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

603-03929-11 20111972c2

1 A bill to be entitled
2 An act relating to health and human services; amending
3 s. 163.387, F.S.; exempting hospital districts from
4 the requirement to provide funding to a community
5 redevelopment agency; creating s. 200.186, F.S.;
6 requiring hospital district ad valorem revenues
7 dispersed to other entities to be spent only on health
8 care services; amending s. 393.0661, F.S.; conforming
9 provisions to changes made by the act; amending s.
10 409.016, F.S.; conforming provisions to changes made
11 by the act; creating s. 409.16713, F.S.; providing for
12 medical assistance for children in out-of-home care
13 and adopted children; specifying how those services
14 will be funded under certain circumstances; providing
15 legislative intent; providing a directive to the
16 Division of Statutory Revision; transferring,
17 renumbering, and amending s. 624.91, F.S.; decreasing
18 the administrative cost and raising the minimum loss
19 ratio for health plans; increasing compensation to the
20 insurer or provider for dental contracts; requiring
21 the Florida Healthy Kids Corporation to include use of
22 the school breakfast and lunch application form in the
23 corporation’s plan for publicizing the program;
24 conforming provisions to changes made by the act;
25 amending ss. 409.813, 409.8132, 409.815, 409.818,
26 154.503, and 408.915, F.S.; conforming provisions to
27 changes made by the act; amending s. 1006.06, F.S.;
28 requiring school districts to collaborate with the
29 Florida Kidcare program to use the application form

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30 for the school breakfast and lunch programs to provide
31 information about the Florida Kidcare program and to
32 authorize data on the application form be shared with
33 state agencies and the Florida Healthy Kids
34 Corporation and its agents; authorizing each school
35 district the option to share the data electronically;
36 requiring interagency agreements to ensure that the
37 data exchanged is protected from unauthorized
38 disclosure and is used only for enrollment in the
39 Florida Kidcare program; amending s. 409.901, F.S.;
40 revising definitions relating to Medicaid; amending s.
41 409.902, F.S.; revising provisions relating to the
42 designation of the Agency for Health Care
43 Administration as the state Medicaid agency;
44 specifying that eligibility and state funds for
45 medical services apply only to citizens and certain
46 noncitizens; providing exceptions; providing a
47 limitation on persons transferring assets in order to
48 become eligible for certain services; amending s.
49 409.9021, F.S.; revising provisions relating to
50 conditions for Medicaid eligibility; increasing the
51 number of years a Medicaid applicant forfeits
52 entitlements to the Medicaid program if he or she has
53 committed fraud; providing for the payment of monthly
54 premiums by Medicaid recipients; providing exemptions
55 to the premium requirement; requiring applicants to
56 agree to participate in certain health programs;
57 prohibiting a recipient who has access to employer-
58 sponsored health care from obtaining services

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59 reimbursed through the Medicaid fee-for-service
60 system; requiring the agency to develop a process to
61 allow the Medicaid premium that would have been
62 received to be used to pay employer premiums;
63 requiring that the agency allow opt-out opportunities
64 for certain recipients; creating s. 409.9022, F.S.;
65 specifying procedures to be implemented by a state
66 agency if the Medicaid expenditures exceed
67 appropriations; amending s. 409.903, F.S.; conforming
68 provisions to changes made by the act; deleting
69 obsolete provisions; amending s. 409.904, F.S.;
70 conforming provisions to changes made by the act;
71 renaming the “medically needy” program as the
72 “Medicaid nonpoverty medical subsidy”; narrowing the
73 subsidy to cover only certain services for a family,
74 persons age 65 or older, or blind or disabled persons;
75 revising the criteria for the agency’s assessment of
76 need for private duty nursing services; amending s.
77 409.905, F.S.; conforming provisions to changes made
78 by the act; requiring prior authorization for home
79 health services; amending s. 409.906, F.S.; providing
80 for a parental fee based on family income to be
81 assessed against the parents of children with
82 developmental disabilities served by home and
83 community-based waivers; prohibiting the agency from
84 paying for certain psychotropic medications prescribed
85 for a child; conforming provisions to changes made by
86 the act; amending ss. 409.9062 and 409.907, F.S.;
87 conforming provisions to changes made by the act;

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88 amending s. 409.908, F.S.; modifying the nursing home
89 patient care per diem rate to include dental care,
90 vision care, hearing care, and podiatric care;
91 directing the agency to seek a waiver to treat a
92 portion of the nursing home per diem as capital for
93 self-insurance purposes; requiring primary physicians
94 to be paid the Medicare fee-for-service rate by a
95 certain date; deleting the requirement that the agency
96 contract for transportation services with the
97 community transportation system; authorizing qualified
98 plans to contract for transportation services;
99 deleting obsolete provisions; conforming provisions to
100 changes made by the act; amending s. 409.9081, F.S.;
101 revising copayments for physician visits; requiring
102 the agency to seek a waiver to allow the increase of
103 copayments for nonemergency services furnished in a
104 hospital emergency department; amending s. 409.912,
105 F.S.; requiring Medicaid-eligible children who have
106 open child welfare cases and who reside in AHCA area
107 10 to be enrolled in specified capitated managed care
108 plans; expanding the number of children eligible to
109 receive behavioral health care services through a
110 specialty prepaid plan; repealing provisions relating
111 to a provider lock-in program; eliminating obsolete
112 provisions and updating provisions; conforming cross-
113 references; amending s. 409.915, F.S.; conforming
114 provisions to changes made by the act; transferring,
115 renumbering, and amending s. 409.9301, F.S.;
116 conforming provisions to changes made by the act;

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

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

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

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204 that plans make certain payments to providers within a
205 certain time; requiring the agency to develop a
206 methodology and request a state plan amendment to
207 ensure the availability of certified public
208 expenditures in the Medicaid managed care program to
209 support certain noninstitutional teaching faculty
210 providers; creating s. 409.969, F.S.; authorizing
211 Medicaid recipients to select any plan within a
212 region; providing for automatic enrollment of
213 recipients by the agency in specified circumstances;
214 providing criteria for automatic enrollment;
215 authorizing disenrollment under certain circumstances;
216 providing for a grievance process; defining the term
217 “good cause” for purposes of disenrollment; requiring
218 recipients to stay in plans for a specified time;
219 providing for reenrollment of recipients who move out
220 of a region; creating s. 409.970, F.S.; requiring the
221 agency to maintain an encounter data system; providing
222 requirements for prepaid plans to submit data in a
223 certain format; requiring the agency to analyze the
224 data; requiring the agency to test the data for
225 certain purposes by a certain date; creating s.
226 409.971, F.S.; providing for managed care medical
227 assistance; providing deadlines for beginning and
228 finalizing implementation; creating s. 409.972, F.S.;
229 establishing minimum services for the managed medical
230 assistance; providing for optional services;
231 authorizing plans to customize benefit packages;
232 requiring the agency to provide certain services to

