger to
260 include a review by a child psychiatrist; providing
261 that a court may not authorize the administration of

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262 such medication absent a finding of compelling state
263 interest based on the review; amending s. 216.262,
264 F.S.; providing that limitations on an agency's total
265 number of positions does not apply to certain
266 positions in the Department of Health; amending s.
267 381.06014, F.S.; redefining the term "blood
268 establishment" and defining the term "volunteer
269 donor"; requiring that blood establishments disclose
270 specified information on their Internet website;
271 providing an exception for certain hospitals;
272 authorizing the Department of Legal Affairs to assess
273 a civil penalty against a blood establishment that
274 fails to disclose the information; providing that the
275 civil penalty accrues to the state and requiring that
276 it be deposited into the General Revenue Fund;
277 prohibiting local governments from restricting access
278 to public facilities or infrastructure for certain
279 activities based on whether a blood establishment is
280 operating as a for-profit or not-for-profit
281 organization; prohibiting a blood establishment from
282 considering whether certain customers are operating as
283 for-profit or not-for-profit organizations when
284 determining service fees for blood or blood
285 components; amending s. 400.023, F.S.; requiring the
286 trial judge to conduct an evidentiary hearing to
287 determine the sufficiency of evidence for claims
288 against certain persons relating to a nursing home;
289 limiting noneconomic damages in a wrongful death
290 action against the nursing home; amending s. 400.0237,

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291 F.S.; revising provisions relating to punitive damages
292 against a nursing home; authorizing a defendant to
293 proffer admissible evidence to refute a claimant's
294 proffer of evidence for punitive damages; requiring
295 the trial judge to conduct an evidentiary hearing and
296 the plaintiff to demonstrate that a reasonable basis
297 exists for the recovery of punitive damages;
298 prohibiting discovery of the defendant's financial
299 worth until the judge approves the pleading on
300 punitive damages; revising definitions; amending s.
301 408.7057, F.S.; requiring that the dispute resolution
302 program include a hearing in specified circumstances;
303 providing that the dispute resolution program
304 established to resolve claims disputes between
305 providers and health plans does not provide an
306 independent right of recovery; requiring that the
307 conclusions of law in the written recommendation of
308 the resolution organization identify certain
309 information; providing a directive to the Division of
310 Statutory Revision; amending s. 409.1671, F.S.;
311 modifying the amount and limits of general liability
312 coverage, automobile coverage, and tort coverage that
313 must be carried by eligible community lead agency
314 providers and their subcontractors; providing that the
315 Department of Children and Family Services is not
316 liable for the acts or omissions of such lead agencies
317 and that the agencies may not be required to indemnify
318 the department; creating ss. 458.3167 and 459.0078,
319 F.S.; providing for an expert witness certificate for

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320 allopathic and osteopathic physicians licensed in
321 other states or Canada which authorizes such
322 physicians to provide expert medical opinions in this
323 state; providing application requirements and
324 timeframes for approval or denial by the Board of
325 Medicine and Board of Osteopathic Medicine,
326 respectively; requiring the boards to adopt rules and
327 set fees; providing for expiration of a certificate;
328 amending ss. 458.331 and 459.015, F.S.; providing
329 grounds for disciplinary action for providing
330 misleading, deceptive, or fraudulent expert witness
331 testimony relating to the practice of medicine and of
332 osteopathic medicine, respectively; providing for
333 construction with respect to the doctrine of
334 incorporation by reference; amending s. 499.003, F.S.;
335 redefining the term “health care entity” to clarify
336 that a blood establishment is a health care entity
337 that may engage in certain activities; amending s.
338 499.005, F.S.; clarifying provisions that prohibit the
339 unauthorized wholesale distribution of a prescription
340 drug that was purchased by a hospital or other health
341 care entity or donated or supplied at a reduced price
342 to a charitable organization, to conform to changes
343 made by the act; amending s. 499.01, F.S.; exempting
344 certain blood establishments from the requirements to
345 be permitted as a prescription drug manufacturer and
346 register products; requiring that certain blood
347 establishments obtain a restricted prescription drug
348 distributor permit under specified conditions;

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349 limiting the prescription drugs that a blood
350 establishment may distribute under a restricted
351 prescription drug distributor permit; authorizing the
352 Department of Health to adopt rules regarding the
353 distribution of prescription drugs by blood
354 establishments; amending s. 626.9541, F.S.;
355 authorizing insurers to offer rewards or incentives to
356 health benefit plan members to encourage or reward
357 participation in wellness or health improvement
358 programs; authorizing insurers to require plan members
359 not participating in programs to provide verification
360 that their medical condition warrants
361 nonparticipation; providing application; amending s.
362 627.4147, F.S.; deleting a requirement that a medical
363 malpractice insurance contract include a clause
364 authorizing an insurer to admit liability and make a
365 settlement offer if the offer is within policy limits
366 without the insured’s permission; amending s. 766.102,
367 F.S.; providing that a physician who is an expert
368 witness in a medical malpractice presuit action must
369 meet certain requirements; amending s. 766.104, F.S.;
370 requiring a good faith demonstration in a medical
371 malpractice case that there has been a breach of the
372 standard of care; amending s. 766.106, F.S.;
373 clarifying that a physician acting as an expert
374 witness is subject to disciplinary actions; amending
375 s. 766.1115, F.S.; conforming provisions to changes
376 made by the act; creating s. 766.1183, F.S.; defining
377 terms; providing for the recovery of civil damages by

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378 Medicaid recipients according to a modified standard
379 of care; providing for recovery of certain excess
380 judgments by act of the Legislature; requiring the
381 Department of Children and Family Services to provide
382 notice to program applicants; creating s. 766.1184,
383 F.S.; defining terms; providing for the recovery of
384 civil damages by certain recipients of primary care
385 services at primary care clinics receiving specified
386 low-income pool funds according to a modified standard
387 of care; providing for recovery of certain excess
388 judgments by act of the Legislature; providing
389 requirements of health care providers receiving such
390 funds in order for the liability provisions to apply;
391 requiring notice to low-income pool recipients;
392 amending s. 766.203, F.S.; requiring the presuit
393 investigations conducted by the claimant and the
394 prospective defendant in a medical malpractice action
395 to provide grounds for a breach of the standard of
396 care; amending s. 768.28, F.S.; revising a definition;
397 providing that certain colleges and universities that
398 own or operate an accredited medical school and their
399 employees and agents providing patient services in a
400 teaching hospital pursuant to an affiliation agreement
401 or contract with the teaching hospital are considered
402 agents of the hospital for the purposes of sovereign
403 immunity; providing definitions; requiring patients of
404 such hospitals to be provided with notice of their
405 remedies under sovereign immunity; providing an
406 exception; providing legislative findings and intent

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407 with respect to including certain colleges and
408 universities and their employees and agents under
409 sovereign immunity; providing a statement of public
410 necessity; amending s. 1004.41, F.S.; clarifying
411 provisions relating to references to the corporation
412 known as Shands Teaching Hospital and Clinics, Inc.;
413 clarifying provisions regarding the purpose of the
414 corporation; authorizing the corporation to create
415 corporate subsidiaries and affiliates; providing that
416 Shands Teaching Hospital and Clinics, Inc., Shands
417 Jacksonville Medical Center, Inc., Shands Jacksonville
418 Healthcare, Inc., and any not-for-profit subsidiary of
419 such entities are instrumentalities of the state for
420 purposes of sovereign immunity; repealing s. 409.9121,
421 F.S., relating to legislative intent concerning
422 managed care; repealing s. 409.919, F.S., relating to
423 rule authority; repealing s. 624.915, F.S., relating
424 to the Florida Healthy Kids Corporation operating
425 fund; renumbering and transferring ss. 409.942,
426 409.944, 409.945, 409.946, 409.953, and 409.9531,
427 F.S., as ss. 414.29, 163.464, 163.465, 163.466,
428 402.81, and 402.82, F.S., respectively; amending s.
429 443.111, F.S.; conforming a cross-reference; directing
430 the Agency for Health Care Administration to submit a
431 reorganization plan to the Legislature; providing for
432 the state’s withdrawal from the Medicaid program under
433 certain circumstances; providing for severability;
434 providing an effective date.
435

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436 Be It Enacted by the Legislature of the State of Florida:
437
438 Section 1. Present subsections (7) and (8) of section
439 393.0661, Florida Statutes, are redesignated as subsections (8)
440 and (9), respectively, a new subsection (7) is added to that
441 section, and present subsection (7) of that section is amended,
442 to read:
443 393.0661 Home and community-based services delivery system;
444 comprehensive redesign.—The Legislature finds that the home and
445 community-based services delivery system for persons with
446 developmental disabilities and the availability of appropriated
447 funds are two of the critical elements in making services
448 available. Therefore, it is the intent of the Legislature that
449 the Agency for Persons with Disabilities shall develop and
450 implement a comprehensive redesign of the system.
451 (7) The agency shall impose and collect the fee authorized
452 by s. 409.906(13)(d) upon approval by the Centers for Medicare
453 and Medicaid Services.
454 (8) ~~(7)~~ ~~Nothing in~~ This section or related ~~in any~~
455 ~~administrative~~ rule does not ~~shall be construed to~~ prevent or
456 limit the Agency for Health Care Administration, in consultation
457 with the Agency for Persons with Disabilities, from adjusting
458 fees, reimbursement rates, lengths of stay, number of visits, or
459 number of services, or from limiting enrollment, or making any
460 other adjustment necessary to comply with the availability of
461 moneys and any limitations or directions provided ~~for~~ in the
462 General Appropriations Act or pursuant to s. 409.9022.
463 Section 2. The Division of Statutory Revision is requested
464 to designate ss. 409.016-409.803, Florida Statutes, as part I of

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465 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC
466 ASSISTANCE."
467 Section 3. Section 409.016, Florida Statutes, is amended to
468 read:
469 409.016 Definitions.—As used in this part, the term
470 ~~chapter~~:
471 (1) "Department~~,~~" ~~unless otherwise specified,~~ means the
472 Department of Children and Family Services.
473 (2) "Secretary" means the Secretary of ~~the Department of~~
474 Children and Family Services.
475 (3) "Social and economic services~~,~~" ~~within the meaning of~~
476 ~~this chapter,~~ means the providing of financial assistance as
477 well as preventive and rehabilitative social services for
478 children, adults, and families.
479 Section 4. Section 409.16713, Florida Statutes, is created
480 to read:
481 409.16713 Medical assistance for children in out-of-home
482 care and adopted children.—
483 (1) A child who is eligible under Title IV-E of the Social
484 Security Act, as amended, for subsidized board payments, foster
485 care, or adoption subsidies, and a child for whom the state has
486 assumed temporary or permanent responsibility and who does not
487 qualify for Title IV-E assistance but is in foster care, shelter
488 or emergency shelter care, or subsidized adoption is eligible
489 for medical assistance as provided in s. 409.903(4). This
490 includes a young adult who is eligible to receive services under
491 s. 409.1451(5) until the young adult reaches 21 years of age,
492 and a person who was eligible, as a child, under Title IV-E for
493 foster care or the state-provided foster care and who is a

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494 participant in the Road-to-Independence Program.
495 (2) If medical assistance under Title XIX of the Social
496 Security Act, as amended, is not available due to the refusal of
497 the federal Department of Health and Human Services to provide
498 federal funds, a child or young adult described in subsection
499 (1) is eligible for medical services under the Medicaid managed
500 care program established in s. 409.963. Such medical assistance
501 shall be obtained by the community-based care lead agencies
502 established under s. 409.1671 and is subject to the availability
503 of funds appropriated for such purpose in the General
504 Appropriations Act.
505 (3) It is the intent of the Legislature that the provision
506 of medical assistance meet the requirements of s. 471(a)(21) of
507 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),
508 related to eligibility for Title IV-E of the Social Security
509 Act, and that compliance with such provisions meet the
510 requirements of s. 402(a)(3) of the Social Security Act, as
511 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary
512 Assistance for Needy Families Block Grant Program.
513 Section 5. The Division of Statutory Revision is requested
514 to designate ss. 409.810-409.821, Florida Statutes, as part II
515 of chapter 409, Florida Statutes, entitled "KIDCARE."
516 Section 6. Section 624.91, Florida Statutes, is
517 transferred, renumbered as section 409.8115, Florida Statutes,
518 paragraph (b) of subsection (5) of that section is amended, and
519 subsection (8) is added to that section, to read:
520 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.—
521 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
522 (b) The Florida Healthy Kids Corporation shall:

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523 1. Arrange for the collection of any family, local
524 contributions, or employer payment or premium, in an amount to
525 be determined by the board of directors, to provide for payment
526 of premiums for comprehensive insurance coverage and for the
527 actual or estimated administrative expenses.
528 2. Arrange for the collection of any voluntary
529 contributions ~~to provide~~ for payment of ~~Florida~~ Kidcare program
530 premiums for children who are not eligible for medical
531 assistance under Title XIX or Title XXI of the Social Security
532 Act.
533 3. Subject to ~~the provisions of~~ s. 409.8134, accept
534 voluntary supplemental local match contributions that comply
535 with ~~the requirements of~~ Title XXI of the Social Security Act
536 for the purpose of providing additional ~~Florida~~ Kidcare coverage
537 in contributing counties under Title XXI.
538 4. Establish the administrative and accounting procedures
539 for the operation of the corporation.
540 5. Establish, with consultation from appropriate
541 professional organizations, standards for preventive health
542 services and providers and comprehensive insurance benefits
543 appropriate to children if~~, provided that~~ such standards for
544 rural areas do ~~shall~~ not limit primary care providers to board-
545 certified pediatricians.
546 6. Determine eligibility for children seeking to
547 participate in the Title XXI-funded components of the ~~Florida~~
548 Kidcare program consistent with the requirements specified in s.
549 409.814, as well as the non-Title-XXI-eligible children as
550 provided in subsection (3).
551 7. Establish procedures under which providers of local

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552 match to, applicants to, and participants in the program may
553 have grievances reviewed by an impartial body and reported to
554 the board of directors of the corporation.
555 8. Establish participation criteria and, if appropriate,
556 contract with an authorized insurer, health maintenance
557 organization, or third-party administrator to provide
558 administrative services to the corporation.
559 9. Establish enrollment criteria that include penalties or
560 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage
561 upon voluntary cancellation for nonpayment of family premiums.
562 10. Contract with authorized insurers or providers ~~any~~
563 ~~provider~~ of health care services, who meet ~~meeting~~ standards
564 established by the corporation, for the provision of
565 comprehensive insurance coverage to participants. Such standards
566 must ~~shall~~ include criteria under which the corporation may
567 contract with more than one provider of health care services in
568 program sites. Health plans shall be selected through a
569 competitive bid process. The Florida Healthy Kids Corporation
570 shall purchase goods and services in the most cost-effective
571 manner consistent with the delivery of quality medical care. The
572 maximum administrative cost for a Florida Healthy Kids
573 Corporation contract shall be 10 ~~15~~ percent. For health care
574 contracts, the minimum medical loss ratio for a Florida Healthy
575 Kids Corporation contract shall be 90 ~~85~~ percent. For dental
576 contracts, the remaining compensation to be paid to the
577 authorized insurer or provider must be at least 90 ~~under a~~
578 ~~Florida Healthy Kids Corporation contract shall be no less than~~
579 ~~an amount which is 85~~ percent of the premium, and~~;~~ to the extent
580 any contract provision does not provide for this minimum

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581 compensation, this section prevails ~~shall prevail~~. The health
582 plan selection criteria and scoring system, and the scoring
583 results, shall be available upon request for inspection after
584 the bids have been awarded.
585 11. Establish disenrollment criteria if ~~in the event~~ local
586 matching funds are insufficient to cover enrollments.
587 12. Develop and implement a plan to publicize the Florida
588 Kidcare program, the eligibility requirements of the program,
589 and the procedures for enrollment in the program and to maintain
590 public awareness of the corporation and the program. Such plan
591 must include using the application form for the school lunch and
592 breakfast programs as provided under s. 1006.06(7).
593 13. Secure staff necessary to properly administer the
594 corporation. Staff costs shall be funded from state and local
595 matching funds and such other private or public funds as become
596 available. The board of directors shall determine the number of
597 staff members necessary to administer the corporation.
598 14. In consultation with the partner agencies, provide an
599 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the
600 Governor, the Chief Financial Officer, the Commissioner of
601 Education, the President of the Senate, the Speaker of the House
602 of Representatives, and the Minority Leaders of the Senate and
603 the House of Representatives.
604 15. Provide information on a quarterly basis to the
605 Legislature and the Governor which compares the costs and
606 utilization of the full-pay enrolled population and the Title
607 XXI-subsidized enrolled population in the Florida Kidcare
608 program. ~~The information,~~ At a minimum, the information must
609 include:

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610 a. The monthly enrollment and expenditure for full-pay
611 enrollees in the Medikids and Florida Healthy Kids programs
612 compared to the Title XXI-subsidized enrolled population; and
613 b. The costs and utilization by service of the full-pay
614 enrollees in the Medikids and Florida Healthy Kids programs and
615 the Title XXI-subsidized enrolled population.
616
617 By February 1, 2010, the Florida Healthy Kids Corporation shall
618 provide a study to the Legislature and the Governor on premium
619 impacts to the subsidized portion of the program from the
620 inclusion of the full-pay program, which must ~~shall~~ include
621 recommendations on how to eliminate or mitigate possible impacts
622 to the subsidized premiums.
623 16. Establish benefit packages that conform to ~~the~~
624 ~~provisions of~~ the Florida Kidcare program, as created under this
625 part ~~in ss. 409.810-409.821~~.
626 (8) OPERATING FUND.—The Florida Healthy Kids Corporation
627 may establish and manage an operating fund for the purposes of
628 addressing the corporation's unique cash-flow needs and
629 facilitating the fiscal management of the corporation. At any
630 given time, the corporation may accumulate and maintain in the
631 operating fund a cash balance reserve equal to no more than 25
632 percent of its annualized operating expenses. Upon dissolution
633 of the corporation, any remaining cash balances of state funds
634 shall revert to the General Revenue Fund, or such other state
635 funds consistent with the appropriated funding, as provided by
636 law.
637 Section 7. Subsection (1) of section 409.813, Florida
638 Statutes, is amended to read:

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639 409.813 Health benefits coverage; program components;
640 entitlement and nonentitlement.—
641 (1) The Florida Kidcare program includes health benefits
642 coverage provided to children through the following program
643 components, which shall be marketed as the Florida Kidcare
644 program:
645 (a) Medicaid.~~;~~
646 (b) Medikids as created in s. 409.8132.~~;~~
647 (c) The Florida Healthy Kids Corporation as created in s.
648 409.8115. ~~624.91;~~
649 (d) Employer-sponsored group health insurance plans
650 approved under this part. ~~ss. 409.810-409.821; and~~
651 (e) The Children's Medical Services network ~~established in~~
652 ~~chapter 391~~.
653 Section 8. Subsection (4) of section 409.8132, Florida
654 Statutes, is amended to read:
655 409.8132 Medikids program component.—
656 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
657 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
658 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,
659 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,
660 409.987, 409.988, and 409.989 apply to the administration of the
661 Medikids program component of the Florida Kidcare program,
662 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified
663 by ~~the provisions of~~ subsection (7).
664 Section 9. Subsection (1) of section 409.815, Florida
665 Statutes, is amended to read:
666 409.815 Health benefits coverage; limitations.—
667 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare

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668 program, benefits available under Medicaid and Medikids include
669 those goods and services provided under the medical assistance
670 program authorized by Title XIX of the Social Security Act, and
671 regulations thereunder, as administered in this state by the
672 agency. This includes those mandatory Medicaid services
673 authorized under s. 409.905 and optional Medicaid services
674 authorized under s. 409.906, rendered on behalf of eligible
675 individuals by qualified providers, in accordance with federal
676 requirements ~~for Title XIX~~, subject to any limitations or
677 directions provided ~~for~~ in the General Appropriations Act, ~~or~~
678 chapter 216, or s. 409.9022, and according to methodologies and
679 limitations set forth in agency rules and policy manuals and
680 handbooks incorporated by reference ~~thereto~~.
681 Section 10. Subsection (5) of section 409.818, Florida
682 Statutes, is amended to read:
683 409.818 Administration.—In order to implement ss. 409.810-
684 409.821, the following agencies shall have the following duties:
685 (5) The Florida Healthy Kids Corporation shall retain its
686 functions as authorized in s. 409.8115 ~~624.91~~, including
687 eligibility determination for participation in the Healthy Kids
688 program.
689 Section 11. Paragraph (e) of subsection (2) of section
690 154.503, Florida Statutes, is amended to read:
691 154.503 Primary Care for Children and Families Challenge
692 Grant Program; creation; administration.—
693 (2) The department shall:
694 (e) Coordinate with the primary care program developed
695 pursuant to s. 154.011, the Florida Healthy Kids Corporation
696 program created in s. 409.8115 ~~624.91~~, the school health

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697 services program created in ss. 381.0056 and 381.0057, the
698 Healthy Communities, Healthy People Program created in s.
699 381.734, and the volunteer health care provider program
700 established ~~developed~~ pursuant to s. 766.1115.
701 Section 12. Paragraph (c) of subsection (4) of section
702 408.915, Florida Statutes, is amended to read:
703 408.915 Eligibility pilot project.—The Agency for Health
704 Care Administration, in consultation with the steering committee
705 established in s. 408.916, shall develop and implement a pilot
706 project to integrate the determination of eligibility for health
707 care services with information and referral services.
708 (4) The pilot project shall include eligibility
709 determinations for the following programs:
710 (c) Florida Healthy Kids as described in s. 409.8115 ~~624.91~~
711 and within eligibility guidelines provided in s. 409.814.
712 Section 13. Subsection (7) is added to section 1006.06,
713 Florida Statutes, to read:
714 1006.06 School food service programs.—
715 (7) Each school district shall collaborate with the Florida
716 Kidcare program created pursuant to ss. 409.810-409.821 to:
717 (a) At a minimum:
718 1. Provide application information about the Kidcare
719 program or an application for Kidcare to students at the
720 beginning of each school year.
721 2. Modify the school district's application form for the
722 lunch program under subsection (4) and the breakfast program
723 under subsection (5) to incorporate a provision that permits the
724 school district to share data from the application form with the
725 state agencies and the Florida Healthy Kids Corporation and its

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726 agents that administer the Kidcare program unless the child's
727 parent or guardian opts out of the provision.
728 (b) At the option of the school district, share income and
729 other demographic data through an electronic interchange with
730 the Florida Healthy Kids Corporation and other state agencies in
731 order to determine eligibility for the Kidcare program on a
732 regular and periodic basis.
733 (c) Establish interagency agreements ensuring that data
734 exchanged under this subsection is used only to enroll eligible
735 children in the Florida Kidcare program and is protected from
736 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).
737 Section 14. The Division of Statutory Revision is requested
738 to designate ss. 409.901 through 409.9205, Florida Statutes, as
739 part III of chapter 409, Florida Statutes, entitled "MEDICAID."
740 Section 15. Section 409.901, Florida Statutes, is amended
741 to read:
742 409.901 Definitions~~; ss. 409.901-409.920~~.—As used in this
743 part and part IV ~~ss. 409.901-409.920, except as otherwise~~
744 ~~specifically provided~~, the term:
745 (1) "Affiliate" or "affiliated person" means any person who
746 directly or indirectly manages, controls, or oversees the
747 operation of a corporation or other business entity that is a
748 Medicaid provider, regardless of whether such person is a
749 partner, shareholder, owner, officer, director, agent, or
750 employee of the entity.
751 (2) "Agency" means the Agency for Health Care
752 Administration. ~~The agency is the Medicaid agency for the state,~~
753 ~~as provided under federal law.~~
754 (3) "Applicant" means an individual whose written

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755 application for medical assistance provided by Medicaid ~~under~~
756 ~~ss. 409.903-409.906~~ has been submitted to the Department of
757 Children and Family Services, or to the Social Security
758 Administration if the application is for Supplemental Security
759 Income, but has not received final action. The ~~This~~ term
760 includes an individual, who need not be alive at the time of
761 application, and whose application is submitted through a
762 representative or a person acting for the individual.
763 (4) "Benefit" means any benefit, assistance, aid,
764 obligation, promise, debt, liability, or the like, related to
765 any covered injury, illness, or necessary medical care, goods,
766 or services.
767 (5) "Capitation" means a prospective per-member, per-month
768 payment designed to represent, in the aggregate, an actuarially
769 sound estimate of expenditures required for the management and
770 provision of a specified set of medical services or long-term
771 care services needed by members enrolled in a prepaid health
772 plan.
773 (6) ~~(5)~~ "Change of ownership" has the same meaning as in s.
774 408.803 and includes ~~means:~~
775 ~~(a) An event in which the provider ownership changes to a~~
776 ~~different individual entity as evidenced by a change in federal~~
777 ~~employer identification number or taxpayer identification~~
778 ~~number;~~
779 ~~(b) An event in which 51 percent or more of the ownership,~~
780 ~~shares, membership, or controlling interest of a provider is in~~
781 ~~any manner transferred or otherwise assigned. This paragraph~~
782 ~~does not apply to a licensee that is publicly traded on a~~
783 ~~recognized stock exchange; or~~

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784 ~~(c) When the provider is licensed or registered by the~~
785 ~~agency,~~ an event considered a change of ownership under part II
786 of chapter 408 ~~for licensure as defined in s. 408.803~~.
787
788 ~~A change solely in the management company or board of directors~~
789 ~~is not a change of ownership.~~
790 (7) ~~(6)~~ “Claim” means any communication, whether written or
791 electronic (electronic impulse or magnetic), which is used by
792 any person to apply for payment from the Medicaid program, ~~or~~
793 its fiscal agent, or a qualified plan under part IV of this
794 chapter for each item or service purported ~~by any person~~ to have
795 been provided ~~by a person~~ to a ~~any~~ Medicaid recipient.
796 (8) ~~(7)~~ “Collateral” means:
797 (a) Any and all causes of action, suits, claims,
798 counterclaims, and demands that accrue to a ~~the~~ recipient or to
799 a ~~the~~ recipient’s legal representative, related to any covered
800 injury, illness, or necessary medical care, goods, or services
801 that resulted in ~~necessitated that~~ Medicaid providing ~~provide~~
802 medical assistance.
803 (b) All judgments, settlements, and settlement agreements
804 rendered or entered into and related to ~~such~~ causes of action,
805 suits, claims, counterclaims, demands, or judgments.
806 (c) Proceeds, as defined in this section.
807 (9) ~~(8)~~ “Convicted” or “conviction” means a finding of
808 guilt, with or without an adjudication of guilt, in any federal
809 or state trial court ~~of record relating to charges brought by~~
810 ~~indictment or information,~~ as a result of a jury verdict,
811 nonjury trial, or entry of a plea of guilty or nolo contendere,
812 regardless of whether an appeal from judgment is pending.

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813 (10)~~(9)~~ "Covered injury or illness" means any sickness,
814 injury, disease, disability, deformity, abnormality disease,
815 necessary medical care, pregnancy, or death for which a third
816 party is, may be, could be, should be, or has been liable, and
817 for which Medicaid is, or may be, obligated to provide, or has
818 provided, medical assistance.
819 (11)~~(10)~~ "Emergency medical condition" has the same meaning
820 as in s. 395.002. ~~means:~~
821 ~~(a) A medical condition manifesting itself by acute~~
822 ~~symptoms of sufficient severity, which may include severe pain~~
823 ~~or other acute symptoms, such that the absence of immediate~~
824 ~~medical attention could reasonably be expected to result in any~~
825 ~~of the following:~~
826 ~~1. Serious jeopardy to the health of a patient, including a~~
827 ~~pregnant woman or a fetus.~~
828 ~~2. Serious impairment to bodily functions.~~
829 ~~3. Serious dysfunction of any bodily organ or part.~~
830 ~~(b) With respect to a pregnant woman:~~
831 ~~1. That there is inadequate time to effect safe transfer to~~
832 ~~another hospital prior to delivery.~~
833 ~~2. That a transfer may pose a threat to the health and~~
834 ~~safety of the patient or fetus.~~
835 ~~3. That there is evidence of the onset and persistence of~~
836 ~~uterine contractions or rupture of the membranes.~~
837 (12)~~(11)~~ "Emergency services and care" has the same meaning
838 as in s. 395.002 ~~means medical screening, examination, and~~
839 ~~evaluation by a physician, or, to the extent permitted by~~
840 ~~applicable laws, by other appropriate personnel under the~~
841 ~~supervision of a physician, to determine whether an emergency~~

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842 ~~medical condition exists and, if it does, the care, treatment,~~
843 ~~or surgery for a covered service by a physician which is~~
844 ~~necessary to relieve or eliminate the emergency medical~~
845 ~~condition, within the service capability of a hospital~~.
846 (13) ~~(12)~~ "Legal representative" means a guardian,
847 conservator, survivor, or personal representative of a recipient
848 or applicant, or of the property or estate of a recipient or
849 applicant.
850 (14) ~~(13)~~ "Managed care plan" means a health insurer
851 authorized under chapter 624, an exclusive provider organization
852 authorized under chapter 627, a health maintenance organization
853 authorized under chapter 641, a provider service network
854 authorized under s. 409.912(4)(d), or an accountable care
855 organization authorized under federal law ~~health maintenance~~
856 ~~organization authorized pursuant to chapter 641 or a prepaid~~
857 ~~health plan authorized pursuant to s. 409.912~~.
858 (15) ~~(14)~~ "Medicaid" or Medicaid program means the medical
859 assistance program authorized by Title XIX of the Social
860 Security Act, 42 U.S.C. s. 1396 et seq., and regulations
861 thereunder, as administered in this state by the agency.
862 ~~(15) "Medicaid agency" or "agency" means the single state~~
863 ~~agency that administers or supervises the administration of the~~
864 ~~state Medicaid plan under federal law.~~
865 ~~(16) "Medicaid program" means the program authorized under~~
866 ~~Title XIX of the federal Social Security Act which provides for~~
867 ~~payments for medical items or services, or both, on behalf of~~
868 ~~any person who is determined by the Department of Children and~~
869 ~~Family Services, or, for Supplemental Security Income, by the~~
870 ~~Social Security Administration, to be eligible on the date of~~

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871 ~~service for Medicaid assistance.~~
872 (16) ~~(17)~~ “Medicaid provider” or “provider” means a person
873 or entity that has a Medicaid provider agreement in effect with
874 the agency and is in good standing with the agency. The term
875 also includes a person or entity that provides medical services
876 to a Medicaid recipient under the Medicaid managed care program
877 in part IV of this chapter.
878 (17) ~~(18)~~ “Medicaid provider agreement” or “provider
879 agreement” means a contract between the agency and a provider
880 for the provision of services or goods, or both, to Medicaid
881 recipients pursuant to Medicaid.
882 (18) ~~(19)~~ “Medicaid recipient” or “recipient” means an
883 individual whom the Department of Children and Family Services,
884 or, for Supplemental Security Income, ~~by~~ the Social Security
885 Administration, determines is eligible, pursuant to federal and
886 state law, to receive medical assistance and related services
887 for which the agency may make payments under the Medicaid
888 program. For the purposes of determining third-party liability,
889 the term includes an individual formerly determined to be
890 eligible for Medicaid, an individual who has received medical
891 assistance under ~~the~~ Medicaid ~~program~~, or an individual on whose
892 behalf Medicaid has become obligated.
893 (19) ~~(20)~~ “Medicaid-related records” means records that
894 relate to the provider’s business or profession and to a
895 Medicaid recipient. The term includes ~~Medicaid-related records~~
896 ~~include~~ records related to non-Medicaid customers, clients, or
897 patients but only to the extent that the documentation is shown
898 by the agency to be necessary for determining ~~to determine~~ a
899 provider’s entitlement to payments under the Medicaid program.

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900 (20)~~(21)~~ “Medical assistance” means any provision of,
901 payment for, or liability for medical services or care by
902 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.
903 (21)~~(22)~~ “Medical services” or “medical care” means medical
904 or medically related institutional or noninstitutional care,
905 goods, or services covered by the Medicaid program. The term
906 includes any services authorized and funded in the General
907 Appropriations Act.
908 (22)~~(23)~~ “MediPass” means a primary care case management
909 program operated by the agency.
910 (23)~~(24)~~ “Minority physician network” means a network of
911 primary care physicians with experience in managing Medicaid or
912 Medicare recipients which ~~that~~ is predominantly owned by
913 minorities, as defined in s. 288.703, and which may have a
914 collaborative partnership with a public college or university
915 and a tax-exempt charitable corporation.
916 (24)~~(25)~~ “Payment,” as it relates to third-party benefits,
917 means performance of a duty, promise, or obligation, or
918 discharge of a debt or liability, by the delivery, provision, or
919 transfer of third-party benefits for medical services. To “pay”
920 means to do any of the acts set forth in this subsection.
921 (25)~~(26)~~ “Proceeds” means whatever is received upon the
922 sale, exchange, collection, or other disposition of the
923 collateral or proceeds thereon and includes insurance payable by
924 reason of loss or damage to the collateral or proceeds. Money,
925 checks, deposit accounts, and the like are “cash proceeds.” All
926 other proceeds are “noncash proceeds.”
927 (26)~~(27)~~ “Third party” means an individual, entity, or
928 program, excluding Medicaid, that is, may be, could be, should

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929 be, or has been liable for all or part of the cost of medical
930 services related to any medical assistance covered by Medicaid.
931 A third party includes a third-party administrator or a pharmacy
932 benefits manager.
933 (27) ~~(28)~~ "Third-party benefit" means any benefit that is or
934 may be available at any time through contract, court award,
935 judgment, settlement, agreement, or any arrangement between a
936 third party and any person or entity, including, without
937 limitation, a Medicaid recipient, a provider, another third
938 party, an insurer, or the agency, for any Medicaid-covered
939 injury, illness, goods, or services, including costs of medical
940 services related thereto, for personal injury or for death of
941 the recipient, but specifically excluding policies of life
942 insurance on the recipient, unless available under terms of the
943 policy to pay medical expenses prior to death. The term
944 includes, without limitation, collateral, as defined in this
945 section, health insurance, any benefit under a health
946 maintenance organization, a preferred provider arrangement, a
947 prepaid health clinic, liability insurance, uninsured motorist
948 insurance or personal injury protection coverage, medical
949 benefits under workers' compensation, and any obligation under
950 law or equity to provide medical support.
951 Section 16. Section 409.902, Florida Statutes, is amended
952 to read:
953 409.902 Designated single state agency; eligibility
954 determinations; rules ~~payment requirements; program title;~~
955 ~~release of medical records~~.—
956 (1) The agency ~~for Health Care Administration~~ is designated
957 as the single state agency authorized to administer the Medicaid

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958 state plan and to make payments for medical assistance and
959 related services under Title XIX of the Social Security Act.
960 These payments shall be made, subject to any limitations or
961 directions provided for in the General Appropriations Act, only
962 for services included in the Medicaid program, ~~shall be made~~
963 only on behalf of eligible individuals, and ~~shall be made~~ only
964 to qualified providers in accordance with federal requirements
965 under ~~for~~ Title XIX of the Social Security Act and ~~the~~
966 ~~provisions of~~ state law.
967 (a) The agency must notify the Legislature before seeking
968 an amendment to the state plan for purposes of implementing
969 provisions authorized by the Deficit Reduction Act of 2005.
970 (b) The agency shall adopt any rules necessary to carry out
971 its statutory duties under this subsection and any other
972 statutory provisions related to its responsibility for the
973 Medicaid program and state compliance with federal Medicaid
974 requirements, including the Medicaid managed care program. ~~This~~
975 ~~program of medical assistance is designated the "Medicaid~~
976 ~~program."~~
977 (2) The Department of Children and Family Services is
978 responsible for determining Medicaid eligibility ~~determinations~~,
979 including, but not limited to, policy, rules, and the agreement
980 with the Social Security Administration for Medicaid eligibility
981 ~~determinations~~ for Supplemental Security Income recipients, as
982 well as the actual determination of eligibility. ~~As a condition~~
983 ~~of Medicaid eligibility, subject to federal approval, the agency~~
984 ~~for Health Care Administration and the Department of Children~~
985 ~~and Family Services shall ensure that each recipient of Medicaid~~
986 ~~consents to the release of her or his medical records to the~~

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987 ~~agency for Health Care Administration and the Medicaid Fraud~~
988 ~~Control Unit of the Department of Legal Affairs.~~
989 (a) Eligibility is restricted to United States citizens and
990 to lawfully admitted noncitizens who meet the criteria provided
991 in s. 414.095(3).
992 1. Citizenship or immigration status must be verified. For
993 noncitizens, this includes verification of the validity of
994 documents with the United States Citizenship and Immigration
995 Services using the federal SAVE verification process.
996 2. State funds may not be used to provide medical services
997 to individuals who do not meet the requirements of this
998 paragraph unless the services are necessary to treat an
999 emergency medical condition or are for pregnant women. Such
1000 services are authorized only to the extent provided under
1001 federal law and in accordance with federal regulations as
1002 provided in 42 C.F.R. s. 440.255.
1003 (b) When adopting rules relating to eligibility for
1004 institutional care services, hospice services, and home and
1005 community-based waiver programs, and regardless of whether a
1006 penalty will be applied due to the unlawful transfer of assets,
1007 the payment of fair compensation by an applicant for a personal
1008 care services contract entered into on or after October 1, 2011,
1009 shall be evaluated using the following criteria:
1010 1. The contracted services do not duplicate services
1011 available through other sources or providers, such as Medicaid,
1012 Medicare, private insurance, or another legally obligated third
1013 party;
1014 2. The contracted services directly benefit the individual
1015 and are not services normally provided out of love and

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1016 consideration for the individual;
1017 3. The actual cost to deliver services is computed in a
1018 manner that clearly reflects the actual number of hours to be
1019 expended, and the contract clearly identifies each specific
1020 service and the average number of hours of each service to be
1021 delivered each month;
1022 4. The hourly rate for each contracted service is equal to
1023 or less than the amount normally charged by a professional who
1024 traditionally provides the same or similar services;
1025 5. The contracted services are provided on a prospective
1026 basis only and not for services provided in the past; and
1027 6. The contract provides fair compensation to the
1028 individual in his or her lifetime as set forth in life
1029 expectancy tables adopted in rule 65A-1.716, Florida
1030 Administrative Code.
1031 (c) The department shall adopt any rules necessary to carry
1032 out its statutory duties under this subsection for receiving and
1033 processing Medicaid applications and determining Medicaid
1034 eligibility, and any other statutory provisions related to
1035 responsibility for the determination of Medicaid eligibility.
1036 Section 17. Section 409.9021, Florida Statutes, is amended
1037 to read:
1038 409.9021 Conditions for Medicaid ~~Forfeiture of~~ eligibility
1039 ~~agreement~~.—As a condition of Medicaid eligibility, subject to
1040 federal regulation and approval:~~,~~
1041 (1) A Medicaid applicant must consent ~~shall agree~~ in
1042 writing to:
1043 (a) Have her or his medical records released to the agency
1044 and the Medicaid Fraud Control Unit of the Department of Legal

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1045 Affairs.
1046 (b) Forfeit all entitlements to any goods or services
1047 provided through the Medicaid program for the next 10 years if
1048 he or she has been found to have committed Medicaid fraud~~,~~
1049 through judicial or administrative determination~~, two times in a~~
1050 ~~period of 5 years~~. This provision applies only to the Medicaid
1051 recipient found to have committed or participated in Medicaid
1052 ~~the~~ fraud and does not apply to any family member of the
1053 recipient who was not involved in the fraud.
1054 (2) A Medicaid applicant must pay a $10 monthly premium
1055 that covers all Medicaid-eligible recipients in the applicant's
1056 family. However, an individual who is eligible for the
1057 Supplemental Security Income related Medicaid and is receiving
1058 institutional care payments is exempt from this requirement. The
1059 agency shall seek a federal waiver to authorize the imposition
1060 and collection of this premium effective December 31, 2011. Upon
1061 approval, the agency shall establish by rule procedures for
1062 collecting premiums from recipients, advance notice of
1063 cancellation, and waiting periods for reinstatement of coverage
1064 upon voluntary cancellation for nonpayment of premiums.
1065 (3) A Medicaid applicant must participate, in good faith,
1066 in:
1067 (a) A medically approved smoking cessation program if the
1068 applicant smokes.
1069 (b) A medically directed weight loss program if the
1070 applicant is or becomes morbidly obese.
1071 (c) A medically approved alcohol or substance abuse
1072 recovery program if the applicant is or becomes diagnosed as a
1073 substance abuser.