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233 hemophiliacs; creating s. 409.973, F.S.; providing for
234 managed long-term care; providing deadlines for
235 beginning and finalizing implementation; providing
236 duties for the Department of Elderly Affairs relating
237 to the program; creating s. 409.974, F.S.; providing
238 recipient eligibility requirements for managed long-
239 term care; listing programs for which certain
240 recipients are eligible; specifying that an
241 entitlement to home and community-based services is
242 not created; creating s. 409.975, F.S.; establishing
243 minimum services for managed long-term care; creating
244 s. 409.976, F.S.; providing criteria for the selection
245 of plans to provide managed long-term care; creating
246 s. 409.977, F.S.; providing for managed long-term care
247 plan accountability; requiring the agency to establish
248 standards for specified providers; creating s.
249 409.978, F.S.; requiring that the agency operate the
250 Comprehensive Assessment and Review for Long-Term Care
251 Services program through an interagency agreement with
252 the Department of Elderly Affairs; providing duties of
253 the program; requiring the program to assign plan
254 enrollees to a level of care; providing for the
255 evaluation of dually eligible nursing home residents;
256 transferring, renumbering, and amending ss. 409.91207,
257 409.91211, and 409.9122, F.S.; conforming provisions
258 to changes made by the act; updating provisions and
259 deleting obsolete provisions; transferring and
260 renumbering ss. 409.9123 and 409.9124, F.S.; amending
261 s. 430.04, F.S.; eliminating outdated provisions;

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262 requiring the Department of Elderly Affairs to develop
263 a transition plan for specified elders and disabled
264 adults receiving long-term care Medicaid services if
265 qualified plans become available; amending s.
266 430.2053, F.S.; eliminating outdated provisions;
267 providing additional duties of aging resource centers;
268 providing an additional exception to direct services
269 that may not be provided by an aging resource center;
270 providing for the cessation of specified payments by
271 the department as qualified plans become available;
272 eliminating provisions requiring reports; amending s.
273 39.407, F.S.; requiring a motion by the Department of
274 Children and Family Services to provide psychotropic
275 medication to a child 10 years of age or younger to
276 include a review by a child psychiatrist; providing
277 that a court may not authorize the administration of
278 such medication absent a finding of compelling state
279 interest based on the review; amending s. 216.262,
280 F.S.; providing that limitations on an agency's total
281 number of positions does not apply to certain
282 positions in the Department of Health; amending s.
283 381.06014, F.S.; redefining the term "blood
284 establishment" and defining the term "volunteer
285 donor"; requiring that blood establishments disclose
286 specified information on their Internet website;
287 providing an exception for certain hospitals;
288 authorizing the Department of Legal Affairs to assess
289 a civil penalty against a blood establishment that
290 fails to disclose the information; providing that the

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291 civil penalty accrues to the state and requiring that
292 it be deposited into the General Revenue Fund;
293 prohibiting local governments from restricting access
294 to public facilities or infrastructure for certain
295 activities based on whether a blood establishment is
296 operating as a for-profit or not-for-profit
297 organization; prohibiting a blood establishment from
298 considering whether certain customers are operating as
299 for-profit or not-for-profit organizations when
300 determining service fees for blood or blood
301 components; amending s. 400.023, F.S.; requiring the
302 trial judge to conduct an evidentiary hearing to
303 determine the sufficiency of evidence for claims
304 against certain persons relating to a nursing home;
305 limiting noneconomic damages in a wrongful death
306 action against the nursing home; amending s. 400.0237,
307 F.S.; revising provisions relating to punitive damages
308 against a nursing home; authorizing a defendant to
309 proffer admissible evidence to refute a claimant's
310 proffer of evidence for punitive damages; requiring
311 the trial judge to conduct an evidentiary hearing and
312 the plaintiff to demonstrate that a reasonable basis
313 exists for the recovery of punitive damages;
314 prohibiting discovery of the defendant's financial
315 worth until the judge approves the pleading on
316 punitive damages; revising definitions; amending s.
317 408.7057, F.S.; requiring that the dispute resolution
318 program include a hearing in specified circumstances;
319 providing that the dispute resolution program

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320 established to resolve claims disputes between
321 providers and health plans does not provide an
322 independent right of recovery; requiring that the
323 conclusions of law in the written recommendation of
324 the resolution organization identify certain
325 information; providing a directive to the Division of
326 Statutory Revision; creating ss. 458.3167 and
327 459.0078, F.S.; providing for an expert witness
328 certificate for allopathic and osteopathic physicians
329 licensed in other states or Canada which authorizes
330 such physicians to provide expert medical opinions in
331 this state; providing application requirements and
332 timeframes for approval or denial by the Board of
333 Medicine and Board of Osteopathic Medicine,
334 respectively; requiring the boards to adopt rules and
335 set fees; providing for expiration of a certificate;
336 amending ss. 458.331 and 459.015, F.S.; providing
337 grounds for disciplinary action for providing
338 misleading, deceptive, or fraudulent expert witness
339 testimony relating to the practice of medicine and of
340 osteopathic medicine, respectively; providing for
341 construction with respect to the doctrine of
342 incorporation by reference; amending s. 499.003, F.S.;
343 redefining the term “health care entity” to clarify
344 that a blood establishment is a health care entity
345 that may engage in certain activities; amending s.
346 499.005, F.S.; clarifying provisions that prohibit the
347 unauthorized wholesale distribution of a prescription
348 drug that was purchased by a hospital or other health

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349 care entity or donated or supplied at a reduced price
350 to a charitable organization, to conform to changes
351 made by the act; amending s. 499.01, F.S.; exempting
352 certain blood establishments from the requirements to
353 be permitted as a prescription drug manufacturer and
354 register products; requiring that certain blood
355 establishments obtain a restricted prescription drug
356 distributor permit under specified conditions;
357 limiting the prescription drugs that a blood
358 establishment may distribute under a restricted
359 prescription drug distributor permit; authorizing the
360 Department of Health to adopt rules regarding the
361 distribution of prescription drugs by blood
362 establishments; amending s. 626.9541, F.S.;
363 authorizing insurers to offer rewards or incentives to
364 health benefit plan members to encourage or reward
365 participation in wellness or health improvement
366 programs; authorizing insurers to require plan members
367 not participating in programs to provide verification
368 that their medical condition warrants
369 nonparticipation; providing application; amending s.
370 627.4147, F.S.; deleting a requirement that a medical
371 malpractice insurance contract include a clause
372 authorizing an insurer to admit liability and make a
373 settlement offer if the offer is within policy limits
374 without the insured’s permission; amending s. 766.102,
375 F.S.; providing that a physician who is an expert
376 witness in a medical malpractice presuit action must
377 meet certain requirements; amending s. 766.104, F.S.;