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1074

1075 The agency shall seek a federal waiver to authorize the
1076 implementation of this subsection in order to assist the
1077 recipient in mitigating lifestyle choices and avoiding behaviors
1078 associated with the use of high-cost medical services.
1079 (4) A person who is eligible for Medicaid services and who
1080 has access to health care coverage through an employer-sponsored
1081 health plan may not receive Medicaid services reimbursed under
1082 s. 409.908, s. 409.912,or s. 409.986, but may use Medicaid
1083 financial assistance to pay the cost of premiums for the
1084 employer-sponsored health plan for the eligible person and his
1085 or her Medicaid-eligible family members.
1086 (5) A Medicaid recipient who has access to other insurance
1087 or coverage created pursuant to state or federal law may opt out
1088 of the Medicaid services provided under s. 409.908, s. 409.912,
1089 or s. 409.986 and use Medicaid financial assistance to pay the
1090 cost of premiums for the recipient and the recipient's Medicaid
1091 eligible family members.
1092 (6) Subsections (4) and (5) shall be administered by the
1093 agency in accordance with s. 409.964(1)(j). The maximum amount
1094 available for the Medicaid financial assistance shall be
1095 calculated based on the Medicaid capitated rate as if the
1096 Medicaid recipient and the recipient's eligible family members
1097 participated in a qualified plan for Medicaid managed care under
1098 part IV of this chapter.
1099 Section 18. Section 409.9022, Florida Statutes, is created
1100 to read:
1101 409.9022 Limitations on Medicaid expenditures.—
1102 (1) Except as specifically authorized in this section, a

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1103 state agency may not obligate or expend funds for the Medicaid
1104 program in excess of the amount appropriated in the General
1105 Appropriations Act.
1106 (2) If, at any time during the fiscal year, a state agency
1107 determines that Medicaid expenditures may exceed the amount
1108 appropriated during the fiscal year, the state agency shall
1109 notify the Social Services Estimating Conference, which shall
1110 meet to estimate Medicaid expenditures for the remainder of the
1111 fiscal year. If, pursuant to this paragraph or for any other
1112 purpose, the conference determines that Medicaid expenditures
1113 will exceed appropriations for the fiscal year, the state agency
1114 shall develop and submit a plan for revising Medicaid
1115 expenditures in order to remain within the annual appropriation.
1116 The plan must include cost-mitigating strategies to negate the
1117 projected deficit for the remainder of the fiscal year and shall
1118 be submitted in the form of a budget amendment to the
1119 Legislative Budget Commission. The conference shall also
1120 estimate the amount of savings which will result from such cost-
1121 mitigating strategies proposed by the state agency as well as
1122 any other strategies the conference may consider and recommend.
1123 (3) In preparing the budget amendment to revise Medicaid
1124 expenditures in order to remain within appropriations, a state
1125 agency shall include the following revisions to the Medicaid
1126 state plan, in the priority order listed below:
1127 (a) Reduction in administrative costs.
1128 (b) Elimination of optional benefits.
1129 (c) Elimination of optional eligibility groups.
1130 (d) Reduction to institutional and provider reimbursement
1131 rates.

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1132 (e) Reduction in the amount, duration, and scope of
1133 mandatory benefits.
1134
1135 The state agency may not implement any of these cost-containment
1136 measures until the amendment is approved by the Legislative
1137 Budget Commission.
1138 (4) In order to remedy a projected expenditure in excess of
1139 the amount appropriated in a specific appropriation within the
1140 Medicaid budget, a state agency may, consistent with chapter
1141 216:
1142 (a) Submit a budget amendment to transfer budget authority
1143 between appropriation categories;
1144 (b) Submit a budget amendment to increase federal trust
1145 authority or grants and donations trust authority if additional
1146 federal or local funds are available; or
1147 (c) Submit any other budget amendment consistent with
1148 chapter 216.
1149 (5) The agency shall amend the Medicaid state plan to
1150 incorporate the provisions of this section.
1151 (6) Chapter 216 does not permit the transfer of funds from
1152 any other program into the Medicaid program or the transfer of
1153 funds out of the Medicaid program into any other program.
1154 Section 19. Section 409.903, Florida Statutes, is amended
1155 to read:
1156 409.903 Mandatory payments for eligible persons.—The agency
1157 shall make payments for medical assistance and related services
1158 on behalf of the following categories of persons who the
1159 Department of Children and Family Services, or the Social
1160 Security Administration by contract with the department ~~of~~

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1161 ~~Children and Family Services~~, determines to be eligible for
1162 Medicaid, subject to the income, assets, and categorical
1163 eligibility tests set forth in federal and state law. Payment on
1164 behalf of these recipients ~~Medicaid eligible persons~~ is subject
1165 to the availability of moneys and any limitations established by
1166 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1167 (1) Low-income families with children if ~~are eligible for~~
1168 ~~Medicaid provided~~ they meet the following requirements:
1169 (a) The family includes a dependent child who is living
1170 with a caretaker relative.
1171 (b) The family's income does not exceed the gross income
1172 test limit.
1173 (c) The family's countable income and resources do not
1174 exceed the applicable Aid to Families with Dependent Children
1175 (AFDC) income and resource standards under the AFDC state plan
1176 in effect on ~~in~~ July 1996, except as amended in the Medicaid
1177 state plan to conform as closely as possible to the requirements
1178 of the welfare transition program, to the extent permitted by
1179 federal law.
1180 (2) A person who receives payments from, who is determined
1181 eligible for, or who was eligible for but lost cash benefits
1182 from the federal program known as the Supplemental Security
1183 Income program (SSI). This ~~category~~ includes a low-income person
1184 age 65 or over and a low-income person under age 65 considered
1185 to be permanently and totally disabled.
1186 (3) A child under age 21 living in a low-income, two-parent
1187 family, and a child under age 7 living with a nonrelative~~,~~ if
1188 the income and assets of the family or child, as applicable, do
1189 not exceed the resource limits under the Temporary Cash

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1190 Assistance Program.
1191 (4) A child who is eligible under Title IV-E of the Social
1192 Security Act for subsidized board payments, foster care, or
1193 adoption subsidies, and a child for whom the state has assumed
1194 temporary or permanent responsibility and who does not qualify
1195 for Title IV-E assistance but is in foster care, shelter or
1196 emergency shelter care, or subsidized adoption. This ~~category~~
1197 includes a young adult who is eligible to receive services under
1198 s. 409.1451(5), until the young adult reaches 21 years of age~~,~~
1199 without regard to any income, resource, or categorical
1200 eligibility test that is otherwise required. This ~~category~~ also
1201 includes a person who as a child was eligible under Title IV-E
1202 of the Social Security Act for foster care or the state-provided
1203 foster care and who is a participant in the Road-to-Independence
1204 Program.
1205 (5) A pregnant woman for the duration of her pregnancy and
1206 for the postpartum period as defined in federal law and rule, or
1207 a child under age 1, if either is living in a family that has an
1208 income which is at or below ~~150 percent of the most current~~
1209 ~~federal poverty level, or, effective January 1, 1992, that has~~
1210 ~~an income which is at or below~~ 185 percent of the most current
1211 federal poverty level. Such a person is not subject to an assets
1212 test. ~~Further,~~ A pregnant woman who applies for eligibility for
1213 the Medicaid program through a qualified Medicaid provider must
1214 be offered the opportunity, subject to federal rules, to be made
1215 presumptively eligible for the Medicaid program.
1216 (6) A child ~~born after September 30, 1983,~~ living in a
1217 family that has an income which is at or below 100 percent of
1218 the current federal poverty level, who has attained the age of

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1219 6, but has not attained the age of 19. In determining the
1220 eligibility of such a child, an assets test is not required. A
1221 child who is eligible ~~for Medicaid~~ under this subsection must be
1222 offered the opportunity, subject to federal rules, to be made
1223 presumptively eligible. A child who has been deemed
1224 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in
1225 a managed care plan until the child's full eligibility
1226 ~~determination~~ for Medicaid has been determined ~~completed~~.
1227 (7) A child living in a family that has an income that
1228 ~~which~~ is at or below 133 percent of the current federal poverty
1229 level, who has attained the age of 1, but has not attained the
1230 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an
1231 assets test is not required. A child who is eligible ~~for~~
1232 ~~Medicaid~~ under this subsection must be offered the opportunity,
1233 subject to federal rules, to be made presumptively eligible. A
1234 child who has been deemed presumptively eligible may ~~for~~
1235 ~~Medicaid shall~~ not be enrolled in a managed care plan until the
1236 child's full eligibility ~~determination~~ for Medicaid has been
1237 determined ~~completed~~.
1238 (8) A person who is age 65 or over or is determined by the
1239 agency to be disabled, whose income is at or below 100 percent
1240 of the most current federal poverty level and whose assets do
1241 not exceed limitations established by the agency. However, the
1242 agency may only pay for premiums, coinsurance, and deductibles,
1243 as required by federal law, unless additional coverage is
1244 provided for any or all members of this group under ~~by~~ s.
1245 409.904(1).
1246 Section 20. Section 409.904, Florida Statutes, is amended
1247 to read:

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1248 409.904 Optional payments for eligible persons.—The agency
1249 may make payments for medical assistance and related services on
1250 behalf of the following categories of persons who are determined
1251 to be eligible for Medicaid, subject to the income, assets, and
1252 categorical eligibility tests set forth in federal and state
1253 law. Payment on behalf of these ~~Medicaid eligible~~ persons is
1254 subject to the availability of moneys and any limitations
1255 established by the General Appropriations Act, ~~or~~ chapter 216,
1256 or s. 409.9022.
1257 (1) ~~Effective January 1, 2006, and~~ Subject to federal
1258 waiver approval, a person who is age 65 or older or is
1259 determined to be disabled, whose income is at or below 88
1260 percent of the federal poverty level, whose assets do not exceed
1261 established limitations, and who is not eligible for Medicare
1262 or, if eligible for Medicare, is also eligible for and receiving
1263 Medicaid-covered institutional care services, hospice services,
1264 or home and community-based services. The agency shall seek
1265 federal authorization through a waiver to provide this coverage.
1266 This subsection expires June 30, 2011.
1267 (2) The following persons who are eligible for the Medicaid
1268 nonpoverty medical subsidy, which includes the same services as
1269 those provided to other Medicaid recipients, with the exception
1270 of services in skilled nursing facilities and intermediate care
1271 facilities for the developmentally disabled:
1272 (a) A family, a pregnant woman, a child under age 21, a
1273 person age 65 or over, or a blind or disabled person, who would
1274 be eligible under any group listed in s. 409.903(1), (2), or
1275 (3), except that the income or assets of such family or person
1276 exceed established limitations. For a family or person in one of

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1277 these coverage groups, medical expenses are deductible from
1278 income in accordance with federal requirements in order to make
1279 a determination of eligibility. ~~A family or person eligible~~
1280 ~~under the coverage known as the "medically needy," is eligible~~
1281 ~~to receive the same services as other Medicaid recipients, with~~
1282 ~~the exception of services in skilled nursing facilities and~~
1283 ~~intermediate care facilities for the developmentally disabled.~~
1284 This paragraph expires June 30, 2011.
1285 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a
1286 child younger than 21 years of age who would be eligible under
1287 any group listed in s. 409.903, except that the income or assets
1288 of such group exceed established limitations. For a person in
1289 one of these coverage groups, medical expenses are deductible
1290 from income in accordance with federal requirements in order to
1291 make a determination of eligibility. ~~A person eligible under the~~
1292 ~~coverage known as the "medically needy" is eligible to receive~~
1293 ~~the same services as other Medicaid recipients, with the~~
1294 ~~exception of services in skilled nursing facilities and~~
1295 ~~intermediate care facilities for the developmentally disabled.~~
1296 (c) A family, a person age 65 or older, or a blind or
1297 disabled person, who would be eligible under any group listed in
1298 s. 409.903(1), (2), or (3), except that the income or assets of
1299 such family or person exceed established limitations. For a
1300 family or person in one of these coverage groups, medical
1301 expenses are deductible from income in accordance with federal
1302 requirements in order to make a determination of eligibility. A
1303 family, a person age 65 or older, or a blind or disabled person,
1304 covered under the Medicaid nonpoverty medical subsidy, is
1305 eligible to receive physician services only.

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1306 (3) A person who is in need of the services of a licensed
1307 nursing facility, a licensed intermediate care facility for the
1308 developmentally disabled, or a state mental hospital, whose
1309 income does not exceed 300 percent of the SSI income standard,
1310 and who meets the assets standards established under federal and
1311 state law. In determining the person's responsibility for the
1312 cost of care, the following amounts must be deducted from the
1313 person's income:
1314 (a) The monthly personal allowance for residents as set
1315 based on appropriations.
1316 (b) The reasonable costs of medically necessary services
1317 and supplies that are not reimbursable by the Medicaid program.
1318 (c) The cost of premiums, copayments, coinsurance, and
1319 deductibles for supplemental health insurance.
1320 (4) A low-income person who meets all other requirements
1321 for Medicaid eligibility except citizenship and who is in need
1322 of emergency medical services. The eligibility of such a
1323 recipient is limited to the period of the emergency, in
1324 accordance with federal regulations.
1325 (5) Subject to specific federal authorization, a woman
1326 living in a family that has an income that is at or below 185
1327 percent of the most current federal poverty level. Coverage is
1328 limited to ~~is eligible for~~ family planning services as specified
1329 in s. 409.905(3) for a period of up to 24 months following a
1330 loss of Medicaid benefits.
1331 (6) A child who has not attained the age of 19 who has been
1332 determined eligible for the Medicaid program is deemed to be
1333 eligible for a total of 6 months, regardless of changes in
1334 circumstances other than attainment of the maximum age.

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1335 ~~Effective January 1, 1999,~~ A child who has not attained the age
1336 of 5 and who has been determined eligible for the Medicaid
1337 program is deemed to be eligible for a total of 12 months
1338 regardless of changes in circumstances other than attainment of
1339 the maximum age.
1340 (7) A child under 1 year of age who lives in a family that
1341 has an income above 185 percent of the most recently published
1342 federal poverty level, but which is at or below 200 percent of
1343 such poverty level. In determining the eligibility ~~of such~~
1344 ~~child~~, an assets test is not required. A child who is eligible
1345 ~~for Medicaid~~ under this subsection must be offered the
1346 opportunity, subject to federal rules, to be made presumptively
1347 eligible.
1348 (8) An eligible person ~~A Medicaid-eligible individual~~ for
1349 the individual's health insurance premiums, if the agency
1350 determines that such payments are cost-effective.
1351 (9) Eligible women with incomes at or below 200 percent of
1352 the federal poverty level and under age 65, for cancer treatment
1353 pursuant to the federal Breast and Cervical Cancer Prevention
1354 and Treatment Act of 2000, screened through the Mary Brogan
1355 Breast and Cervical Cancer Early Detection Program established
1356 under s. 381.93.
1357 Section 21. Section 409.905, Florida Statutes, is amended
1358 to read:
1359 409.905 Mandatory Medicaid services.—The agency shall ~~may~~
1360 make payments for the following services, which are required ~~of~~
1361 ~~the state~~ by Title XIX of the Social Security Act, furnished by
1362 Medicaid providers to recipients who are ~~determined to be~~
1363 eligible on the dates on which the services were provided. Any

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1364 service under this section shall be provided only when medically
1365 necessary and in accordance with state and federal law.
1366 Mandatory services rendered by providers in mobile units to
1367 Medicaid recipients may be restricted by the agency. This
1368 section does not ~~Nothing in this section shall be construed to~~
1369 prevent or limit the agency from adjusting fees, reimbursement
1370 rates, lengths of stay, number of visits, number of services, or
1371 any other adjustments necessary to comply with the availability
1372 of moneys and any limitations or directions provided ~~for~~ in the
1373 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1374 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The
1375 agency shall pay for services provided to a recipient by a
1376 licensed advanced registered nurse practitioner who has a valid
1377 collaboration agreement with a licensed physician on file with
1378 the Department of Health or who provides anesthesia services in
1379 accordance with established protocol required by state law and
1380 approved by the medical staff of the facility in which the
1381 ~~anesthetic~~ service is performed. Reimbursement for such services
1382 must be provided in an amount that equals at least ~~not less than~~
1383 80 percent of the reimbursement to a physician who provides the
1384 same services, unless otherwise provided ~~for~~ in the General
1385 Appropriations Act.
1386 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
1387 SERVICES.—The agency shall pay for early and periodic screening
1388 and diagnosis of a recipient under age 21 to ascertain physical
1389 and mental problems and conditions and ~~provide treatment to~~
1390 ~~correct or ameliorate these problems and conditions. These~~
1391 ~~services include~~ all services determined by the agency to be
1392 medically necessary for the treatment, correction, or

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1393 amelioration of these problems and conditions, including
1394 personal care, private duty nursing, durable medical equipment,
1395 physical therapy, occupational therapy, speech therapy,
1396 respiratory therapy, and immunizations.
1397 (3) FAMILY PLANNING SERVICES.—The agency shall pay for
1398 services necessary to enable a recipient voluntarily to plan
1399 family size or to space children. These services include
1400 information; education; counseling regarding the availability,
1401 benefits, and risks of each method of pregnancy prevention;
1402 drugs and supplies; and necessary medical care and followup.
1403 Each recipient participating in ~~the~~ family planning ~~portion of~~
1404 ~~the Medicaid program~~ must be provided the choice of ~~freedom to~~
1405 ~~choose~~ any alternative method of family planning, as required by
1406 federal law.
1407 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
1408 nursing and home health aide services, supplies, appliances, and
1409 durable medical equipment, necessary to assist a recipient
1410 living at home. An entity that provides such services must
1411 ~~pursuant to this subsection shall~~ be licensed under part III of
1412 chapter 400. These services, equipment, and supplies, or
1413 reimbursement therefor, may be limited as provided in the
1414 General Appropriations Act and do not include services,
1415 equipment, or supplies provided to a person residing in a
1416 hospital or nursing facility.
1417 (a) ~~In providing home health care services,~~ The agency
1418 shall ~~may~~ require prior authorization of home health services
1419 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing
1420 rates. ~~The agency shall require prior authorization for visits~~
1421 ~~for home health services that are not associated with a skilled~~

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1422 ~~nursing visit when the home health agency billing rates exceed~~
1423 ~~the state average by 50 percent or more.~~ The home health agency
1424 must submit the recipient's plan of care and documentation that
1425 supports the recipient's diagnosis to the agency when requesting
1426 prior authorization.
1427 (b) The agency shall implement a comprehensive utilization
1428 management program ~~that requires prior authorization~~ of all
1429 private duty nursing services, an individualized treatment plan
1430 that includes information about medication and treatment orders,
1431 treatment goals, methods of care to be used, and plans for care
1432 coordination by nurses and other health professionals. The
1433 utilization management program must ~~shall~~ also include a process
1434 for periodically reviewing the ongoing use of private duty
1435 nursing services. The assessment of need shall be based on a
1436 child's condition; ~~,~~ family support and care supplements; ~~,~~ a
1437 family's ability to provide care; ~~, and~~ a family's and child's
1438 schedule regarding work, school, sleep, and care for other
1439 family dependents; and a determination of the medical necessity
1440 for private duty nursing instead of other more cost-effective
1441 in-home services. When implemented, the private duty nursing
1442 utilization management program shall replace the current
1443 authorization program used by the agency ~~for Health Care~~
1444 ~~Administration~~ and the Children's Medical Services program of
1445 the Department of Health. The agency may competitively bid ~~on~~ a
1446 contract to select a qualified organization to provide
1447 utilization management of private duty nursing services. The
1448 agency may ~~is authorized to~~ seek federal waivers to implement
1449 this initiative.
1450 (c) The agency may not pay for home health services unless

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1451 the services are medically necessary and:
1452 1. The services are ordered by a physician.
1453 2. The written prescription for the services is signed and
1454 dated by the recipient’s physician before the development of a
1455 plan of care and before any request requiring prior
1456 authorization.
1457 3. The physician ordering the services is not employed,
1458 under contract with, or otherwise affiliated with the home
1459 health agency rendering the services. However, this subparagraph
1460 does not apply to a home health agency affiliated with a
1461 retirement community, of which the parent corporation or a
1462 related legal entity owns a rural health clinic certified under
1463 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
1464 under part II of chapter 400, or an apartment or single-family
1465 home for independent living. For purposes of this subparagraph,
1466 the agency may, on a case-by-case basis, provide an exception
1467 for medically fragile children who are younger than 21 years of
1468 age.
1469 4. The physician ordering the services has examined the
1470 recipient within the 30 days preceding the initial request for
1471 the services and biannually thereafter.
1472 5. The written prescription for the services includes the
1473 recipient’s acute or chronic medical condition or diagnosis, the
1474 home health service required, and, for skilled nursing services,
1475 the frequency and duration of the services.
1476 6. The national provider identifier, Medicaid
1477 identification number, or medical practitioner license number of
1478 the physician ordering the services is listed on the written
1479 prescription for the services, the claim for home health

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1480 reimbursement, and the prior authorization request.
1481 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1482 all covered services provided for the medical care and treatment
1483 of a recipient who is admitted as an inpatient by a licensed
1484 physician or dentist to a hospital licensed under part I of
1485 chapter 395. However, the agency shall limit the payment for
1486 inpatient hospital services for a Medicaid recipient 21 years of
1487 age or older to 45 days or the number of days necessary to
1488 comply with the General Appropriations Act.
1489 (a) The agency may ~~is authorized to~~ implement reimbursement
1490 and utilization management reforms in order to comply with any
1491 limitations or directions in the General Appropriations Act,
1492 which may include, but are not limited to~~:~~ prior authorization
1493 for inpatient psychiatric days; prior authorization for
1494 nonemergency hospital inpatient admissions for individuals 21
1495 years of age and older; authorization of emergency and urgent-
1496 care admissions within 24 hours after admission; enhanced
1497 utilization and concurrent review programs for highly utilized
1498 services; reduction or elimination of covered days of service;
1499 adjusting reimbursement ceilings for variable costs; adjusting
1500 reimbursement ceilings for fixed and property costs; and
1501 implementing target rates of increase. The agency may limit
1502 prior authorization for hospital inpatient services to selected
1503 diagnosis-related groups, based on an analysis of the cost and
1504 potential for unnecessary hospitalizations represented by
1505 certain diagnoses. Admissions for normal delivery and newborns
1506 are exempt from requirements for prior authorization. In
1507 implementing the provisions of this section related to prior
1508 authorization, the agency must ~~shall~~ ensure that the process for

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1509 authorization is accessible 24 hours per day, 7 days per week
1510 and that authorization is automatically granted if ~~when~~ not
1511 denied within 4 hours after the request. Authorization
1512 procedures must include steps for reviewing ~~review of~~ denials.
1513 Upon implementing the prior authorization program for hospital
1514 inpatient services, the agency shall discontinue its hospital
1515 retrospective review program.
1516 (b) A licensed hospital maintained primarily for the care
1517 and treatment of patients having mental disorders or mental
1518 diseases may ~~is~~ not ~~eligible to~~ participate in the hospital
1519 inpatient portion of the Medicaid program except as provided in
1520 federal law. However, the Department of Children and Family
1521 Services shall apply for a waiver~~, within 9 months after June 5,~~
1522 ~~1991,~~ designed to provide hospitalization services for mental
1523 health reasons to children and adults in the most cost-effective
1524 and lowest cost setting possible. Such waiver shall include a
1525 request for the opportunity to pay for care in hospitals known
1526 under federal law as “institutions for mental disease” or
1527 “IMD’s.” The waiver proposal shall propose no additional
1528 aggregate cost to the state or Federal Government, and shall be
1529 conducted in Hillsborough County, Highlands County, Hardee
1530 County, Manatee County, and Polk County. The waiver proposal may
1531 incorporate competitive bidding for hospital services,
1532 comprehensive brokering, prepaid capitated arrangements, or
1533 other mechanisms deemed by the department to show promise in
1534 reducing the cost of acute care and increasing the effectiveness
1535 of preventive care. When developing the waiver proposal, the
1536 department shall take into account price, quality,
1537 accessibility, linkages of the hospital to community services

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1538 and family support programs, plans of the hospital to ensure the
1539 earliest discharge possible, and the comprehensiveness of the
1540 mental health and other health care services offered by
1541 participating providers.
1542 (c) The agency shall adjust a hospital's current inpatient
1543 per diem rate to reflect the cost of serving the Medicaid
1544 population at that institution if:
1545 1. The hospital experiences an increase in Medicaid
1546 caseload by more than 25 percent in any year, primarily
1547 resulting from the closure of a hospital in the same service
1548 area occurring after July 1, 1995;
1549 2. The hospital's Medicaid per diem rate is at least 25
1550 percent below the Medicaid per patient cost for that year; or
1551 3. The hospital is located in a county that has six or
1552 fewer general acute care hospitals, began offering obstetrical
1553 services on or after September 1999, and has submitted a request
1554 in writing to the agency for a rate adjustment after July 1,
1555 2000, but before September 30, 2000, in which case such
1556 hospital's Medicaid inpatient per diem rate shall be adjusted to
1557 cost, effective July 1, 2002. By October 1 of each year, the
1558 agency must provide estimated costs for any adjustment in a
1559 hospital inpatient per diem rate to the Executive Office of the
1560 Governor, the House of Representatives General Appropriations
1561 Committee, and the Senate Appropriations Committee. Before the
1562 agency implements a change in a hospital's inpatient per diem
1563 rate pursuant to this paragraph, the Legislature must have
1564 specifically appropriated sufficient funds in the General
1565 Appropriations Act to support the increase in cost as estimated
1566 by the agency.

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1567 (d) The agency shall implement a hospitalist program in
1568 nonteaching hospitals, select counties, or statewide. The
1569 program shall require hospitalists to manage Medicaid
1570 recipients' hospital admissions and lengths of stay. Individuals
1571 who are dually eligible for Medicare and Medicaid are exempted
1572 from this requirement. Medicaid participating physicians and
1573 other practitioners with hospital admitting privileges shall
1574 coordinate and review admissions of Medicaid recipients with the
1575 hospitalist. The agency may competitively bid a contract for
1576 selection of a single qualified organization to provide
1577 hospitalist services. The agency may procure hospitalist
1578 services by individual county or may combine counties in a
1579 single procurement. The qualified organization shall contract
1580 with or employ board-eligible physicians in Miami-Dade, Palm
1581 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency
1582 may ~~is authorized to~~ seek federal waivers to implement this
1583 program.
1584 (e) The agency shall implement a comprehensive utilization
1585 management program for hospital neonatal intensive care stays in
1586 certain high-volume participating hospitals, select counties, or
1587 statewide, and shall replace existing hospital inpatient
1588 utilization management programs for neonatal intensive care
1589 admissions. The program shall be designed to manage the lengths
1590 of stay for children being treated in neonatal intensive care
1591 units and must seek the earliest medically appropriate discharge
1592 to the child's home or other less costly treatment setting. The
1593 agency may competitively bid a contract for selection of a
1594 qualified organization to provide neonatal intensive care
1595 utilization management services. The agency may ~~is authorized to~~

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1596 seek any federal waivers to implement this initiative.
1597 (f) The agency may develop and implement a program to
1598 reduce the number of hospital readmissions among the non-
1599 Medicare population eligible in areas 9, 10, and 11.
1600 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for
1601 preventive, diagnostic, therapeutic, or palliative care and
1602 other services provided to a recipient in the outpatient portion
1603 of a hospital licensed under part I of chapter 395, and provided
1604 under the direction of a licensed physician or licensed dentist,
1605 except that payment for such care and services is limited to
1606 $1,500 per state fiscal year per recipient, unless an exception
1607 has been made by the agency, and with the exception of a
1608 Medicaid recipient under age 21, in which case the only
1609 limitation is medical necessity.
1610 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay
1611 for medically necessary diagnostic laboratory procedures ordered
1612 by a licensed physician or other licensed health care
1613 practitioner ~~of the healing arts~~ which are provided for a
1614 recipient in a laboratory that meets the requirements for
1615 Medicare participation and is licensed under chapter 483, if
1616 required.
1617 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-
1618 hour-a-day nursing and rehabilitative services for a recipient
1619 in a nursing facility licensed under part II of chapter 400 or
1620 in a rural hospital, as defined in s. 395.602, or in a Medicare
1621 certified skilled nursing facility operated by a general
1622 hospital, as defined in ~~by~~ s. 395.002~~(10)~~, which ~~that~~ is
1623 licensed under part I of chapter 395, and in accordance with
1624 ~~provisions set forth in~~ s. 409.908(2)(a), which services are

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1625 ordered by and provided under the direction of a licensed
1626 physician. However, if a nursing facility has been destroyed or
1627 otherwise made uninhabitable by natural disaster or other
1628 emergency and another nursing facility is not available, the
1629 agency must pay for similar services temporarily in a hospital
1630 licensed under part I of chapter 395 provided federal funding is
1631 approved and available. The agency shall pay only for bed-hold
1632 days if the facility has an occupancy rate of 95 percent or
1633 greater. The agency is authorized to seek any federal waivers to
1634 implement this policy.
1635 (9) PHYSICIAN SERVICES.—The agency shall pay for covered
1636 services and procedures rendered to a Medicaid recipient by, or
1637 under the personal supervision of, a person licensed under state
1638 law to practice medicine or osteopathic medicine. These services
1639 may be furnished in the physician's office, the ~~Medicaid~~
1640 recipient's home, a hospital, a nursing facility, or elsewhere,
1641 but must ~~shall~~ be medically necessary for the treatment of a
1642 covered ~~an~~ injury or~~,~~ illness~~, or disease~~ within the scope of
1643 the practice of medicine or osteopathic medicine as defined by
1644 state law. The agency may ~~shall~~ not pay for services that are
1645 clinically unproven, experimental, or for purely cosmetic
1646 purposes.
1647 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for
1648 professional and technical portable radiological services
1649 ordered by a licensed physician or other licensed health care
1650 practitioner ~~of the healing arts~~ which are provided by a
1651 licensed professional in a setting other than a hospital,
1652 clinic, or office of a physician or practitioner ~~of the healing~~
1653 ~~arts~~, on behalf of a recipient.

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1654 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for
1655 outpatient primary ~~health~~ care services for a recipient provided
1656 by a clinic certified by and participating in the Medicare
1657 program which is located in a federally designated, rural,
1658 medically underserved area and has on its staff one or more
1659 licensed primary care nurse practitioners or physician
1660 assistants, and a licensed staff supervising physician or a
1661 consulting supervising physician.
1662 (12) TRANSPORTATION SERVICES.—The agency shall ensure that
1663 appropriate transportation services are available for a Medicaid
1664 recipient in need of transport to a qualified Medicaid provider
1665 for medically necessary ~~and Medicaid-compensable~~ services, if
1666 the recipient's ~~provided a client's~~ ability to choose a specific
1667 transportation provider is ~~shall be~~ limited to those options
1668 resulting from policies established by the agency to meet the
1669 fiscal limitations of the General Appropriations Act. The agency
1670 may pay for necessary transportation and other related travel
1671 expenses ~~as necessary~~ only if these services are not otherwise
1672 available.
1673 Section 22. Section 409.906, Florida Statutes, is amended
1674 to read:
1675 409.906 Optional Medicaid services.—Subject to specific
1676 appropriations, the agency may make payments for services which
1677 are optional to the state under Title XIX of the Social Security
1678 Act and are furnished by Medicaid providers to recipients who
1679 are determined to be eligible on the dates on which the services
1680 were provided. Any optional service that is provided shall be
1681 provided only when medically necessary and in accordance with
1682 state and federal law. Optional services rendered by providers

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1683 in mobile units to Medicaid recipients may be restricted or
1684 prohibited by the agency. ~~Nothing in~~ This section does not ~~shall~~
1685 ~~be construed to~~ prevent or limit the agency from adjusting fees,
1686 reimbursement rates, lengths of stay, number of visits, or
1687 number of services, or making any other adjustments necessary to
1688 comply with the availability of moneys and any limitations or
1689 directions provided for in the General Appropriations Act, ~~or~~
1690 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~
1691 ~~state's systems of providing services to elderly and disabled~~
1692 ~~persons and subject to the notice and review provisions of s.~~
1693 ~~216.177, the Governor may direct the Agency for Health Care~~
1694 ~~Administration to amend the Medicaid state plan to delete the~~
1695 ~~optional Medicaid service known as "Intermediate Care Facilities~~
1696 ~~for the Developmentally Disabled."~~ Optional services may
1697 include:
1698 (1) ADULT DENTAL SERVICES.—For a recipient who is 21 years
1699 of age or older:
1700 (a) The agency may pay for medically necessary, emergency
1701 dental procedures to alleviate pain or infection. Emergency
1702 dental care is ~~shall be~~ limited to emergency oral examinations,
1703 necessary radiographs, extractions, and incision and drainage of
1704 abscess~~, for a recipient who is 21 years of age or older~~.
1705 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or
1706 partial dentures, the procedures required to seat full or
1707 partial dentures, and the repair and reline of full or partial
1708 dentures, provided by or under the direction of a licensed
1709 dentist~~, for a recipient who is 21 years of age or older~~.
1710 (c) ~~However,~~ Medicaid will not provide reimbursement for
1711 dental services provided in a mobile dental unit, except for a

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1712 mobile dental unit:
1713 1. Owned by, operated by, or having a contractual agreement
1714 with the Department of Health and complying with Medicaid's
1715 county health department clinic services program specifications
1716 as a county health department clinic services provider.
1717 2. Owned by, operated by, or having a contractual
1718 arrangement with a federally qualified health center and
1719 complying with Medicaid's federally qualified health center
1720 specifications as a federally qualified health center provider.
1721 3. Rendering dental services to Medicaid recipients, 21
1722 years of age and older, at nursing facilities.
1723 4. Owned by, operated by, or having a contractual agreement
1724 with a state-approved dental educational institution.
1725 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for
1726 an annual routine physical examination, conducted by or under
1727 the direction of a licensed physician, for a recipient age 21 or
1728 older, without regard to medical necessity, in order to detect
1729 and prevent disease, disability, or other health condition or
1730 its progression.
1731 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay
1732 for services provided to a recipient in an ambulatory surgical
1733 center licensed under part I of chapter 395, by or under the
1734 direction of a licensed physician or dentist.
1735 (4) BIRTH CENTER SERVICES.—The agency may pay for
1736 examinations and delivery, recovery, ~~and~~ newborn assessment, and
1737 related services, provided in a licensed birth center staffed
1738 with licensed physicians, certified nurse midwives, and midwives
1739 licensed in accordance with chapter 467, to a recipient expected
1740 to experience a low-risk pregnancy and delivery.

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1741 (5) CASE MANAGEMENT SERVICES.—The agency may pay for
1742 primary care case management services rendered to a recipient
1743 pursuant to a federally approved waiver~~,~~ and targeted case
1744 management services for specific groups of targeted recipients,
1745 for which funding has been provided and which are rendered
1746 pursuant to federal guidelines. The agency may ~~is authorized to~~
1747 limit reimbursement for targeted case management services in
1748 order to comply with any limitations or directions provided for
1749 in the General Appropriations Act.
1750 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
1751 diagnostic, preventive, or corrective procedures, including
1752 orthodontia in severe cases, provided to a recipient under age
1753 21, by or under the supervision of a licensed dentist. Services
1754 ~~provided under this program~~ include treatment of the teeth and
1755 associated structures of the oral cavity, as well as treatment
1756 of disease, injury, or impairment that may affect the oral or
1757 general health of the individual. However, Medicaid may ~~will~~ not
1758 provide reimbursement for dental services provided in a mobile
1759 dental unit, except for a mobile dental unit:
1760 (a) Owned by, operated by, or having a contractual
1761 agreement with the Department of Health and complying with
1762 Medicaid's county health department clinic services program
1763 specifications as a county health department clinic services
1764 provider.
1765 (b) Owned by, operated by, or having a contractual
1766 arrangement with a federally qualified health center and
1767 complying with Medicaid's federally qualified health center
1768 specifications as a federally qualified health center provider.
1769 (c) Rendering dental services to Medicaid recipients, 21

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1770 years of age and older, at nursing facilities.
1771 (d) Owned by, operated by, or having a contractual
1772 agreement with a state-approved dental educational institution.
1773 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
1774 manipulation of the spine and initial services, screening, and X
1775 rays provided to a recipient by a licensed chiropractic
1776 physician.
1777 (8) COMMUNITY MENTAL HEALTH SERVICES.—
1778 ~~(a)~~ The agency may pay for rehabilitative services provided
1779 to a recipient by a mental health or substance abuse provider
1780 under contract with the agency or the Department of Children and
1781 Family Services to provide such services. ~~Those~~ Services that
1782 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or
1783 recommended by a psychiatrist, and ~~those~~ services that ~~which~~ are
1784 medical in nature must ~~shall~~ be rendered or recommended by a
1785 physician or psychiatrist.
1786 (a) The agency shall ~~must~~ develop a provider enrollment
1787 process for community mental health providers which bases
1788 provider enrollment on an assessment of service need. The
1789 provider enrollment process shall be designed to control costs,
1790 prevent fraud and abuse, consider provider expertise and
1791 capacity, and assess provider success in managing utilization of
1792 care and measuring treatment outcomes. Providers must ~~will~~ be
1793 selected through a competitive procurement or selective
1794 contracting process. In addition ~~to other community mental~~
1795 ~~health providers~~, the agency shall consider enrolling ~~for~~
1796 ~~enrollment~~ mental health programs licensed under chapter 395 and
1797 group practices licensed under chapter 458, chapter 459, chapter
1798 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~

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1799 continue the operation of its behavioral health utilization
1800 management program and ~~may~~ develop new services, if ~~these~~
1801 ~~actions are~~ necessary, to ensure savings from the implementation
1802 of the utilization management system. The agency shall
1803 coordinate the implementation of this enrollment process with
1804 the Department of Children and Family Services and the
1805 Department of Juvenile Justice. The agency may use ~~is authorized~~
1806 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,
1807 ~~to~~ preauthorize certain high-cost or highly utilized services,
1808 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make
1809 any other adjustments necessary to comply with any limitations
1810 or directions provided for in the General Appropriations Act.
1811 (b) The agency may ~~is authorized to~~ implement reimbursement
1812 and use management reforms in order to comply with any
1813 limitations or directions in the General Appropriations Act,
1814 which may include, but are not limited to~~:~~ prior authorization
1815 of treatment and service plans; prior authorization of services;
1816 enhanced use review programs for highly used services; and
1817 limits on services for recipients ~~those~~ determined to be abusing
1818 their benefit coverages.
1819 (9) DIALYSIS FACILITY SERVICES.—Subject to specific
1820 appropriations being provided for this purpose, the agency may
1821 pay a dialysis facility that is approved as a dialysis facility
1822 in accordance with Title XVIII of the Social Security Act, for
1823 dialysis services that are provided to a Medicaid recipient
1824 under the direction of a physician licensed to practice medicine
1825 or osteopathic medicine in this state, including dialysis
1826 services provided in the recipient's home by a hospital-based or
1827 freestanding dialysis facility.

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1828 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize
1829 and pay for certain durable medical equipment and supplies
1830 provided to a Medicaid recipient as medically necessary.
1831 (11) HEALTHY START SERVICES.—The agency may pay for a
1832 continuum of risk-appropriate medical and psychosocial services
1833 for the Healthy Start program in accordance with a federal
1834 waiver. The agency may not implement the federal waiver unless
1835 the waiver permits the state to limit enrollment or the amount,
1836 duration, and scope of services to ensure that expenditures will
1837 not exceed funds appropriated by the Legislature or available
1838 from local sources. If ~~the Health Care Financing Administration~~
1839 ~~does not approve~~ a federal waiver for Healthy Start services is
1840 not approved, the agency, in consultation with the Department of
1841 Health and the Florida Association of Healthy Start Coalitions,
1842 may ~~is authorized to~~ establish a Medicaid certified-match
1843 program for Healthy Start services. Participation in the Healthy
1844 Start certified-match program is ~~shall be~~ voluntary, and
1845 reimbursement is ~~shall be~~ limited to the federal Medicaid share
1846 provided to Medicaid-enrolled Healthy Start coalitions for
1847 services provided to Medicaid recipients. The agency may not
1848 ~~shall~~ take ~~no~~ action to implement a certified-match program
1849 without ensuring that the amendment and review requirements of
1850 ss. 216.177 and 216.181 have been met.
1851 (12) HEARING SERVICES.—The agency may pay for hearing and
1852 related services, including hearing evaluations, hearing aid
1853 devices, dispensing of the hearing aid, and related repairs~~, if~~
1854 provided to a recipient by a licensed hearing aid specialist,
1855 otolaryngologist, otologist, audiologist, or physician.
1856 (13) HOME AND COMMUNITY-BASED SERVICES.—

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1857 (a) The agency may pay for home-based or community-based
1858 services that are rendered to a recipient in accordance with a
1859 federally approved waiver program. The agency may limit or
1860 eliminate coverage for certain services, preauthorize high-cost
1861 or highly utilized services, or make any other adjustments
1862 necessary to comply with any limitations or directions provided
1863 ~~for~~ in the General Appropriations Act.
1864 (b) The agency may consolidate types of services offered in
1865 the Aged and Disabled Waiver, the Channeling Waiver, the Project
1866 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury
1867 Waiver programs in order to group similar services under a
1868 single service, or continue a service upon evidence of the need
1869 for including a particular service type in a particular waiver.
1870 The agency may ~~is authorized to~~ seek a Medicaid state plan
1871 amendment or federal waiver approval to implement this policy.
1872 (c) The agency may implement a utilization management
1873 program designed to prior-authorize home and community-based
1874 service plans which ~~and~~ includes, but is not limited to,
1875 assessing proposed quantity and duration of services and
1876 monitoring ongoing service use by participants in the program.
1877 The agency may ~~is authorized to~~ competitively procure a
1878 qualified organization to provide utilization management of home
1879 and community-based services. The agency may ~~is authorized to~~
1880 seek any federal waivers to implement this initiative.
1881 (d) The agency shall assess a fee against the parents of a
1882 child who is being served by a waiver under this subsection if
1883 the adjusted household income is greater than 100 percent of the
1884 federal poverty level. The amount of the fee shall be calculated
1885 using a sliding scale based on the size of the family, the

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1886 amount of the parent's adjusted gross income, and the federal
1887 poverty guidelines. The agency shall seek a federal waiver to
1888 implement this provision.
1889 (14) HOSPICE CARE SERVICES.—The agency may pay for all
1890 reasonable and necessary services for the palliation or
1891 management of a recipient's terminal illness, if the services
1892 are provided by a hospice that is licensed under part IV of
1893 chapter 400 and meets Medicare certification requirements.
1894 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
1895 DISABLED SERVICES.—The agency may pay for health-related care
1896 and services provided on a 24-hour-a-day basis by a facility
1897 licensed and certified as a Medicaid Intermediate Care Facility
1898 for the Developmentally Disabled, for a recipient who needs such
1899 care because of a developmental disability. Payment may ~~shall~~
1900 not include bed-hold days except in facilities with occupancy
1901 rates of 95 percent or greater. The agency may ~~is authorized to~~
1902 seek any federal waiver approvals to implement this policy. If
1903 necessary to safeguard the state's systems of providing services
1904 to elderly and disabled persons and subject to notice and review
1905 under s. 216.177, the Governor may direct the agency to amend
1906 the Medicaid state plan to delete these services.
1907 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-
1908 hour-a-day intermediate care nursing and rehabilitation services
1909 rendered to a recipient in a nursing facility licensed under
1910 part II of chapter 400~~,~~ if the services are ordered by and
1911 provided under the direction of a physician.
1912 (17) OPTOMETRIC SERVICES.—The agency may pay for services
1913 provided to a recipient, including examination, diagnosis,
1914 treatment, and management, related to ocular pathology~~,~~ if the

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1915 services are provided by a licensed optometrist or physician.
1916 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for
1917 all services provided to a recipient by a physician assistant
1918 licensed under s. 458.347 or s. 459.022. Reimbursement for such
1919 services must be at least ~~not less than~~ 80 percent of the
1920 reimbursement that would be paid to a physician who provided the
1921 same services.
1922 (19) PODIATRIC SERVICES.—The agency may pay for services,
1923 including diagnosis and medical, surgical, palliative, and
1924 mechanical treatment, related to ailments of the human foot and
1925 lower leg, if provided to a recipient by a podiatric physician
1926 licensed under state law.
1927 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for
1928 medications that are prescribed for a recipient by a physician
1929 or other licensed health care practitioner ~~of the healing arts~~
1930 authorized to prescribe medications and that are dispensed to
1931 the recipient by a licensed pharmacist or physician in
1932 accordance with applicable state and federal law. However, the
1933 agency may not pay for any psychotropic medication prescribed
1934 for a child younger than the age for which the federal Food and
1935 Drug Administration has approved its use.
1936 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency
1937 may pay for all services provided to a recipient by a registered
1938 nurse first assistant as described in s. 464.027. Reimbursement
1939 for such services must be at least ~~may not be less than~~ 80
1940 percent of the reimbursement that would be paid to a physician
1941 providing the same services.
1942 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-
1943 inclusive psychiatric inpatient hospital care provided to a

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1944 recipient age 65 or older in a state mental hospital.
1945 (23) VISUAL SERVICES.—The agency may pay for visual
1946 examinations, eyeglasses, and eyeglass repairs for a recipient
1947 if they are prescribed by a licensed physician specializing in
1948 diseases of the eye or by a licensed optometrist. Eyeglass
1949 frames for adult recipients are ~~shall be~~ limited to one pair per
1950 recipient every 2 years, except a second pair may be provided
1951 ~~during that period~~ after prior authorization. Eyeglass lenses
1952 for adult recipients are ~~shall be~~ limited to one pair per year
1953 except a second pair may be provided ~~during that period~~ after
1954 prior authorization.
1955 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~
1956 ~~Health Care Administration~~, in consultation with the Department
1957 of Children and Family Services, may establish a targeted case-
1958 management project in those counties identified by the
1959 department ~~of Children and Family Services~~ and for all counties
1960 with a community-based child welfare project, as authorized
1961 under s. 409.1671, which have been specifically approved by the
1962 department. The covered group that is ~~of individuals who are~~
1963 eligible for ~~to receive~~ targeted case management include
1964 children who are eligible for Medicaid; who are between the ages
1965 of birth through 21; and who are under protective supervision or
1966 postplacement supervision, under foster-care supervision, or in
1967 shelter care or foster care. The number of eligible children
1968 ~~individuals who are eligible to receive targeted case management~~
1969 is limited to the number for whom the department ~~of Children and~~
1970 ~~Family Services~~ has matching funds to cover the costs. The
1971 general revenue funds required to match the funds for services
1972 provided by the community-based child welfare projects are

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1973 limited to funds available for services described under s.
1974 409.1671. The department ~~of Children and Family Services~~ may
1975 transfer the general revenue matching funds as billed by the
1976 agency ~~for Health Care Administration~~.
1977 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for
1978 assistive-care services provided to recipients with functional
1979 or cognitive impairments residing in assisted living facilities,
1980 adult family-care homes, or residential treatment facilities.
1981 These services may include health support, assistance with the
1982 activities of daily living and the instrumental acts of daily
1983 living, assistance with medication administration, and
1984 arrangements for health care.
1985 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM
1986 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~
1987 ~~authorized to~~ seek federal approval through a Medicaid waiver or
1988 a state plan amendment for the provision of occupational
1989 therapy, speech therapy, physical therapy, behavior analysis,
1990 and behavior assistant services to individuals who are 5 years
1991 of age and under and have a diagnosed developmental disability
1992 as defined in s. 393.063, or autism spectrum disorder as defined
1993 in s. 627.6686~~, or Down syndrome, a genetic disorder caused by~~
1994 ~~the presence of extra chromosomal material on chromosome 21~~.
1995 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~
1996 ~~Robertsonian Translocation, and other duplications of a portion~~
1997 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited
1998 to $36,000 annually and may not exceed $108,000 in total
1999 lifetime benefits. The agency shall submit an annual report
2000 beginning ~~on~~ January 1, 2009, to the President of the Senate,
2001 the Speaker of the House of Representatives, and the relevant

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2002 committees of the Senate and the House of Representatives
2003 regarding progress on obtaining federal approval and
2004 recommendations for the implementation of these home and
2005 community-based services. The agency may not implement this
2006 subsection without prior legislative approval.
2007 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may
2008 pay for all services provided to a recipient by an
2009 anesthesiologist assistant licensed under s. 458.3475 or s.
2010 459.023. Reimbursement for such services must be at least ~~not~~
2011 ~~less than~~ 80 percent of the reimbursement that would be paid to
2012 a physician who provided the same services.
2013 Section 23. Section 409.9062, Florida Statutes, is amended
2014 to read:
2015 409.9062 Lung transplant services for Medicaid recipients.—
2016 Subject to the availability of funds and ~~subject to~~ any
2017 limitations or directions provided ~~for~~ in the General
2018 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~
2019 ~~for Health Care Administration~~ Medicaid program shall pay for
2020 medically necessary lung transplant services for Medicaid
2021 recipients. These payments must be used to reimburse approved
2022 lung transplant facilities a global fee for providing lung
2023 transplant services to Medicaid recipients.
2024 Section 24. Paragraph (h) of subsection (3) of section
2025 409.907, Florida Statutes, is amended to read:
2026 409.907 Medicaid provider agreements.—The agency may make
2027 payments for medical assistance and related services rendered to
2028 Medicaid recipients only to an individual or entity who has a
2029 provider agreement in effect with the agency, who is performing
2030 services or supplying goods in accordance with federal, state,

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2031 and local law, and who agrees that no person shall, on the
2032 grounds of handicap, race, color, or national origin, or for any
2033 other reason, be subjected to discrimination under any program
2034 or activity for which the provider receives payment from the
2035 agency.
2036 (3) The provider agreement developed by the agency, in
2037 addition to the requirements specified in subsections (1) and
2038 (2), shall require the provider to:
2039 (h) Be liable for and indemnify, defend, and hold the
2040 agency harmless from all claims, suits, judgments, or damages,
2041 including court costs and attorney's fees, arising out of the
2042 negligence or omissions of the provider in the course of
2043 providing services to a recipient or a person believed to be a
2044 recipient, subject to s. 766.1183 or s. 766.1184.
2045 Section 25. Section 409.908, Florida Statutes, is amended
2046 to read:
2047 409.908 Reimbursement of Medicaid providers.—Subject to
2048 specific appropriations, the agency shall reimburse Medicaid
2049 providers, in accordance with state and federal law, according
2050 to methodologies set forth in the rules of the agency and in
2051 policy manuals and handbooks incorporated by reference therein.
2052 These methodologies may include fee schedules, reimbursement
2053 methods based on cost reporting, negotiated fees, competitive
2054 bidding pursuant to s. 287.057, and other mechanisms the agency
2055 considers efficient and effective for purchasing services or
2056 goods on behalf of recipients. ~~If a provider is reimbursed based~~
2057 ~~on cost reporting and submits a cost report late and that cost~~
2058 ~~report would have been used to set a lower reimbursement rate~~
2059 ~~for a rate semester, then the provider's rate for that semester~~

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2060 ~~shall be retroactively calculated using the new cost report, and~~
2061 ~~full payment at the recalculated rate shall be effected~~
2062 ~~retroactively. Medicare-granted extensions for filing cost~~
2063 ~~reports, if applicable, shall also apply to Medicaid cost~~
2064 ~~reports.~~ Payment for Medicaid compensable services made on
2065 behalf of Medicaid eligible persons is subject to the
2066 availability of moneys and any limitations or directions
2067 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,
2068 or s. 409.9022. ~~Further, nothing in~~ This section does not ~~shall~~
2069 ~~be construed to~~ prevent or limit the agency from adjusting fees,
2070 reimbursement rates, lengths of stay, number of visits, or
2071 number of services, or making any other adjustments necessary to
2072 comply with the availability of moneys and any limitations or
2073 directions provided ~~for~~ in the General Appropriations Act if~~,~~
2074 ~~provided~~ the adjustment is consistent with legislative intent.
2075 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed
2076 under part I of chapter 395 must be made prospectively or on the
2077 basis of negotiation.
2078 (a) Inpatient care.—
2079 1. Reimbursement for inpatient care is limited as provided
2080 ~~for~~ in s. 409.905(5), except for:
2081 a.~~1.~~ The raising of rate reimbursement caps, excluding
2082 rural hospitals.
2083 b.~~2.~~ Recognition of the costs of graduate medical
2084 education.
2085 c.~~3.~~ Other methodologies recognized in the General
2086 Appropriations Act.
2087 2. If ~~During the years~~ funds are transferred from the
2088 Department of Health, any reimbursement supported by such funds

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2089 is ~~shall be~~ subject to certification by the Department of Health
2090 that the hospital has complied with s. 381.0403. The agency may
2091 ~~is authorized to~~ receive funds from state entities, including,
2092 but not limited to, the Department of Health, local governments,
2093 and other local political subdivisions, for the purpose of
2094 making special exception payments, including federal matching
2095 funds, through the Medicaid inpatient reimbursement
2096 methodologies. Funds received from state entities or local
2097 governments for this purpose shall be separately accounted for
2098 and may ~~shall~~ not be commingled with other state or local funds
2099 in any manner. The agency may certify all local governmental
2100 funds used as state match under Title XIX of the Social Security
2101 Act, to the extent that the identified local health care
2102 provider that is otherwise entitled to and is contracted to
2103 receive such local funds is the benefactor under the state's
2104 Medicaid program as determined under the General Appropriations
2105 Act and pursuant to an agreement between the agency ~~for Health~~
2106 ~~Care Administration~~ and the local governmental entity. The local
2107 governmental entity shall use a certification form prescribed by
2108 the agency. At a minimum, the certification form must ~~shall~~
2109 identify the amount being certified and describe the
2110 relationship between the certifying local governmental entity
2111 and the local health care provider. The agency shall prepare an
2112 annual statement of impact which documents the specific
2113 activities undertaken during the previous fiscal year pursuant
2114 to this paragraph, to be submitted to the Legislature annually
2115 by ~~no later than~~ January 1~~, annually~~.
2116 (b) Outpatient care.—
2117 1. Reimbursement for hospital outpatient care is limited to

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2118 $1,500 per state fiscal year per recipient, except for:
2119 a.~~1.~~ ~~Such~~ Care provided to a Medicaid recipient under age
2120 21, in which case the only limitation is medical necessity.
2121 b.~~2.~~ Renal dialysis services.
2122 c.~~3.~~ Other exceptions made by the agency.
2123 2. The agency may ~~is authorized to~~ receive funds from state
2124 entities, including, but not limited to, the Department of
2125 Health, the Board of Governors of the State University System,
2126 local governments, and other local political subdivisions, for
2127 the purpose of making payments, including federal matching
2128 funds, through the Medicaid outpatient reimbursement
2129 methodologies. Funds received ~~from state entities and local~~
2130 ~~governments~~ for this purpose shall be separately accounted for
2131 and may ~~shall~~ not be commingled with other state or local funds
2132 ~~in any manner~~.
2133 3. The agency may limit inflationary increases for
2134 outpatient hospital services as directed by the General
2135 Appropriations Act.
2136 (c) Disproportionate share.—Hospitals that provide services
2137 to a disproportionate share of low-income Medicaid recipients,
2138 ~~or~~ that participate in the regional perinatal intensive care
2139 center program under chapter 383, or that participate in the
2140 statutory teaching hospital disproportionate share program may
2141 receive additional reimbursement. The total amount of payment
2142 for disproportionate share hospitals shall be fixed by the
2143 General Appropriations Act. The computation of these payments
2144 must comply ~~be made in compliance~~ with all federal regulations
2145 and the methodologies described in ss. 409.911, 409.9112, and
2146 409.9113.

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2147 ~~(d) The agency is authorized to limit inflationary~~
2148 ~~increases for outpatient hospital services as directed by the~~
2149 ~~General Appropriations Act.~~
2150 (2) NURSING HOME CARE.—
2151 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II
2152 of chapter 400 and state-owned-and-operated intermediate care
2153 facilities for the developmentally disabled licensed under part
2154 VIII of chapter 400 must be made prospectively.
2155 (a)~~2.~~ Unless otherwise limited or directed in the General
2156 Appropriations Act, reimbursement to hospitals licensed under
2157 part I of chapter 395 for ~~the provision of~~ swing-bed nursing
2158 home services must be based ~~made~~ on ~~the basis of~~ the average
2159 statewide nursing home payment, and reimbursement to a hospital
2160 ~~licensed under part I of chapter 395~~ for ~~the provision of~~
2161 skilled nursing services must be based ~~made~~ on ~~the basis of~~ the
2162 average nursing home payment for those services in the county in
2163 which the hospital is located. If ~~When~~ a hospital is located in
2164 a county that does not have any community nursing homes,
2165 reimbursement shall be determined by averaging the nursing home
2166 payments in counties that surround the county in which the
2167 hospital is located. Reimbursement to hospitals, including
2168 Medicaid payment of Medicare copayments, for skilled nursing
2169 services is ~~shall be~~ limited to 30 days, unless a prior
2170 authorization has been obtained from the agency. Medicaid
2171 reimbursement may be extended by the agency beyond 30 days, and
2172 approval must be based upon verification by the patient's
2173 physician that the patient requires short-term rehabilitative
2174 and recuperative services only, in which case an extension of no
2175 more than 15 days may be approved. Reimbursement to a hospital

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2176 ~~licensed under part I of chapter 395~~ for the temporary provision
2177 of skilled nursing services to nursing home residents who have
2178 been displaced as the result of a natural disaster or other
2179 emergency may not exceed the average county nursing home payment
2180 for those services in the county in which the hospital is
2181 located and is limited to the period of time which the agency
2182 considers necessary for continued placement of the nursing home
2183 residents in the hospital.
2184 (b) Subject to any limitations or directions provided ~~for~~
2185 in the General Appropriations Act, the agency shall establish
2186 and implement a Florida Title XIX Long-Term Care Reimbursement
2187 Plan (Medicaid) for nursing home care in order to provide care
2188 and services that conform to ~~in conformance with the~~ applicable
2189 state and federal laws, rules, regulations, and quality and
2190 safety standards and to ensure that individuals eligible for
2191 medical assistance have reasonable geographic access to such
2192 care.
2193 1. The agency shall amend the long-term care reimbursement
2194 plan and cost reporting system to create direct care and
2195 indirect care subcomponents of the patient care component of the
2196 per diem rate. These two subcomponents together must ~~shall~~ equal
2197 the patient care component of the per diem rate. Separate cost-
2198 based ceilings shall be calculated for each patient care
2199 subcomponent. The direct care subcomponent of the per diem rate
2200 is ~~shall be~~ limited by the cost-based class ceiling, and the
2201 indirect care subcomponent may be limited by the lower of the
2202 cost-based class ceiling, the target rate class ceiling, or the
2203 individual provider target.
2204 2. The direct care subcomponent includes ~~shall include~~

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2205 salaries and benefits of direct care staff providing nursing
2206 services, including registered nurses, licensed practical
2207 nurses, and certified nursing assistants who deliver care
2208 directly to residents in the nursing home facility. This
2209 excludes nursing administration, minimum data set, and care plan
2210 coordinators, staff development, and the staffing coordinator.
2211 The direct care subcomponent also includes medically necessary
2212 dental care or podiatric care.
2213 3. All other patient care costs are ~~shall be~~ included in
2214 the indirect care cost subcomponent of the patient care per diem
2215 rate. ~~There shall be no~~ Costs may not be directly or indirectly
2216 allocated to the direct care subcomponent from a home office or
2217 management company.
2218 4. On July 1 of each year, the agency shall report to the
2219 Legislature direct and indirect care costs, including average
2220 direct and indirect care costs per resident per facility and
2221 direct care and indirect care salaries and benefits per category
2222 of staff member per facility.
2223 5. In order to offset the cost of general and professional
2224 liability insurance, the agency shall amend the plan to allow
2225 for interim rate adjustments to reflect increases in the cost of
2226 general or professional liability insurance for nursing homes.
2227 This provision shall be implemented to the extent existing
2228 appropriations are available.
2229
2230 It is the intent of the Legislature that the reimbursement plan
2231 achieve the goal of providing access to health care for nursing
2232 home residents who require large amounts of care while
2233 encouraging diversion services as an alternative to nursing home

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2234 care for residents who can be served within the community. The
2235 agency shall base the establishment of any maximum rate of
2236 payment, whether overall or component, on the available moneys
2237 ~~as~~ provided ~~for~~ in the General Appropriations Act. The agency
2238 may base the maximum rate of payment on the results of
2239 scientifically valid analysis and conclusions derived from
2240 objective statistical data pertinent to the particular maximum
2241 rate of payment.
2242 (c) The agency shall request and implement Medicaid waivers
2243 approved by the federal Centers for Medicare and Medicaid
2244 Services to advance and treat a portion of the Medicaid nursing
2245 home per diem as capital for creating and operating a risk-
2246 retention group for self-insurance purposes, consistent with
2247 federal and state laws and rules.
2248 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any
2249 limitations or directions provided ~~for~~ in the General
2250 Appropriations Act, the following Medicaid services and goods
2251 may be reimbursed on a fee-for-service basis. For each allowable
2252 service or goods furnished in accordance with Medicaid rules,
2253 policy manuals, handbooks, and state and federal law, the
2254 payment shall be the amount billed by the provider, the
2255 provider’s usual and customary charge, or the maximum allowable
2256 fee established by the agency, whichever amount is less, with
2257 the exception of those services or goods for which the agency
2258 makes payment using a methodology based on capitation rates,
2259 average costs, or negotiated fees.
2260 (a) Advanced registered nurse practitioner services.
2261 (b) Birth center services.
2262 (c) Chiropractic services.

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2263 (d) Community mental health services.
2264 (e) Dental services, including oral and maxillofacial
2265 surgery.
2266 (f) Durable medical equipment.
2267 (g) Hearing services.
2268 (h) Occupational therapy for Medicaid recipients under age
2269 21.
2270 (i) Optometric services.
2271 (j) Orthodontic services.
2272 (k) Personal care for Medicaid recipients under age 21.
2273 (l) Physical therapy for Medicaid recipients under age 21.
2274 (m) Physician assistant services.
2275 (n) Podiatric services.
2276 (o) Portable X-ray services.
2277 (p) Private-duty nursing for Medicaid recipients under age
2278 21.
2279 (q) Registered nurse first assistant services.
2280 (r) Respiratory therapy for Medicaid recipients under age
2281 21.
2282 (s) Speech therapy for Medicaid recipients under age 21.
2283 (t) Visual services.
2284 (4) MANAGED CARE SERVICES.—Subject to any limitations or
2285 directions provided ~~for~~ in the General Appropriations Act,
2286 alternative health plans, health maintenance organizations, and
2287 prepaid health plans shall be reimbursed a fixed, prepaid amount
2288 negotiated, or competitively bid pursuant to s. 287.057, by the
2289 agency and prospectively paid to the provider monthly for each
2290 Medicaid recipient enrolled. The amount may not exceed the
2291 average amount the agency determines it would have paid, based

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2292 on claims experience, for recipients in the same or similar
2293 category of eligibility. The agency shall calculate capitation
2294 rates on a regional basis and~~, beginning September 1, 1995,~~
2295 ~~shall~~ include age-band differentials in such calculations.
2296 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical
2297 center shall be reimbursed the lesser of the amount billed by
2298 the provider or the Medicare-established allowable amount for
2299 the facility.
2300 (6) EPSDT SERVICES.—A provider of early and periodic
2301 screening, diagnosis, and treatment services to Medicaid
2302 recipients who are ~~children~~ under age 21 shall be reimbursed
2303 using an all-inclusive rate stipulated in a fee schedule
2304 established by the agency. A provider of the visual, dental, and
2305 hearing components of such services shall be reimbursed the
2306 lesser of the amount billed by the provider or the Medicaid
2307 maximum allowable fee established by the agency.
2308 (7) FAMILY PLANNING SERVICES.—A provider of family planning
2309 services shall be reimbursed the lesser of the amount billed by
2310 the provider or an all-inclusive amount per type of visit for
2311 physicians and advanced registered nurse practitioners, as
2312 established by the agency in a fee schedule.
2313 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-
2314 based or community-based services rendered pursuant to a
2315 federally approved waiver shall be reimbursed based on an
2316 established or negotiated rate for each service. These rates
2317 shall be established according to an analysis of the expenditure
2318 history and prospective budget developed by each contract
2319 provider participating in the waiver program, or under any other
2320 methodology adopted by the agency and approved by the Federal

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2321 Government in accordance with the waiver. Privately owned and
2322 operated community-based residential facilities that ~~which~~ meet
2323 agency requirements and ~~which~~ formerly received Medicaid
2324 reimbursement for the optional intermediate care facility for
2325 the mentally retarded service may participate in the
2326 developmental services waiver as part of a home-and-community-
2327 based continuum of care for Medicaid recipients who receive
2328 waiver services.
2329 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider
2330 of home health care services or of medical supplies and
2331 appliances shall be reimbursed on the basis of competitive
2332 bidding or for the lesser of the amount billed by the provider
2333 or the agency's established maximum allowable amount, except
2334 that~~, in the case of the rental of durable medical equipment,~~
2335 the total rental payments for durable medical equipment may not
2336 exceed the purchase price of the equipment over its expected
2337 useful life or the agency's established maximum allowable
2338 amount, whichever amount is less.
2339 (10) HOSPICE.—A hospice shall be reimbursed through a
2340 prospective system for each Medicaid hospice patient at Medicaid
2341 rates using the methodology established for hospice
2342 reimbursement pursuant to Title XVIII of the federal Social
2343 Security Act.
2344 (11) LABORATORY SERVICES.—A provider of independent
2345 laboratory services shall be reimbursed on the basis of
2346 competitive bidding or for the least of the amount billed by the
2347 provider, the provider's usual and customary charge, or the
2348 Medicaid maximum allowable fee established by the agency.
2349 (12) PHYSICIAN SERVICES.—

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2350 (a) A physician shall be reimbursed the lesser of the
2351 amount billed by the provider or the Medicaid maximum allowable
2352 fee established by the agency.
2353 (b) The agency shall adopt a fee schedule, subject to any
2354 limitations or directions provided ~~for~~ in the General
2355 Appropriations Act, based on a resource-based relative value
2356 scale for pricing Medicaid physician services. Under the ~~this~~
2357 fee schedule, physicians shall be paid a dollar amount for each
2358 service based on the average resources required to provide the
2359 service, including, but not limited to, estimates of average
2360 physician time and effort, practice expense, and the costs of
2361 professional liability insurance. The fee schedule must ~~shall~~
2362 provide increased reimbursement for preventive and primary care
2363 services and lowered reimbursement for specialty services by
2364 using at least two conversion factors, one for cognitive
2365 services and another for procedural services. The fee schedule
2366 may ~~shall~~ not increase total Medicaid physician expenditures
2367 unless moneys are available. The agency ~~for Health Care~~
2368 ~~Administration~~ shall seek the advice of a 16-member advisory
2369 panel in formulating and adopting the fee schedule. The panel
2370 shall consist of Medicaid physicians licensed under chapters 458
2371 and 459 and ~~shall~~ be composed of 50 percent primary care
2372 physicians and 50 percent specialty care physicians.
2373 (c) Notwithstanding paragraph (b), reimbursement fees to
2374 physicians for providing total obstetrical services to Medicaid
2375 recipients, which include prenatal, delivery, and postpartum
2376 care, must ~~shall~~ be at least $1,500 per delivery for a pregnant
2377 woman with low medical risk and at least $2,000 per delivery for
2378 a pregnant woman with high medical risk. However, reimbursement

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2379 to physicians working in regional perinatal intensive care
2380 centers designated pursuant to chapter 383, for services to
2381 ~~certain~~ pregnant Medicaid recipients with a high medical risk,
2382 may be made according to obstetrical care and neonatal care
2383 groupings and rates established by the agency. Nurse midwives
2384 licensed under part I of chapter 464 or midwives licensed under
2385 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent
2386 of the low medical risk fee. The agency shall by rule determine,
2387 for the purpose of this paragraph, what constitutes a high or
2388 low medical risk pregnant woman and may ~~shall~~ not pay more based
2389 solely on the fact that a caesarean section was performed,
2390 rather than a vaginal delivery. The agency shall by rule
2391 determine a prorated payment for obstetrical services ~~in cases~~
2392 where only part of the total prenatal, delivery, or postpartum
2393 care was performed. The Department of Health shall adopt rules
2394 for appropriate insurance coverage for midwives licensed under
2395 chapter 467. Before issuing and renewing ~~Prior to the issuance~~
2396 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~
2397 ~~of~~ an inactive license for midwives licensed under chapter 467,
2398 such licensees must ~~shall~~ submit proof of coverage with each
2399 application.
2400 (d) Effective January 1, 2013, Medicaid fee-for-service
2401 payments to primary care physicians for primary care services
2402 must be at least 100 percent of the Medicare payment rate for
2403 such services.
2404 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for
2405 persons eligible for both Medicare and Medicaid coverage shall
2406 be paid at the rates established by Title XVIII of the Social
2407 Security Act. For Medicare services rendered to Medicaid-

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2408 eligible persons, Medicaid shall pay Medicare deductibles and
2409 coinsurance as follows:
2410 (a) Medicaid's financial obligation for deductibles and
2411 coinsurance payments shall be based on Medicare allowable fees,
2412 not on a provider's billed charges.
2413 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare
2414 deductibles and coinsurance if ~~when~~ payment that Medicare has
2415 made for the service equals or exceeds what Medicaid would have
2416 paid if it had been the sole payor. The combined payment of
2417 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid
2418 would have paid had it been the sole payor. The Legislature
2419 finds that there has been confusion regarding the reimbursement
2420 for services rendered to dually eligible Medicare beneficiaries.
2421 Accordingly, the Legislature clarifies that it has always been
2422 the intent of the Legislature before and after 1991 that, in
2423 reimbursing in accordance with fees established by Title XVIII
2424 for premiums, deductibles, and coinsurance for Medicare services
2425 rendered by physicians to Medicaid eligible persons, physicians
2426 be reimbursed at the lesser of the amount billed by the
2427 physician or the Medicaid maximum allowable fee established by
2428 the agency ~~for Health Care Administration~~, as is permitted by
2429 federal law. It has never been the intent of the Legislature
2430 ~~with regard to such services rendered by physicians~~ that
2431 Medicaid be required to provide any payment for deductibles,
2432 coinsurance, or copayments for Medicare cost sharing, or any
2433 expenses incurred relating thereto, in excess of the payment
2434 amount provided for under the State Medicaid plan for physician
2435 services ~~such service~~. This payment methodology is applicable
2436 even in those situations in which the payment for Medicare cost

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2437 sharing for a qualified Medicare beneficiary with respect to an
2438 item or service is reduced or eliminated. This expression of the
2439 Legislature clarifies ~~is in clarification of~~ existing law and
2440 applies ~~shall apply~~ to payment for, and with respect to provider
2441 agreements with respect to, items or services furnished on or
2442 after July 1, 2000 ~~the effective date of this act~~. This
2443 paragraph applies to payment by Medicaid for items and services
2444 furnished before July 1, 2000, ~~the effective date of this act~~ if
2445 such payment is the subject of a lawsuit that is based on ~~the~~
2446 ~~provisions of~~ this section, and that is pending as of, or is
2447 initiated after that date~~, the effective date of this act~~.
2448 (c) Notwithstanding paragraphs (a) and (b):
2449 1. Medicaid payments for Nursing Home Medicare part A
2450 coinsurance are limited to the Medicaid nursing home per diem
2451 rate less any amounts paid by Medicare, but only up to the
2452 amount of Medicare coinsurance. The Medicaid per diem rate is
2453 ~~shall be~~ the rate in effect for the dates of service of the
2454 crossover claims and may not be subsequently adjusted due to
2455 subsequent per diem rate adjustments.
2456 2. Medicaid shall pay all deductibles and coinsurance for
2457 Medicare-eligible recipients receiving freestanding end stage
2458 renal dialysis center services.
2459 3. Medicaid payments for general and specialty hospital
2460 inpatient services are limited to the Medicare deductible and
2461 coinsurance per spell of illness. Medicaid payments for hospital
2462 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid
2463 hospital per diem rate less any amounts paid by Medicare, but
2464 only up to the amount of Medicare coinsurance. Medicaid payments
2465 for coinsurance are ~~shall be~~ limited to the Medicaid per diem

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2466 rate in effect for the dates of service of the crossover claims
2467 and may not be subsequently adjusted due to subsequent per diem
2468 adjustments.
2469 4. Medicaid shall pay all deductibles and coinsurance for
2470 Medicare emergency transportation services provided by
2471 ambulances licensed pursuant to chapter 401.
2472 5. Medicaid shall pay all deductibles and coinsurance for
2473 portable X-ray Medicare Part B services provided in a nursing
2474 home.
2475 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall
2476 be reimbursed the least of the amount billed by the provider,
2477 the provider's usual and customary charge, or the Medicaid
2478 maximum allowable fee established by the agency, plus a
2479 dispensing fee. The Medicaid maximum allowable fee for
2480 ingredient cost must ~~will~~ be based on the lower of the~~:~~ average
2481 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition
2482 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the
2483 state maximum allowable cost (SMAC), or the usual and customary
2484 (UAC) charge billed by the provider.
2485 (a) Medicaid providers must ~~are required to~~ dispense
2486 generic drugs if available at lower cost and the agency has not
2487 determined that the branded product is more cost-effective,
2488 unless the prescriber has requested and received approval to
2489 require the branded product.
2490 (b) The agency shall ~~is directed to~~ implement a variable
2491 dispensing fee for ~~payments for~~ prescribed medicines while
2492 ensuring continued access for Medicaid recipients. The variable
2493 dispensing fee may be based upon, but not limited to, either or
2494 both the volume of prescriptions dispensed by a specific

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2495 pharmacy provider, the volume of prescriptions dispensed to an
2496 individual recipient, and dispensing of preferred-drug-list
2497 products.
2498 (c) The agency may increase the pharmacy dispensing fee
2499 authorized by statute and in the ~~annual~~ General Appropriations
2500 Act by $0.50 for the dispensing of a Medicaid preferred-drug-
2501 list product and reduce the pharmacy dispensing fee by $0.50 for
2502 the dispensing of a Medicaid product that is not included on the
2503 preferred drug list.
2504 (d) The agency may establish a supplemental pharmaceutical
2505 dispensing fee to be paid to providers returning unused unit-
2506 dose packaged medications to stock and crediting the Medicaid
2507 program for the ingredient cost of those medications if the
2508 ingredient costs to be credited exceed the value of the
2509 supplemental dispensing fee.
2510 (e) The agency may ~~is authorized to~~ limit reimbursement for
2511 prescribed medicine in order to comply with any limitations or
2512 directions provided ~~for~~ in the General Appropriations Act, which
2513 may include implementing a prospective or concurrent utilization
2514 review program.
2515 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary
2516 care case management services rendered pursuant to a federally
2517 approved waiver shall be reimbursed by payment of a fixed,
2518 prepaid monthly sum for each Medicaid recipient enrolled with
2519 the provider.
2520 (16) RURAL HEALTH CLINICS.—A provider of rural health
2521 clinic services and federally qualified health center services
2522 shall be reimbursed a rate per visit based on total reasonable
2523 costs of the clinic, as determined by the agency in accordance