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378 requiring a good faith demonstration in a medical
379 malpractice case that there has been a breach of the
380 standard of care; amending s. 766.106, F.S.;
381 clarifying that a physician acting as an expert
382 witness is subject to disciplinary actions; amending
383 s. 766.1115, F.S.; conforming provisions to changes
384 made by the act; creating s. 766.1183, F.S.; defining
385 terms; providing for the recovery of civil damages by
386 Medicaid recipients according to a modified standard
387 of care; providing for recovery of certain excess
388 judgments by act of the Legislature; requiring the
389 Department of Children and Family Services to provide
390 notice to program applicants; creating s. 766.1184,
391 F.S.; defining terms; providing for the recovery of
392 civil damages by certain recipients of primary care
393 services at primary care clinics receiving specified
394 low-income pool funds according to a modified standard
395 of care; providing for recovery of certain excess
396 judgments by act of the Legislature; providing
397 requirements of health care providers receiving such
398 funds in order for the liability provisions to apply;
399 requiring notice to low-income pool recipients;
400 amending s. 766.203, F.S.; requiring the presuit
401 investigations conducted by the claimant and the
402 prospective defendant in a medical malpractice action
403 to provide grounds for a breach of the standard of
404 care; amending s. 768.28, F.S.; revising a definition;
405 providing that certain colleges and universities that
406 own or operate an accredited medical school and their

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407 employees and agents providing patient services in a
408 teaching hospital pursuant to an affiliation agreement
409 or contract with the teaching hospital are considered
410 agents of the hospital for the purposes of sovereign
411 immunity; providing definitions; requiring patients of
412 such hospitals to be provided with notice of their
413 remedies under sovereign immunity; providing an
414 exception; providing that providers and vendors
415 providing services to certain persons with
416 disabilities on behalf of the state are agents of the
417 state for the purposes of sovereign immunity;
418 providing legislative findings and intent with respect
419 to including certain colleges and universities and
420 their employees and agents under sovereign immunity;
421 providing a statement of public necessity; amending s.
422 1004.41, F.S.; clarifying provisions relating to
423 references to the corporation known as Shands Teaching
424 Hospital and Clinics, Inc.; clarifying provisions
425 regarding the purpose of the corporation; authorizing
426 the corporation to create corporate subsidiaries and
427 affiliates; providing that Shands Teaching Hospital
428 and Clinics, Inc., Shands Jacksonville Medical Center,
429 Inc., Shands Jacksonville Healthcare, Inc., and any
430 not-for-profit subsidiary of such entities are
431 instrumentalities of the state for purposes of
432 sovereign immunity; repealing s. 409.9121, F.S.,
433 relating to legislative intent concerning managed
434 care; repealing s. 409.919, F.S., relating to rule
435 authority; repealing s. 624.915, F.S., relating to the

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436 Florida Healthy Kids Corporation operating fund;
437 renumbering and transferring ss. 409.942, 409.944,
438 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.
439 414.29, 163.464, 163.465, 163.466, 402.81, and 402.82,
440 F.S., respectively; amending s. 443.111, F.S.;
441 conforming a cross-reference; directing the Agency for
442 Health Care Administration to submit a reorganization
443 plan to the Legislature; providing for the state's
444 withdrawal from the Medicaid program under certain
445 circumstances; providing for severability; providing
446 an effective date.
447
448 Be It Enacted by the Legislature of the State of Florida:
449
450 Section 1. Paragraph (c) of subsection (2) of section
451 163.387, Florida Statutes, is amended to read:
452 163.387 Redevelopment trust fund.—
453 (2)
454 (c) The following public bodies or taxing authorities are
455 exempt from paragraph (a):
456 1. A special district that levies ad valorem taxes on
457 taxable real property in more than one county.
458 2. A special district for which the sole available source
459 of revenue the district has the authority to levy is ad valorem
460 taxes at the time an ordinance is adopted under this section.
461 However, revenues or aid that may be dispensed or appropriated
462 to a district as defined in s. 388.011 at the discretion of an
463 entity other than such district shall not be deemed available.
464 3. A library district, except a library district in a

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465 jurisdiction where the community redevelopment agency had
466 validated bonds as of April 30, 1984.
467 4. A neighborhood improvement district created under the
468 Safe Neighborhoods Act.
469 5. A metropolitan transportation authority.
470 6. A water management district created under s. 373.069.
471 7. A hospital district that is a special district as
472 defined in s. 189.403, a county hospital that has taxing
473 authority under chapter 155, or a public health trust
474 established pursuant to s. 154.07.
475 Section 2. Section 200.186, Florida Statutes, is created to
476 read:
477 200.186 Hospital districts.—Notwithstanding any special act
478 or other law governing the expenditure of ad valorem revenues,
479 ad valorem revenues raised pursuant to a special act
480 establishing a hospital district, by a county hospital pursuant
481 to chapter 155, or a public health trust established pursuant to
482 s. 154.07, and disbursed by the district, county hospital, or
483 trust to municipalities or other organizations, may be used only
484 to pay for health care services.
485 Section 3. Present subsections (7) and (8) of section
486 393.0661, Florida Statutes, are redesignated as subsections (8)
487 and (9), respectively, a new subsection (7) is added to that
488 section, and present subsection (7) of that section is amended,
489 to read:
490 393.0661 Home and community-based services delivery system;
491 comprehensive redesign.—The Legislature finds that the home and
492 community-based services delivery system for persons with
493 developmental disabilities and the availability of appropriated

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494 funds are two of the critical elements in making services
495 available. Therefore, it is the intent of the Legislature that
496 the Agency for Persons with Disabilities shall develop and
497 implement a comprehensive redesign of the system.
498 (7) The agency shall impose and collect the fee authorized
499 by s. 409.906(13)(d) upon approval by the Centers for Medicare
500 and Medicaid Services.
501 (8) ~~(7)~~ ~~Nothing in~~ This section or related ~~in any~~
502 ~~administrative~~ rule does not ~~shall be construed to~~ prevent or
503 limit the Agency for Health Care Administration, in consultation
504 with the Agency for Persons with Disabilities, from adjusting
505 fees, reimbursement rates, lengths of stay, number of visits, or
506 number of services, or from limiting enrollment, or making any
507 other adjustment necessary to comply with the availability of
508 moneys and any limitations or directions provided ~~for~~ in the
509 General Appropriations Act or pursuant to s. 409.9022.
510 Section 4. The Division of Statutory Revision is requested
511 to designate ss. 409.016-409.803, Florida Statutes, as part I of
512 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC
513 ASSISTANCE."
514 Section 5. Section 409.016, Florida Statutes, is amended to
515 read:
516 409.016 Definitions.—As used in this part, the term
517 ~~chapter~~:
518 (1) "Department~~,~~" ~~unless otherwise specified,~~ means the
519 Department of Children and Family Services.
520 (2) "Secretary" means the Secretary of ~~the Department of~~
521 Children and Family Services.
522 (3) "Social and economic services~~,~~" ~~within the meaning of~~

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523 ~~this chapter,~~ means the providing of financial assistance as
524 well as preventive and rehabilitative social services for
525 children, adults, and families.
526 Section 6. Section 409.16713, Florida Statutes, is created
527 to read:
528 409.16713 Medical assistance for children in out-of-home
529 care and adopted children.—
530 (1) A child who is eligible under Title IV-E of the Social
531 Security Act, as amended, for subsidized board payments, foster
532 care, or adoption subsidies, and a child for whom the state has
533 assumed temporary or permanent responsibility and who does not
534 qualify for Title IV-E assistance but is in foster care, shelter
535 or emergency shelter care, or subsidized adoption is eligible
536 for medical assistance as provided in s. 409.903(4). This
537 includes a young adult who is eligible to receive services under
538 s. 409.1451(5) until the young adult reaches 21 years of age,
539 and a person who was eligible, as a child, under Title IV-E for
540 foster care or the state-provided foster care and who is a
541 participant in the Road-to-Independence Program.
542 (2) If medical assistance under Title XIX of the Social
543 Security Act, as amended, is not available due to the refusal of
544 the federal Department of Health and Human Services to provide
545 federal funds, a child or young adult described in subsection
546 (1) is eligible for medical services under the Medicaid managed
547 care program established in s. 409.963. Such medical assistance
548 shall be obtained by the community-based care lead agencies
549 established under s. 409.1671 and is subject to the availability
550 of funds appropriated for such purpose in the General
551 Appropriations Act.

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552 (3) It is the intent of the Legislature that the provision
553 of medical assistance meet the requirements of s. 471(a)(21) of
554 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),
555 related to eligibility for Title IV-E of the Social Security
556 Act, and that compliance with such provisions meet the
557 requirements of s. 402(a)(3) of the Social Security Act, as
558 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary
559 Assistance for Needy Families Block Grant Program.
560 Section 7. The Division of Statutory Revision is requested
561 to designate ss. 409.810-409.821, Florida Statutes, as part II
562 of chapter 409, Florida Statutes, entitled "KIDCARE."
563 Section 8. Section 624.91, Florida Statutes, is
564 transferred, renumbered as section 409.8115, Florida Statutes,
565 paragraph (b) of subsection (5) of that section is amended, and
566 subsection (8) is added to that section, to read:
567 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.—
568 (5) CORPORATION AUTHORIZATION, DUTIES, POWERS.—
569 (b) The Florida Healthy Kids Corporation shall:
570 1. Arrange for the collection of any family, local
571 contributions, or employer payment or premium, in an amount to
572 be determined by the board of directors, to provide for payment
573 of premiums for comprehensive insurance coverage and for the
574 actual or estimated administrative expenses.
575 2. Arrange for the collection of any voluntary
576 contributions ~~to provide~~ for payment of ~~Florida~~ Kidcare program
577 premiums for children who are not eligible for medical
578 assistance under Title XIX or Title XXI of the Social Security
579 Act.
580 3. Subject to ~~the provisions of~~ s. 409.8134, accept

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581 voluntary supplemental local match contributions that comply
582 with ~~the requirements of~~ Title XXI of the Social Security Act
583 for the purpose of providing additional ~~Florida~~ Kidcare coverage
584 in contributing counties under Title XXI.
585 4. Establish the administrative and accounting procedures
586 for the operation of the corporation.
587 5. Establish, with consultation from appropriate
588 professional organizations, standards for preventive health
589 services and providers and comprehensive insurance benefits
590 appropriate to children if~~, provided that~~ such standards for
591 rural areas do ~~shall~~ not limit primary care providers to board-
592 certified pediatricians.
593 6. Determine eligibility for children seeking to
594 participate in the Title XXI-funded components of the ~~Florida~~
595 Kidcare program consistent with the requirements specified in s.
596 409.814, as well as the non-Title-XXI-eligible children as
597 provided in subsection (3).
598 7. Establish procedures under which providers of local
599 match to, applicants to, and participants in the program may
600 have grievances reviewed by an impartial body and reported to
601 the board of directors of the corporation.
602 8. Establish participation criteria and, if appropriate,
603 contract with an authorized insurer, health maintenance
604 organization, or third-party administrator to provide
605 administrative services to the corporation.
606 9. Establish enrollment criteria that include penalties or
607 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage
608 upon voluntary cancellation for nonpayment of family premiums.
609 10. Contract with authorized insurers or providers ~~any~~

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610 ~~provider~~ of health care services, who meet ~~meeting~~ standards
611 established by the corporation, for the provision of
612 comprehensive insurance coverage to participants. Such standards
613 must ~~shall~~ include criteria under which the corporation may
614 contract with more than one provider of health care services in
615 program sites. Health plans shall be selected through a
616 competitive bid process. The Florida Healthy Kids Corporation
617 shall purchase goods and services in the most cost-effective
618 manner consistent with the delivery of quality medical care. The
619 maximum administrative cost for a Florida Healthy Kids
620 Corporation contract shall be 10 ~~15~~ percent. For health care
621 contracts, the minimum medical loss ratio for a Florida Healthy
622 Kids Corporation contract shall be 90 ~~85~~ percent. For dental
623 contracts, the remaining compensation to be paid to the
624 authorized insurer or provider must be at least 90 ~~under a~~
625 ~~Florida Healthy Kids Corporation contract shall be no less than~~
626 ~~an amount which is 85~~ percent of the premium, and~~;~~ to the extent
627 any contract provision does not provide for this minimum
628 compensation, this section prevails ~~shall prevail~~. The health
629 plan selection criteria and scoring system, and the scoring
630 results, shall be available upon request for inspection after
631 the bids have been awarded.
632 11. Establish disenrollment criteria if ~~in the event~~ local
633 matching funds are insufficient to cover enrollments.
634 12. Develop and implement a plan to publicize the Florida
635 Kidcare program, the eligibility requirements of the program,
636 and the procedures for enrollment in the program and to maintain
637 public awareness of the corporation and the program. Such plan
638 must include using the application form for the school lunch and

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639 breakfast programs as provided under s. 1006.06(7).
640 13. Secure staff necessary to properly administer the
641 corporation. Staff costs shall be funded from state and local
642 matching funds and such other private or public funds as become
643 available. The board of directors shall determine the number of
644 staff members necessary to administer the corporation.
645 14. In consultation with the partner agencies, provide an
646 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the
647 Governor, the Chief Financial Officer, the Commissioner of
648 Education, the President of the Senate, the Speaker of the House
649 of Representatives, and the Minority Leaders of the Senate and
650 the House of Representatives.
651 15. Provide information on a quarterly basis to the
652 Legislature and the Governor which compares the costs and
653 utilization of the full-pay enrolled population and the Title
654 XXI-subsidized enrolled population in the Florida Kidcare
655 program. ~~The information,~~ At a minimum, the information must
656 include:
657 a. The monthly enrollment and expenditure for full-pay
658 enrollees in the Medikids and Florida Healthy Kids programs
659 compared to the Title XXI-subsidized enrolled population; and
660 b. The costs and utilization by service of the full-pay
661 enrollees in the Medikids and Florida Healthy Kids programs and
662 the Title XXI-subsidized enrolled population.
663
664 By February 1, 2010, the Florida Healthy Kids Corporation shall
665 provide a study to the Legislature and the Governor on premium
666 impacts to the subsidized portion of the program from the
667 inclusion of the full-pay program, which must ~~shall~~ include