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2524 with federal regulations.
2525 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case
2526 management services shall be reimbursed pursuant to an
2527 established fee, except where the Federal Government requires a
2528 public provider be reimbursed on the basis of average actual
2529 costs.
2530 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the
2531 General Appropriations Act, a provider of transportation
2532 services shall be reimbursed the lesser of the amount billed by
2533 the provider or the Medicaid maximum allowable fee established
2534 by the agency, except if ~~when~~ the agency has entered into a
2535 direct contract with the provider, or with a community
2536 transportation coordinator, for the provision of an all-
2537 inclusive service, or if ~~when~~ services are provided pursuant to
2538 an agreement negotiated between the agency and the provider. ~~The~~
2539 ~~agency, as provided for in s. 427.0135, shall purchase~~
2540 ~~transportation services through the community coordinated~~
2541 ~~transportation system, if available, unless the agency, after~~
2542 ~~consultation with the commission, determines that it cannot~~
2543 ~~reach mutually acceptable contract terms with the commission.~~
2544 ~~The agency may then contract for the same transportation~~
2545 ~~services provided in a more cost-effective manner and of~~
2546 ~~comparable or higher quality and standards. Nothing in~~
2547 (a) This subsection does not ~~shall be construed to~~ limit or
2548 preclude the agency from contracting for services using a
2549 prepaid capitation rate or from establishing maximum fee
2550 schedules, individualized reimbursement policies by provider
2551 type, negotiated fees, prior authorization, competitive bidding,
2552 increased use of mass transit, or any other mechanism that the

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2553 agency considers efficient and effective for the purchase of
2554 services on behalf of Medicaid clients, including implementing a
2555 transportation eligibility process.
2556 (b) The agency may ~~shall~~ not ~~be required to~~ contract with
2557 any community transportation coordinator or transportation
2558 operator that has been determined by the agency, the Department
2559 of Legal Affairs Medicaid Fraud Control Unit, or any other state
2560 or federal agency to have engaged in any abusive or fraudulent
2561 billing activities.
2562 (c) The agency shall ~~is authorized to~~ competitively procure
2563 transportation services or make other changes necessary to
2564 secure approval of federal waivers needed to permit federal
2565 financing of Medicaid transportation services at the service
2566 matching rate rather than the administrative matching rate.
2567 ~~Notwithstanding chapter 427, the agency is authorized to~~
2568 ~~continue contracting for Medicaid nonemergency transportation~~
2569 ~~services in agency service area 11 with managed care plans that~~
2570 ~~were under contract for those services before July 1, 2004.~~
2571 (d) Transportation to access covered services provided by a
2572 qualified plan pursuant to part IV of this chapter shall be
2573 contracted for by the plan. A qualified plan is not required to
2574 purchase such services through a coordinated transportation
2575 system established pursuant to part I of chapter 427.
2576 (19) COUNTY HEALTH DEPARTMENTS.—County health department
2577 services shall be reimbursed a rate per visit based on total
2578 reasonable costs of the clinic, as determined by the agency in
2579 accordance with federal regulations under the authority of 42
2580 C.F.R. s. 431.615.
2581 (20) DIALYSIS.—A renal dialysis facility that provides

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2582 dialysis services under s. 409.906(9) must be reimbursed the
2583 lesser of the amount billed by the provider, the provider's
2584 usual and customary charge, or the maximum allowable fee
2585 established by the agency, whichever ~~amount~~ is less.
2586 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse
2587 school districts that ~~which~~ certify the state match pursuant to
2588 ss. 409.9071 and 1011.70 for the federal portion of the school
2589 district's allowable costs to deliver the services, based on the
2590 reimbursement schedule. The school district shall determine the
2591 costs for delivering services as authorized in ss. 409.9071 and
2592 1011.70 for which the state match will be certified.
2593 Reimbursement of school-based providers is contingent on such
2594 providers being enrolled as Medicaid providers and meeting the
2595 qualifications contained in 42 C.F.R. s. 440.110, unless
2596 otherwise waived by the federal Centers for Medicare and
2597 Medicaid Services ~~Health Care Financing Administration~~. Speech
2598 therapy providers who are certified through the Department of
2599 Education pursuant to rule 6A-4.0176, Florida Administrative
2600 Code, are eligible for reimbursement for services that are
2601 provided on school premises. Any employee of the school district
2602 who has been fingerprinted and has received a criminal
2603 background check in accordance with Department of Education
2604 rules and guidelines is ~~shall be~~ exempt from any agency
2605 requirements relating to criminal background checks.
2606 ~~(22) The agency shall request and implement Medicaid~~
2607 ~~waivers from the federal Health Care Financing Administration to~~
2608 ~~advance and treat a portion of the Medicaid nursing home per~~
2609 ~~diem as capital for creating and operating a risk-retention~~
2610 ~~group for self-insurance purposes, consistent with federal and~~

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2611 ~~state laws and rules.~~
2612 (22) ~~(23)(a)~~ LIMITATION ON REIMBURSEMENT RATES.—The agency
2613 shall establish rates at a level that ensures no increase in
2614 statewide expenditures resulting from a change in unit costs for
2615 2 fiscal years effective July 1, 2009. Reimbursement rates for
2616 the 2 fiscal years shall be as provided in the General
2617 Appropriations Act.
2618 (a) ~~(b)~~ This subsection applies to the following provider
2619 types:
2620 1. Inpatient hospitals.
2621 2. Outpatient hospitals.
2622 3. Nursing homes.
2623 4. County health departments.
2624 5. Community intermediate care facilities for the
2625 developmentally disabled.
2626 6. Prepaid health plans.
2627 (b) The agency shall apply ~~the effect of~~ this subsection to
2628 the reimbursement rates for nursing home diversion programs.
2629 ~~(c) The agency shall create a workgroup on hospital~~
2630 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
2631 ~~and a workgroup on managed care plan payment. The workgroups~~
2632 ~~shall evaluate alternative reimbursement and payment~~
2633 ~~methodologies for hospitals, nursing facilities, and managed~~
2634 ~~care plans, including prospective payment methodologies for~~
2635 ~~hospitals and nursing facilities. The nursing facility workgroup~~
2636 ~~shall also consider price-based methodologies for indirect care~~
2637 ~~and acuity adjustments for direct care. The agency shall submit~~
2638 ~~a report on the evaluated alternative reimbursement~~
2639 ~~methodologies to the relevant committees of the Senate and the~~

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2640 ~~House of Representatives by November 1, 2009.~~
2641 (c) ~~(d)~~ This subsection expires June 30, 2011.
2642 (23) PAYMENT METHODOLOGIES.—If a provider is reimbursed
2643 based on cost reporting and submits a cost report late and that
2644 cost report would have been used to set a lower reimbursement
2645 rate for a rate semester, the provider's rate for that semester
2646 shall be retroactively calculated using the new cost report, and
2647 full payment at the recalculated rate shall be applied
2648 retroactively. Medicare-granted extensions for filing cost
2649 reports, if applicable, also apply to Medicaid cost reports.
2650 (24) RETURN OF PAYMENTS.—If a provider fails to notify the
2651 agency within 5 business days after suspension or disenrollment
2652 from Medicare, sanctions may be imposed pursuant to this
2653 chapter, and the provider may be required to return funds paid
2654 to the provider during the period of time that the provider was
2655 suspended or disenrolled ~~as a Medicare provider~~.
2656 Section 26. Subsection (1) of section 409.9081, Florida
2657 Statutes, is amended to read:
2658 409.9081 Copayments.—
2659 (1) ~~The agency shall require,~~ Subject to federal
2660 regulations and limitations, each Medicaid recipient must ~~to~~ pay
2661 at the time of service a nominal copayment for the following
2662 Medicaid services:
2663 (a) Hospital outpatient services: up to $3 for each
2664 hospital outpatient visit.
2665 (b) Physician services: up to $2 copayment for each visit
2666 with a primary care physician and up to $3 copayment for each
2667 visit with a specialty care physician ~~licensed under chapter~~
2668 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463~~.

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2669 (c) Hospital emergency department visits for nonemergency
2670 care: 5 percent of up to the first $300 of the Medicaid payment
2671 for emergency room services, not to exceed $15. The agency shall
2672 seek a federal waiver of the requirement that cost-sharing
2673 amounts for nonemergency services and care furnished in a
2674 hospital emergency department be nominal. Upon waiver approval,
2675 a Medicaid recipient who requests such services and care, must
2676 pay a $100 copayment to the hospital for the nonemergency
2677 services and care provided in the hospital emergency department.
2678 (d) Prescription drugs: a coinsurance equal to 2.5 percent
2679 of the Medicaid cost of the prescription drug at the time of
2680 purchase. The maximum coinsurance is ~~shall be~~ $7.50 per
2681 prescription drug purchased.
2682 Section 27. Paragraph (b) and (d) of subsection (4) and
2683 subsections (8), (34), (44), (47), and (53) of section 409.912,
2684 Florida Statutes, are amended, and subsections (48) through (52)
2685 of that section are renumbered as subsections (47) through (51)
2686 respectively, to read:
2687 409.912 Cost-effective purchasing of health care.—The
2688 agency shall purchase goods and services for Medicaid recipients
2689 in the most cost-effective manner consistent with the delivery
2690 of quality medical care. To ensure that medical services are
2691 effectively utilized, the agency may, in any case, require a
2692 confirmation or second physician’s opinion of the correct
2693 diagnosis for purposes of authorizing future services under the
2694 Medicaid program. This section does not restrict access to
2695 emergency services or poststabilization care services as defined
2696 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2697 shall be rendered in a manner approved by the agency. The agency

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2698 shall maximize the use of prepaid per capita and prepaid
2699 aggregate fixed-sum basis services when appropriate and other
2700 alternative service delivery and reimbursement methodologies,
2701 including competitive bidding pursuant to s. 287.057, designed
2702 to facilitate the cost-effective purchase of a case-managed
2703 continuum of care. The agency shall also require providers to
2704 minimize the exposure of recipients to the need for acute
2705 inpatient, custodial, and other institutional care and the
2706 inappropriate or unnecessary use of high-cost services. The
2707 agency shall contract with a vendor to monitor and evaluate the
2708 clinical practice patterns of providers in order to identify
2709 trends that are outside the normal practice patterns of a
2710 provider’s professional peers or the national guidelines of a
2711 provider’s professional association. The vendor must be able to
2712 provide information and counseling to a provider whose practice
2713 patterns are outside the norms, in consultation with the agency,
2714 to improve patient care and reduce inappropriate utilization.
2715 The agency may mandate prior authorization, drug therapy
2716 management, or disease management participation for certain
2717 populations of Medicaid beneficiaries, certain drug classes, or
2718 particular drugs to prevent fraud, abuse, overuse, and possible
2719 dangerous drug interactions. The Pharmaceutical and Therapeutics
2720 Committee shall make recommendations to the agency on drugs for
2721 which prior authorization is required. The agency shall inform
2722 the Pharmaceutical and Therapeutics Committee of its decisions
2723 regarding drugs subject to prior authorization. The agency is
2724 authorized to limit the entities it contracts with or enrolls as
2725 Medicaid providers by developing a provider network through
2726 provider credentialing. The agency may competitively bid single-

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2727 source-provider contracts if procurement of goods or services
2728 results in demonstrated cost savings to the state without
2729 limiting access to care. The agency may limit its network based
2730 on the assessment of beneficiary access to care, provider
2731 availability, provider quality standards, time and distance
2732 standards for access to care, the cultural competence of the
2733 provider network, demographic characteristics of Medicaid
2734 beneficiaries, practice and provider-to-beneficiary standards,
2735 appointment wait times, beneficiary use of services, provider
2736 turnover, provider profiling, provider licensure history,
2737 previous program integrity investigations and findings, peer
2738 review, provider Medicaid policy and billing compliance records,
2739 clinical and medical record audits, and other factors. Providers
2740 shall not be entitled to enrollment in the Medicaid provider
2741 network. The agency shall determine instances in which allowing
2742 Medicaid beneficiaries to purchase durable medical equipment and
2743 other goods is less expensive to the Medicaid program than long-
2744 term rental of the equipment or goods. The agency may establish
2745 rules to facilitate purchases in lieu of long-term rentals in
2746 order to protect against fraud and abuse in the Medicaid program
2747 as defined in s. 409.913. The agency may seek federal waivers
2748 necessary to administer these policies.
2749 (4) The agency may contract with:
2750 (b) An entity that is providing comprehensive behavioral
2751 health care services to ~~certain~~ Medicaid recipients through a
2752 capitated, prepaid arrangement pursuant to the federal waiver
2753 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.
2754 Such entity must be licensed under chapter 624, chapter 636, or
2755 chapter 641, or authorized under paragraph (c) or paragraph (d),

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2756 and must possess the clinical systems and operational competence
2757 to manage risk and provide comprehensive behavioral health care
2758 to Medicaid recipients. As used in this paragraph, the term
2759 “comprehensive behavioral health care services” means covered
2760 mental health and substance abuse treatment services that are
2761 available to Medicaid recipients. The Secretary ~~of the~~
2762 ~~Department~~ of Children and Family Services must ~~shall~~ approve
2763 ~~provisions of~~ procurements related to children in the
2764 department’s care or custody before enrolling such children in a
2765 prepaid behavioral health plan. Any contract awarded under this
2766 paragraph must be competitively procured. ~~In developing~~ The
2767 behavioral health care prepaid plan procurement document must
2768 require~~, the agency shall ensure that the procurement document~~
2769 ~~requires~~ the contractor to develop and implement a plan to
2770 ensure compliance with s. 394.4574 related to services provided
2771 to residents of licensed assisted living facilities that hold a
2772 limited mental health license. Except as provided in
2773 subparagraph 5. ~~8.~~, and except in counties where the Medicaid
2774 managed care pilot program is authorized pursuant to s. 409.986
2775 ~~409.91211~~, the agency shall seek federal approval to contract
2776 with a single entity ~~meeting these requirements~~ to provide
2777 comprehensive behavioral health care services to all Medicaid
2778 recipients not enrolled in a Medicaid managed care plan
2779 authorized under s. 409.986 ~~409.91211~~, a provider service
2780 network authorized under paragraph (d), or a Medicaid health
2781 maintenance organization in an AHCA area. In an AHCA area where
2782 the Medicaid managed care pilot program is authorized pursuant
2783 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may
2784 procure a contract with a single entity to serve the remaining

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2785 counties as an AHCA area or the remaining counties may be
2786 included with an adjacent AHCA area and are subject to this
2787 paragraph. Each entity must offer a ~~sufficient~~ choice of
2788 providers in its network to ensure recipient access to care and
2789 the opportunity to select a provider with whom they are
2790 satisfied. The network shall include all public mental health
2791 hospitals. To ensure unimpaired access to behavioral health care
2792 services by Medicaid recipients, all contracts issued pursuant
2793 to this paragraph must require that 90 ~~80~~ percent of the
2794 capitation paid to the managed care plan, including health
2795 maintenance organizations and capitated provider service
2796 networks, ~~to~~ be expended for the provision of behavioral health
2797 care services. If the managed care plan expends less than 90 ~~80~~
2798 percent ~~of the capitation paid~~ for the provision of behavioral
2799 health care services, the difference shall be returned to the
2800 agency. The agency shall provide the plan with a certification
2801 letter indicating the amount of capitation paid during each
2802 calendar year for behavioral health care services pursuant to
2803 this section. The agency may reimburse ~~for~~ substance abuse
2804 treatment services on a fee-for-service basis until the agency
2805 finds that adequate funds are available for capitated, prepaid
2806 arrangements.
2807 1. ~~By January 1, 2001,~~ The agency shall modify the
2808 contracts with the entities providing comprehensive inpatient
2809 and outpatient mental health care services to Medicaid
2810 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
2811 Counties, to include substance abuse treatment services.
2812 ~~2. By July 1, 2003, the agency and the Department of~~
2813 ~~Children and Family Services shall execute a written agreement~~

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2814 ~~that requires collaboration and joint development of all policy,~~
2815 ~~budgets, procurement documents, contracts, and monitoring plans~~
2816 ~~that have an impact on the state and Medicaid community mental~~
2817 ~~health and targeted case management programs.~~
2818 2.~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~
2819 ~~2006,~~ the agency and the Department of Children and Family
2820 Services shall contract with managed care entities in each AHCA
2821 area ~~except area 6~~ or arrange to provide comprehensive inpatient
2822 and outpatient mental health and substance abuse services
2823 through capitated prepaid arrangements to all Medicaid
2824 recipients who are eligible to participate in such plans under
2825 federal law and regulation. In AHCA areas where there are fewer
2826 than 150,000 eligible individuals ~~number less than 150,000~~, the
2827 agency shall contract with a single managed care plan to provide
2828 comprehensive behavioral health services to all recipients who
2829 are not enrolled in a Medicaid health maintenance organization,
2830 a provider service network authorized under paragraph (d), or a
2831 Medicaid capitated managed care plan authorized under s. 409.986
2832 ~~409.91211~~. The agency may contract with more than one
2833 comprehensive behavioral health provider to provide care to
2834 recipients who are not enrolled in a Medicaid capitated managed
2835 care plan authorized under s. 409.986 ~~409.91211~~, a provider
2836 service network authorized under paragraph (d), or a Medicaid
2837 health maintenance organization in AHCA areas where the eligible
2838 population exceeds 150,000. In an AHCA area where the Medicaid
2839 managed care pilot program is authorized pursuant to s. 409.986
2840 ~~409.91211~~ in one or more counties, the agency may procure a
2841 contract with a single entity to serve the remaining counties as
2842 an AHCA area or the remaining counties may be included with an

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2843 adjacent AHCA area and shall be subject to this paragraph.
2844 Contracts for comprehensive behavioral health providers awarded
2845 pursuant to this section must ~~shall~~ be competitively procured.
2846 Both for-profit and not-for-profit corporations are eligible to
2847 compete. Managed care plans contracting with the agency under
2848 subsection (3) or paragraph (d), shall provide and receive
2849 payment for the same comprehensive behavioral health benefits as
2850 provided in AHCA rules, including handbooks incorporated by
2851 reference. In AHCA area 11, the agency shall contract with at
2852 least two comprehensive behavioral health care providers to
2853 provide behavioral health care to recipients ~~in that area~~ who
2854 are enrolled in, or assigned to, the MediPass program. One of
2855 the ~~behavioral health care~~ contracts must be with the existing
2856 provider service network pilot project, as described in
2857 paragraph (d), for the purpose of demonstrating the cost-
2858 effectiveness of the provision of quality mental health services
2859 through a public hospital-operated managed care model. Payment
2860 shall be at an agreed-upon capitated rate to ensure cost
2861 savings. Of the recipients in area 11 who are assigned to
2862 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those
2863 MediPass-enrolled recipients shall be assigned to the existing
2864 provider service network in area 11 for their behavioral care.
2865 ~~4. By October 1, 2003, the agency and the department shall~~
2866 ~~submit a plan to the Governor, the President of the Senate, and~~
2867 ~~the Speaker of the House of Representatives which provides for~~
2868 ~~the full implementation of capitated prepaid behavioral health~~
2869 ~~care in all areas of the state.~~
2870 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
2871 ~~of the state where the agency is able to establish sufficient~~

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2872 ~~capitation rates.~~
2873 ~~b. If the agency determines that the proposed capitation~~
2874 ~~rate in any area is insufficient to provide appropriate~~
2875 ~~services, the agency may adjust the capitation rate to ensure~~
2876 ~~that care will be available. The agency and the department may~~
2877 ~~use existing general revenue to address any additional required~~
2878 ~~match but may not over-obligate existing funds on an annualized~~
2879 ~~basis.~~
2880 ~~c. Subject to any limitations provided in the General~~
2881 ~~Appropriations Act, the agency, in compliance with appropriate~~
2882 ~~federal authorization, shall develop policies and procedures~~
2883 ~~that allow for certification of local and state funds.~~
2884 3.~~5.~~ Children residing in a statewide inpatient psychiatric
2885 program, or in a Department of Juvenile Justice or a Department
2886 of Children and Family Services residential program approved as
2887 a Medicaid behavioral health overlay services provider may not
2888 be included in a behavioral health care prepaid health plan or
2889 any other Medicaid managed care plan pursuant to this paragraph.
2890 ~~6. In converting to a prepaid system of delivery, the~~
2891 ~~agency shall in its procurement document require an entity~~
2892 ~~providing only comprehensive behavioral health care services to~~
2893 ~~prevent the displacement of indigent care patients by enrollees~~
2894 ~~in the Medicaid prepaid health plan providing behavioral health~~
2895 ~~care services from facilities receiving state funding to provide~~
2896 ~~indigent behavioral health care, to facilities licensed under~~
2897 ~~chapter 395 which do not receive state funding for indigent~~
2898 ~~behavioral health care, or reimburse the unsubsidized facility~~
2899 ~~for the cost of behavioral health care provided to the displaced~~
2900 ~~indigent care patient.~~

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2901 4.~~7.~~ Traditional community mental health providers under
2902 contract with the Department of Children and Family Services
2903 pursuant to part IV of chapter 394, ~~child welfare providers~~
2904 ~~under contract with the Department of Children and Family~~
2905 ~~Services in areas 1 and 6,~~ and inpatient mental health providers
2906 licensed pursuant to chapter 395 must be offered an opportunity
2907 to accept or decline a contract to participate in any provider
2908 network for prepaid behavioral health services.
2909 5.~~8.~~ All Medicaid-eligible children, except children in
2910 area 1 and children in ~~Highlands County, Hardee County, Polk~~
2911 ~~County, or~~ Manatee County in ~~of~~ area 6, whose cases ~~that~~ are
2912 open for child welfare services in the statewide automated child
2913 welfare information ~~HomeSafeNet~~ system, shall receive their
2914 behavioral health care services through a specialty prepaid plan
2915 operated by community-based lead agencies through a single
2916 agency or formal agreements among several agencies. The
2917 specialty prepaid plan must result in savings to the state
2918 comparable to savings achieved in other Medicaid managed care
2919 and prepaid programs. Such plan must provide mechanisms to
2920 maximize state and local revenues. The specialty prepaid plan
2921 shall be developed by the agency and the Department of Children
2922 and Family Services. The agency may seek federal waivers to
2923 implement this initiative. Medicaid-eligible children whose
2924 cases are open for child welfare services in the statewide
2925 automated child welfare information ~~HomeSafeNet~~ system and who
2926 reside in AHCA area 10 shall be enrolled in a capitated managed
2927 care plan, which includes provider service networks, which, in
2928 coordination with available community-based care providers
2929 specified in s. 409.1671, shall provide sufficient medical,

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2930 developmental, behavioral, and emotional services to meet the
2931 needs of these children, subject to funding as provided in the
2932 General Appropriations Act ~~are exempt from the specialty prepaid~~
2933 ~~plan upon the development of a service delivery mechanism for~~
2934 ~~children who reside in area 10 as specified in s.~~
2935 ~~409.91211(3)(dd)~~.
2936 (d) A provider service network, which may be reimbursed on
2937 a fee-for-service or prepaid basis.
2938 1. A provider service network that ~~which~~ is reimbursed by
2939 the agency on a prepaid basis is ~~shall be~~ exempt from parts I
2940 and III of chapter 641, but must comply with the solvency
2941 requirements in s. 641.2261(2) and meet appropriate financial
2942 reserve, quality assurance, and patient rights requirements ~~as~~
2943 established by the agency.
2944 2. ~~Medicaid recipients assigned to a provider service~~
2945 ~~network shall be chosen equally from those who would otherwise~~
2946 ~~have been assigned to prepaid plans and MediPass.~~ The agency may
2947 ~~is authorized to~~ seek federal Medicaid waivers as necessary to
2948 implement ~~the provisions of~~ this section. ~~Any contract~~
2949 ~~previously awarded to a provider service network operated by a~~
2950 ~~hospital pursuant to this subsection shall remain in effect for~~
2951 ~~a period of 3 years following the current contract expiration~~
2952 ~~date, regardless of any contractual provisions to the contrary.~~
2953 3. A provider service network is a network established or
2954 organized and operated by a health care provider, or group of
2955 affiliated health care providers, including minority physician
2956 networks and emergency room diversion programs that meet the
2957 requirements of s. 409.986 ~~409.91211~~, which provides a
2958 substantial proportion of the health care items and services

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2959 under a contract directly through the provider or affiliated
2960 group of providers and may make arrangements with physicians or
2961 other health care professionals, health care institutions, or
2962 any combination of such individuals or institutions to assume
2963 all or part of the financial risk on a prospective basis for the
2964 provision of basic health services by the physicians, by other
2965 health professionals, or through the institutions. The health
2966 care providers must have a controlling interest in the governing
2967 body of the provider service network organization.
2968 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum
2969 basis with an exclusive provider organization to provide health
2970 care services to Medicaid recipients if ~~provided that~~ the
2971 exclusive provider organization meets applicable managed care
2972 plan requirements in this section, ss. 409.987, 409.988
2973 ~~409.9122, 409.9123~~, 409.9128, and 627.6472, and other applicable
2974 provisions of law.
2975 ~~(b) For a period of no longer than 24 months after the~~
2976 ~~effective date of this paragraph, when a member of an exclusive~~
2977 ~~provider organization that is contracted by the agency to~~
2978 ~~provide health care services to Medicaid recipients in rural~~
2979 ~~areas without a health maintenance organization obtains services~~
2980 ~~from a provider that participates in the Medicaid program in~~
2981 ~~this state, the provider shall be paid in accordance with the~~
2982 ~~appropriate fee schedule for services provided to eligible~~
2983 ~~Medicaid recipients. The agency may seek waiver authority to~~
2984 ~~implement this paragraph.~~
2985 (34) The agency and entities that contract with the agency
2986 to provide health care services to Medicaid recipients under
2987 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~

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2988 must comply with the provisions of s. 641.513 in providing
2989 emergency services and care to Medicaid recipients and MediPass
2990 recipients. Where feasible, safe, and cost-effective, the agency
2991 shall encourage hospitals, emergency medical services providers,
2992 and other public and private health care providers to work
2993 together in their local communities to enter into agreements or
2994 arrangements to ensure access to alternatives to emergency
2995 services and care for those Medicaid recipients who need
2996 nonemergent care. The agency shall coordinate with hospitals,
2997 emergency medical services providers, private health plans,
2998 capitated managed care networks as established in s. 409.986
2999 ~~409.91211~~, and other public and private health care providers to
3000 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),
3001 627.6405, and 641.31097 to develop and implement emergency
3002 department diversion programs for Medicaid recipients.
3003 (44) The agency ~~for Health Care Administration~~ shall ensure
3004 that any Medicaid managed care plan as defined in s.
3005 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis
3006 or a shared savings basis, is cost-effective. For purposes of
3007 this subsection, the term “cost-effective” means that a
3008 network’s per-member, per-month costs to the state, including,
3009 but not limited to, fee-for-service costs, administrative costs,
3010 and case-management fees, if any, must be no greater than the
3011 state’s costs associated with contracts for Medicaid services
3012 established under subsection (3), which may be adjusted for
3013 health status. The agency shall conduct actuarially sound
3014 adjustments for health status in order to ensure such cost-
3015 effectiveness and shall annually publish the results on its
3016 Internet website. Contracts established pursuant to this

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3017 subsection which are not cost-effective may not be renewed.
3018 ~~(47) The agency shall conduct a study of available~~
3019 ~~electronic systems for the purpose of verifying the identity and~~
3020 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
3021 ~~to the Legislature a plan to implement an electronic~~
3022 ~~verification system for Medicaid recipients by January 31, 2005.~~
3023 ~~(53) Before seeking an amendment to the state plan for~~
3024 ~~purposes of implementing programs authorized by the Deficit~~
3025 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~
3026 Section 28. Paragraph (a) of subsection (1) of section
3027 409.915, Florida Statutes, is amended to read:
3028 409.915 County contributions to Medicaid.—Although the
3029 state is responsible for the full portion of the state share of
3030 the matching funds required for the Medicaid program, in order
3031 to acquire a certain portion of these funds, the state shall
3032 charge the counties for certain items of care and service as
3033 provided in this section.
3034 (1) Each county shall participate in the following items of
3035 care and service:
3036 (a) For both health maintenance members and fee-for-service
3037 beneficiaries, payments for inpatient hospitalization in excess
3038 of 10 days, but not in excess of 45 days, with the exception of
3039 pregnant women and children whose income is greater than ~~in~~
3040 ~~excess of~~ the federal poverty level and who do not receive a
3041 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~
3042 ~~medically needy Program~~, and for adult lung transplant services.
3043 Section 29. Section 409.9301, Florida Statutes, is
3044 transferred, renumbered as section 409.9067, Florida Statutes,
3045 and subsections (1) and (2) of that section are amended, to

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3046 read:
3047 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—
3048 (1) PROGRAM ESTABLISHED.—A program is established in the
3049 agency ~~for Health Care Administration~~ to provide pharmaceutical
3050 expense assistance to individuals diagnosed with cancer or
3051 individuals who have obtained ~~received~~ organ transplants who
3052 received a Medicaid nonpoverty medical subsidy before ~~were~~
3053 ~~medically needy recipients prior to~~ January 1, 2006.
3054 (2) ELIGIBILITY.—Eligibility for the program is limited to
3055 an individual who:
3056 (a) Is a resident of this state;
3057 (b) Was a Medicaid recipient who received a nonpoverty
3058 medical subsidy before ~~under the Florida Medicaid medically~~
3059 ~~needy program prior to~~ January 1, 2006;
3060 (c) Is eligible for Medicare;
3061 (d) Is a cancer patient or an organ transplant recipient;
3062 and
3063 (e) Requests to be enrolled in the program.
3064 Section 30. Subsection (1) of section 409.9126, Florida
3065 Statutes, is amended to read:
3066 409.9126 Children with special health care needs.—
3067 (1) Except as provided in subsection (4), children eligible
3068 for Children's Medical Services who receive Medicaid benefits,
3069 and other Medicaid-eligible children with special health care
3070 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987
3071 ~~409.9122~~ and shall be served through the Children's Medical
3072 Services network established in chapter 391.
3073 Section 31. The Division of Statutory Revision is requested
3074 to create part IV of chapter 409, Florida Statutes, consisting

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3075 of sections 409.961-409.978, Florida Statutes, entitled
3076 "MEDICAID MANAGED CARE."
3077 Section 32. Section 409.961, Florida Statutes, is created
3078 to read:
3079 409.961 Construction; applicability.—It is the intent of
3080 the Legislature that if any conflict exists between ss. 409.961-
3081 409.978 and other parts or sections of this chapter, the
3082 provisions in ss. 409.961-409.978 control. Sections 409.961-
3083 409.978 apply only to the Medicaid managed care program, as
3084 provided in this part.
3085 Section 33. Section 409.962, Florida Statutes, is created
3086 to read:
3087 409.962 Definitions.—As used in this part, and including
3088 the terms defined in s. 409.901, the term:
3089 (1) "Direct care management" means care management
3090 activities that involve direct interaction between providers and
3091 patients.
3092 (2) "Home and community-based services" means a specific
3093 set of services designed to assist recipients qualifying under
3094 s. 409.974 in avoiding institutionalization.
3095 (3) "Medicaid managed care program" means the integrated,
3096 statewide Medicaid program created in this part, which includes
3097 the provision of managed care medical assistance services
3098 described in ss. 409.971 and 409.972 and managed long-term care
3099 services described in ss. 409.973-409.978.
3100 (4) "Provider service network" means an entity of which a
3101 controlling interest is owned by a health care provider, a group
3102 of affiliated providers, or a public agency or entity that
3103 delivers health services. Health care providers include Florida-

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3104 licensed health care professionals or licensed health care
3105 facilities, federally qualified health care centers, and home
3106 health care agencies.
3107 (5) "Qualified plan" means a managed care plan that is
3108 determined eligible to participate in the Medicaid managed care
3109 program pursuant to s. 409.965.
3110 (6) "Specialty plan" means a qualified plan that serves
3111 Medicaid recipients who meet specified criteria based on age,
3112 medical condition, or diagnosis.
3113 Section 34. Section 409.963, Florida Statutes, is created
3114 to read:
3115 409.963 Medicaid managed care program.—The Medicaid managed
3116 care program is established as a statewide, integrated managed
3117 care program for all covered medical assistance services and
3118 long-term care services as provided under this part. Pursuant to
3119 s. 409.902, the program shall be administered by the agency, and
3120 eligibility for the program shall be determined by the
3121 Department of Children and Family Services.
3122 (1) The agency shall submit amendments to the Medicaid
3123 state plan or to existing waivers, or submit new waiver requests
3124 under section 1115 or other applicable sections of the Social
3125 Security Act, by August 1, 2011, as needed to implement the
3126 managed care program. At a minimum, the waiver requests must
3127 include a waiver that allows home and community-based services
3128 to be preferred over nursing home services for persons who can
3129 be safely managed in the home and community, and a waiver that
3130 requires dually eligible recipients to participate in the
3131 Medicaid managed care program. The waiver requests must also
3132 include provisions authorizing the state to limit enrollment in

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3133 managed long-term care, establish waiting lists, and limit the
3134 amount, duration, and scope of home and community-based services
3135 to ensure that expenditures for persons eligible for managed
3136 long-term care services do not exceed funds provided in the
3137 General Appropriations Act.
3138 (a) The agency shall initiate any necessary procurements
3139 required to implement the managed care program as soon as
3140 practicable, but no later than July 1, 2011, in anticipation of
3141 prompt approval of the waivers needed for the managed care
3142 program by the United States Department of Health and Human
3143 Services.
3144 (b) In submitting waivers, the agency shall work with the
3145 federal Centers for Medicare and Medicaid Services to accomplish
3146 approval of all waivers by December 1, 2011, in order to begin
3147 implementation of the managed care program by December 31, 2011.
3148 (c) Before seeking a waiver, the agency shall provide
3149 public notice and the opportunity for public comment and include
3150 public feedback in the waiver application.
3151 (2) The agency shall begin implementation of the Medicaid
3152 managed care program on December 31, 2011. If waiver approval is
3153 obtained, the program shall be implemented in accordance with
3154 the terms and conditions of the waiver. If necessary waivers
3155 have not been timely received, the agency shall notify the
3156 Centers for Medicare and Medicaid Services of the state's
3157 implementation of the managed care program and request the
3158 federal agency to continue providing federal funds equivalent to
3159 the funding level provided under the Federal Medical Assistance
3160 Percentage in order to implement the managed care program.
3161 (a) If the Centers for Medicare and Medicaid Services

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3162 refuses to continue providing federal funds, the managed care
3163 program shall be implemented as a state-only funded program to
3164 the extent state funds are available.
3165 (b) If implemented as a state-only funded program, priority
3166 shall be given to providing:
3167 1. Nursing home services to persons eligible for nursing
3168 home care.
3169 2. Medical services to persons served by the Agency for
3170 Persons with Disabilities.
3171 3. Medical services to pregnant women.
3172 4. Physician and hospital services to persons who are
3173 determined to be eligible for Medicaid subject to the income,
3174 assets, and categorical eligibility tests set forth in federal
3175 and state law.
3176 5. Services provided under the Healthy Start waiver.
3177 6. Medical services provided to persons in the Nursing Home
3178 Diversion waiver.
3179 7. Medical services provided to persons in intermediate
3180 care facilities for the developmentally disabled.
3181 8. Services to children in the child welfare system whose
3182 medical care is provided in accordance with s. 409.16713, as
3183 authorized by the General Appropriations Act.
3184 (c) If implemented as a state-only funded program pursuant
3185 to paragraph (b), provisions related to the eligibility
3186 standards of the state and federally funded Medicaid program
3187 remain in effect, except as otherwise provided under the managed
3188 care program.
3189 (d) If implemented as a state-only funded program pursuant
3190 to paragraph (a), provider agreements and other contracts that

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3191 provide for Medicaid services to recipients identified in
3192 paragraph (b) continue in effect.
3193 Section 35. Section 409.964, Florida Statutes, is created
3194 to read:
3195 409.964 Enrollment.—All Medicaid recipients shall receive
3196 medical services through the Medicaid managed care program
3197 established under this part unless excluded under this section.
3198 (1) The following recipients are excluded from
3199 participation in the Medicaid managed care program:
3200 (a) Women who are eligible only for family planning
3201 services.
3202 (b) Women who are eligible only for breast and cervical
3203 cancer services.
3204 (c) Persons who have a developmental disability as defined
3205 in s. 393.063.
3206 (d) Persons who are eligible for a Medicaid nonpoverty
3207 medical subsidy.
3208 (e) Persons who receive eligible services under emergency
3209 Medicaid for aliens.
3210 (f) Persons who are residing in a nursing home facility or
3211 are considered residents under the nursing home's bed-hold
3212 policy on or before July 1, 2011.
3213 (g) Persons who are eligible for and receiving prescribed
3214 pediatric extended care.
3215 (h) Persons who are dependent on a respirator by medical
3216 necessity and who meet the definition of a medically dependent
3217 or technologically dependent child under s. 400.902.
3218 (i) Persons who select the Medicaid hospice benefit and are
3219 receiving hospice services from a hospice licensed under part IV

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3220 of chapter 400.
3221 (j) A person who is eligible for services under the
3222 Medicaid program who has access to health care coverage through
3223 an employer-sponsored health plan. Such person may not receive
3224 Medicaid services under the fee-for-service program but may use
3225 Medicaid financial assistance to pay the cost of premiums for
3226 the employer-sponsored health plan. For purposes of this
3227 paragraph, access to health care coverage through an employer-
3228 sponsored health plan means that the Medicaid financial
3229 assistance available to the person is sufficient to pay the
3230 premium for the employer-sponsored health plan for the eligible
3231 person and his or her Medicaid eligible family members.
3232 1. The agency shall develop a process that allows a
3233 recipient who has access to employer-sponsored health coverage
3234 to use Medicaid financial assistance to pay the cost of the
3235 premium for the recipient and the recipient's Medicaid-eligible
3236 family members for such coverage. The amount of financial
3237 assistance may not exceed the Medicaid capitated rate that would
3238 have been paid to a qualified plan for that recipient and the
3239 recipient's family members.
3240 2. Contingent upon federal approval, the agency shall also
3241 allow recipients who have access to other insurance or coverage
3242 created pursuant to state or federal law to opt out of Medicaid
3243 managed care and apply the Medicaid capitated rate that would
3244 have been paid to a qualified plan for that recipient and the
3245 recipient's family to pay for the other insurance product.
3246 (2) The following Medicaid recipients are exempt from
3247 mandatory enrollment in the managed care program but may
3248 volunteer to participate in the program:

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3249 (a) Recipients residing in residential commitment
3250 facilities operated through the Department of Juvenile Justice,
3251 group care facilities operated by the Department of Children and
3252 Family Services, or treatment facilities funded through the
3253 substance abuse and mental health program of the Department of
3254 Children and Family Services.
3255 (b) Persons eligible for refugee assistance.
3256 (3) Medicaid recipients who are exempt from mandatory
3257 participation under this section and who do not choose to enroll
3258 in the Medicaid managed care program shall be served though the
3259 Medicaid fee-for-service program as provided under part III of
3260 this chapter.
3261 Section 36. Section 409.965, Florida Statutes, is created
3262 to read:
3263 409.965 Qualified plans; regions; selection criteria.—
3264 Services in the Medicaid managed care program shall be provided
3265 by qualified plans.
3266 (1) The agency shall select qualified plans to participate
3267 in the Medicaid managed care program using an invitation to
3268 negotiate issued pursuant to s. 287.057.
3269 (a) The agency shall notice separate invitations to
3270 negotiate for the managed medical assistance component and the
3271 managed long-term care component of the managed care program.
3272 (b) At least 30 days before noticing the invitation to
3273 negotiate and annually thereafter, the agency shall compile and
3274 publish a databook consisting of a comprehensive set of
3275 utilization and spending data for the 3 most recent contract
3276 years, consistent with the rate-setting periods for all Medicaid
3277 recipients by region and county. Pursuant to s. 409.970, the

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3278 source of the data must include both historic fee-for-service
3279 claims and validated data from the Medicaid Encounter Data
3280 System. The report shall be made available electronically and
3281 must delineate utilization by age, gender, eligibility group,
3282 geographic area, and acuity level.
3283 (2) Separate and simultaneous procurements shall be
3284 conducted in each of the following regions:
3285 (a) Region 1, which consists of Escambia, Okaloosa, Santa
3286 Rosa, and Walton counties.
3287 (b) Region 2, which consists of Franklin, Gadsden,
3288 Jefferson, Leon, Liberty, and Wakulla counties.
3289 (c) Region 3, which consists of Columbia, Dixie, Hamilton,
3290 Lafayette, Madison, Suwannee, and Taylor counties.
3291 (d) Region 4, which consists of Baker, Clay, Duval, and
3292 Nassau counties.
3293 (e) Region 5, which consists of Citrus, Hernando, Lake,
3294 Marion, and Sumter counties.
3295 (f) Region 6, which consists of Pasco and Pinellas
3296 counties.
3297 (g) Region 7, which consists of Flagler, Putnam, St. Johns,
3298 and Volusia counties.
3299 (h) Region 8, which consists of Alachua, Bradford,
3300 Gilchrist, Levy, and Union counties.
3301 (i) Region 9, which consists of Orange and Osceola
3302 counties.
3303 (j) Region 10, which consists of Hardee, Highlands, and
3304 Polk counties.
3305 (k) Region 11, which consists of Miami-Dade and Monroe
3306 counties.