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668 recommendations on how to eliminate or mitigate possible impacts
669 to the subsidized premiums.
670 16. Establish benefit packages that conform to ~~the~~
671 ~~provisions of~~ the Florida Kidcare program, as created under this
672 part ~~in ss. 409.810-409.821~~.
673 (8) OPERATING FUND.—The Florida Healthy Kids Corporation
674 may establish and manage an operating fund for the purposes of
675 addressing the corporation's unique cash-flow needs and
676 facilitating the fiscal management of the corporation. At any
677 given time, the corporation may accumulate and maintain in the
678 operating fund a cash balance reserve equal to no more than 25
679 percent of its annualized operating expenses. Upon dissolution
680 of the corporation, any remaining cash balances of state funds
681 shall revert to the General Revenue Fund, or such other state
682 funds consistent with the appropriated funding, as provided by
683 law.
684 Section 9. Subsection (1) of section 409.813, Florida
685 Statutes, is amended to read:
686 409.813 Health benefits coverage; program components;
687 entitlement and nonentitlement.—
688 (1) The Florida Kidcare program includes health benefits
689 coverage provided to children through the following program
690 components, which shall be marketed as the Florida Kidcare
691 program:
692 (a) Medicaid.~~;~~
693 (b) Medikids as created in s. 409.8132.~~;~~
694 (c) The Florida Healthy Kids Corporation as created in s.
695 409.8115. ~~624.91;~~
696 (d) Employer-sponsored group health insurance plans

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697 approved under this part. ~~ss. 409.810-409.821; and~~
698 (e) The Children's Medical Services network ~~established in~~
699 ~~chapter 391~~.
700 Section 10. Subsection (4) of section 409.8132, Florida
701 Statutes, is amended to read:
702 409.8132 Medikids program component.—
703 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The
704 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,
705 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,
706 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,
707 409.987, 409.988, and 409.989 apply to the administration of the
708 Medikids program component of the Florida Kidcare program,
709 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified
710 by ~~the provisions of~~ subsection (7).
711 Section 11. Subsection (1) of section 409.815, Florida
712 Statutes, is amended to read:
713 409.815 Health benefits coverage; limitations.—
714 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare
715 program, benefits available under Medicaid and Medikids include
716 those goods and services provided under the medical assistance
717 program authorized by Title XIX of the Social Security Act, and
718 regulations thereunder, as administered in this state by the
719 agency. This includes those mandatory Medicaid services
720 authorized under s. 409.905 and optional Medicaid services
721 authorized under s. 409.906, rendered on behalf of eligible
722 individuals by qualified providers, in accordance with federal
723 requirements ~~for Title XIX~~, subject to any limitations or
724 directions provided ~~for~~ in the General Appropriations Act, ~~or~~
725 chapter 216, or s. 409.9022, and according to methodologies and

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726 limitations set forth in agency rules and policy manuals and
727 handbooks incorporated by reference ~~thereto~~.
728 Section 12. Subsection (5) of section 409.818, Florida
729 Statutes, is amended to read:
730 409.818 Administration.—In order to implement ss. 409.810-
731 409.821, the following agencies shall have the following duties:
732 (5) The Florida Healthy Kids Corporation shall retain its
733 functions as authorized in s. 409.8115 ~~624.91~~, including
734 eligibility determination for participation in the Healthy Kids
735 program.
736 Section 13. Paragraph (e) of subsection (2) of section
737 154.503, Florida Statutes, is amended to read:
738 154.503 Primary Care for Children and Families Challenge
739 Grant Program; creation; administration.—
740 (2) The department shall:
741 (e) Coordinate with the primary care program developed
742 pursuant to s. 154.011, the Florida Healthy Kids Corporation
743 program created in s. 409.8115 ~~624.91~~, the school health
744 services program created in ss. 381.0056 and 381.0057, the
745 Healthy Communities, Healthy People Program created in s.
746 381.734, and the volunteer health care provider program
747 established ~~developed~~ pursuant to s. 766.1115.
748 Section 14. Paragraph (c) of subsection (4) of section
749 408.915, Florida Statutes, is amended to read:
750 408.915 Eligibility pilot project.—The Agency for Health
751 Care Administration, in consultation with the steering committee
752 established in s. 408.916, shall develop and implement a pilot
753 project to integrate the determination of eligibility for health
754 care services with information and referral services.

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755 (4) The pilot project shall include eligibility
756 determinations for the following programs:
757 (c) Florida Healthy Kids as described in s. 409.8115 ~~624.91~~
758 and within eligibility guidelines provided in s. 409.814.
759 Section 15. Subsection (7) is added to section 1006.06,
760 Florida Statutes, to read:
761 1006.06 School food service programs.—
762 (7) Each school district shall collaborate with the Florida
763 Kidcare program created pursuant to ss. 409.810-409.821 to:
764 (a) At a minimum:
765 1. Provide application information about the Kidcare
766 program or an application for Kidcare to students at the
767 beginning of each school year.
768 2. Modify the school district's application form for the
769 lunch program under subsection (4) and the breakfast program
770 under subsection (5) to incorporate a provision that permits the
771 school district to share data from the application form with the
772 state agencies and the Florida Healthy Kids Corporation and its
773 agents that administer the Kidcare program unless the child's
774 parent or guardian opts out of the provision.
775 (b) At the option of the school district, share income and
776 other demographic data through an electronic interchange with
777 the Florida Healthy Kids Corporation and other state agencies in
778 order to determine eligibility for the Kidcare program on a
779 regular and periodic basis.
780 (c) Establish interagency agreements ensuring that data
781 exchanged under this subsection is used only to enroll eligible
782 children in the Florida Kidcare program and is protected from
783 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).