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3307 (l) Region 12, which consists of DeSoto, Manatee, and
3308 Sarasota counties.
3309 (m) Region 13, which consists of Hillsborough County.
3310 (n) Region 14, which consists of Bay, Calhoun, Gulf,
3311 Holmes, Jackson, and Washington counties.
3312 (o) Region 15, which consists of Palm Beach County.
3313 (p) Region 16, which consists of Broward County.
3314 (q) Region 17, which consists of Brevard and Seminole
3315 counties.
3316 (r) Region 18, which consists of Indian River, Martin,
3317 Okeechobee, and St. Lucie counties.
3318 (s) Region 19, which consists of Charlotte, Collier,
3319 Glades, Hendry, and Lee counties.
3320 (3) The invitation to negotiate must specify the criteria
3321 and the relative weight of the criteria to be used for
3322 determining the acceptability of a reply and guiding the
3323 selection of qualified plans with which the agency shall
3324 contract. In addition to other criteria developed by the agency,
3325 the agency shall give preference to the following factors in
3326 selecting qualified plans:
3327 (a) Accreditation by the National Committee for Quality
3328 Assurance or another nationally recognized accrediting body.
3329 (b) Experience serving similar populations, including the
3330 organization’s record in achieving specific quality standards
3331 for similar populations.
3332 (c) Availability and accessibility of primary care and
3333 specialty physicians in the provider network.
3334 (d) Establishment of partnerships with community providers
3335 that provide community-based services.

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3336 (e) The organization's commitment to quality improvement
3337 and documentation of achievements in specific quality-
3338 improvement projects, including active involvement by the
3339 organization's leadership.
3340 (f) Provision of additional benefits, particularly dental
3341 care for all recipients, disease management, and other programs
3342 offering additional benefits.
3343 (g) Establishment of incentive programs that reward
3344 specific behaviors with health-related benefits not otherwise
3345 covered by the organizations' benefit plan. Such behaviors may
3346 include participation in smoking-cessation programs, weight-loss
3347 programs, or other activities designed to mitigate lifestyle
3348 choices and avoid behaviors associated with the use of high-cost
3349 medical services.
3350 (h) Organizations without a history of voluntary or
3351 involuntary withdrawal from any state Medicaid program or
3352 program area.
3353 (i) Evidence that an organization has written agreements or
3354 signed contracts or has made substantial progress in
3355 establishing relationships with providers before the
3356 organization submits a reply. The agency shall evaluate such
3357 evidence based on the following factors:
3358 1. Contracts with primary care and specialty physicians in
3359 sufficient numbers to meet the specific performance standards
3360 established pursuant to s. 409.966(2)(b).
3361 2. Specific arrangements that provide evidence that the
3362 compensation offered by the plan is sufficient to retain primary
3363 care and specialty physicians in sufficient numbers to comply
3364 with the performance standards established pursuant to s.

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3365 409.966(2) throughout the 5-year contract term. The agency shall
3366 give preference to plans that provide evidence that primary care
3367 physicians within the plan's provider network will be
3368 compensated for primary care services with payments equivalent
3369 to or greater than payments for such services under the Medicare
3370 program, whether compensation is made on a fee-for-service basis
3371 or by sub-capitation.
3372 3. Contracts with community pharmacies located in rural
3373 areas; contracts with community pharmacies serving specialty
3374 disease populations, including, but not limited to, HIV/AIDS
3375 patients, hemophiliacs, patients suffering from end-stage renal
3376 disease, diabetes, or cancer; community pharmacies located
3377 within distinct cultural communities that reflect the unique
3378 cultural dynamics of such communities, including, but not
3379 limited to, languages spoken, ethnicities served, unique disease
3380 states serviced, and geographic location within the
3381 neighborhoods of culturally distinct populations; and community
3382 pharmacies providing value-added services to patients, such as
3383 free delivery, immunizations, disease management, diabetes
3384 education, and medication utilization review.
3385 4. Contracts with cancer disease management programs that
3386 have a proven record of clinical efficiencies and cost savings.
3387 5. Contracts with diabetes disease management programs that
3388 have a proven record of clinical efficiencies and cost savings.
3389 (j) The capitated rates provided in the reply to the
3390 invitation to negotiate.
3391 (k) Establishment of a claims payment process to ensure
3392 that claims that are not contested or denied will be paid within
3393 20 days after receipt.

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3394 (l) For long-term care plans, additional criteria as
3395 specified in s. 409.976(3).
3396 (4) Acceptable replies to the invitation to negotiate for
3397 each region shall be ranked, and the agency shall select the
3398 number of qualified plans with which to contract in each region.
3399 (a) The agency may not select more than one plan per 20,000
3400 Medicaid recipients residing in the region who are subject to
3401 mandatory managed care enrollment, except that, in addition to
3402 the Children's Medical Services Network, a region may not have
3403 more than 10 qualified plans for the managed medical assistance
3404 or the managed long-term care components of the program.
3405 (b) If the funding available in the General Appropriations
3406 Act is not adequate to meet the proposed statewide requirement
3407 under the Medicaid managed care program, the agency shall enter
3408 into negotiations with qualified plans that responded to the
3409 invitation to negotiate. The negotiation process may alter the
3410 rank of a qualified plan. If negotiations are conducted, the
3411 agency shall select qualified plans that are responsive and
3412 provide the best value to the state.
3413 (5) The agency may issue a new invitation to negotiate in
3414 any region:
3415 (a) At any time if:
3416 1. Data becomes available to the agency indicating that the
3417 population of recipients residing in the region who are subject
3418 to mandatory managed care enrollment cannot be served by the
3419 plans under contract with the agency in that region or has
3420 increased by more than 20,000 since the most recent invitation
3421 to negotiate was issued in that region; and
3422 2. The agency has not contracted with the maximum number of

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3423 plans authorized for that region.
3424 (b) At any time during the first 2 years after the initial
3425 contract period and upon the request of a qualified plan under
3426 contract in one or more regions if:
3427 1. Data becomes available to the agency indicating that the
3428 population of Medicaid recipients residing in the region who are
3429 subject to mandatory managed care enrollment has increased by
3430 more than 20,000 since the initial invitation to negotiate was
3431 issued for the contract period; and
3432 2. The agency has not contracted with the maximum number of
3433 plans authorized for that region.
3434
3435 The term of a contract executed under this subsection shall be
3436 for the remainder of the 5-year contract cycle.
3437 (6) The Children's Medical Services Network authorized
3438 under chapter 391 is a qualified plan for purposes of the
3439 managed care medical assistance component of the Medicaid
3440 managed care program. Participation by the network shall be
3441 pursuant to a single statewide contract with the agency which is
3442 not subject to the procurement requirements of this section. The
3443 network must meet all other plan requirements for the managed
3444 care medical assistance component of the program.
3445 (7) In order to allow a provider service network in rural
3446 areas sufficient time to develop an adequate provider network to
3447 participate in the Medicaid managed care program on a capitated
3448 basis, the network may submit an application or invitation to
3449 negotiate after July 1, 2011, as required by the agency, for a
3450 region where there was no Medicaid-contracted health maintenance
3451 organization or provider service network on July 1, 2011. For

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3452 the first 12 months that the network operates in the region, the
3453 agency shall assign existing Medicaid provider agreements to the
3454 provider service network for purposes of administering managed
3455 care services and building an adequate provider network to meet
3456 the access standards established by the agency.
3457 Section 37. Section 409.966, Florida Statutes, is created
3458 to read:
3459 409.966 Plan contracts.—
3460 (1) The agency shall execute a 5-year contract with each
3461 qualified plan selected through the procurement process
3462 described in s. 409.965. A contract between the agency and the
3463 qualified plan may be amended annually, or as needed, to reflect
3464 capitated rate adjustments due to funding availability pursuant
3465 to the General Appropriations Act and ss. 409.9022, 409.972, and
3466 409.975(2).
3467 (a) A plan contract may not be renewed; however, the agency
3468 may extend the term of a contract, keeping intact all
3469 operational provisions in the contract, including capitation
3470 rates, to cover any delays in transitioning to a new plan.
3471 (b) If a plan applies for a rate increase that is not the
3472 result of a solicitation from the agency and the application for
3473 rate increase is not timely withdrawn, the plan will be deemed
3474 to have submitted a notice of intent to leave the region before
3475 the end of the contract term.
3476 (2) The agency shall establish such contract requirements
3477 as are necessary for the operation of the Medicaid managed care
3478 program. In addition to any other provisions the agency may deem
3479 necessary, the contract must require:
3480 (a) *Access.*—The agency shall establish specific standards

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3481 for the number, type, and regional distribution of providers in
3482 plan networks in order to ensure access to care. Each qualified
3483 plan shall:
3484 1. Maintain a network of providers in sufficient numbers to
3485 meet the access standards for specified services for all
3486 recipients enrolled in the plan.
3487 2. Establish and maintain an accurate and complete
3488 electronic database of contracted providers, including
3489 information about licensure or registration, locations and hours
3490 of operation, specialty credentials and other certifications,
3491 specific performance indicators, and such other information as
3492 the agency deems necessary. The provider database must be
3493 available online to both the agency and the public and allow
3494 comparison of the availability of providers to network adequacy
3495 standards, and accept and display feedback from each provider's
3496 patients.
3497 3. Provide for reasonable and adequate hours of operation,
3498 including 24-hour availability of information, referral, and
3499 treatment for emergency medical conditions.
3500 4. Assign each new enrollee to a primary care provider and
3501 ensure that an appointment with that provider has been scheduled
3502 within 30 days after the enrollment in the plan.
3503 5. Submit quarterly reports to the agency identifying the
3504 number of enrollees assigned to each primary care provider.
3505 (b) *Performance standards.*—The agency shall establish
3506 specific performance standards and expected milestones or
3507 timelines for improving plan performance over the term of the
3508 contract.
3509 1. Each plan shall establish an internal health care

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3510 quality improvement system that includes enrollee satisfaction
3511 and disenrollment surveys and incentives and disincentives for
3512 network providers.
3513 2. Each plan must collect and report the Health Plan
3514 Employer Data and Information Set (HEDIS) measures, as specified
3515 by the agency. These measures must be published on the plan's
3516 website in a manner that allows recipients to reliably compare
3517 the performance of plans. The agency shall use the HEDIS
3518 measures as a tool to monitor plan performance.
3519 3. A qualified plan that is not accredited when the
3520 contract is executed with the agency must become accredited or
3521 have initiated the accreditation process within 1 year after the
3522 contract is executed. If the plan is not accredited within 18
3523 months after executing the contract, the plan shall be suspended
3524 from automated enrollments pursuant to s. 409.969(2).
3525 4. In addition to agency standards, a qualified plan must
3526 ensure that the agency is notified of the impending birth of a
3527 child to an enrollee or as soon as practicable after the child's
3528 birth. Upon the birth, the child is deemed enrolled with the
3529 qualified plan, regardless of the administrative enrollment
3530 procedures, and the qualified plan is responsible for providing
3531 Medicaid services to the child on a capitated basis.
3532 (c) *Program integrity.*—Each plan shall establish program
3533 integrity functions and activities in order to reduce the
3534 incidence of fraud and abuse, including, at a minimum:
3535 1. A provider credentialing system and ongoing provider
3536 monitoring. Each plan must verify at least annually that all
3537 providers have a valid and unencumbered license or permit to
3538 provide services to Medicaid recipients, and shall establish a

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3539 procedure for providers to notify the plan when the provider has
3540 been notified by a licensing or regulatory agency that the
3541 provider's license or permit is to be revoked or suspended, or
3542 when an event has occurred which would prevent the provider from
3543 renewing its license or permit. The provider must also notify
3544 the plan if the license or permit is revoked or suspended, if
3545 renewal of the license or permit is denied or expires by
3546 operation of law, or if the provider requests that the license
3547 or permit be inactivated. The plan must immediately exclude a
3548 provider from the plan's provider network if the provider's
3549 license is suspended or invalid;
3550 2. An effective prepayment and postpayment review process
3551 that includes, at a minimum, data analysis, system editing, and
3552 auditing of network providers;
3553 3. Procedures for reporting instances of fraud and abuse
3554 pursuant to s. 409.91212;
3555 4. The establishment of an anti-fraud plan pursuant to s.
3556 409.91212; and
3557 5. Designation of a program integrity compliance officer.
3558 (d) *Encounter data.*—Each plan must comply with the agency's
3559 reporting requirements for the Medicaid Encounter Data System
3560 under s. 409.970. The agency shall assess a fine of $5,000 per
3561 day against a qualified plan for failing to comply with this
3562 requirement. If a plan fails to comply for more than 30 days,
3563 the agency shall assess a fine of $10,000 per day beginning on
3564 the 31st day. If a plan is fined $300,000 or more for failing to
3565 comply, in addition to paying the fine, the plan shall be
3566 disqualified from the Medicaid managed care program for 3 years.
3567 If the plan is disqualified, the plan shall be deemed to have

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3568 terminated its contract before the scheduled end date and shall
3569 also be subject to applicable penalties under paragraph (l).
3570 However, the agency may waive or reduce the fine upon a showing
3571 of good cause for the failure to comply.
3572 (e) *Electronic claims.*—Plans shall accept electronic claims
3573 that are in compliance with federal standards.
3574 (f) *Prompt payment.*—All qualified plans must comply with
3575 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay
3576 nursing homes by the 10th day of the month for enrollees who are
3577 residing in the nursing home on the 1st day of the month.
3578 Payment for the month in which an enrollee initiates residency
3579 in a nursing home shall be in accordance with s. 641.3155. On an
3580 annual basis, qualified plans shall submit a report certifying
3581 compliance with the prompt payment requirements for the plan
3582 year.
3583 (g) *Emergency services.*—Qualified plans must pay for
3584 emergency services and care required under ss. 395.1041 and
3585 401.45 and rendered by a noncontracted provider in accordance
3586 with the prompt payment standards established in s. 641.3155.
3587 The payment rate shall be the fee-for-service rate the agency
3588 would pay the noncontracted provider for such services.
3589 (h) *Surety bond.*—A qualified plan shall post and maintain a
3590 surety bond with the agency, payable to the agency, or in lieu
3591 of a surety bond, establish and maintain an irrevocable letter
3592 of credit or a deposit in a trust account in a financial
3593 institution, payable to the agency.
3594 1. The amount of the surety bond, letter of credit, or
3595 trust account shall be 125 percent of the estimated annual
3596 guaranteed savings for each qualified plan, and at least $2

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3597 million but no more than $15 million for each qualified plan.
3598 The estimated guaranteed savings shall be calculated before the
3599 execution of the contract as follows:
3600 a. The agreed-upon monthly contractual capitated rate for
3601 each level of acuity multiplied by the estimated population in
3602 the region for the plan for each level of acuity, multiplied by
3603 12 months, multiplied by 7 percent, multiplied by 125 percent.
3604 b. The estimated population in the region for the plan
3605 under sub-subparagraph a. shall be based on the maximum enrollee
3606 level that the agency initially authorizes. The factors that the
3607 agency may consider in determining the maximum enrollee level
3608 include, but are not limited to, requested capacity, projected
3609 enrollment, network adequacy, and the available budget in the
3610 General Appropriations Act.
3611 2. The purpose of the surety bond, letter of credit, or
3612 trust account is to protect the agency if the entity terminates
3613 its contract with the agency before the scheduled end date for
3614 the contract, if the plan fails to comply with the terms of the
3615 contract, including, but not limited to, the timely submission
3616 of encounter data, if the agency imposes fines or penalties for
3617 noncompliance, or if the plan fails to achieve the guaranteed
3618 savings. If any of those events occurs, the agency shall first
3619 request payment from the qualified plan. If the qualified plan
3620 does not pay all costs, fines, penalties, or the differential in
3621 the guaranteed savings in full within 30 days, the agency shall
3622 pursue a claim against the surety bond, letter of credit, or
3623 trust account for all applicable moneys and the legal and
3624 administrative costs associated with pursuing such claim.
3625 (i) *Grievance resolution.*—Each plan shall establish and the

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3626 agency shall approve an internal process for reviewing and
3627 responding to grievances from enrollees consistent with s.
3628 641.511. Each plan shall submit quarterly reports to the agency
3629 on the number, description, and outcome of grievances filed by
3630 enrollees.
3631 (j) *Solvency.*—A qualified plan must meet and maintain the
3632 surplus and solvency requirements under s. 409.912(17) and (18).
3633 A provider service network may satisfy the surplus and solvency
3634 requirements if the network's performance and financial
3635 obligations are guaranteed in writing by an entity licensed by
3636 the Office of Insurance Regulation which meets the surplus and
3637 solvency requirements of s. 624.408 or s. 641.225.
3638 (k) *Guaranteed savings.*—During the first contract period, a
3639 qualified plan must agree to provide a guaranteed minimum
3640 savings of 7 percent to the state. The agency shall conduct a
3641 cost reconciliation to determine the amount of cost savings
3642 achieved by the qualified plan compared with the reimbursements
3643 the agency would have incurred under fee-for-service provisions.
3644 (l) *Costs and penalties.*—Plans that reduce enrollment
3645 levels or leave a region before the end of the contract term
3646 must reimburse the agency for the cost of enrollment changes and
3647 other transition activities. If more than one plan leaves a
3648 region at the same time, costs shall be shared by the departing
3649 plans proportionate to their enrollment. In addition to the
3650 payment of costs, departing plans must pay a penalty of 1
3651 month's payment calculated as an average of the past 12 months
3652 of payments, or since inception if the plan has not contracted
3653 with the agency for 12 months, plus the differential of the
3654 guaranteed savings based on the original contract term and the

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3655 corresponding termination date. Plans must provide the agency
3656 with at least 180 days' notice before withdrawing from a region.
3657 (3) If the agency terminates more than one regional
3658 contract with a qualified plan due to the plan's noncompliance
3659 with one or more requirements of this section, the agency shall
3660 terminate all regional contracts with the plan under the
3661 Medicaid managed care program, as well as any other contracts or
3662 agreements for other programs or services, and the plan may not
3663 be awarded new contracts for 3 years.
3664 Section 38. Section 409.967, Florida Statutes, is created
3665 to read:
3666 409.967 Plan accountability.—In addition to the contract
3667 requirements of s. 409.966, plans and providers participating in
3668 the Medicaid managed care program must comply with this section.
3669 (1) The agency shall require qualified plans to use a
3670 uniform method of reporting and accounting for medical, direct
3671 care management, and nonmedical costs and shall evaluate plan-
3672 spending patterns after the plan completes 2 full years of
3673 operation and at least annually thereafter.
3674 (2) The agency shall implement the following thresholds and
3675 consequences of various spending patterns for qualified plans
3676 under the managed medical assistance component of the Medicaid
3677 managed care program:
3678 (a) The minimum medical loss ratio shall be 90 percent.
3679 (b) A plan that spends less than 90 percent of its Medicaid
3680 capitation revenue on medical services and direct care
3681 management, as determined by the agency, must pay back to the
3682 agency a share of the dollar difference between the plan's
3683 actual medical loss ratio and the minimum medical loss ratio, as

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3684 follows:
3685 1. If the plan's actual medical loss ratio is not lower
3686 than 87 percent, the plan must pay back 50 percent of the dollar
3687 difference between the actual medical loss ratio and the minimum
3688 medical loss ratio of 90 percent.
3689 2. If the plan's actual medical loss ratio is lower than 87
3690 percent, the plan must pay back 50 percent of the dollar
3691 difference between a medical loss ratio of 87 percent and the
3692 minimum medical loss ratio of 90 percent, plus 100 percent of
3693 the dollar difference between the actual medical loss ratio and
3694 a medical loss ratio of 87 percent.
3695 (c) To administer this subsection, the agency shall adopt
3696 rules that specify a methodology for calculating medical loss
3697 ratios and the requirements for plans to annually report
3698 information related to medical loss ratios. Repayments required
3699 by this subsection must be made annually.
3700 (3) Plans may limit the providers in their networks.
3701 (a) However, during the first year in which a qualified
3702 plan is operating in a region after the initial plan procurement
3703 for that region, the plan must offer a network contract to the
3704 following providers in the region:
3705 1. Federally qualified health centers.
3706 2. Nursing homes if the plan is providing managed long-term
3707 care services.
3708 3. Aging network service providers that have previously
3709 participated in home and community-based waivers serving elders,
3710 or community-service programs administered by the Department of
3711 Elderly Affairs if the plan is providing managed long-term care
3712 services.

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3713 (b) After 12 months of active participation in a plan's
3714 network, the plan may exclude any of the providers listed in
3715 paragraph (a) from the network while maintaining the network
3716 performance standards required under s. 409.966(2)(b). If the
3717 plan excludes a nursing home that meets the standards for
3718 ongoing Medicaid certification, the plan must provide an
3719 alternative residence in that community for Medicaid recipients
3720 residing in that nursing home. If a Medicaid recipient residing
3721 in an excluded nursing home does not choose to change residence,
3722 the plan must continue to pay for the recipient's care in that
3723 nursing home. If the plan excludes a provider, the plan must
3724 provide written notice to all enrollees who have chosen that
3725 provider for care. Notice to excluded providers must be
3726 delivered at least 30 days before the effective date of the
3727 exclusion.
3728 (c) Qualified plans and providers shall engage in good
3729 faith negotiations to reach contract terms.
3730 1. If a qualified plan seeks to develop a provider network
3731 in a county or region that, as of June 30, 2011, does not have a
3732 capitated managed care plan providing comprehensive acute care
3733 for Medicaid recipients, and the qualified plan has made at
3734 least three documented, unsuccessful, good faith attempts to
3735 contract with a specific provider, the plan may request the
3736 agency to examine the negotiation process. During the
3737 examination, the agency shall consider similar counties or
3738 regions in which qualified plans have contracted with providers
3739 under similar circumstances, as well as the contracted rates
3740 between qualified plans and that provider and similar providers
3741 in the same region. If the agency determines that the plan has

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3742 made three good faith attempts to contract with the provider,
3743 the agency shall consider that provider to be part of the
3744 qualified plan's provider network for the purpose of determining
3745 network adequacy, and the plan shall pay the provider for
3746 services to Medicaid recipients on a noncontracted basis at a
3747 rate or rates determined by the agency to be the average of
3748 rates for corresponding services paid by the qualified plan and
3749 other qualified plans in the region and in similar counties or
3750 regions under similar circumstances.
3751 2. The agency may continue to calculate Medicaid hospital
3752 inpatient per diem rates and outpatient rates. However, these
3753 rates may not be the basis for contract negotiations between a
3754 managed care plan and a hospital.
3755 (4) Each qualified plan shall monitor the quality and
3756 performance of each provider within its network based on metrics
3757 established by the agency for evaluating and documenting
3758 provider performance and determining continued participation in
3759 the network. The agency shall establish requirements for
3760 qualified plans to report, at least annually, provider
3761 performance data compiled under this subsection. If a plan uses
3762 additional metrics to evaluate the provider's performance and to
3763 determine continued participation in the network, the plan must
3764 notify the network providers of these metrics at the beginning
3765 of the contract period.
3766 (a) At a minimum, a qualified plan shall hold primary care
3767 physicians responsible for the following activities:
3768 1. Supervision, coordination, and provision of care to each
3769 assigned enrollee.
3770 2. Initiation of referrals for medically necessary

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3771 specialty care and other services.
3772 3. Maintaining continuity of care for each assigned
3773 enrollee.
3774 4. Maintaining the enrollee's medical record, including
3775 documentation of all medical services provided to the enrollee
3776 by the primary care physician, as well as any specialty or
3777 referral services.
3778 (b) Qualified plans shall establish and implement policies
3779 and procedures to monitor primary care physician activities and
3780 ensure that primary care physicians are adequately notified and
3781 receive documentation of specialty and referral services
3782 provided to enrollees by specialty physicians and other health
3783 care providers within the plan's provider network.
3784 (5) Each qualified plan shall establish specific programs
3785 and procedures to improve pregnancy outcomes and infant health,
3786 including, but not limited to, coordination with the Healthy
3787 Start program, immunization programs, and referral to the
3788 Special Supplemental Nutrition Program for Women, Infants, and
3789 Children, and the Children's Medical Services Program for
3790 children with special health care needs.
3791 (a) Qualified plans must ensure that primary care
3792 physicians who provide obstetrical care are available to
3793 pregnant recipients and that an obstetrical care provider is
3794 assigned to each pregnant recipient for the duration of her
3795 pregnancy and postpartum care, by referral of the recipient's
3796 primary care physician if necessary.
3797 (b) Qualified plans within the managed long-term care
3798 component are exempt from this subsection.
3799 (6) Each qualified plan shall achieve an annual screening

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3800 rate for early and periodic screening, diagnosis, and treatment
3801 services of at least 80 percent of those recipients continuously
3802 enrolled for at least 8 months. Qualified plans within the
3803 managed long-term care component are exempt from this
3804 requirement.
3805 (7) Effective January 1, 2013, qualified plans must
3806 compensate primary care physicians for primary care services at
3807 payment rates that are equivalent to or greater than payments
3808 under the federal Medicare program, whether compensation is made
3809 on a fee-for-service basis or by sub-capitation.
3810 (8) In order to protect the continued operation of the
3811 Medicaid managed care program, unresolved disputes, including
3812 claim and other types of disputes, between a qualified plan and
3813 a provider shall proceed in accordance with s. 408.7057. This
3814 process may not be used to review or reverse a decision by a
3815 qualified plan to exclude a provider from its network if the
3816 decision does not conflict with s. 409.967(3).
3817 Section 39. Section 409.968, Florida Statutes, is created
3818 to read:
3819 409.968 Plan payment.—Payments for managed medical
3820 assistance and managed long-term care services under this part
3821 shall be made in accordance with a capitated managed care model.
3822 Qualified plans shall receive per-member, per-month payments
3823 pursuant to the procurements described in s. 409.965 and annual
3824 adjustments as described in s. 409.966(1). Payment rates must be
3825 based on the acuity level for each member pursuant to ss.
3826 409.972 and 409.978. Payment rates for managed long-term care
3827 plans shall be combined with rates for managed medical
3828 assistance plans.

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3829 (1) The agency shall develop a methodology and request a
3830 waiver that ensures the availability of intergovernmental
3831 transfers in the Medicaid managed care program to support
3832 providers that have historically served Medicaid recipients.
3833 Such providers include, but are not limited to, safety net
3834 providers, trauma hospitals, children's hospitals, statutory
3835 teaching hospitals, and medical and osteopathic physicians
3836 employed by or under contract with a medical school in this
3837 state. The agency may develop a supplemental capitation rate,
3838 risk pool, or incentive payment for plans that contract with
3839 these providers. A plan is eligible for a supplemental payment
3840 only if there are sufficient intergovernmental transfers
3841 available from allowable sources.
3842 (2) The agency shall evaluate the development of the rate
3843 cell to accurately reflect the underlying utilization to the
3844 maximum extent possible. This methodology may include interim
3845 rate adjustments as permitted under federal regulations. Any
3846 such methodology must preserve federal funding to these entities
3847 and be actuarially sound. In the absence of federal approval of
3848 the methodology, the agency may set an enhanced rate and require
3849 that plans pay the rate if the agency determines the enhanced
3850 rate is necessary to ensure access to care by the providers
3851 described in this subsection.
3852 (3) The amount paid to the plans to make supplemental
3853 payments or to enhance provider rates pursuant to this
3854 subsection must be reconciled to the exact amounts the plans are
3855 required to pay providers. The plans shall make the designated
3856 payments to providers within 15 business days after notification
3857 by the agency regarding provider-specific distributions.

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3858 Section 40. Section 409.969, Florida Statutes, is created
3859 to read:
3860 409.969 Enrollment; disenrollment; grievance procedure.—
3861 (1) Each Medicaid recipient may choose any available plan
3862 within the region in which the recipient resides unless that
3863 plan is a specialty plan for which the recipient does not
3864 qualify. The agency may not provide or contract for choice
3865 counseling services for persons enrolling in the Medicaid
3866 managed care program.
3867 (2) If a recipient has not made a choice of plans within 30
3868 days after having been notified to choose a plan, the agency
3869 shall assign the recipient to a plan in accordance with the
3870 following:
3871 (a) A recipient who was previously enrolled in a plan
3872 within the preceding 90 days shall automatically be enrolled in
3873 the same plan, if available.
3874 (b) Newborns of eligible mothers enrolled in a plan at the
3875 time of the child's birth shall be enrolled in the mother's
3876 plan; however, the mother may choose another plan for the
3877 newborn within 90 days after the child's birth.
3878 (c) If the recipient is diagnosed with HIV/AIDS and resides
3879 in region 11, region 15, or region 16, the agency shall assign
3880 the recipient to a plan that:
3881 1. Is a specialty plan under contract with the agency
3882 pursuant to s. 409.965; and
3883 2. Offers a delivery system through a teaching- and
3884 research-oriented organization that specializes in providing
3885 health care services and treatment for individuals diagnosed
3886 with HIV/AIDS.

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3888 The agency shall assign recipients under this paragraph on an
3889 even basis among all such plans within a region under contract
3890 with the agency.
3891 (d) Other recipients shall be enrolled into a qualified
3892 plan in accordance with an auto-assignment enrollment algorithm
3893 that the agency develops by rule. The algorithm must heavily
3894 weigh family continuity.
3895 1. Automatic enrollment of recipients in plans must be
3896 based on the following criteria:
3897 a. Whether the plan has sufficient network capacity to meet
3898 the needs of recipients.
3899 b. Whether the recipient has previously received services
3900 from one of the plan's primary care providers.
3901 c. Whether primary care providers in one plan are more
3902 geographically accessible to the recipient's residence than
3903 providers in other plans.
3904 d. If a recipient is eligible for long-term care services,
3905 whether the recipient has previously received services from one
3906 of the plan's home and community-based service providers.
3907 e. If a recipient is eligible for long-term care services,
3908 whether the home and community-based providers in one plan are
3909 more geographically accessible to the recipient's residence than
3910 providers in other plans.
3911 2. The agency shall automatically enroll recipients in
3912 plans that meet or exceed the performance or quality standards
3913 established pursuant to s. 409.967, and may not automatically
3914 enroll recipients in a plan that is not meeting those standards.
3915 Except as provided by law or rule, the agency may not engage in

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3916 practices that favor one qualified plan over another.
3917 (3) After a recipient has enrolled in a qualified plan, the
3918 enrollee shall have 90 days to voluntarily disenroll and select
3919 another plan. After 90 days, no further changes may be made
3920 except for good cause. Good cause includes, but is not limited
3921 to, poor quality of care, lack of access to necessary specialty
3922 services, an unreasonable delay or denial of service, or
3923 fraudulent enrollment. The agency shall determine whether good
3924 cause exists. The agency may require an enrollee to use the
3925 plan's grievance process before the agency makes a determination
3926 of good cause, unless an immediate risk of permanent damage to
3927 the enrollee's health is alleged.
3928 (a) If used, the qualified plan's internal grievance
3929 process must be completed in time to allow the enrollee to
3930 disenroll by the first day of the second month after the month
3931 the disenrollment request was made. If the grievance process
3932 approves an enrollee's request to disenroll, the agency is not
3933 required to make a determination of good cause.
3934 (b) The agency must make a determination of good cause and
3935 take final action on an enrollee's request so that disenrollment
3936 occurs by the first day of the second month after the month the
3937 request was made. If the agency fails to act within this
3938 timeframe, the enrollee's request to disenroll is deemed
3939 approved as of the date agency action was required. Enrollees
3940 who disagree with the agency's finding that good cause for
3941 disenrollment does not exist shall be advised of their right to
3942 pursue a Medicaid fair hearing to dispute the agency's finding.
3943 (c) Medicaid recipients enrolled in a qualified plan after
3944 the 90-day period must remain in the plan for the remainder of

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3945 the 12-month period. After 12 months, the enrollee may select
3946 another plan. An enrollee may change primary care providers
3947 within the plan at any time.
3948 (d) On the first day of the next month after receiving
3949 notice from a recipient that the recipient has moved to another
3950 region, the agency shall automatically disenroll the recipient
3951 from the plan the recipient is currently enrolled in and treat
3952 the recipient as if the recipient is a new enrollee. At that
3953 time, the recipient may choose another plan pursuant to the
3954 enrollment process established in this section.
3955 Section 41. Section 409.970, Florida Statutes, is created
3956 to read:
3957 409.970 Medicaid Encounter Data System.—The agency shall
3958 maintain and operate the Medicaid Encounter Data System to
3959 collect, process, and report on covered services provided to all
3960 Medicaid recipients enrolled in qualified plans.
3961 (1) Qualified plans shall submit encounter data
3962 electronically in a format that complies with provisions of the
3963 federal Health Insurance Portability and Accountability Act for
3964 electronic claims and in accordance with deadlines established
3965 by the agency. Plans must certify that the data reported is
3966 accurate and complete. The agency is responsible for validating
3967 the data submitted by the plans.
3968 (2) The agency shall develop methods and protocols for
3969 ongoing analysis of the encounter data, which must adjust for
3970 differences in the characteristics of enrollees in order to
3971 allow for the comparison of service utilization among plans. The
3972 analysis shall be used to identify possible cases of systemic
3973 overutilization, underutilization, inappropriate denials of

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3974 claims, and inappropriate utilization of covered services, such
3975 as higher than expected emergency department and pharmacy
3976 encounters. One of the primary focus areas for the analysis
3977 shall be the use of prescription drugs.
3978 (3) The agency shall provide periodic feedback to the plans
3979 based on the analysis and establish corrective action plans if
3980 necessary.
3981 (4) The agency shall make encounter data available to plans
3982 accepting enrollees who are reassigned to them from other plans
3983 leaving a region.
3984 (5) Beginning July 1, 2011, the agency shall conduct
3985 appropriate tests and establish specific criteria for
3986 determining whether the Medicaid Encounter Data System has
3987 valid, complete, and sound data for a sufficient period of time
3988 to provide qualified plans with a reliable basis for determining
3989 and proposing actuarially sound payment rates.
3990 Section 42. Section 409.971, Florida Statutes, is created
3991 to read:
3992 409.971 Managed care medical assistance.—Pursuant to s.
3993 409.902, the agency shall administer the managed care medical
3994 assistance component of the Medicaid managed care program
3995 described in this section and s. 409.972. Unless otherwise
3996 specified, the provisions of ss. 409.961-409.970 apply to the
3997 provision of managed care medical assistance. By December 31,
3998 2011, the agency shall begin implementation of managed care
3999 medical assistance, and full implementation in all regions must
4000 be completed by December 31, 2012.
4001 Section 43. Section 409.972, Florida Statutes, is created
4002 to read:

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4003 409.972 Managed care medical assistance services.—
4004 (1) Qualified plans providing managed care medical
4005 assistance must, at a minimum, cover the following services:
4006 (a) Ambulatory patient services.
4007 (b) Dental services for a recipient who is under age 21.
4008 (c) Dental services as provided in s. 627.419(7) for a
4009 recipient who is 21 years of age or older.
4010 (d) Dialysis services.
4011 (e) Durable medical equipment and supplies.
4012 (f) Early periodic screening diagnosis and treatment
4013 services, hearing services and hearing aids, and vision services
4014 and eyeglasses for enrollees under age 21.
4015 (g) Emergency services.
4016 (h) Family planning services.
4017 (i) Hearing services for a recipient who is under age 21.
4018 (j) Hearing services that are medically indicated for a
4019 recipient who is 21 years of age or older.
4020 (k) Home health services.
4021 (l) Hospital inpatient services.
4022 (m) Hospital outpatient services.
4023 (n) Laboratory and imaging services.
4024 (o) Maternity and newborn care and birth center services.
4025 (p) Mental health services, substance abuse disorder
4026 services, and behavioral health treatment.
4027 (q) Prescription drugs.
4028 (r) Primary care service, referred specialty care services,
4029 preventive services, and wellness services.
4030 (s) Skilled nursing facility or inpatient rehabilitation
4031 facility services.

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4032 (t) Transplant services.
4033 (u) Transportation to access covered services.
4034 (v) Vision services for a recipient who is under age 21.
4035 (w) Vision services that are medically indicated for a
4036 recipient who is 21 years of age or older.
4037 (2) Subject to specific appropriations, the agency may make
4038 payments for services that are optional.
4039 (3) Qualified plans may customize benefit packages for
4040 nonpregnant adults, vary cost-sharing provisions, and provide
4041 coverage for additional services. The agency shall evaluate the
4042 proposed benefit packages to ensure that services are sufficient
4043 to meet the needs of the plans' enrollees and to verify
4044 actuarial equivalence.
4045 (4) For Medicaid recipients diagnosed with hemophilia who
4046 have been prescribed anti-hemophilic-factor replacement
4047 products, the agency shall provide for those products and
4048 hemophilia overlay services through the agency's hemophilia
4049 disease management program authorized under s. 409.912.
4050 (5) Managed care medical assistance services provided under
4051 this section must be medically necessary and provided in
4052 accordance with state and federal law. This section does not
4053 prevent the agency from adjusting fees, reimbursement rates,
4054 lengths of stay, number of visits, or number of services, or
4055 from making any other adjustments necessary to comply with the
4056 availability of funding and any limitations or directions
4057 provided in the General Appropriations Act, chapter 216, or s.
4058 409.9022.
4059 Section 44. Section 409.973, Florida Statutes, is created
4060 to read:

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4061 409.973 Managed long-term care.—
4062 (1) Qualified plans providing managed care medical
4063 assistance may also participate in the managed long-term care
4064 component of the Medicaid managed care program. Unless otherwise
4065 specified, the provisions of ss. 409.961-409.970 apply to the
4066 managed long-term care component of the managed care program.
4067 (2) Pursuant to s. 409.902, the agency shall administer the
4068 managed long-term care component described in this section and
4069 ss. 409.974-409.978, but may delegate specific duties and
4070 responsibilities to the Department of Elderly Affairs and other
4071 state agencies. By March 31, 2012, the agency shall begin
4072 implementation of the managed long-term care component, with
4073 full implementation in all regions by March 31, 2013.
4074 (3) The Department of Elderly Affairs shall assist the
4075 agency in developing specifications for use in the invitation to
4076 negotiate and the model contract, determining clinical
4077 eligibility for enrollment in managed long-term care plans,
4078 monitoring plan performance and measuring quality of service
4079 delivery, assisting clients and families in order to address
4080 complaints with the plans, facilitating working relationships
4081 between plans and providers serving elders and disabled adults,
4082 and performing other functions specified in a memorandum of
4083 agreement.
4084 Section 45. Section 409.974, Florida Statutes, is created
4085 to read:
4086 409.974 Recipient eligibility for managed long-term care.—
4087 (1) Medicaid recipients shall receive covered long-term
4088 care services through the managed long-term care component of
4089 the Medicaid managed care program unless excluded pursuant to s.

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4090 409.964. In order to participate in the managed long-term care
4091 component, the recipient must be:
4092 (a) Sixty-five years of age or older or eligible for
4093 Medicaid by reason of a disability; and
4094 (b) Determined by the Comprehensive Assessment Review and
4095 Evaluation for Long-Term Care Services (CARES) Program to meet
4096 the criteria for nursing facility care.
4097 (2) Medicaid recipients who are enrolled in one of the
4098 following Medicaid long-term care waiver programs on the date
4099 that a managed long-term care plan becomes available in the
4100 recipient's region may remain in that program if it is
4101 operational on that date:
4102 (a) The Assisted Living for the Frail Elderly Waiver.
4103 (b) The Aged and Disabled Adult Waiver.
4104 (c) The Adult Day Health Care Waiver.
4105 (d) The Consumer-Directed Care Program as described in s.
4106 409.221.
4107 (e) The Program of All-inclusive Care for the Elderly.
4108 (f) The Long-Term Care Community Diversion Pilot Project as
4109 described in s. 430.705.
4110 (g) The Channeling Services Waiver for Frail Elders.
4111 (3) If a long-term care waiver program in which the
4112 recipient is enrolled ceases to operate, the Medicaid recipient
4113 may transfer to another long-term care waiver program or to the
4114 Medicaid managed long-term care component of the Medicaid
4115 managed care program. If no waivers are operational in the
4116 recipient's region and the recipient continues to participate in
4117 Medicaid, the recipient must transfer to the managed long-term
4118 care component of the Medicaid managed care program.

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4119 (4) New enrollment in a waiver program ends on the date
4120 that a managed long-term care plan becomes available in a
4121 region.
4122 (5) Medicaid recipients who are residing in a nursing home
4123 facility on the date that a managed long-term care plan becomes
4124 available in the recipient's region are eligible for the long-
4125 term care Medicaid waiver programs.
4126 (6) This section does not create an entitlement to any home
4127 and community-based services provided under the managed long-
4128 term care component.
4129 Section 46. Section 409.975, Florida Statutes, is created
4130 to read:
4131 409.975 Managed long-term care services.—
4132 (1) Qualified plans participating in the managed long-term
4133 care component of the Medicaid managed care program, at a
4134 minimum, shall cover the following services:
4135 (a) The services listed in s. 409.972.
4136 (b) Nursing facility services.
4137 (c) Home and community-based services, including, but not
4138 limited to, assisted living facility services.
4139 (2) Services provided under this section must be medically
4140 necessary and provided in accordance with state and federal law.
4141 This section does not prevent the agency from adjusting fees,
4142 reimbursement rates, lengths of stay, number of visits, or
4143 number of services, or from making any other adjustments
4144 necessary to comply with the availability of funding and any
4145 limitations or directions provided in the General Appropriations
4146 Act, chapter 216, or s. 409.9022.
4147 Section 47. Section 409.976, Florida Statutes, is created

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4148 to read:
4149 409.976 Qualified managed long-term care plans.—
4150 (1) For purposes of managed long-term care, qualified plans
4151 also include:
4152 (a) Entities who are qualified under 42 C.F.R. part 422 as
4153 Medicare Advantage Preferred Provider Organizations, Medicare
4154 Advantage Provider-sponsored Organizations, and Medicare
4155 Advantage Special Needs Plans. Such plans may participate in the
4156 managed long-term care component. A plan submitting a response
4157 to the invitation to negotiate for the managed long-term care
4158 component may reference one or more of these entities as part of
4159 its demonstration of network adequacy for the provision of
4160 services required under s. 409.972 for dually eligible
4161 enrollees.
4162 (b) The Program of All-inclusive Care for the Elderly
4163 (PACE). Participation by PACE shall be pursuant to a contract
4164 with the agency and is not subject to the procurement
4165 requirements of this section. PACE plans may continue to provide
4166 services to recipients at such levels and enrollment caps as
4167 authorized by the General Appropriations Act.
4168 (2) The agency shall select qualified plans through the
4169 procurement described in s. 409.965. The agency shall notice the
4170 invitation to negotiate by November 14, 2011.
4171 (3) In addition to the criteria established in s. 409.965,
4172 the agency shall give preference to the following factors in
4173 selecting qualified plans:
4174 (a) The plan's employment of executive managers having
4175 expertise and experience in serving aged and disabled persons
4176 who require long-term care.

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4177 (b) The plan's establishment of a network of service
4178 providers dispersed throughout the region and in sufficient
4179 numbers to meet specific service standards established by the
4180 agency for a continuum of care, beginning from the provision of
4181 assistance with the activities of daily living at a recipient's
4182 home and the provision of other home and community-based care
4183 through the provision of nursing home care. These providers
4184 include:
4185 1. Adult day centers.
4186 2. Adult family care homes.
4187 3. Assisted living facilities.
4188 4. Health care services pools.
4189 5. Home health agencies.
4190 6. Homemaker and companion services.
4191 7. Community Care for the Elderly lead agencies.
4192 8. Nurse registries.
4193 9. Nursing homes.
4194
4195 All providers are not required to be located within the region;
4196 however, the provider network must be sufficient to ensure that
4197 services are available throughout the region.
4198 (c) Whether a plan offers consumer-directed care services
4199 to enrollees pursuant to s. 409.221 or includes attendant care
4200 or paid family caregivers in the benefit package. Consumer-
4201 directed care services must provide a flexible budget, which is
4202 managed by enrollees and their families or representatives, and
4203 allows them to choose service providers, determine provider
4204 rates of payment, and direct the delivery of services to best
4205 meet their special long-term care needs. If all other factors

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4206 are equal among competing qualified plans, the agency shall give
4207 preference to such plans.
4208 (d) Evidence that a qualified plan has written agreements
4209 or signed contracts or has made substantial progress in
4210 establishing relationships with providers before the plan
4211 submits a response.
4212 (e) The availability and accessibility of case managers in
4213 the plan and provider network.
4214 Section 48. Section 409.977, Florida Statutes, is created
4215 to read:
4216 409.977 Managed long-term plan and provider
4217 accountability.—In addition to the requirements of ss. 409.966
4218 and 409.967, plans and providers participating in managed long-
4219 term care must comply with s. 641.31(25) and with the specific
4220 standards established by the agency for the number, type, and
4221 regional distribution of the following providers in the plan's
4222 network, which must include:
4223 (1) Adult day centers.
4224 (2) Adult family care homes.
4225 (3) Assisted living facilities.
4226 (4) Health care services pools.
4227 (5) Home health agencies.
4228 (6) Homemaker and companion services.
4229 (7) Community Care for the Elderly lead agencies.
4230 (8) Nurse registries.
4231 (9) Nursing homes.
4232 Section 49. Section 409.978, Florida Statutes, is created
4233 to read:
4234 409.978 CARES program screening; levels of care.—

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4235 (1) The agency shall operate the Comprehensive Assessment
4236 and Review for Long-Term Care Services (CARES) preadmission
4237 screening program to ensure that only recipients whose
4238 conditions require long-term care services are enrolled in
4239 managed long-term care plans.
4240 (2) The agency shall operate the CARES program through an
4241 interagency agreement with the Department of Elderly Affairs.
4242 The agency, in consultation with the department, may contract
4243 for any function or activity of the CARES program, including any
4244 function or activity required by 42 C.F.R. part 483.20, relating
4245 to preadmission screening and review.
4246 (3) The CARES program shall determine if a recipient
4247 requires nursing facility care and, if so, assign the recipient
4248 to one of the following levels of care:
4249 (a) Level of care 1 consists of enrollees who require the
4250 constant availability of routine medical and nursing treatment
4251 and care, have a limited need for health-related care and
4252 services, are mildly medically or physically incapacitated, and
4253 cannot be managed at home due to inadequacy of home-based
4254 services.
4255 (b) Level of care 2 consists of enrollees who require the
4256 constant availability of routine medical and nursing treatment
4257 and care, and require extensive health-related care and services
4258 because of mental or physical incapacitation. Current enrollees
4259 in home and community-based waiver programs for persons who are
4260 elderly or adults with physical disability, or both, who remain
4261 financially eligible for Medicaid are not required to meet new
4262 level-of-care criteria except for immediate placement in a
4263 nursing home.

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4264 (c) Level of care 3 consists of enrollees residing in
4265 nursing homes, or needing immediate placement in a nursing home,
4266 and who have a priority score of 5 or above as determined by
4267 CARES.
4268 (4) For recipients whose nursing home stay is initially
4269 funded by Medicare and Medicare coverage is being terminated for
4270 lack of progress towards rehabilitation, CARES staff shall
4271 consult with the person determining the recipient's progress
4272 toward rehabilitation in order to ensure that the recipient is
4273 not being inappropriately disqualified from Medicare coverage.
4274 If, in their professional judgment, CARES staff believes that a
4275 Medicare beneficiary is still making progress, they may assist
4276 the Medicare beneficiary with appealing the disqualification
4277 from Medicare coverage. The CARES teams may review Medicare
4278 denials for coverage under this section only if it is determined
4279 that such reviews qualify for federal matching funds through
4280 Medicaid. The agency shall seek or amend federal waivers as
4281 necessary to implement this section.
4282 Section 50. Section 409.91207, Florida Statutes, is
4283 transferred, renumbered as section 409.985, Florida Statutes,
4284 and subsection (1) of that section is amended to read:
4285 409.985 ~~409.91207~~ Medical home pilot project.—
4286 (1) The agency shall develop a plan to implement a medical
4287 home pilot project that uses ~~utilizes~~ primary care case
4288 management enhanced by medical home networks to provide
4289 coordinated and cost-effective care that is reimbursed on a fee-
4290 for-service basis and to compare the performance of the medical
4291 home networks with other existing Medicaid managed care models.
4292 The agency may ~~is authorized to~~ seek a federal Medicaid waiver

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4293 or an amendment to any existing Medicaid waiver, except for the
4294 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,
4295 as needed, to develop the pilot project created in this section
4296 but must obtain approval of the Legislature before ~~prior to~~
4297 implementing the pilot project.
4298 Section 51. Section 409.91211, Florida Statutes, is
4299 transferred, renumbered as section 409.986, Florida Statutes,
4300 and paragraph (aa) of subsection (3) and paragraph (a) of
4301 subsection (4) of that section are amended, to read:
4302 409.986 ~~409.91211~~ Medicaid managed care pilot program.—
4303 (3) The agency shall have the following powers, duties, and
4304 responsibilities with respect to the pilot program:
4305 (aa) To implement a mechanism whereby Medicaid recipients
4306 who are already enrolled in a managed care plan or the MediPass
4307 program in the pilot areas are ~~shall be~~ offered the opportunity
4308 to change to capitated managed care plans on a staggered basis,
4309 as defined by the agency. All Medicaid recipients shall have 30
4310 days in which to make a choice of capitated managed care plans.
4311 Those Medicaid recipients who do not make a choice shall be
4312 assigned to a capitated managed care plan in accordance with
4313 paragraph (4)(a) and shall be exempt from s. 409.987 ~~409.9122~~.
4314 To facilitate continuity of care for a Medicaid recipient who is
4315 also a recipient of Supplemental Security Income (SSI), prior to
4316 assigning the SSI recipient to a capitated managed care plan,
4317 the agency shall determine whether the SSI recipient has an
4318 ongoing relationship with a provider or capitated managed care
4319 plan, and, if so, the agency shall assign the SSI recipient to
4320 that provider or capitated managed care plan where feasible.
4321 Those SSI recipients who do not have such a provider

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4322 relationship shall be assigned to a capitated managed care plan
4323 provider in accordance with paragraph (4)(a) and shall be exempt
4324 from s. 409.987 ~~409.9122~~.
4325 (4)(a) A Medicaid recipient in the pilot area who is not
4326 currently enrolled in a capitated managed care plan upon
4327 implementation is not eligible for services as specified in ss.
4328 409.905 and 409.906, for the amount of time that the recipient
4329 does not enroll in a capitated managed care network. If a
4330 Medicaid recipient has not enrolled in a capitated managed care
4331 plan within 30 days after eligibility, the agency shall assign
4332 the Medicaid recipient to a capitated managed care plan based on
4333 the assessed needs of the recipient as determined by the agency
4334 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When
4335 making assignments, the agency shall take into account the
4336 following criteria:
4337 1. A capitated managed care network has sufficient network
4338 capacity to meet the needs of members.
4339 2. The capitated managed care network has previously
4340 enrolled the recipient as a member, or one of the capitated
4341 managed care network's primary care providers has previously
4342 provided health care to the recipient.
4343 3. The agency has knowledge that the member has previously
4344 expressed a preference for a particular capitated managed care
4345 network as indicated by Medicaid fee-for-service claims data,
4346 but has failed to make a choice.
4347 4. The capitated managed care network's primary care
4348 providers are geographically accessible to the recipient's
4349 residence.
4350 Section 52. Section 409.9122, Florida Statutes, is

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4351 transferred, renumbered as section 409.987, and paragraph (a) of
4352 subsection (2) of that section is amended to read:
4353 409.987 ~~409.9122~~ Mandatory Medicaid managed care
4354 enrollment; programs and procedures.—
4355 (2)(a) The agency shall enroll all Medicaid recipients in a
4356 managed care plan or MediPass ~~all Medicaid recipients~~, except
4357 ~~those Medicaid~~ recipients who are~~:~~ in an institution, receiving
4358 a Medicaid nonpoverty medical subsidy,~~; enrolled in the Medicaid~~
4359 ~~medically needy Program;~~ or eligible for both Medicaid and
4360 Medicare. Upon enrollment, recipients may ~~individuals will be~~
4361 ~~able to~~ change their managed care option during the 90-day opt
4362 out period required by federal Medicaid regulations. The agency
4363 may ~~is authorized to~~ seek the necessary Medicaid state plan
4364 amendment to implement this policy. ~~However, to the extent~~
4365 1. If permitted by federal law, the agency may enroll ~~in a~~
4366 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
4367 from mandatory managed care enrollment in a managed care plan or
4368 MediPass if~~, provided that~~:
4369 a.~~1.~~ The recipient's decision to enroll in a managed care
4370 plan or MediPass is voluntary;
4371 b.~~2.~~ ~~If~~ The recipient chooses to enroll in a managed care
4372 plan, the agency has determined that the ~~managed care~~ plan
4373 provides specific programs and services that ~~which~~ address the
4374 special health needs of the recipient; and
4375 c.~~3.~~ The agency receives the ~~any~~ necessary waivers from the
4376 federal Centers for Medicare and Medicaid Services.
4377 2. The agency shall develop rules to establish policies by
4378 which exceptions to the mandatory managed care enrollment
4379 requirement may be made on a case-by-case basis. The rules must

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4380 ~~shall~~ include the specific criteria to be applied when
4381 determining ~~making a determination as to~~ whether to exempt a
4382 recipient from mandatory enrollment ~~in a managed care plan or~~
4383 ~~MediPass~~.
4384 3. School districts participating in the certified school
4385 match program pursuant to ss. 409.908(21) and 1011.70 shall be
4386 reimbursed by Medicaid, subject to the limitations of s.
4387 1011.70(1), for a Medicaid-eligible child participating in the
4388 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
4389 409.9071, regardless of whether the child is enrolled in
4390 MediPass or a managed care plan. Managed care plans must ~~shall~~
4391 make a good faith effort to execute agreements with school
4392 districts regarding the coordinated provision of services
4393 authorized under s. 1011.70.
4394 4. County health departments delivering school-based
4395 services pursuant to ss. 381.0056 and 381.0057 shall be
4396 reimbursed by Medicaid for the federal share for a Medicaid-
4397 eligible child who receives Medicaid-covered services in a
4398 school setting, regardless of whether the child is enrolled in
4399 MediPass or a managed care plan. Managed care plans shall make a
4400 good faith effort to execute agreements with county health
4401 departments that coordinate the ~~regarding the coordinated~~
4402 provision of services to a Medicaid-eligible child. To ensure
4403 continuity of care for Medicaid patients, the agency, the
4404 Department of Health, and the Department of Education shall
4405 develop procedures for ensuring that a student's managed care
4406 plan or MediPass provider receives information relating to
4407 services provided in accordance with ss. 381.0056, 381.0057,
4408 409.9071, and 1011.70.

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4409 Section 53. Section 409.9123, Florida Statutes, is
4410 transferred and renumbered as section 409.988, Florida Statutes.
4411 Section 54. Section 409.9124, Florida Statutes, is
4412 transferred and renumbered as section 409.989.
4413 Section 55. Subsection (15) of section 430.04, Florida
4414 Statutes, is amended to read:
4415 430.04 Duties and responsibilities of the Department of
4416 Elderly Affairs.—The Department of Elderly Affairs shall:
4417 (15) Administer all Medicaid waivers and programs relating
4418 to elders and their appropriations. The waivers include, but are
4419 not limited to:
4420 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
4421 ~~established in s. 430.502(7), (8), and (9).~~
4422 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.
4423 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.
4424 (c) ~~(d)~~ The Adult Day Health Care Waiver.
4425 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined
4426 in s. 409.221.
4427 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.
4428 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
4429 Project as described in s. 430.705.
4430 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
4431
4432 The department shall develop a transition plan for recipients
4433 receiving services under long-term care Medicaid waivers for
4434 elders or disabled adults on the date qualified plans become
4435 available in each recipient's region pursuant to s. 409.973(2)
4436 in order to enroll those recipients in qualified plans.
4437 Section 56. Section 430.2053, Florida Statutes, is amended

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4438 to read:
4439 430.2053 Aging resource centers.—
4440 (1) The department, in consultation with the Agency for
4441 Health Care Administration and the Department of Children and
4442 Family Services, shall develop pilot projects for aging resource
4443 centers. ~~By October 31, 2004, the department, in consultation~~
4444 ~~with the agency and the Department of Children and Family~~
4445 ~~Services, shall develop an implementation plan for aging~~
4446 ~~resource centers and submit the plan to the Governor, the~~
4447 ~~President of the Senate, and the Speaker of the House of~~
4448 ~~Representatives. The plan must include qualifications for~~
4449 ~~designation as a center, the functions to be performed by each~~
4450 ~~center, and a process for determining that a current area agency~~
4451 ~~on aging is ready to assume the functions of an aging resource~~
4452 ~~center.~~
4453 ~~(2) Each area agency on aging shall develop, in~~
4454 ~~consultation with the existing community care for the elderly~~
4455 ~~lead agencies within their planning and service areas, a~~
4456 ~~proposal that describes the process the area agency on aging~~
4457 ~~intends to undertake to transition to an aging resource center~~
4458 ~~prior to July 1, 2005, and that describes the area agency's~~
4459 ~~compliance with the requirements of this section. The proposals~~
4460 ~~must be submitted to the department prior to December 31, 2004.~~
4461 ~~The department shall evaluate all proposals for readiness and,~~
4462 ~~prior to March 1, 2005, shall select three area agencies on~~
4463 ~~aging which meet the requirements of this section to begin the~~
4464 ~~transition to aging resource centers. Those area agencies on~~
4465 ~~aging which are not selected to begin the transition to aging~~
4466 ~~resource centers shall, in consultation with the department and~~

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4467 ~~the existing community care for the elderly lead agencies within~~
4468 ~~their planning and service areas, amend their proposals as~~
4469 ~~necessary and resubmit them to the department prior to July 1,~~
4470 ~~2005. The department may transition additional area agencies to~~
4471 ~~aging resource centers as it determines that area agencies are~~
4472 ~~in compliance with the requirements of this section.~~
4473 ~~(3) The Auditor General and the Office of Program Policy~~
4474 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
4475 ~~review and assess the department's process for determining an~~
4476 ~~area agency's readiness to transition to an aging resource~~
4477 ~~center.~~
4478 ~~(a) The review must, at a minimum, address the~~
4479 ~~appropriateness of the department's criteria for selection of an~~
4480 ~~area agency to transition to an aging resource center, the~~
4481 ~~instruments applied, the degree to which the department~~
4482 ~~accurately determined each area agency's compliance with the~~
4483 ~~readiness criteria, the quality of the technical assistance~~
4484 ~~provided by the department to an area agency in correcting any~~
4485 ~~weaknesses identified in the readiness assessment, and the~~
4486 ~~degree to which each area agency overcame any identified~~
4487 ~~weaknesses.~~
4488 ~~(b) Reports of these reviews must be submitted to the~~
4489 ~~appropriate substantive and appropriations committees in the~~
4490 ~~Senate and the House of Representatives on March 1 and September~~
4491 ~~1 of each year until full transition to aging resource centers~~
4492 ~~has been accomplished statewide, except that the first report~~
4493 ~~must be submitted by February 1, 2005, and must address all~~
4494 ~~readiness activities undertaken through December 31, 2004. The~~
4495 ~~perspectives of all participants in this review process must be~~

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4496 ~~included in each report.~~
4497 (2) ~~(4)~~ The purposes of an aging resource center are ~~shall~~
4498 ~~be~~:
4499 (a) To provide Florida's elders and their families with a
4500 locally focused, coordinated approach to integrating information
4501 and referral for all available services for elders with the
4502 eligibility determination entities for state and federally
4503 funded long-term-care services.
4504 (b) To provide for easier access to long-term-care services
4505 by Florida's elders and their families by creating multiple
4506 access points to the long-term-care network that flow through
4507 one established entity with wide community recognition.
4508 (3) ~~(5)~~ The duties of an aging resource center are to:
4509 (a) Develop referral agreements with local community
4510 service organizations, such as senior centers, existing elder
4511 service providers, volunteer associations, and other similar
4512 organizations, to better assist clients who do not need or do
4513 not wish to enroll in programs funded by the department or the
4514 agency. The referral agreements must also include a protocol,
4515 developed and approved by the department, which provides
4516 specific actions that an aging resource center and local
4517 community service organizations must take when an elder or an
4518 elder's representative seeking information on long-term-care
4519 services contacts a local community service organization prior
4520 to contacting the aging resource center. The protocol shall be
4521 designed to ensure that elders and their families are able to
4522 access information and services in the most efficient and least
4523 cumbersome manner possible.
4524 (b) Provide an initial screening of all clients who request

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4525 long-term-care services to determine whether the person would be
4526 most appropriately served through any combination of federally
4527 funded programs, state-funded programs, locally funded or
4528 community volunteer programs, or private funding for services.
4529 (c) Determine eligibility for the programs and services
4530 listed in subsection (9) ~~(11)~~ for persons residing within the
4531 geographic area served by the aging resource center and
4532 determine a priority ranking for services which is based upon
4533 the potential recipient's frailty level and likelihood of
4534 institutional placement without such services.
4535 (d) Manage the availability of financial resources for the
4536 programs and services listed in subsection (9) ~~(11)~~ for persons
4537 residing within the geographic area served by the aging resource
4538 center.
4539 (e) If ~~When~~ financial resources become available, refer a
4540 client to the most appropriate entity to begin receiving
4541 services. The aging resource center shall make referrals to lead
4542 agencies for service provision that ensure that individuals who
4543 are vulnerable adults in need of services pursuant to s.
4544 415.104(3)(b), or who are victims of abuse, neglect, or
4545 exploitation in need of immediate services to prevent further
4546 harm and are referred by the adult protective services program,
4547 are given primary consideration for receiving community-care-
4548 for-the-elderly services in compliance with the requirements of
4549 s. 430.205(5)(a) and that other referrals for services are in
4550 compliance with s. 430.205(5)(b).
4551 (f) Convene a work group to advise in the planning,
4552 implementation, and evaluation of the aging resource center. The
4553 work group shall be composed ~~comprised~~ of representatives of

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4554 local service providers, Alzheimer's Association chapters,
4555 housing authorities, social service organizations, advocacy
4556 groups, representatives of clients receiving services through
4557 the aging resource center, and ~~any~~ other persons or groups as
4558 determined by the department. The aging resource center, in
4559 consultation with the work group, must develop annual program
4560 improvement plans that shall be submitted to the department for
4561 consideration. The department shall review each annual
4562 improvement plan and make recommendations on how to implement
4563 the components of the plan.
4564 (g) Enhance the existing area agency on aging in each
4565 planning and service area by integrating, ~~either~~ physically or
4566 virtually, the staff and services of the area agency on aging
4567 with the staff of the department's local CARES Medicaid ~~nursing~~
4568 ~~home~~ preadmission screening unit and a sufficient number of
4569 staff from the Department of Children and Family Services'
4570 Economic Self-Sufficiency Unit necessary to determine the
4571 financial eligibility for all persons age 60 and older residing
4572 within the area served by the aging resource center who ~~that~~ are
4573 seeking Medicaid services, Supplemental Security Income, and
4574 food assistance.
4575 (h) Assist clients who request long-term care services in
4576 being evaluated for eligibility for the long-term care managed
4577 care component of the Medicaid managed care program as qualified
4578 plans become available in each of the regions pursuant to s.
4579 409.973(2).
4580 (i) Provide enrollment and coverage information to Medicaid
4581 managed long-term care enrollees as qualified plans become
4582 available in each of the regions pursuant to s. 409.973(2).

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4583 (j) Assist enrollees in the Medicaid long-term care managed
4584 care program with informally resolving grievances with a managed
4585 care network and in accessing the managed care network's formal
4586 grievance process as qualified plans become available in each of
4587 the regions pursuant to s. 409.973(2).
4588 (4) ~~(6)~~ The department shall select the entities to become
4589 aging resource centers based on each entity's readiness and
4590 ability to perform the duties listed in subsection (3) ~~(5)~~ and
4591 the entity's:
4592 (a) Expertise in the needs of each target population the
4593 center proposes to serve and a thorough knowledge of the
4594 providers that serve these populations.
4595 (b) Strong connections to service providers, volunteer
4596 agencies, and community institutions.
4597 (c) Expertise in information and referral activities.
4598 (d) Knowledge of long-term-care resources, including
4599 resources designed to provide services in the least restrictive
4600 setting.
4601 (e) Financial solvency and stability.
4602 (f) Ability to collect, monitor, and analyze data in a
4603 timely and accurate manner, along with systems that meet the
4604 department's standards.
4605 (g) Commitment to adequate staffing by qualified personnel
4606 to effectively perform all functions.
4607 (h) Ability to meet all performance standards established
4608 by the department.
4609 (5) ~~(7)~~ The aging resource center shall have a governing
4610 body which shall be the same entity described in s. 20.41(7),
4611 and an executive director who may be the same person as

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4612 described in s. 20.41(7). The governing body shall annually
4613 evaluate the performance of the executive director.
4614 (6) ~~(8)~~ The aging resource center may not be a provider of
4615 direct services other than information and referral services,
4616 and screening.
4617 (7) ~~(9)~~ The aging resource center must agree to allow the
4618 department to review any financial information the department
4619 determines is necessary for monitoring or reporting purposes,
4620 including financial relationships.
4621 (8) ~~(10)~~ The duties and responsibilities of the community
4622 care for the elderly lead agencies within each area served by an
4623 aging resource center shall be to:
4624 (a) Develop strong community partnerships to maximize the
4625 use of community resources for the purpose of assisting elders
4626 to remain in their community settings for as long as it is
4627 safely possible.
4628 (b) Conduct comprehensive assessments of clients that have
4629 been determined eligible and develop a care plan consistent with
4630 established protocols that ensures that the unique needs of each
4631 client are met.
4632 (9) ~~(11)~~ The services to be administered through the aging
4633 resource center shall include those funded by the following
4634 programs:
4635 (a) Community care for the elderly.
4636 (b) Home care for the elderly.
4637 (c) Contracted services.
4638 (d) Alzheimer’s disease initiative.
4639 (e) Aged and disabled adult Medicaid waiver.
4640 (f) Assisted living for the frail elderly Medicaid waiver.

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4641 (g) Older Americans Act.
4642 (10) ~~(12)~~ The department shall, prior to designation of an
4643 aging resource center, develop by rule operational and quality
4644 assurance standards and outcome measures to ensure that clients
4645 receiving services through all long-term-care programs
4646 administered through an aging resource center are receiving the
4647 appropriate care they require and that contractors and
4648 subcontractors are adhering to the terms of their contracts and
4649 are acting in the best interests of the clients they are
4650 serving, consistent with the intent of the Legislature to reduce
4651 the use of and cost of nursing home care. The department shall
4652 by rule provide operating procedures for aging resource centers,
4653 which shall include:
4654 (a) Minimum standards for financial operation, including
4655 audit procedures.
4656 (b) Procedures for monitoring and sanctioning of service
4657 providers.
4658 (c) Minimum standards for technology utilized by the aging
4659 resource center.
4660 (d) Minimum staff requirements which shall ensure that the
4661 aging resource center employs sufficient quality and quantity of
4662 staff to adequately meet the needs of the elders residing within
4663 the area served by the aging resource center.
4664 (e) Minimum accessibility standards, including hours of
4665 operation.
4666 (f) Minimum oversight standards for the governing body of
4667 the aging resource center to ensure its continuous involvement
4668 in, and accountability for, all matters related to the
4669 development, implementation, staffing, administration, and

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4670 operations of the aging resource center.
4671 (g) Minimum education and experience requirements for
4672 executive directors and other executive staff positions of aging
4673 resource centers.
4674 (h) Minimum requirements regarding any executive staff
4675 positions that the aging resource center must employ and minimum
4676 requirements that a candidate must meet in order to be eligible
4677 for appointment to such positions.
4678 (11) ~~(13)~~ In an area in which the department has designated
4679 an area agency on aging as an aging resource center, the
4680 department and the agency may ~~shall~~ not make payments for the
4681 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
4682 Community Diversion Project for ~~such~~ persons who were not
4683 screened and enrolled through the aging resource center. The
4684 department shall cease making these payments for enrollees in
4685 qualified plans as qualified plans become available in each of
4686 the regions pursuant to s. 409.973(2).
4687 (12) ~~(14)~~ Each aging resource center shall enter into a
4688 memorandum of understanding with the department for
4689 collaboration with the CARES unit staff. The memorandum of
4690 understanding must ~~shall~~ outline the staff person responsible
4691 for each function and ~~shall~~ provide the staffing levels
4692 necessary to carry out the functions of the aging resource
4693 center.
4694 (13) ~~(15)~~ Each aging resource center shall enter into a
4695 memorandum of understanding with the Department of Children and
4696 Family Services for collaboration with the Economic Self-
4697 Sufficiency Unit staff. The memorandum of understanding must
4698 ~~shall~~ outline which staff persons are responsible for which

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4699 functions and ~~shall~~ provide the staffing levels necessary to
4700 carry out the functions of the aging resource center.
4701 (14) ~~(16)~~ If any of the state activities described in this
4702 section are outsourced, ~~either~~ in part or in whole, the contract
4703 executing the outsourcing must ~~shall~~ mandate that the contractor
4704 or its subcontractors shall, ~~either~~ physically or virtually,
4705 execute the provisions of the memorandum of understanding
4706 instead of the state entity whose function the contractor or
4707 subcontractor now performs.
4708 (15) ~~(17)~~ In order to be eligible to begin transitioning to
4709 an aging resource center, an area agency on aging board must
4710 ensure that the area agency on aging which it oversees meets all
4711 of the minimum requirements set by law and in rule.
4712 ~~(18) The department shall monitor the three initial~~
4713 ~~projects for aging resource centers and report on the progress~~
4714 ~~of those projects to the Governor, the President of the Senate,~~
4715 ~~and the Speaker of the House of Representatives by June 30,~~
4716 ~~2005. The report must include an evaluation of the~~
4717 ~~implementation process.~~
4718 (16) ~~(19)~~(a) Once an aging resource center is operational,
4719 the department, in consultation with the agency, may develop
4720 capitation rates for any of the programs administered through
4721 the aging resource center. Capitation rates for programs must
4722 ~~shall~~ be based on the historical cost experience of the state in
4723 providing those same services to the population age 60 or older
4724 residing within each area served by an aging resource center.
4725 Each capitated rate may vary by geographic area as determined by
4726 the department.
4727 (b) The department and the agency may determine for each

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4728 area served by an aging resource center whether it is
4729 appropriate, consistent with federal and state laws and
4730 regulations, to develop and pay separate capitated rates for
4731 each program administered through the aging resource center or
4732 to develop and pay capitated rates for service packages which
4733 include more than one program or service administered through
4734 the aging resource center.
4735 (c) Once capitation rates have been developed and certified
4736 as actuarially sound, the department and the agency may pay
4737 service providers the capitated rates for services if ~~when~~
4738 appropriate.
4739 (d) The department, in consultation with the agency, shall
4740 annually reevaluate and recertify the capitation rates,
4741 adjusting forward to account for inflation, programmatic
4742 changes.
4743 ~~(20) The department, in consultation with the agency, shall~~
4744 ~~submit to the Governor, the President of the Senate, and the~~
4745 ~~Speaker of the House of Representatives, by December 1, 2006, a~~
4746 ~~report addressing the feasibility of administering the following~~
4747 ~~services through aging resource centers beginning July 1, 2007:~~
4748 ~~(a) Medicaid nursing home services.~~
4749 ~~(b) Medicaid transportation services.~~
4750 ~~(c) Medicaid hospice care services.~~
4751 ~~(d) Medicaid intermediate care services.~~
4752 ~~(e) Medicaid prescribed drug services.~~
4753 ~~(f) Medicaid assistive care services.~~
4754 ~~(g) Any other long-term-care program or Medicaid service.~~
4755 (17) ~~(21)~~ This section does ~~shall~~ not ~~be construed to~~ allow
4756 an aging resource center to restrict, manage, or impede the

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4757 local fundraising activities of service providers.
4758 Section 57. Paragraphs (c) and (d) of subsection (3) of
4759 section 39.407, Florida Statutes, are amended to read:
4760 39.407 Medical, psychiatric, and psychological examination
4761 and treatment of child; physical, mental, or substance abuse
4762 examination of person with or requesting child custody.—
4763 (3)
4764 (c) Except as provided in paragraphs (b) and (e), the
4765 department must file a motion seeking the court's authorization
4766 to initially provide or continue to provide psychotropic
4767 medication to a child in its legal custody. The motion must be
4768 supported by a written report prepared by the department which
4769 describes the efforts made to enable the prescribing physician
4770 to obtain express and informed consent to provide ~~for providing~~
4771 the medication to the child and other treatments considered or
4772 recommended for the child. ~~In addition,~~ The motion must also be
4773 supported by the prescribing physician's signed medical report
4774 providing:
4775 1. The name of the child, the name and range of the dosage
4776 of the psychotropic medication, and the ~~that there is a~~ need to
4777 prescribe psychotropic medication to the child based upon a
4778 diagnosed condition for which such medication is being
4779 prescribed.
4780 2. A statement indicating that the physician has reviewed
4781 all medical information concerning the child which has been
4782 provided.
4783 3. A statement indicating that the psychotropic medication,
4784 at its prescribed dosage, is appropriate for treating the
4785 child's diagnosed medical condition, as well as the behaviors

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4786 and symptoms the medication, at its prescribed dosage, is
4787 expected to address.
4788 4. An explanation of the nature and purpose of the
4789 treatment; the recognized side effects, risks, and
4790 contraindications of the medication; drug-interaction
4791 precautions; the possible effects of stopping the medication;
4792 and how the treatment will be monitored, followed by a statement
4793 indicating that this explanation was provided to the child if
4794 age appropriate and to the child's caregiver.
4795 5. Documentation addressing whether the psychotropic
4796 medication will replace or supplement any other currently
4797 prescribed medications or treatments; the length of time the
4798 child is expected to be taking the medication; and any
4799 additional medical, mental health, behavioral, counseling, or
4800 other services that the prescribing physician recommends.
4801 6. For a child 10 years of age or younger who is in an out-
4802 of-home placement, the results of a review of the administration
4803 of the medication by a child psychiatrist who is licensed under
4804 chapter 458 or chapter 459. The review must be provided to the
4805 child and the parent or legal guardian before final express and
4806 informed consent is given. The review must include a
4807 determination of the following:
4808 a. The presence of a genetic psychiatric disorder or a
4809 family history of a psychiatric disorder;
4810 b. Whether the cause of a psychiatric disorder is physical
4811 or environmental; and
4812 c. The likelihood of the child being an imminent danger to
4813 self or others.
4814 (d)~~1.~~ The department must notify all parties of the

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4815 proposed action taken under paragraph (c) in writing or by
4816 whatever other method best ensures that all parties receive
4817 notification of the proposed action within 48 hours after the
4818 motion is filed. If any party objects to the department's
4819 motion, that party shall file the objection within 2 working
4820 days after being notified of the department's motion. If any
4821 party files an objection to the authorization of the proposed
4822 psychotropic medication, the court shall hold a hearing as soon
4823 as possible before authorizing the department to initially
4824 provide or to continue providing psychotropic medication to a
4825 child in the legal custody of the department.
4826 1. At such hearing and notwithstanding s. 90.803, the
4827 medical report described in paragraph (c) is admissible in
4828 evidence. The prescribing physician need not attend the hearing
4829 or testify unless the court specifically orders such attendance
4830 or testimony, or a party subpoenas the physician to attend the
4831 hearing or provide testimony.
4832 2. If, after considering any testimony received, the court
4833 finds that the department's motion and the physician's medical
4834 report meet the requirements of this subsection and that it is
4835 in the child's best interests, the court may order that the
4836 department provide or continue to provide the psychotropic
4837 medication to the child without additional testimony or
4838 evidence.
4839 3. At any hearing held under this paragraph, the court
4840 shall ~~further~~ inquire of the department as to whether additional
4841 medical, mental health, behavioral, counseling, or other
4842 services are being provided to the child by the department which
4843 the prescribing physician considers to be necessary or

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4844 beneficial in treating the child's medical condition and which
4845 the physician recommends or expects to provide to the child in
4846 concert with the medication. The court may order additional
4847 medical consultation, including consultation with the MedConsult
4848 line at the University of Florida, if available, or require the
4849 department to obtain a second opinion within a reasonable
4850 timeframe as established by the court, not to exceed 21 calendar
4851 days, ~~after such order~~ based upon consideration of the best
4852 interests of the child. The department must make a referral for
4853 an appointment for a second opinion with a physician within 1
4854 working day.
4855 4. The court may not order the discontinuation of
4856 prescribed psychotropic medication if such order is contrary to
4857 the decision of the prescribing physician unless the court first
4858 obtains an opinion from a licensed psychiatrist, if available,
4859 or, if not available, a physician licensed under chapter 458 or
4860 chapter 459, stating that more likely than not, discontinuing
4861 the medication would not cause significant harm to the child.
4862 If, however, the prescribing psychiatrist specializes in mental
4863 health care for children and adolescents, the court may not
4864 order the discontinuation of prescribed psychotropic medication
4865 unless the required opinion is also from a psychiatrist who
4866 specializes in mental health care for children and adolescents.
4867 The court may also order the discontinuation of prescribed
4868 psychotropic medication if a child's treating physician,
4869 licensed under chapter 458 or chapter 459, states that
4870 continuing the prescribed psychotropic medication would cause
4871 significant harm to the child due to a diagnosed nonpsychiatric
4872 medical condition.