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784 Section 16. The Division of Statutory Revision is requested
785 to designate ss. 409.901 through 409.9205, Florida Statutes, as
786 part III of chapter 409, Florida Statutes, entitled "MEDICAID."
787 Section 17. Section 409.901, Florida Statutes, is amended
788 to read:
789 409.901 Definitions~~; ss. 409.901-409.920~~.—As used in this
790 part and part IV ~~ss. 409.901-409.920, except as otherwise~~
791 ~~specifically provided~~, the term:
792 (1) "Affiliate" or "affiliated person" means any person who
793 directly or indirectly manages, controls, or oversees the
794 operation of a corporation or other business entity that is a
795 Medicaid provider, regardless of whether such person is a
796 partner, shareholder, owner, officer, director, agent, or
797 employee of the entity.
798 (2) "Agency" means the Agency for Health Care
799 Administration. ~~The agency is the Medicaid agency for the state,~~
800 ~~as provided under federal law.~~
801 (3) "Applicant" means an individual whose written
802 application for medical assistance provided by Medicaid ~~under~~
803 ~~ss. 409.903-409.906~~ has been submitted to the Department of
804 Children and Family Services, or to the Social Security
805 Administration if the application is for Supplemental Security
806 Income, but has not received final action. The ~~This~~ term
807 includes an individual, who need not be alive at the time of
808 application, and whose application is submitted through a
809 representative or a person acting for the individual.
810 (4) "Benefit" means any benefit, assistance, aid,
811 obligation, promise, debt, liability, or the like, related to
812 any covered injury, illness, or necessary medical care, goods,

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813 or services.
814 (5) “Capitation” means a prospective per-member, per-month
815 payment designed to represent, in the aggregate, an actuarially
816 sound estimate of expenditures required for the management and
817 provision of a specified set of medical services or long-term
818 care services needed by members enrolled in a prepaid health
819 plan.
820 (6) ~~(5)~~ “Change of ownership” has the same meaning as in s.
821 408.803 and includes ~~means:~~
822 ~~(a) An event in which the provider ownership changes to a~~
823 ~~different individual entity as evidenced by a change in federal~~
824 ~~employer identification number or taxpayer identification~~
825 ~~number;~~
826 ~~(b) An event in which 51 percent or more of the ownership,~~
827 ~~shares, membership, or controlling interest of a provider is in~~
828 ~~any manner transferred or otherwise assigned. This paragraph~~
829 ~~does not apply to a licensee that is publicly traded on a~~
830 ~~recognized stock exchange; or~~
831 ~~(c) When the provider is licensed or registered by the~~
832 ~~agency,~~ an event considered a change of ownership under part II
833 of chapter 408 ~~for licensure as defined in s. 408.803~~.
834
835 ~~A change solely in the management company or board of directors~~
836 ~~is not a change of ownership.~~
837 (7) ~~(6)~~ “Claim” means any communication, whether written or
838 electronic (electronic impulse or magnetic), which is used by
839 any person to apply for payment from the Medicaid program, ~~or~~
840 its fiscal agent, or a qualified plan under part IV of this
841 chapter for each item or service purported ~~by any person~~ to have

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842 been provided ~~by a person~~ to a ~~any~~ Medicaid recipient.
843 (8) ~~(7)~~ “Collateral” means:
844 (a) Any and all causes of action, suits, claims,
845 counterclaims, and demands that accrue to a ~~the~~ recipient or to
846 a ~~the~~ recipient’s legal representative, related to any covered
847 injury, illness, or necessary medical care, goods, or services
848 that resulted in ~~necessitated that~~ Medicaid providing ~~provide~~
849 medical assistance.
850 (b) All judgments, settlements, and settlement agreements
851 rendered or entered into and related to ~~such~~ causes of action,
852 suits, claims, counterclaims, demands, or judgments.
853 (c) Proceeds, as defined in this section.
854 (9) ~~(8)~~ “Convicted” or “conviction” means a finding of
855 guilt, with or without an adjudication of guilt, in any federal
856 or state trial court ~~of record relating to charges brought by~~
857 ~~indictment or information,~~ as a result of a jury verdict,
858 nonjury trial, or entry of a plea of guilty or nolo contendere,
859 regardless of whether an appeal from judgment is pending.
860 (10) ~~(9)~~ “Covered injury or illness” means any sickness,
861 injury, disease, disability, deformity, abnormality disease,
862 necessary medical care, pregnancy, or death for which a third
863 party is, may be, could be, should be, or has been liable, and
864 for which Medicaid is, or may be, obligated to provide, or has
865 provided, medical assistance.
866 (11) ~~(10)~~ “Emergency medical condition” has the same meaning
867 as in s. 395.002. ~~means:~~
868 ~~(a) A medical condition manifesting itself by acute~~
869 ~~symptoms of sufficient severity, which may include severe pain~~
870 ~~or other acute symptoms, such that the absence of immediate~~

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871 ~~medical attention could reasonably be expected to result in any~~
872 ~~of the following:~~
873 ~~1. Serious jeopardy to the health of a patient, including a~~
874 ~~pregnant woman or a fetus.~~
875 ~~2. Serious impairment to bodily functions.~~
876 ~~3. Serious dysfunction of any bodily organ or part.~~
877 ~~(b) With respect to a pregnant woman:~~
878 ~~1. That there is inadequate time to effect safe transfer to~~
879 ~~another hospital prior to delivery.~~
880 ~~2. That a transfer may pose a threat to the health and~~
881 ~~safety of the patient or fetus.~~
882 ~~3. That there is evidence of the onset and persistence of~~
883 ~~uterine contractions or rupture of the membranes.~~
884 (12)~~(11)~~ "Emergency services and care" has the same meaning
885 as in s. 395.002 ~~means medical screening, examination, and~~
886 ~~evaluation by a physician, or, to the extent permitted by~~
887 ~~applicable laws, by other appropriate personnel under the~~
888 ~~supervision of a physician, to determine whether an emergency~~
889 ~~medical condition exists and, if it does, the care, treatment,~~
890 ~~or surgery for a covered service by a physician which is~~
891 ~~necessary to relieve or eliminate the emergency medical~~
892 ~~condition, within the service capability of a hospital~~.
893 (13)~~(12)~~ "Legal representative" means a guardian,
894 conservator, survivor, or personal representative of a recipient
895 or applicant, or of the property or estate of a recipient or
896 applicant.
897 (14)~~(13)~~ "Managed care plan" means a health insurer
898 authorized under chapter 624, an exclusive provider organization
899 authorized under chapter 627, a health maintenance organization

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900 authorized under chapter 641, a provider service network
901 authorized under s. 409.912(4)(d), or an accountable care
902 organization authorized under federal law ~~health maintenance~~
903 ~~organization authorized pursuant to chapter 641 or a prepaid~~
904 ~~health plan authorized pursuant to s. 409.912~~.
905 (15) ~~(14)~~ "Medicaid" or Medicaid program means the medical
906 assistance program authorized by Title XIX of the Social
907 Security Act, 42 U.S.C. s. 1396 et seq., and regulations
908 thereunder, as administered in this state by the agency.
909 ~~(15) "Medicaid agency" or "agency" means the single state~~
910 ~~agency that administers or supervises the administration of the~~
911 ~~state Medicaid plan under federal law.~~
912 ~~(16) "Medicaid program" means the program authorized under~~
913 ~~Title XIX of the federal Social Security Act which provides for~~
914 ~~payments for medical items or services, or both, on behalf of~~
915 ~~any person who is determined by the Department of Children and~~
916 ~~Family Services, or, for Supplemental Security Income, by the~~
917 ~~Social Security Administration, to be eligible on the date of~~
918 ~~service for Medicaid assistance.~~
919 (16) ~~(17)~~ "Medicaid provider" or "provider" means a person
920 or entity that has a Medicaid provider agreement in effect with
921 the agency and is in good standing with the agency. The term
922 also includes a person or entity that provides medical services
923 to a Medicaid recipient under the Medicaid managed care program
924 in part IV of this chapter.
925 (17) ~~(18)~~ "Medicaid provider agreement" or "provider
926 agreement" means a contract between the agency and a provider
927 for the provision of services or goods, or both, to Medicaid
928 recipients pursuant to Medicaid.