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4873 5. If a child who is in out-of-home placement is 10 years
4874 of age or younger, psychotropic medication may not be authorized
4875 by the court absent a finding of a compelling governmental
4876 interest. In making such finding, the court shall review the
4877 psychiatric review described in subparagraph (c)6.
4878 6.~~2.~~ The burden of proof at any hearing held under this
4879 paragraph shall be by a preponderance of the evidence.
4880 Section 58. Paragraph (a) of subsection (1) of section
4881 216.262, Florida Statutes, is amended to read:
4882 216.262 Authorized positions.—
4883 (1)(a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by
4884 law, the total number of authorized positions may not exceed the
4885 total provided in the appropriations acts. If a ~~In the event any~~
4886 state agency or entity of the judicial branch finds that the
4887 number of positions so provided is not sufficient to administer
4888 its authorized programs, it may file an application with the
4889 Executive Office of the Governor or the Chief Justice~~;~~ and, if
4890 the Executive Office of the Governor or Chief Justice certifies
4891 that there are no authorized positions available for addition,
4892 deletion, or transfer within the agency or entity as provided in
4893 paragraph (c), may recommend ~~and recommends~~ an increase in the
4894 number of positions.~~,~~
4895 1. The Governor or the Chief Justice may recommend an
4896 increase in the number of positions for the following reasons
4897 only:
4898 a.~~1.~~ To implement or provide for continuing federal grants
4899 or changes in grants not previously anticipated.
4900 b.~~2.~~ To meet emergencies pursuant to s. 252.36.
4901 c.~~3.~~ To satisfy new federal regulations or changes therein.

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4902 d.~~4.~~ To take advantage of opportunities to reduce operating
4903 expenditures or to increase the revenues of the state or local
4904 government.
4905 e.~~5.~~ To authorize positions that were not fixed by the
4906 Legislature due to ~~through~~ error in drafting the appropriations
4907 acts.
4908 2. Actions recommended pursuant to this paragraph are
4909 subject to approval by the Legislative Budget Commission. The
4910 certification and the final authorization shall be provided to
4911 the Legislative Budget Commission, the legislative
4912 appropriations committees, and the Auditor General.
4913 3. The provisions of this paragraph do not apply to
4914 positions in the Department of Health which are funded by the
4915 County Health Department Trust Fund.
4916 Section 59. Section 381.06014, Florida Statutes, is amended
4917 to read:
4918 381.06014 Blood establishments.—
4919 (1) As used in this section, the term:
4920 (a) "Blood establishment" means any person, entity, or
4921 organization, operating within the state, which examines an
4922 individual for the purpose of blood donation or which collects,
4923 processes, stores, tests, or distributes blood or blood
4924 components collected from the human body for the purpose of
4925 transfusion, for any other medical purpose, or for the
4926 production of any biological product. A person, entity, or
4927 organization that uses a mobile unit to conduct such activities
4928 within the state is also a blood establishment.
4929 (b) "Volunteer donor" means a person who does not receive
4930 remuneration, other than an incentive, for a blood donation

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4931 intended for transfusion, and the product container of the
4932 donation from the person qualifies for labeling with the
4933 statement "volunteer donor" under 21 C.F.R. s. 606.121.
4934 (2) An entity or organization may not hold itself out and
4935 engage in the activities of a ~~Any~~ blood establishment in this
4936 state ~~operating in the state may not conduct any activity~~
4937 ~~defined in subsection (1)~~ unless it operates in accordance ~~that~~
4938 ~~blood establishment is operated in a manner consistent~~ with ~~the~~
4939 ~~provisions of~~ Title 21 C.F.R. parts 211 and 600-640~~, Code of~~
4940 ~~Federal Regulations~~.
4941 (3) A ~~Any~~ blood establishment determined to be operating in
4942 the state in a manner not consistent with ~~the provisions of~~
4943 Title 21 C.F.R. parts 211 and 600-640, ~~Code of Federal~~
4944 ~~Regulations,~~ and in a manner that constitutes a danger to the
4945 health or well-being of donors or recipients as evidenced by the
4946 federal Food and Drug Administration's inspection reports and
4947 the revocation of the blood establishment's license or
4948 registration is ~~shall be~~ in violation of this chapter, ~~and shall~~
4949 ~~immediately cease all operations in the state.~~
4950 ~~(4) The operation of a blood establishment in a manner not~~
4951 ~~consistent with the provisions of Title 21 parts 211 and 600-~~
4952 ~~640, Code of Federal Regulations, and in a manner that~~
4953 ~~constitutes a danger to the health or well-being of blood donors~~
4954 ~~or recipients as evidenced by the federal Food and Drug~~
4955 ~~Administration's inspection process~~ is declared a nuisance and
4956 inimical to the public health, welfare, and safety, and must
4957 immediately cease all operations in this state. The Agency for
4958 Health Care Administration or any state attorney may bring an
4959 action for an injunction to restrain such operations or enjoin

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4960 the future operation of the blood establishment.
4961 (4) A local government may not restrict access to or the
4962 use of any public facility or infrastructure for the collection
4963 of blood or blood components from volunteer donors based on
4964 whether the blood establishment is operating as a for-profit or
4965 not-for-profit organization.
4966 (5) In determining the service fee of blood or blood
4967 components received from volunteer donors and sold to hospitals
4968 or other health care providers, a blood establishment may not
4969 base the service fee of the blood or blood component solely on
4970 whether the purchasing entity is a for-profit or not-for-profit
4971 organization.
4972 (6) A blood establishment that collects blood or blood
4973 components from volunteer donors must disclose the following
4974 information on its Internet website in order to educate and
4975 inform donors and the public about the blood establishment's
4976 activities, and the information required to be disclosed may be
4977 cumulative for all blood establishments within a business
4978 entity:
4979 (a) A description of the steps involved in collecting,
4980 processing, and distributing volunteer donations.
4981 (b) By March 1 of each year, the number of units of blood
4982 components which were:
4983 1. Produced by the blood establishment during the preceding
4984 calendar year;
4985 2. Obtained from other sources during the preceding
4986 calendar year;
4987 3. Distributed during the preceding calendar year to health
4988 care providers located outside this state. However, if the blood

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4989 establishment collects donations in a county outside this state,
4990 distributions to health care providers in that county are
4991 excluded. Such information shall be reported in the aggregate
4992 for health care providers located within the United States and
4993 its territories or outside the United States and its
4994 territories; and
4995 4. Distributed during the preceding calendar year to
4996 entities that are not health care providers. Such information
4997 shall be reported in the aggregate for purchasers located within
4998 the United States and its territories or outside the United
4999 States and its territories.
5000 (c) The blood establishment's conflict-of-interest policy,
5001 policy concerning related-party transactions, whistleblower
5002 policy, and policy for determining executive compensation. If a
5003 change occurs to any of these documents, the revised document
5004 must be available on the blood establishment's website by the
5005 following March 1.
5006 (d) Except for a hospital that collects blood or blood
5007 components from volunteer donors:
5008 1. The most recent 3 years of the Return of Organization
5009 Exempt from Income Tax, Internal Revenue Service Form 990, if
5010 the business entity for the blood establishment is eligible to
5011 file such return. The Form 990 must be available on the blood
5012 establishment's website within 60 calendar days after it is
5013 filed with the Internal Revenue Service; or
5014 2. If the business entity for the blood establishment is
5015 not eligible to file the Form 990 return, a balance sheet,
5016 income statement, and statement of changes in cash flow, along
5017 with the expression of an opinion thereon by an independent

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5018 certified public accountant who audited or reviewed such
5019 financial statements. Such documents must be available on the
5020 blood establishment's website within 120 days after the end of
5021 the blood establishment's fiscal year and must remain on the
5022 blood establishment's website for at least 36 months.
5023
5024 A hospital that collects blood or blood components to be used
5025 only by that hospital's licensed facilities or by a health care
5026 provider that is a part of the hospital's business entity is
5027 exempt from the disclosure requirements of this subsection.
5028 (7) A blood establishment is liable for a civil penalty for
5029 failing to make the disclosures required under subsection (6).
5030 The Department of Legal Affairs may assess a civil penalty
5031 against the blood establishment for each day that it fails to
5032 make such required disclosures, but the penalty may not exceed
5033 $10,000 per year. If multiple blood establishments operated by a
5034 single business entity fail to meet such disclosure
5035 requirements, the civil penalty may be assessed against only one
5036 of the business entity's blood establishments. The Department of
5037 Legal Affairs may terminate an action if the blood establishment
5038 agrees to pay a stipulated civil penalty. A civil penalty so
5039 collected accrues to the state and shall be deposited as
5040 received into the General Revenue Fund unallocated. The
5041 Department of Legal Affairs may terminate the action and waive
5042 the civil penalty upon a showing of good cause by the blood
5043 establishment as to why the required disclosures were not made.
5044 Section 60. Subsection (9) of section 393.063, Florida
5045 Statutes, is amended, present subsections (13) through (40) of
5046 that section are redesignated as subsections (14) through (41),

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5047 respectively, and a new subsection (13) is added to that
5048 section, to read:
5049 393.063 Definitions.—For the purposes of this chapter, the
5050 term:
5051 (9) "Developmental disability" means a disorder or syndrome
5052 that is attributable to retardation, cerebral palsy, autism,
5053 spina bifida, Down syndrome, or Prader-Willi syndrome; that
5054 manifests before the age of 18; and that constitutes a
5055 substantial handicap that can reasonably be expected to continue
5056 indefinitely.
5057 (13) "Down syndrome" means a disorder that is caused by the
5058 presence of an extra chromosome 21.
5059 Section 61. Section 400.023, Florida Statutes, is reordered
5060 and amended to read:
5061 400.023 Civil enforcement.—
5062 (1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a
5063 violation of rights as specified in this part has ~~are violated~~
5064 ~~shall have~~ a cause of action against the licensee or its
5065 management company, as identified in the state application for
5066 nursing home licensure. However, the cause of action may not be
5067 asserted individually against an officer, director, owner,
5068 including an owner designated as having a controlling interest
5069 on the state application for nursing home licensure, or agent of
5070 a licensee or management company unless, following an
5071 evidentiary hearing, the court determines there is sufficient
5072 evidence in the record or proffered by the claimant which
5073 establishes a reasonable basis for finding that the person or
5074 entity breached, failed to perform, or acted outside the scope
5075 of duties as an officer, director, owner, or agent, and that the

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5076 breach, failure to perform, or action outside the scope of
5077 duties is a legal cause of actual loss, injury, death, or damage
5078 to the resident.
5079 (2) The action may be brought by the resident or his or her
5080 guardian, by a person or organization acting on behalf of a
5081 resident with the consent of the resident or his or her
5082 guardian, or by the personal representative of the estate of a
5083 deceased resident regardless of the cause of death.
5084 (5) If the action alleges a claim for the resident's rights
5085 or for negligence that:
5086 (a) Caused the death of the resident, the claimant must
5087 ~~shall be required to~~ elect ~~either~~ survival damages pursuant to
5088 s. 46.021 or wrongful death damages pursuant to s. 768.21. If
5089 the claimant elects wrongful death damages, total noneconomic
5090 damages may not exceed $250,000, regardless of the number of
5091 claimants.
5092 (b) ~~If the action alleges a claim for the resident's rights~~
5093 ~~or for negligence that~~ Did not cause the death of the resident,
5094 the personal representative of the estate may recover damages
5095 for the negligence that caused injury to the resident.
5096 (3) The action may be brought in any court of competent
5097 jurisdiction to enforce such rights and to recover actual and
5098 punitive damages for any violation of the rights of a resident
5099 or for negligence.
5100 (10) Any resident who prevails in seeking injunctive relief
5101 or a claim for an administrative remedy may ~~is entitled to~~
5102 recover the costs of the action, and a reasonable attorney's fee
5103 assessed against the defendant not to exceed $25,000. Fees shall
5104 be awarded solely for the injunctive or administrative relief

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5105 and not for any claim or action for damages whether such claim
5106 or action is brought together with a request for an injunction
5107 or administrative relief or as a separate action, except as
5108 provided under s. 768.79 or the Florida Rules of Civil
5109 Procedure. Sections 400.023-400.0238 provide the exclusive
5110 remedy for a cause of action for recovery of damages for the
5111 personal injury or death of a nursing home resident arising out
5112 of negligence or a violation of rights specified in s. 400.022.
5113 This section does not preclude theories of recovery not arising
5114 out of negligence or s. 400.022 which are available to a
5115 resident or to the agency. The provisions of chapter 766 do not
5116 apply to any cause of action brought under ss. 400.023-400.0238.
5117 (6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part
5118 alleges ~~alleging~~ a violation of resident's rights or negligence
5119 causing injury to or the death of a resident, the claimant shall
5120 have the burden of proving, by a preponderance of the evidence,
5121 that:
5122 (a) The defendant owed a duty to the resident;
5123 (b) The defendant breached the duty to the resident;
5124 (c) The breach of the duty is a legal cause of loss,
5125 injury, death, or damage to the resident; and
5126 (d) The resident sustained loss, injury, death, or damage
5127 as a result of the breach.
5128 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~
5129 create strict liability. A violation of the rights set forth in
5130 s. 400.022 or in any other standard or guidelines specified in
5131 this part or in any applicable administrative standard or
5132 guidelines of this state or a federal regulatory agency is ~~shall~~
5133 ~~be~~ evidence of negligence but may ~~shall~~ not be considered

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5134 negligence per se.
5135 (7) ~~(3)~~ In any claim brought pursuant to this section, a
5136 licensee, person, or entity has ~~shall have~~ a duty to exercise
5137 reasonable care. Reasonable care is that degree of care which a
5138 reasonably careful licensee, person, or entity would use under
5139 like circumstances.
5140 (9) ~~(4)~~ In any claim for resident's rights violation or
5141 negligence by a nurse licensed under part I of chapter 464, such
5142 nurse has a ~~shall have the~~ duty to exercise care consistent with
5143 the prevailing professional standard of care for a nurse. The
5144 prevailing professional standard of care for a nurse is ~~shall be~~
5145 that level of care, skill, and treatment which, in light of all
5146 relevant surrounding circumstances, is recognized as acceptable
5147 and appropriate by reasonably prudent similar nurses.
5148 (8) ~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical
5149 negligence of any physician rendering care or treatment to the
5150 resident except for the administrative services of a medical
5151 director as required in this part. ~~Nothing in~~ This subsection
5152 does not ~~shall be construed to~~ protect a licensee, person, or
5153 entity from liability for failure to provide a resident with
5154 appropriate observation, assessment, nursing diagnosis,
5155 planning, intervention, and evaluation of care by nursing staff.
5156 (4) ~~(6)~~ The resident or the resident's legal representative
5157 shall serve a copy of any complaint alleging in whole or in part
5158 a violation of any rights specified in this part to the agency
5159 ~~for Health Care Administration~~ at the time of filing the initial
5160 complaint with the clerk of the court for the county in which
5161 the action is pursued. ~~The requirement of~~ Providing a copy of
5162 the complaint to the agency does not impair the resident's legal

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5163 rights or ability to seek relief for his or her claim.
5164 (11) ~~(7)~~ An action under this part for a violation of rights
5165 or negligence ~~recognized herein~~ is not a claim for medical
5166 malpractice, and the provisions of s. 768.21(8) do not apply to
5167 a claim alleging death of the resident.
5168 Section 62. Subsections (1), (2), and (3) of section
5169 400.0237, Florida Statutes, are amended to read:
5170 400.0237 Punitive damages; pleading; burden of proof.—
5171 (1) In any action ~~for damages~~ brought under this part, a ~~no~~
5172 claim for punitive damages is not ~~shall be~~ permitted unless,
5173 based on admissible ~~there is a reasonable showing by~~ evidence ~~in~~
5174 ~~the record or~~ proffered by the claimant, ~~which would provide~~ a
5175 reasonable basis for recovery of such damages is demonstrated
5176 upon applying the criteria set forth in this section. The
5177 defendant may proffer admissible evidence to refute the
5178 claimant's proffer of evidence to recover punitive damages. The
5179 trial judge shall conduct an evidentiary hearing and weigh the
5180 admissible evidence proffered by the claimant and the defendant
5181 to ensure that there is a reasonable basis to believe that the
5182 claimant, at trial, will be able to demonstrate by clear and
5183 convincing evidence that the recovery of such damages is
5184 warranted. The claimant may move to amend her or his complaint
5185 to assert a claim for punitive damages as allowed by the rules
5186 of civil procedure. ~~The rules of civil procedure shall be~~
5187 ~~liberally construed so as to allow the claimant discovery of~~
5188 ~~evidence which appears reasonably calculated to lead to~~
5189 ~~admissible evidence on the issue of punitive damages.~~ ~~No~~
5190 Discovery of financial worth may not ~~shall~~ proceed until after
5191 the trial judge approves the pleading on ~~concerning~~ punitive

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5192 damages ~~is permitted~~.
5193 (2) A defendant, including the licensee or management
5194 company, against whom punitive damages is sought may be held
5195 liable for punitive damages only if the trier of fact, based on
5196 clear and convincing evidence, finds that a specific individual
5197 or corporate defendant actively and knowingly participated in
5198 intentional misconduct, or engaged in conduct that constituted
5199 gross negligence, and that conduct contributed to the loss,
5200 damages, or injury suffered by the claimant ~~the defendant was~~
5201 ~~personally guilty of intentional misconduct or gross negligence~~.
5202 As used in this section, the term:
5203 (a) "Intentional misconduct" means that the defendant
5204 against whom a claim for punitive damages is sought had actual
5205 knowledge of the wrongfulness of the conduct and the high
5206 probability that injury or damage to the claimant would result
5207 and, despite that knowledge, intentionally pursued that course
5208 of conduct, resulting in injury or damage.
5209 (b) "Gross negligence" means that the defendant's conduct
5210 was so reckless or wanting in care that it constituted a
5211 conscious disregard or indifference to the life, safety, or
5212 rights of persons exposed to such conduct.
5213 (3) In the case of vicarious liability of an employer,
5214 principal, corporation, or other legal entity, punitive damages
5215 may not be imposed for the conduct of an identified employee or
5216 agent unless ~~only if~~ the conduct of the employee or agent meets
5217 the criteria specified in subsection (2) and officers,
5218 directors, or managers of the actual employer corporation or
5219 legal entity condoned, ratified, or consented to the specific
5220 conduct as alleged by the claimant in subsection (2).~~:~~

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5221 ~~(a) The employer, principal, corporation, or other legal~~
5222 ~~entity actively and knowingly participated in such conduct;~~
5223 ~~(b) The officers, directors, or managers of the employer,~~
5224 ~~principal, corporation, or other legal entity condoned,~~
5225 ~~ratified, or consented to such conduct; or~~
5226 ~~(c) The employer, principal, corporation, or other legal~~
5227 ~~entity engaged in conduct that constituted gross negligence and~~
5228 ~~that contributed to the loss, damages, or injury suffered by the~~
5229 ~~claimant.~~
5230 Section 63. Subsections (3) and (4) of section 408.7057,
5231 Florida Statutes, are amended, subsection (7) of that section is
5232 redesignated as subsection (8), and a new subsection (7) is
5233 added to that section, to read:
5234 408.7057 Statewide provider and health plan claim dispute
5235 resolution program.—
5236 (3) The agency shall adopt rules to establish a process to
5237 be used by the resolution organization in considering claim
5238 disputes submitted by a provider or health plan which must
5239 include a hearing, if requested by the respondent, and the
5240 issuance by the resolution organization of a written
5241 recommendation, supported by findings of fact and conclusions of
5242 law, to the agency within 60 days after the requested
5243 information is received by the resolution organization within
5244 the timeframes specified by the resolution organization. ~~In no~~
5245 ~~event shall~~ The review time may not exceed 90 days following
5246 receipt of the initial claim dispute submission by the
5247 resolution organization.
5248 (4) Within 30 days after receipt of the recommendation of
5249 the resolution organization, the agency shall adopt the

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5250 recommendation as a final order subject to chapter 120.
5251 (7) This section creates a procedure for dispute resolution
5252 and not an independent right of recovery. The conclusions of law
5253 contained in the written recommendation of the resolution
5254 organization must identify the provisions of law or contract
5255 which, under the particular facts and circumstances of the case,
5256 entitle the provider or health plan to the amount awarded, if
5257 any.
5258 Section 64. Paragraphs (f), (h), (j), and (l) of subsection
5259 (1) and subsection (2) of section 409.1671, Florida Statutes,
5260 are amended to read:
5261 409.1671 Foster care and related services; outsourcing.—
5262 (1)
5263 (f)~~1.~~ The Legislature finds that the state has
5264 traditionally provided foster care services to children who are
5265 ~~have been~~ the responsibility of the state. As such, foster
5266 children have not had the right to recover for injuries beyond
5267 the limitations specified in s. 768.28. The Legislature has also
5268 determined that foster care and related services need to be
5269 outsourced ~~pursuant to this section~~ and that the provision of
5270 such services is of paramount importance to the state. The
5271 purpose for such outsourcing is to increase the level of safety,
5272 security, and stability of children who are or become the
5273 responsibility of the state.
5274 1. One of the components necessary to secure a safe and
5275 stable environment for such children is for ~~that~~ private
5276 providers to maintain adequate liability insurance. ~~As~~ Such~~,~~
5277 insurance needs to be available and remain available to
5278 nongovernmental foster care and related services providers

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5279 without the resources of such providers being significantly
5280 reduced by the cost of maintaining such insurance. To ensure
5281 that these resources are not significantly reduced, specified
5282 limits of liability are necessary for eligible lead community-
5283 based providers and subcontractors engaged in the provision of
5284 services previously performed by the department.
5285 2. The Legislature further finds that, by requiring the
5286 following minimum levels of insurance, children in outsourced
5287 foster care and related services will gain increased protection
5288 ~~and rights of recovery in the event of injury than provided for~~
5289 ~~in s. 768.28~~.
5290 (h) Other than an entity to which s. 768.28 applies, an ~~any~~
5291 eligible lead community-based provider~~, as defined in paragraph~~
5292 ~~(e),~~ or its employees or officers, except as otherwise provided
5293 in paragraph (i), must, as a part of its contract, obtain
5294 general liability coverage for a minimum of $200,000 per claim
5295 or $300,000 per incident ~~a minimum of $1 million per claim/$3~~
5296 ~~million per incident in general liability insurance coverage~~.
5297 1. The eligible lead community-based provider must also
5298 require ~~that~~ staff who transport client children and families in
5299 their personal automobiles in order to carry out their job
5300 responsibilities to obtain minimum bodily injury liability
5301 insurance on their personal automobiles in the amount of
5302 $100,000 per claim or~~,~~ $300,000 per incident~~, on their personal~~
5303 ~~automobiles~~. In lieu of personal motor vehicle insurance, the
5304 lead community-based provider's casualty, liability, or motor
5305 vehicle insurance carrier may provide nonowned automobile
5306 liability coverage~~. This insurance provides liability insurance~~
5307 for automobiles that the provider uses in connection with the

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5308 provider's business but does not own, lease, rent, or borrow.
5309 This coverage includes automobiles owned by the employees of the
5310 provider or a member of the employee's household ~~but only~~ while
5311 the automobiles are used in connection with the provider's
5312 business. The nonowned automobile coverage ~~for the provider~~
5313 applies as excess coverage over any other collectible insurance.
5314 The personal automobile policy for the employee of the provider
5315 shall be primary insurance, and the nonowned automobile coverage
5316 of the provider acts as excess insurance to the primary
5317 insurance. The provider shall provide a minimum limit of $1
5318 million in nonowned automobile coverage.
5319 2. In any tort action brought against ~~such~~ an eligible lead
5320 community-based provider or employee, net economic damages are
5321 ~~shall be~~ limited to $200,000 ~~$1 million~~ per liability claim,
5322 $300,000 per liability incident, and $100,000 per automobile
5323 claim, including, but not limited to, past and future medical
5324 expenses, wage loss, and loss of earning capacity, offset by any
5325 collateral source payment paid or payable. In any tort action
5326 brought against an eligible lead community-based provider, the
5327 total economic damages recoverable by all claimants is limited
5328 to $500,000 in the aggregate. In any tort action brought against
5329 such an eligible lead community-based provider, noneconomic
5330 damages are ~~shall be~~ limited to $200,000 per claim and $300,000
5331 per incident. In any tort action brought against an eligible
5332 lead community-based provider, the total noneconomic damages
5333 recoverable by all claimants are limited to $500,000 in the
5334 aggregate.
5335 3. A claims bill may be brought on behalf of a claimant
5336 pursuant to s. 768.28 for any amount exceeding the limits

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5337 specified in this paragraph. Any offset of collateral source
5338 payments made as of the date of the settlement or judgment shall
5339 be in accordance with s. 768.76. The lead community-based
5340 provider is ~~shall~~ not ~~be~~ liable in tort for the acts or
5341 omissions of its subcontractors or the officers, agents, or
5342 employees of its subcontractors.
5343 (j) Any subcontractor of an eligible lead community-based
5344 provider~~, as defined in paragraph (e),~~ which is a direct
5345 provider of foster care and related services to children and
5346 families, and its employees or officers, except as otherwise
5347 provided in paragraph (i), must, as a part of its contract,
5348 obtain general liability insurance coverage for a minimum of
5349 $200,000 per claim or $300,000 ~~$1 million per claim/$3 million~~
5350 per incident ~~in general liability insurance coverage~~.
5351 1. The subcontractor of an eligible lead community-based
5352 provider must also require that staff who transport client
5353 children and families in their personal automobiles in order to
5354 carry out their job responsibilities obtain minimum bodily
5355 injury liability insurance in the amount of $100,000 per claim,
5356 $300,000 per incident, on their personal automobiles. In lieu of
5357 personal motor vehicle insurance, the subcontractor’s casualty,
5358 liability, or motor vehicle insurance carrier may provide
5359 nonowned automobile liability coverage. This insurance provides
5360 liability insurance for automobiles that the subcontractor uses
5361 in connection with the subcontractor’s business but does not
5362 own, lease, rent, or borrow. This coverage includes automobiles
5363 owned by the employees of the subcontractor or a member of the
5364 employee’s household but only while the automobiles are used in
5365 connection with the subcontractor’s business. The nonowned

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5366 automobile coverage for the subcontractor applies as excess
5367 coverage over any other collectible insurance. The personal
5368 automobile policy for the employee of the subcontractor is ~~shall~~
5369 ~~be~~ primary insurance, and the nonowned automobile coverage of
5370 the subcontractor acts as excess insurance to the primary
5371 insurance. The subcontractor shall provide a minimum limit of $1
5372 million in nonowned automobile coverage.
5373 2. In any tort action brought against such subcontractor or
5374 employee, net economic damages shall be limited to $200,000 ~~$1~~
5375 ~~million~~ per liability claim, $300,000 per liability incident,
5376 and $100,000 per automobile claim, including, but not limited
5377 to, past and future medical expenses, wage loss, and loss of
5378 earning capacity, offset by any collateral source payment paid
5379 or payable. In any tort action brought against such
5380 subcontractor or employee, the total economic damages
5381 recoverable by all claimants is limited to $500,000 in the
5382 aggregate. In any tort action brought against such
5383 subcontractor, noneconomic damages shall be limited to $200,000
5384 per claim and $300,000 per incident. In any tort action brought
5385 against such subcontractor or employee, the total noneconomic
5386 damages recoverable by all claimants is limited to $500,000 in
5387 the aggregate.
5388 3. A claims bill may be brought on behalf of a claimant
5389 pursuant to s. 768.28 for any amount exceeding the limits
5390 specified in this paragraph. Any offset of collateral source
5391 payments made as of the date of the settlement or judgment shall
5392 be in accordance with s. 768.76.
5393 ~~(l) The Legislature is cognizant of the increasing costs of~~
5394 ~~goods and services each year and recognizes that fixing a set~~

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5395 ~~amount of compensation actually has the effect of a reduction in~~
5396 ~~compensation each year. Accordingly, the conditional limitations~~
5397 ~~on damages in this section shall be increased at the rate of 5~~
5398 ~~percent each year, prorated from the effective date of this~~
5399 ~~paragraph to the date at which damages subject to such~~
5400 ~~limitations are awarded by final judgment or settlement.~~
5401 (2)~~(a)~~ The department may contract for the delivery,
5402 administration, or management of protective services, the
5403 services specified in subsection (1) relating to foster care,
5404 and other related services or programs, as appropriate.
5405 (a) The department shall use diligent efforts to ensure
5406 that ~~retain responsibility for the quality of~~ contracted
5407 services and programs ~~and shall ensure that services~~ are of high
5408 quality and delivered in accordance with applicable federal and
5409 state statutes and regulations. However, the department is not
5410 liable in tort for the acts or omissions of eligible lead
5411 community-based providers or their officers, agents, or
5412 employees, or liable in tort for the acts or omissions of the
5413 subcontractors of eligible lead community-based care providers
5414 or their officers, agents, or employees. Further, the department
5415 may not require eligible lead community-based providers or their
5416 subcontractors to indemnify the department for the department's
5417 acts or omissions or require eligible lead-based community
5418 providers or their subcontractors to include the department as
5419 an additional insured on an insurance policy.
5420 (b) The department shall ~~must~~ adopt written policies and
5421 procedures for monitoring the contract for the delivery of
5422 services by lead community-based providers. These policies and
5423 procedures must, at a minimum, address the evaluation of fiscal

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5424 accountability and program operations, including provider
5425 achievement of performance standards, provider monitoring of
5426 subcontractors, and timely followup of corrective actions for
5427 significant monitoring findings related to providers and
5428 subcontractors. The ~~These~~ policies and procedures must also
5429 include provisions for reducing the duplication of the
5430 department's program monitoring activities both internally and
5431 with other agencies, to the extent possible. The department's
5432 written procedures must ensure that the written findings,
5433 conclusions, and recommendations from monitoring the contract
5434 ~~for services of lead community-based providers~~ are communicated
5435 to the director of the provider agency as expeditiously as
5436 possible.
5437 (c) ~~(b)~~ Persons employed by the department in the provision
5438 of foster care and related services whose positions are being
5439 outsourced under this statute shall be given hiring preference
5440 by the provider, if provider qualifications are met.
5441 Section 65. Section 458.3167, Florida Statutes, is created
5442 to read:
5443 458.3167 Expert witness certificate.—
5444 (1) A physician who holds an active and valid license to
5445 practice allopathic medicine in any other state or in Canada,
5446 who submits an application form prescribed by the board to
5447 obtain a certificate to provide expert testimony and pays the
5448 application fee, and who has not had a previous expert witness
5449 certificate revoked by the board shall be issued a certificate
5450 to provide expert testimony.
5451 (2) A physician possessing an expert witness certificate
5452 may use the certificate only to give a verified written medical

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5453 expert opinion as provided in s. 766.203 and to provide expert
5454 testimony concerning the prevailing professional standard of
5455 care for medical negligence litigation pending in this state
5456 against a physician licensed under this chapter or chapter 459.
5457 (3) An application for an expert witness certificate must
5458 be approved or denied within 5 business days after receipt of a
5459 completed application. An application that is not approved or
5460 denied within the required time period is deemed approved. An
5461 applicant seeking to claim certification by default shall notify
5462 the board, in writing, of the intent to rely on the default
5463 certification provision of this subsection. In such case, s.
5464 458.327 does not apply, and the applicant may provide expert
5465 testimony as provided in subsection (2).
5466 (4) All licensure fees, other than the initial certificate
5467 application fee, including the neurological injury compensation
5468 assessment, are waived for those persons obtaining an expert
5469 witness certificate. The possession of an expert witness
5470 certificate alone does not entitle the physician to engage in
5471 the practice of medicine as defined in s. 458.305.
5472 (5) The board shall adopt rules to administer this section,
5473 including rules setting the amount of the expert witness
5474 certificate application fee, which may not exceed $50. An expert
5475 witness certificate expires 2 years after the date of issuance.
5476 Section 66. Subsection (11) is added to section 458.331,
5477 Florida Statutes, present paragraphs (oo) through (qq) of
5478 subsection (1) of that section are redesignated as paragraphs
5479 (pp) through (rr), respectively, and a new paragraph (oo) is
5480 added to that subsection, to read:
5481 458.331 Grounds for disciplinary action; action by the

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5482 board and department.—
5483 (1) The following acts constitute grounds for denial of a
5484 license or disciplinary action, as specified in s. 456.072(2):
5485 (oo) Providing misleading, deceptive, or fraudulent expert
5486 witness testimony related to the practice of medicine.
5487 (11) The purpose of this section is to facilitate uniform
5488 discipline for those acts made punishable under this section
5489 and, to this end, a reference to this section constitutes a
5490 general reference under the doctrine of incorporation by
5491 reference.
5492 Section 67. Section 459.0078, Florida Statutes, is created
5493 to read:
5494 459.0078 Expert witness certificate.—
5495 (1) A physician who holds an active and valid license to
5496 practice osteopathic medicine in any other state or in Canada,
5497 who submits an application form prescribed by the board to
5498 obtain a certificate to provide expert testimony and pays the
5499 application fee, and who has not had a previous expert witness
5500 certificate revoked by the board shall be issued a certificate
5501 to provide expert testimony.
5502 (2) A physician possessing an expert witness certificate
5503 may use the certificate only to give a verified written medical
5504 expert opinion as provided in s. 766.203 and to provide expert
5505 testimony concerning the prevailing professional standard of
5506 care for medical negligence litigation pending in this state
5507 against a physician licensed under this chapter or chapter 458.
5508 (3) An application for an expert witness certificate must
5509 be approved or denied within 5 business days after receipt of a
5510 completed application. An application that is not approved or

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5511 denied within the required time period is deemed approved. An
5512 applicant seeking to claim certification by default shall notify
5513 the board, in writing, of the intent to rely on the default
5514 certification provision of this subsection. In such case, s.
5515 459.013 does not apply, and the applicant may provide expert
5516 testimony as provided in subsection (2).
5517 (4) All licensure fees, other than the initial certificate
5518 application fee, including the neurological injury compensation
5519 assessment, are waived for those persons obtaining an expert
5520 witness certificate. The possession of an expert witness
5521 certificate alone does not entitle the physician to engage in
5522 the practice of osteopathic medicine as defined in s. 459.003.
5523 (5) The board shall adopt rules to administer this section,
5524 including rules setting the amount of the expert witness
5525 certificate application fee, which may not exceed $50. An expert
5526 witness certificate expires 2 years after the date of issuance.
5527 Section 68. Subsection (11) is added to section 459.015,
5528 Florida Statutes, present paragraphs (qq) through (ss) of
5529 subsection (1) of that section are redesignated as paragraphs
5530 (rr) through (tt), respectively, and a new paragraph (qq) is
5531 added to that subsection, to read:
5532 459.015 Grounds for disciplinary action; action by the
5533 board and department.—
5534 (1) The following acts constitute grounds for denial of a
5535 license or disciplinary action, as specified in s. 456.072(2):
5536 (qq) Providing misleading, deceptive, or fraudulent expert
5537 witness testimony related to the practice of osteopathic
5538 medicine.
5539 (11) The purpose of this section is to facilitate uniform

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5540 discipline for those acts made punishable under this section
5541 and, to this end, a reference to this section constitutes a
5542 general reference under the doctrine of incorporation by
5543 reference.
5544 Section 69. Subsection (23) of section 499.003, Florida
5545 Statutes, is amended to read:
5546 499.003 Definitions of terms used in this part.—As used in
5547 this part, the term:
5548 (23) "Health care entity" means a closed pharmacy or any
5549 person, organization, or business entity that provides
5550 diagnostic, medical, surgical, or dental treatment or care, or
5551 chronic or rehabilitative care, but does not include any
5552 wholesale distributor or retail pharmacy licensed under state
5553 law to deal in prescription drugs. However, a blood
5554 establishment is a health care entity that may engage in the
5555 wholesale distribution of prescription drugs under s.
5556 499.01(2)(g)1.c.
5557 Section 70. Subsection (21) of section 499.005, Florida
5558 Statutes, is amended to read:
5559 499.005 Prohibited acts.—It is unlawful for a person to
5560 perform or cause the performance of any of the following acts in
5561 this state:
5562 (21) The wholesale distribution of any prescription drug
5563 that was:
5564 (a) Purchased by a public or private hospital or other
5565 health care entity; or
5566 (b) Donated or supplied at a reduced price to a charitable
5567 organization,
5568

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5569 unless the wholesale distribution of the prescription drug is
5570 authorized in s. 499.01(2)(g)1.c.
5571 Section 71. Paragraphs (a) and (g) of subsection (2) of
5572 section 499.01, Florida Statutes, are amended to read:
5573 499.01 Permits.—
5574 (2) The following permits are established:
5575 (a) *Prescription drug manufacturer permit.*—A prescription
5576 drug manufacturer permit is required for any person that is a
5577 manufacturer of a prescription drug and that manufactures or
5578 distributes such prescription drugs in this state.
5579 1. A person that operates an establishment permitted as a
5580 prescription drug manufacturer may engage in wholesale
5581 distribution of prescription drugs manufactured at that
5582 establishment and must comply with all of the provisions of this
5583 part, except s. 499.01212, and the rules adopted under this
5584 part, except s. 499.01212, which ~~that~~ apply to a wholesale
5585 distributor.
5586 2. A prescription drug manufacturer must comply with all
5587 appropriate state and federal good manufacturing practices.
5588 3. A blood establishment, as defined in s. 381.06014,
5589 operating in a manner consistent with the provisions of Title 21
5590 C.F.R. parts 211 and 600-640 and manufacturing only the
5591 prescription drugs described in s. 499.003(54)(d) is not
5592 required to be permitted as a prescription drug manufacturer
5593 under this paragraph or to register its products under s.
5594 499.015.
5595 (g) *Restricted prescription drug distributor permit.*—
5596 1. A restricted prescription drug distributor permit is
5597 required for:

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5598 a. Any person located in this state that engages in the
5599 distribution of a prescription drug, which distribution is not
5600 considered "wholesale distribution" under s. 499.003(54)(a).
5601 b.~~1.~~ Any ~~A~~ person located in this state who engages in the
5602 receipt or distribution of a prescription drug in this state for
5603 the purpose of processing its return or its destruction ~~must~~
5604 ~~obtain a permit as a restricted prescription drug distributor~~ if
5605 such person is not the person initiating the return, the
5606 prescription drug wholesale supplier of the person initiating
5607 the return, or the manufacturer of the drug.
5608 c. A blood establishment located in this state which
5609 collects blood and blood components only from volunteer donors
5610 as defined in s. 381.06014 or pursuant to an authorized
5611 practitioner's order for medical treatment or therapy and
5612 engages in the wholesale distribution of a prescription drug not
5613 described in s. 499.003(54)(d) to a health care entity. The
5614 health care entity receiving a prescription drug distributed
5615 under this sub-subparagraph must be licensed as a closed
5616 pharmacy or provide health care services at that establishment.
5617 The blood establishment must operate in accordance with s.
5618 381.06014 and may distribute only:
5619 (I) Prescription drugs indicated for a bleeding or clotting
5620 disorder or anemia;
5621 (II) Blood-collection containers approved under s. 505 of
5622 the federal act;
5623 (III) Drugs that are blood derivatives, or a recombinant or
5624 synthetic form of a blood derivative;
5625 (IV) Prescription drugs that are identified in rules
5626 adopted by the department and that are essential to services

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5627 performed or provided by blood establishments and authorized for
5628 distribution by blood establishments under federal law; or
5629 (V) To the extent authorized by federal law, drugs
5630 necessary to collect blood or blood components from volunteer
5631 blood donors; for blood establishment personnel to perform
5632 therapeutic procedures under the direction and supervision of a
5633 licensed physician; and to diagnose, treat, manage, and prevent
5634 any reaction of either a volunteer blood donor or a patient
5635 undergoing a therapeutic procedure performed under the direction
5636 and supervision of a licensed physician,
5637
5638 as long as all of the health care services provided by the blood
5639 establishment are related to its activities as a registered
5640 blood establishment or the health care services consist of
5641 collecting, processing, storing, or administering human
5642 hematopoietic stem cells or progenitor cells or performing
5643 diagnostic testing of specimens if such specimens are tested
5644 together with specimens undergoing routine donor testing.
5645 2. Storage, handling, and recordkeeping of these
5646 distributions by a person required to be permitted as a
5647 restricted prescription drug distributor must comply with the
5648 requirements for wholesale distributors under s. 499.0121, but
5649 not those set forth in s. 499.01212 if the distribution occurs
5650 pursuant to sub-subparagraph 1.a. or sub-subparagraph 1.b.
5651 3. A person who applies for a permit as a restricted
5652 prescription drug distributor, or for the renewal of such a
5653 permit, must provide to the department the information required
5654 under s. 499.012.
5655 4. The department may adopt rules regarding the

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5656 distribution of prescription drugs by hospitals, health care
5657 entities, charitable organizations, ~~or~~ other persons not
5658 involved in wholesale distribution, and blood establishments,
5659 which rules are necessary for the protection of the public
5660 health, safety, and welfare.
5661 Section 72. Subsection (4) is added to section 626.9541,
5662 Florida Statutes, to read:
5663 626.9541 Unfair methods of competition and unfair or
5664 deceptive acts or practices defined.—
5665 (4) WELLNESS OR HEALTH IMPROVEMENT PROGRAMS.—
5666 (a) An insurer issuing a group or individual health benefit
5667 plan may offer a voluntary wellness or health improvement
5668 program and may encourage or reward participation in the program
5669 by authorizing rewards or incentives, including, but not limited
5670 to, merchandise, gift cards, debit cards, premium discounts or
5671 rebates, contributions to a member's health savings account, or
5672 modifications to copayment, deductible, or coinsurance amounts.
5673 (b) An insurer may require a health benefit plan member to
5674 provide verification, such as an affirming statement from the
5675 member's physician, that the member's medical condition makes it
5676 unreasonably difficult or inadvisable to participate in the
5677 wellness or health improvement program.
5678 (c) A reward or incentive offered under this subsection is
5679 not an insurance benefit or violation of this section if it is
5680 disclosed in the policy or certificate. This subsection does not
5681 prohibit insurers from offering other incentives or rewards for
5682 adherence to a wellness or health improvement program if
5683 otherwise authorized by state or federal law.
5684 Section 73. Paragraph (b) of subsection (1) of section

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5685 627.4147, Florida Statutes, is amended to read:
5686 627.4147 Medical malpractice insurance contracts.—
5687 (1) In addition to any other requirements imposed by law,
5688 each self-insurance policy ~~as~~ authorized under s. 627.357 or s.
5689 624.462 or insurance policy providing coverage for claims
5690 arising out of the rendering of, or the failure to render,
5691 medical care or services, including those of the Florida Medical
5692 Malpractice Joint Underwriting Association, must ~~shall~~ include:
5693 (b)~~1. Except as provided in subparagraph 2., a clause~~
5694 ~~authorizing the insurer or self-insurer to determine, to make,~~
5695 ~~and to conclude, without the permission of the insured, any~~
5696 ~~offer of admission of liability and for arbitration pursuant to~~
5697 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~
5698 ~~is within the policy limits. It is against public policy for any~~
5699 ~~insurance or self-insurance policy to contain a clause giving~~
5700 ~~the insured the exclusive right to veto any offer for admission~~
5701 ~~of liability and for arbitration made pursuant to s. 766.106,~~
5702 ~~settlement offer, or offer of judgment, when such offer is~~
5703 ~~within the policy limits. However, any offer of admission of~~
5704 ~~liability, settlement offer, or offer of judgment made by an~~
5705 ~~insurer or self-insurer shall be made in good faith and in the~~
5706 ~~best interests of the insured.~~
5707 1.~~2.a.~~ With respect to dentists licensed under chapter 466,
5708 a clause clearly stating whether or not the insured has the
5709 exclusive right to veto any offer of admission of liability and
5710 for arbitration pursuant to s. 766.106, settlement offer, or
5711 offer of judgment if the offer is within policy limits. An
5712 insurer or self-insurer may ~~shall~~ not make or conclude, without
5713 the permission of the insured, any offer of admission of

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5714 liability and for arbitration pursuant to s. 766.106, settlement
5715 offer, or offer of judgment, if such offer is outside the policy
5716 limits. However, any offer for admission of liability and for
5717 arbitration made under s. 766.106, settlement offer, or offer of
5718 judgment made by an insurer or self-insurer must ~~shall~~ be made
5719 in good faith and in the best interest of the insured.
5720 2.~~b.~~ If the policy contains a clause stating the insured
5721 does not have the exclusive right to veto any offer or admission
5722 of liability and for arbitration made pursuant to s. 766.106,
5723 settlement offer or offer of judgment, the insurer or self-
5724 insurer shall provide to the insured or the insured's legal
5725 representative by certified mail, return receipt requested, a
5726 copy of the final offer of admission of liability and for
5727 arbitration made pursuant to s. 766.106, settlement offer or
5728 offer of judgment and at the same time such offer is provided to
5729 the claimant. A copy of any final agreement reached between the
5730 insurer and claimant shall also be provided to the insurer or
5731 his or her legal representative by certified mail, return
5732 receipt requested within ~~not more than~~ 10 days after affecting
5733 such agreement.
5734 Section 74. Present subsection (12) of section 766.102,
5735 Florida Statutes, is redesignated as subsection (13), and a new
5736 subsection (12) is added to that section, to read:
5737 766.102 Medical negligence; standards of recovery; expert
5738 witness.—
5739 (12) If a physician licensed under chapter 458 or chapter
5740 459 is a party against whom, or on whose behalf, expert
5741 testimony about the prevailing professional standard of care is
5742 offered, the expert witness must otherwise meet the requirements

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5743 of this section and be licensed as a physician under chapter 458
5744 or chapter 459, or must possess a valid expert witness
5745 certificate issued under s. 458.3167 or s. 459.0078.
5746 Section 75. Subsection (1) of section 766.104, Florida
5747 Statutes, is amended to read:
5748 766.104 Pleading in medical negligence cases; claim for
5749 punitive damages; authorization for release of records for
5750 investigation.—
5751 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or
5752 wrongful death arising out of medical negligence, whether in
5753 tort or in contract, may not be filed unless the attorney filing
5754 the action has made a reasonable investigation, as permitted by
5755 the circumstances, to determine that there are grounds for a
5756 good faith belief that there has been negligence in the care or
5757 treatment of the claimant.
5758 (a) The complaint or initial pleading must ~~shall~~ contain a
5759 certificate of counsel that such reasonable investigation gave
5760 rise to a good faith belief that grounds exist for an action
5761 against each named defendant. For purposes of this section, good
5762 faith may be shown ~~to exist~~ if the claimant or his or her
5763 counsel has received a written opinion, ~~which shall~~ not ~~be~~
5764 subject to discovery by an opposing party, of an expert as
5765 defined in s. 766.102 that there appears to be evidence of
5766 medical negligence. If the court determines that the ~~such~~
5767 certificate of counsel was not made in good faith and that no
5768 justiciable issue was presented against a health care provider
5769 that fully cooperated in providing informal discovery, the court
5770 shall award attorney's fees and taxable costs against claimant's
5771 counsel~~,~~ and ~~shall~~ submit the matter to The Florida Bar for

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5772 disciplinary review of the attorney.
5773 (b) If the cause of action requires the plaintiff to
5774 establish the breach of a standard of care other than negligence
5775 in order to impose liability or secure specified damages arising
5776 out of the rendering of, or the failure to render, medical care
5777 or services, and the plaintiff intends to pursue such liability
5778 or damages, the investigation and certification required by this
5779 subsection must demonstrate grounds for a good faith belief that
5780 the requirement is satisfied.
5781 Section 76. Subsection (5) of section 766.106, Florida
5782 Statutes, is amended to read:
5783 766.106 Notice before filing action for medical negligence;
5784 presuit screening period; offers for admission of liability and
5785 for arbitration; informal discovery; review.—
5786 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,
5787 written document, report, or other work product generated by the
5788 presuit screening process is discoverable or admissible in any
5789 civil action for any purpose by the opposing party. All
5790 participants, including, but not limited to, physicians,
5791 investigators, witnesses, and employees or associates of the
5792 defendant, are immune from civil liability arising from
5793 participation in the presuit screening process. This subsection
5794 does not prohibit a physician licensed under chapter 458 or
5795 chapter 459, or a physician who holds a certificate to provide
5796 expert testimony under s. 458.3167 or s. 459.0078, who submits a
5797 verified written expert medical opinion from being subject to
5798 disciplinary action pursuant to s. 456.073.
5799 Section 77. Subsection (11) of section 766.1115, Florida
5800 Statutes, is amended to read:

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5801 766.1115 Health care providers; creation of agency
5802 relationship with governmental contractors.—
5803 (11) APPLICABILITY.—
5804 (a) This section applies to incidents occurring on or after
5805 April 17, 1992.
5806 (b) This section does not apply to any health care contract
5807 entered into by the Department of Corrections which is subject
5808 to s. 768.28(10)(a).
5809 (c) This section does not apply to any affiliation
5810 agreement or other contract subject to s. 768.28(10)(f).
5811 (d) ~~Nothing in~~ This section does not reduce or limit ~~in any~~
5812 ~~way reduces or limits~~ the rights of the state or any of its
5813 agencies or subdivisions to any benefit currently provided under
5814 s. 768.28.
5815 Section 78. Section 766.1183, Florida Statutes, is created
5816 to read:
5817 766.1183 Standard of care for Medicaid providers.—
5818 (1) As used in this section:
5819 (a) The terms "applicant," "medical assistance," "medical
5820 services," and "Medicaid recipient" have the same meaning as in
5821 s. 409.901.
5822 (b) The term "provider" means a health care provider as
5823 defined in s. 766.202 or an entity that qualifies for an
5824 exemption under s. 400.9905(4)(e). The term includes:
5825 1. Any person or entity for whom a provider is vicariously
5826 liable; and
5827 2. Any person or entity whose liability is based solely on
5828 such person or entity being vicariously liable for the actions
5829 of a provider.

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5830 (c) The term "wrongful manner" means in bad faith or with
5831 malicious purpose or in a manner exhibiting wanton and willful
5832 disregard of human rights, safety, or property, and shall be
5833 construed in conformity with the standard set forth in s.
5834 768.28(9)(a).
5835 (2) A provider is not liable in excess of $200,000 per
5836 claimant or $300,000 per occurrence for any cause of action
5837 arising out of the rendering of, or the failure to render,
5838 medical services to a Medicaid recipient, except as provided
5839 under subsection (3). However, a judgment may be claimed and
5840 rendered in excess of the amounts set forth in this subsection.
5841 That portion of the judgment that exceeds these amounts may be
5842 reported to the Legislature, but may be paid in part or in whole
5843 by the state only by further act of the Legislature.
5844 (3) A provider may be liable for an amount in excess of
5845 $200,000 per claimant or $300,000 per occurrence only if the
5846 claimant pleads and proves, by clear and convincing evidence,
5847 that the provider acted in a wrongful manner. If the claimant so
5848 pleads, the court, after a reasonable opportunity for discovery,
5849 shall conduct a hearing before trial to determine if there is a
5850 reasonable basis in evidence to conclude that the provider acted
5851 in a wrongful manner. A claim for wrongful conduct is not
5852 permitted, to the extent it exceeds the amounts set forth in
5853 subsection (2), unless the claimant makes the showing required
5854 by this subsection.
5855 (4) At the time an application for medical assistance is
5856 submitted, the Department of Children and Family Services shall
5857 furnish the applicant with written notice of the provisions of
5858 this section.

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5859 (5) This section does not limit or exclude the application
5860 of any law, including s. 766.118, which places limitations upon
5861 the recovery of civil damages.
5862 (6) This section does not apply to any claim for damages to
5863 which s. 768.28 applies.
5864 Section 79. Section 766.1184, Florida Statutes, is created
5865 to read:
5866 766.1184 Standard of care; low-income pool recipient.—
5867 (1) As used in this section, the term:
5868 (a) "Low-income pool recipient" means a low-income
5869 individual who is uninsured or underinsured and who receives
5870 primary care services from a provider which are delivered
5871 exclusively using funding received by that provider under
5872 proviso language accompanying specific appropriation 191 of the
5873 2010-2011 fiscal year General Appropriations Act to establish
5874 new or expand existing primary care clinics for low-income
5875 persons who are uninsured or underinsured.
5876 (b) "Provider" means a health care provider, as defined in
5877 s. 766.202, which received funding under proviso language
5878 accompanying specific appropriation 191 of the fiscal year 2010-
5879 11 General Appropriations Act to establish new or expand
5880 existing primary care clinics for low-income persons who are
5881 uninsured or underinsured. The term includes:
5882 1. Any person or entity for whom a provider is vicariously
5883 liable; and
5884 2. Any person or entity whose liability is based solely on
5885 such person or entity being vicariously liable for the actions
5886 of a provider.
5887 (c) "Wrongful manner" means in bad faith or with malicious

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5888 purpose or in a manner exhibiting wanton and willful disregard
5889 of human rights, safety, or property, and shall be construed in
5890 conformity with the standard set forth in s. 768.28(9)(a).
5891
5892 The funding of the provider's primary care clinic must have been
5893 awarded pursuant to a plan approved by the Legislative Budget
5894 Commission, and must be the subject of an agreement between the
5895 provider and the Agency for Health Care Administration,
5896 following the competitive solicitation of proposals to use low-
5897 income pool grant funds to provide primary care services in
5898 general acute hospitals, county health departments, faith-based
5899 and community clinics, and federally qualified health centers to
5900 uninsured or underinsured persons.
5901 (2) A provider is not liable in excess of $200,000 per
5902 claimant or $300,000 per occurrence for any cause of action
5903 arising out of the rendering of, or the failure to render,
5904 primary care services to a low-income pool recipient, except as
5905 provided under subsection (3). However, a judgment may be
5906 claimed and rendered in excess of the amounts set forth in this
5907 subsection. That portion of the judgment that exceeds these
5908 amounts may be reported to the Legislature, but may be paid in
5909 part or in whole by the state only by further act of the
5910 Legislature.
5911 (3) A provider may be liable for an amount in excess of
5912 $200,000 per claimant or $300,000 per occurrence only if the
5913 claimant pleads and proves, by clear and convincing evidence,
5914 that the provider acted in a wrongful manner. If the claimant so
5915 pleads, the court, after a reasonable opportunity for discovery,
5916 shall conduct a hearing before trial to determine if there is a

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5917 reasonable basis in evidence to conclude that the provider acted
5918 in a wrongful manner. A claim for wrongful conduct is not
5919 permitted, to the extent it exceeds the amounts set forth in
5920 subsection (2), unless the claimant makes the showing required
5921 by this subsection.
5922 (4) In order for this section to apply, the provider must:
5923 (a) Develop, implement, and maintain policies and
5924 procedures to:
5925 1. Ensure that funds described in subsection (1) are used
5926 exclusively to serve low-income persons who are uninsured or
5927 underinsured;
5928 2. Determine whether funds described in subsection (1) are
5929 being used to provide primary care services to a particular
5930 person; and
5931 3. Identify whether an individual receiving primary care
5932 services is a low-income pool recipient to whom the provisions
5933 of this section apply.
5934 (b) Furnish a low-income pool recipient with written notice
5935 of the provisions of this section before providing primary care
5936 services to the recipient.
5937 (c) Be in compliance with the terms of any agreement
5938 between the provider and the Agency for Health Care
5939 Administration governing the receipt of the funds described in
5940 subsection (1).
5941 (5) This section does not limit or exclude the application
5942 of any law, including s. 766.118, which places limitations upon
5943 the recovery of civil damages.
5944 (6) This section does not apply to any claim for damages to
5945 which s. 768.28 applies.

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5946 Section 80. Subsection (5) is added to section 766.203,
5947 Florida Statutes, to read:
5948 766.203 Presuit investigation of medical negligence claims
5949 and defenses by prospective parties.—
5950 (5) STANDARDS OF CARE.—If the cause of action that is the
5951 basis for the litigation requires the plaintiff to establish the
5952 breach of a standard of care other than negligence in order to
5953 impose liability or secure specified damages arising out of the
5954 rendering of, or the failure to render, medical care or
5955 services, and the plaintiff intends to pursue such liability or
5956 damages, the presuit investigations required of the claimant and
5957 the prospective defendant by this section must ascertain that
5958 there are reasonable grounds to believe that the requirement is
5959 satisfied.
5960 Section 81. Paragraph (b) of subsection (9) of section
5961 768.28, Florida Statutes, is amended, and paragraph (f) is added
5962 to subsection (10) of that section, to read:
5963 768.28 Waiver of sovereign immunity in tort actions;
5964 recovery limits; limitation on attorney fees; statute of
5965 limitations; exclusions; indemnification; risk management
5966 programs.—
5967 (9)
5968 (b) As used in this subsection, the term:
5969 1. “Employee” includes any volunteer firefighter.
5970 2. “Officer, employee, or agent” includes, but is not
5971 limited to, any health care provider when providing services
5972 pursuant to s. 766.1115;~~,~~ any member of the Florida Health
5973 Services Corps, as defined in s. 381.0302, who provides
5974 uncompensated care to medically indigent persons referred by the

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5975 Department of Health; any nonprofit independent college or
5976 university located and chartered in this state which owns or
5977 operates an accredited medical school, and its employees or
5978 agents, when providing patient services pursuant to paragraph
5979 (10)(f);, and any public defender or her or his employee or
5980 agent, including, among others, an assistant public defender and
5981 an investigator.
5982 (10)
5983 (f) For purposes of this section, any nonprofit independent
5984 college or university located and chartered in this state which
5985 owns or operates an accredited medical school, or any of its
5986 employees or agents, and which has agreed in an affiliation
5987 agreement or other contract to provide, or to permit its
5988 employees or agents to provide, patient services as agents of a
5989 teaching hospital, is considered an agent of the teaching
5990 hospital while acting within the scope of and pursuant to
5991 guidelines established in the contract. To the extent allowed by
5992 law, the contract must provide for the indemnification of the
5993 state, up to the limits set out in this chapter, by the agent
5994 for any liability incurred which was caused by the negligence of
5995 the college or university or its employees or agents.
5996 1. For purposes of this paragraph, the term:
5997 a. "Employee or agent" means an officer, employee, agent,
5998 or servant of a nonprofit independent college or university
5999 located and chartered in this state which owns or operates an
6000 accredited medical school, including, but not limited to, the
6001 faculty of the medical school, any health care practitioner or
6002 licensee as defined in s. 456.001 for which the college or
6003 university is vicariously liable, and the staff or administrator

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6004 of the medical school.
6005 b. "Patient services" mean:
6006 (I) Comprehensive health care services as defined in s.
6007 641.19, including any related administrative service, provided
6008 to patients in a teaching hospital or in a health care facility
6009 that is a part of a nonprofit independent college or university
6010 located and chartered in this state which owns or operates an
6011 accredited medical school, pursuant to an affiliation agreement
6012 or other contract with a teaching hospital;
6013 (II) Training and supervision of interns, residents, and
6014 fellows providing patient services in a teaching hospital or in
6015 a health care facility that is a part of a nonprofit independent
6016 college or university located and chartered in this state which
6017 owns or operates an accredited medical school, pursuant to an
6018 affiliation agreement or other contract with a teaching
6019 hospital;
6020 (III) Participation in medical research protocols; or
6021 (IV) Training and supervision of medical students in a
6022 teaching hospital or in a health care facility owned by a not-
6023 for-profit college or university that owns or operates an
6024 accredited medical school, pursuant to an affiliation agreement
6025 or other contract with a teaching hospital.
6026 c. "Teaching hospital" means a teaching hospital as defined
6027 in s. 408.07 which is owned or operated by the state, a county
6028 or municipality, a public health trust, a special taxing
6029 district, a governmental entity having health care
6030 responsibilities, or a not-for-profit entity that operates such
6031 facilities as an agent of the state or a political subdivision
6032 of the state under a lease or other contract.

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6033 2. The teaching hospital or the medical school, or its
6034 employees or agents, must provide written notice to each
6035 patient, or the patient's legal representative, receipt of which
6036 must be acknowledged in writing, that the college or university
6037 that owns or operates the medical school and the employees or
6038 agents of that college or university are acting as agents of the
6039 teaching hospital and that the exclusive remedy for injury or
6040 damage suffered as the result of any act or omission of the
6041 teaching hospital, the college or university that owns or
6042 operates the medical school, or the employees or agents of the
6043 college or university while acting within the scope of duties
6044 pursuant to the affiliation agreement or other contract with a
6045 teaching hospital, is by commencement of an action pursuant to
6046 the provisions of this section.
6047 3. This paragraph does not designate any employee providing
6048 contracted patient services in a teaching hospital as an
6049 employee or agent of the state for purposes of chapter 440.
6050 Section 82. Legislative findings and intent.—
6051 (1) The Legislature finds that:
6052 (a) Access to high-quality, comprehensive, and affordable
6053 health care for all persons in this state is a necessary state
6054 goal and that teaching hospitals play an intrinsic and essential
6055 role in providing that access.
6056 (b) Graduate medical education, provided by nonprofit
6057 independent colleges and universities located and chartered in
6058 this state which own or operate medical schools, helps provide
6059 the comprehensive specialty training needed by medical school
6060 graduates to develop and refine the skills essential to the
6061 provision of high-quality health care for our state residents.

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6062 Much of that education and training is provided in teaching
6063 hospitals under the direct supervision of medical faculty who
6064 provide guidance, training, and oversight, and serve as role
6065 models to their students.
6066 (c) A large proportion of medical care is provided in
6067 teaching hospitals that serve as safety nets for many indigent
6068 and underserved patients who otherwise might not receive the
6069 medical help they need. Resident physician training that takes
6070 place in such hospitals provides much of the care provided to
6071 this population. Medical faculty, supervising such training and
6072 care, are a vital link between educating and training resident
6073 physicians and ensuring the provision of quality care for
6074 indigent and underserved residents. Physicians that assume this
6075 role are often called upon to juggle the demands of patient
6076 care, teaching, research, health policy, and budgetary issues
6077 related to the programs they administer.
6078 (d) While teaching hospitals are afforded sovereign
6079 immunity protections under s. 768.28, Florida Statutes, the
6080 nonprofit independent colleges and universities located and
6081 chartered in this state which own or operate medical schools and
6082 which enter into affiliation agreements or contracts with the
6083 teaching hospitals to provide patient services are not afforded
6084 such sovereign immunity protections.
6085 (e) The employees or agents of nonprofit independent
6086 colleges and universities located and chartered in this state
6087 which enter into affiliation agreements or contracts with
6088 teaching hospitals to provide patient services do not have the
6089 same level of protection against liability claims as teaching
6090 hospitals and their employees and agents that provide the same

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6091 patient services to the same patients. Thus, these colleges and
6092 universities and their employees and agents are
6093 disproportionately affected by claims arising out of alleged
6094 medical malpractice and other allegedly negligent acts. Given
6095 the recent growth in medical schools and medical education
6096 programs and ongoing efforts to support, strengthen, and
6097 increase physician residency training positions and medical
6098 faculty in both existing and newly designated teaching
6099 hospitals, this exposure and the consequent disparity in
6100 liability exposure will continue to increase. The vulnerability
6101 of these colleges and universities to claims of medical
6102 malpractice will only add to the current physician workforce
6103 crisis in Florida and can be alleviated only through legislative
6104 action.
6105 (f) Ensuring that the employees and agents of nonprofit
6106 independent colleges and universities located and chartered in
6107 this state which own or operated medical schools are able to
6108 continue to treat patients, provide graduate medical education,
6109 supervise medical students, engage in research, and provide
6110 administrative support and services in teaching hospitals is an
6111 overwhelming public necessity.
6112 (2) The Legislature intends that:
6113 (a) Employees and agents of nonprofit independent colleges
6114 and universities located and chartered in this state which own
6115 or operate medical schools, who provide patient services as
6116 agents of a teaching hospital be immune from lawsuits in the
6117 same manner and to the same extent as employees and agents of
6118 teaching hospitals in this state under existing law, and that
6119 such colleges and universities and their employees and agents

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6120 not be held personally liable in tort or named as a party
6121 defendant in an action while providing patient services in a
6122 teaching hospital, unless such services are provided in bad
6123 faith, with malicious purpose, or in a manner exhibiting wanton
6124 and willful disregard of human rights, safety, or property.
6125 (b) Nonprofit independent private colleges and universities
6126 located and chartered in this state which own or operate medical
6127 schools and which permit their employees or agents to provide
6128 patient services in teaching hospitals pursuant to an
6129 affiliation agreement or other contract, be afforded sovereign
6130 immunity protections under s. 768.28, Florida Statutes.
6131 (3) The Legislature declares that there is an overwhelming
6132 public necessity for extending the state's sovereign immunity to
6133 nonprofit independent colleges and universities located and
6134 chartered in this state which own or operate medical schools and
6135 provide patient services in teaching hospitals, and to their
6136 employees and agents, and that there is no alternative method of
6137 meeting such public necessity.
6138 (4) The terms "employee or agent," "patient services," and
6139 "teaching hospital" used in this section have the same meaning
6140 as the terms defined in s. 768.28, Florida Statutes, as amended
6141 by this act.
6142 Section 83. Section 1004.41, Florida Statutes, is amended
6143 to read:
6144 1004.41 University of Florida; J. Hillis Miller Health
6145 Center.—
6146 (1) There is established the J. Hillis Miller Health Center
6147 at the University of Florida, including campuses at Gainesville
6148 and Jacksonville and affiliated teaching hospitals, which shall

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6149 include the following colleges:
6150 (a) College of Dentistry.
6151 (b) College of Public Health and Health Professions.
6152 (c) College of Medicine.
6153 (d) College of Nursing.
6154 (e) College of Pharmacy.
6155 (f) College of Veterinary Medicine and related teaching
6156 hospitals.
6157 (2) Each college of the health center shall be ~~so~~
6158 maintained and operated so as to comply with the standards
6159 approved by a nationally recognized association for
6160 accreditation.
6161 (3)(a) The University of Florida Health Center Operations
6162 and Maintenance Trust Fund shall be administered by the
6163 University of Florida Board of Trustees. Funds shall be credited
6164 to the trust fund from the sale of goods and services performed
6165 by the University of Florida Veterinary Medicine Teaching
6166 Hospital. The purpose of the trust fund is to support the
6167 instruction, research, and service missions of the University of
6168 Florida College of Veterinary Medicine.
6169 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and
6170 pursuant to s. 216.351, any balance in the trust fund at the end
6171 of any fiscal year shall remain in the trust fund and ~~shall~~ be
6172 available for carrying out the purposes of the trust fund.
6173 (4)(a) The University of Florida Board of Trustees shall
6174 lease the hospital facilities of the health center known as the
6175 Shands Teaching Hospital and Clinics on the Gainesville campus
6176 of the University of Florida and all furnishings, equipment, and
6177 other chattels or choses in action used in the operation of the

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6178 hospital, to Shands Teaching Hospital and Clinics, Inc., a
6179 private not-for-profit corporation organized ~~solely~~ for the
6180 primary purpose of supporting ~~operating~~ the University of
6181 Florida Board of Trustees' health affairs mission of community
6182 service and patient care, education and training of health
6183 professionals, and clinical research. In furtherance of that
6184 purpose, Shands Teaching Hospital and Clinics, Inc., shall
6185 operate the hospital and ancillary health care facilities as
6186 deemed ~~of the health center and other health care facilities and~~
6187 ~~programs determined to be~~ necessary by the board of Shands
6188 Teaching Hospital and Clinics, Inc. ~~the nonprofit corporation.~~
6189 The rental for the hospital facilities shall be an amount equal
6190 to the debt service on bonds or revenue certificates issued
6191 solely for capital improvements to the hospital facilities or as
6192 otherwise provided by law.
6193 (b) The University of Florida Board of Trustees shall
6194 provide in the lease or by separate contract or agreement with
6195 Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6196 ~~corporation~~ for the following:
6197 1. Approval of the articles of incorporation of Shands
6198 Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6199 ~~corporation~~ by the University of Florida Board of Trustees and
6200 the governance of that ~~the~~ not-for-profit corporation by a board
6201 of directors appointed, subject to removal, and chaired by the
6202 President of the University of Florida, or his or her designee,
6203 and vice chaired by the Vice President for Health Affairs of the
6204 University of Florida, or his or her designee.
6205 2. The use of hospital facilities and personnel in support
6206 of community service and patient care, ~~the~~ research programs,

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6207 and ~~of the~~ teaching roles ~~role~~ of the health center.
6208 3. The continued recognition of the collective bargaining
6209 units and collective bargaining agreements as currently composed
6210 and recognition of the certified labor organizations
6211 representing those units and agreements.
6212 4. The use of hospital facilities and personnel in
6213 connection with research programs conducted by the health
6214 center.
6215 5. Reimbursement to the hospital for indigent patients,
6216 state-mandated programs, underfunded state programs, and costs
6217 to the hospital for support of the teaching and research
6218 programs of the health center. Such reimbursement shall be
6219 appropriated to either the health center or the hospital each
6220 year by the Legislature after review and approval of the request
6221 for funds.
6222 (c) The University of Florida Board of Trustees may, with
6223 the approval of the Legislature, increase the hospital
6224 facilities or remodel or renovate them, provided that the rental
6225 paid by the hospital for such new, remodeled, or renovated
6226 facilities is sufficient to amortize the costs thereof over a
6227 reasonable period of time or fund the debt service for any bonds
6228 or revenue certificates issued to finance such improvements.
6229 (d) The University of Florida Board of Trustees is
6230 authorized to provide to Shands Teaching Hospital and Clinics,
6231 Inc., ~~the not-for-profit corporation leasing the hospital~~
6232 ~~facilities~~ and its not-for-profit subsidiaries and affiliates
6233 comprehensive general liability insurance including professional
6234 liability from a self-insurance trust program established
6235 pursuant to s. 1004.24.

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6236 (e) Shands Teaching Hospital and Clinics, Inc., may, in
6237 support of the health affairs mission of the University of
6238 Florida Board of Trustees and with its prior approval, create
6239 for-profit or not-for-profit corporate subsidiaries and
6240 affiliates, or both. The University of Florida Board of
6241 Trustees, which may act through the President of the University
6242 of Florida or his or her designee, has the right to control
6243 Shands Teaching Hospital and Clinics, Inc. Shands Teaching
6244 Hospital and Clinics, Inc., and any not-for-profit subsidiaries
6245 are conclusively deemed corporations primarily acting as
6246 instrumentalities of the state, pursuant to s. 768.28(2), for
6247 purposes of sovereign immunity.
6248 (f) ~~(e)~~ If ~~In the event that~~ the lease of the hospital
6249 facilities to Shands Teaching Hospital and Clinics, Inc., ~~the~~
6250 ~~not-for-profit corporation~~ is terminated for any reason, the
6251 University of Florida Board of Trustees shall resume management
6252 and operation of the hospital facilities. In such event, the
6253 University of Florida Board of Trustees is authorized to utilize
6254 revenues generated from the operation of the hospital facilities
6255 to pay the costs and expenses of operating the hospital facility
6256 for the remainder of the fiscal year in which such termination
6257 occurs.
6258 (5) ~~(f)~~ Shands Jacksonville Medical Center, Inc., and its
6259 parent Shands Jacksonville Healthcare, Inc., are private not-
6260 for-profit corporations organized primarily to support the
6261 health affairs mission of the University of Florida Board of
6262 Trustees in community service and patient care, education and
6263 training of health affairs professionals, and clinical research.
6264 Shands Jacksonville Medical Center, Inc., is a teaching hospital

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6265 affiliated with the University of Florida Board of Trustees,
6266 located on the Jacksonville Campus of the University of Florida.
6267 Shands Jacksonville Medical Center, Inc., and Shands
6268 Jacksonville Healthcare, Inc., may, in support of the health
6269 affairs mission of the University of Florida Board of Trustees
6270 and with its prior approval, create for-profit or not-for-profit
6271 corporate subsidiaries and affiliates, or both.
6272 (a) The University of Florida Board of Trustees, which may
6273 act through the President of the University of Florida or his or
6274 her designee, has the right to control Shands Jacksonville
6275 Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.
6276 Shands Jacksonville Medical Center, Inc., Shands Jacksonville
6277 Healthcare, Inc., and any not-for-profit subsidiary of Shands
6278 Jacksonville Medical Center, Inc., are conclusively deemed
6279 corporations primarily acting as instrumentalities of the state,
6280 pursuant to s. 768.28(2), for purposes of sovereign immunity.
6281 (b) The University of Florida Board of Trustees is
6282 authorized to provide to Shands Jacksonville Healthcare, Inc.,
6283 and its not-for-profit subsidiaries and affiliates and any
6284 successor corporation that acts in support of the board of
6285 trustees, comprehensive general liability coverage, including
6286 professional liability, from the self-insurance programs
6287 established pursuant to s. 1004.24.
6288 Section 84. Sections 409.9121, 409.919, and 624.915,
6289 Florida Statutes, are repealed.
6290 Section 85. Section 409.942, Florida Statutes, is
6291 transferred and renumbered as section 414.29, Florida Statutes.
6292 Section 86. Paragraph (a) of subsection (1) of section
6293 443.111, Florida Statutes, is amended to read:

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6294 443.111 Payment of benefits.—
6295 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
6296 in accordance with rules adopted by the Agency for Workforce
6297 Innovation, subject to the following requirements:
6298 (a) Benefits are payable by mail or electronically.
6299 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a
6300 system for the payment of benefits by electronic funds transfer,
6301 including, but not limited to, debit cards, electronic payment
6302 cards, or any other means of electronic payment that the agency
6303 deems to be commercially viable or cost-effective. Commodities
6304 or services related to the development of such a system shall be
6305 procured by competitive solicitation, unless they are purchased
6306 from a state term contract pursuant to s. 287.056. The agency
6307 shall adopt rules necessary to administer the system.
6308 Section 87. Sections 409.944, 409.945, and 409.946, Florida
6309 Statutes, are transferred and renumbered as sections 163.464,
6310 163.465, and 163.466, Florida Statutes, respectively.
6311 Section 88. Sections 409.953 and 409.9531, Florida
6312 Statutes, are transferred and renumbered as sections 402.81 and
6313 402.82, Florida Statutes, respectively.
6314 Section 89. The Agency for Health Care Administration shall
6315 submit a reorganizational plan to the Governor, the Speaker of
6316 the House of Representatives, and the President of the Senate by
6317 January 1, 2012, which converts the agency from a check-writing
6318 and fraud-chasing agency into a contract compliance and
6319 monitoring agency.
6320 Section 90. Effective December 1, 2011, if the Legislature
6321 has not received a letter from the Governor stating that the
6322 federal Centers for Medicare and Medicaid has approved the

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6323 waivers necessary to implement the Medicaid managed care reforms
6324 contained in this act, the State of Florida shall withdraw from
6325 the Medicaid program effective December 31, 2011.
6326 Section 91. If any provision of this act or its application
6327 to any person or circumstance is held invalid, the invalidity
6328 does not affect other provisions or applications of the act
6329 which can be given effect without the invalid provision or
6330 application, and to this end the provisions of this act are
6331 severable.
6332 Section 92. This act shall take effect upon becoming a law.

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