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929 (18) ~~(19)~~ “Medicaid recipient” or “recipient” means an
930 individual whom the Department of Children and Family Services,
931 or, for Supplemental Security Income, ~~by~~ the Social Security
932 Administration, determines is eligible, pursuant to federal and
933 state law, to receive medical assistance and related services
934 for which the agency may make payments under the Medicaid
935 program. For the purposes of determining third-party liability,
936 the term includes an individual formerly determined to be
937 eligible for Medicaid, an individual who has received medical
938 assistance under ~~the~~ Medicaid ~~program~~, or an individual on whose
939 behalf Medicaid has become obligated.
940 (19) ~~(20)~~ “Medicaid-related records” means records that
941 relate to the provider’s business or profession and to a
942 Medicaid recipient. The term includes ~~Medicaid-related records~~
943 ~~include~~ records related to non-Medicaid customers, clients, or
944 patients but only to the extent that the documentation is shown
945 by the agency to be necessary for determining ~~to determine~~ a
946 provider’s entitlement to payments under the Medicaid program.
947 (20) ~~(21)~~ “Medical assistance” means any provision of,
948 payment for, or liability for medical services or care by
949 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.
950 (21) ~~(22)~~ “Medical services” or “medical care” means medical
951 or medically related institutional or noninstitutional care,
952 goods, or services covered by the Medicaid program. The term
953 includes any services authorized and funded in the General
954 Appropriations Act.
955 (22) ~~(23)~~ “MediPass” means a primary care case management
956 program operated by the agency.
957 (23) ~~(24)~~ “Minority physician network” means a network of

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958 primary care physicians with experience in managing Medicaid or
959 Medicare recipients which ~~that~~ is predominantly owned by
960 minorities, as defined in s. 288.703, and which may have a
961 collaborative partnership with a public college or university
962 and a tax-exempt charitable corporation.
963 (24) ~~(25)~~ “Payment,” as it relates to third-party benefits,
964 means performance of a duty, promise, or obligation, or
965 discharge of a debt or liability, by the delivery, provision, or
966 transfer of third-party benefits for medical services. To “pay”
967 means to do any of the acts set forth in this subsection.
968 (25) ~~(26)~~ “Proceeds” means whatever is received upon the
969 sale, exchange, collection, or other disposition of the
970 collateral or proceeds thereon and includes insurance payable by
971 reason of loss or damage to the collateral or proceeds. Money,
972 checks, deposit accounts, and the like are “cash proceeds.” All
973 other proceeds are “noncash proceeds.”
974 (26) ~~(27)~~ “Third party” means an individual, entity, or
975 program, excluding Medicaid, that is, may be, could be, should
976 be, or has been liable for all or part of the cost of medical
977 services related to any medical assistance covered by Medicaid.
978 A third party includes a third-party administrator or a pharmacy
979 benefits manager.
980 (27) ~~(28)~~ “Third-party benefit” means any benefit that is or
981 may be available at any time through contract, court award,
982 judgment, settlement, agreement, or any arrangement between a
983 third party and any person or entity, including, without
984 limitation, a Medicaid recipient, a provider, another third
985 party, an insurer, or the agency, for any Medicaid-covered
986 injury, illness, goods, or services, including costs of medical

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987 services related thereto, for personal injury or for death of
988 the recipient, but specifically excluding policies of life
989 insurance on the recipient, unless available under terms of the
990 policy to pay medical expenses prior to death. The term
991 includes, without limitation, collateral, as defined in this
992 section, health insurance, any benefit under a health
993 maintenance organization, a preferred provider arrangement, a
994 prepaid health clinic, liability insurance, uninsured motorist
995 insurance or personal injury protection coverage, medical
996 benefits under workers' compensation, and any obligation under
997 law or equity to provide medical support.
998 Section 18. Section 409.902, Florida Statutes, is amended
999 to read:
1000 409.902 Designated single state agency; eligibility
1001 determinations; rules ~~payment requirements; program title;~~
1002 ~~release of medical records~~.~~—~~
1003 (1) The agency ~~for Health Care Administration~~ is designated
1004 as the single state agency authorized to administer the Medicaid
1005 state plan and to make payments for medical assistance and
1006 related services under Title XIX of the Social Security Act.
1007 These payments shall be made, subject to any limitations or
1008 directions provided for in the General Appropriations Act, only
1009 for services included in the Medicaid program, ~~shall be made~~
1010 only on behalf of eligible individuals, and ~~shall be made~~ only
1011 to qualified providers in accordance with federal requirements
1012 under ~~for~~ Title XIX of the Social Security Act and ~~the~~
1013 ~~provisions of~~ state law.
1014 (a) The agency must notify the Legislature before seeking
1015 an amendment to the state plan for purposes of implementing

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1016 provisions authorized by the Deficit Reduction Act of 2005.
1017 (b) The agency shall adopt any rules necessary to carry out
1018 its statutory duties under this subsection and any other
1019 statutory provisions related to its responsibility for the
1020 Medicaid program and state compliance with federal Medicaid
1021 requirements, including the Medicaid managed care program. ~~This~~
1022 ~~program of medical assistance is designated the "Medicaid~~
1023 ~~program."~~
1024 (2) The Department of Children and Family Services is
1025 responsible for determining Medicaid eligibility ~~determinations~~,
1026 including, but not limited to, policy, rules, and the agreement
1027 with the Social Security Administration for Medicaid eligibility
1028 ~~determinations~~ for Supplemental Security Income recipients, as
1029 well as the actual determination of eligibility. ~~As a condition~~
1030 ~~of Medicaid eligibility, subject to federal approval, the agency~~
1031 ~~for Health Care Administration and the Department of Children~~
1032 ~~and Family Services shall ensure that each recipient of Medicaid~~
1033 ~~consents to the release of her or his medical records to the~~
1034 ~~agency for Health Care Administration and the Medicaid Fraud~~
1035 ~~Control Unit of the Department of Legal Affairs.~~
1036 (a) Eligibility is restricted to United States citizens and
1037 to lawfully admitted noncitizens who meet the criteria provided
1038 in s. 414.095(3).
1039 1. Citizenship or immigration status must be verified. For
1040 noncitizens, this includes verification of the validity of
1041 documents with the United States Citizenship and Immigration
1042 Services using the federal SAVE verification process.
1043 2. State funds may not be used to provide medical services
1044 to individuals who do not meet the requirements of this

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1045 paragraph unless the services are necessary to treat an
1046 emergency medical condition or are for pregnant women. Such
1047 services are authorized only to the extent provided under
1048 federal law and in accordance with federal regulations as
1049 provided in 42 C.F.R. s. 440.255.
1050 (b) When adopting rules relating to eligibility for
1051 institutional care services, hospice services, and home and
1052 community-based waiver programs, and regardless of whether a
1053 penalty will be applied due to the unlawful transfer of assets,
1054 the payment of fair compensation by an applicant for a personal
1055 care services contract entered into on or after October 1, 2011,
1056 shall be evaluated using the following criteria:
1057 1. The contracted services do not duplicate services
1058 available through other sources or providers, such as Medicaid,
1059 Medicare, private insurance, or another legally obligated third
1060 party;
1061 2. The contracted services directly benefit the individual
1062 and are not services normally provided out of love and
1063 consideration for the individual;
1064 3. The actual cost to deliver services is computed in a
1065 manner that clearly reflects the actual number of hours to be
1066 expended, and the contract clearly identifies each specific
1067 service and the average number of hours of each service to be
1068 delivered each month;
1069 4. The hourly rate for each contracted service is equal to
1070 or less than the amount normally charged by a professional who
1071 traditionally provides the same or similar services;
1072 5. The contracted services are provided on a prospective
1073 basis only and not for services provided in the past; and

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1074 6. The contract provides fair compensation to the
1075 individual in his or her lifetime as set forth in life
1076 expectancy tables adopted in rule 65A-1.716, Florida
1077 Administrative Code.
1078 (c) The department shall adopt any rules necessary to carry
1079 out its statutory duties under this subsection for receiving and
1080 processing Medicaid applications and determining Medicaid
1081 eligibility, and any other statutory provisions related to
1082 responsibility for the determination of Medicaid eligibility.
1083 Section 19. Section 409.9021, Florida Statutes, is amended
1084 to read:
1085 409.9021 Conditions for Medicaid ~~Forfeiture of~~ eligibility
1086 ~~agreement~~.—As a condition of Medicaid eligibility, subject to
1087 federal regulation and approval:~~,~~
1088 (1) A Medicaid applicant must consent ~~shall agree~~ in
1089 writing to:
1090 (a) Have her or his medical records released to the agency
1091 and the Medicaid Fraud Control Unit of the Department of Legal
1092 Affairs.
1093 (b) Forfeit all entitlements to any goods or services
1094 provided through the Medicaid program for the next 10 years if
1095 he or she has been found to have committed Medicaid fraud~~,~~
1096 through judicial or administrative determination~~, two times in a~~
1097 ~~period of 5 years~~. This provision applies only to the Medicaid
1098 recipient found to have committed or participated in Medicaid
1099 ~~the~~ fraud and does not apply to any family member of the
1100 recipient who was not involved in the fraud.
1101 (2) A Medicaid applicant must pay a $10 monthly premium
1102 that covers all Medicaid-eligible recipients in the applicant's

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1103 family. However, an individual who is eligible for the
1104 Supplemental Security Income related Medicaid and is receiving
1105 institutional care payments is exempt from this requirement. The
1106 agency shall seek a federal waiver to authorize the imposition
1107 and collection of this premium effective December 31, 2011. Upon
1108 approval, the agency shall establish by rule procedures for
1109 collecting premiums from recipients, advance notice of
1110 cancellation, and waiting periods for reinstatement of coverage
1111 upon voluntary cancellation for nonpayment of premiums.
1112 (3) A Medicaid applicant must participate, in good faith,
1113 in:
1114 (a) A medically approved smoking cessation program if the
1115 applicant smokes.
1116 (b) A medically directed weight loss program if the
1117 applicant is or becomes morbidly obese.
1118 (c) A medically approved alcohol or substance abuse
1119 recovery program if the applicant is or becomes diagnosed as a
1120 substance abuser.
1121
1122 The agency shall seek a federal waiver to authorize the
1123 implementation of this subsection in order to assist the
1124 recipient in mitigating lifestyle choices and avoiding behaviors
1125 associated with the use of high-cost medical services.
1126 (4) A person who is eligible for Medicaid services and who
1127 has access to health care coverage through an employer-sponsored
1128 health plan may not receive Medicaid services reimbursed under
1129 s. 409.908, s. 409.912,or s. 409.986, but may use Medicaid
1130 financial assistance to pay the cost of premiums for the
1131 employer-sponsored health plan for the eligible person and his

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1132 or her Medicaid-eligible family members.
1133 (5) A Medicaid recipient who has access to other insurance
1134 or coverage created pursuant to state or federal law may opt out
1135 of the Medicaid services provided under s. 409.908, s. 409.912,
1136 or s. 409.986 and use Medicaid financial assistance to pay the
1137 cost of premiums for the recipient and the recipient's Medicaid
1138 eligible family members.
1139 (6) Subsections (4) and (5) shall be administered by the
1140 agency in accordance with s. 409.964(1)(j). The maximum amount
1141 available for the Medicaid financial assistance shall be
1142 calculated based on the Medicaid capitated rate as if the
1143 Medicaid recipient and the recipient's eligible family members
1144 participated in a qualified plan for Medicaid managed care under
1145 part IV of this chapter.
1146 Section 20. Section 409.9022, Florida Statutes, is created
1147 to read:
1148 409.9022 Limitations on Medicaid expenditures.—
1149 (1) Except as specifically authorized in this section, a
1150 state agency may not obligate or expend funds for the Medicaid
1151 program in excess of the amount appropriated in the General
1152 Appropriations Act.
1153 (2) If, at any time during the fiscal year, a state agency
1154 determines that Medicaid expenditures may exceed the amount
1155 appropriated during the fiscal year, the state agency shall
1156 notify the Social Services Estimating Conference, which shall
1157 meet to estimate Medicaid expenditures for the remainder of the
1158 fiscal year. If, pursuant to this paragraph or for any other
1159 purpose, the conference determines that Medicaid expenditures
1160 will exceed appropriations for the fiscal year, the state agency

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1161 shall develop and submit a plan for revising Medicaid
1162 expenditures in order to remain within the annual appropriation.
1163 The plan must include cost-mitigating strategies to negate the
1164 projected deficit for the remainder of the fiscal year and shall
1165 be submitted in the form of a budget amendment to the
1166 Legislative Budget Commission. The conference shall also
1167 estimate the amount of savings which will result from such cost-
1168 mitigating strategies proposed by the state agency as well as
1169 any other strategies the conference may consider and recommend.
1170 (3) In preparing the budget amendment to revise Medicaid
1171 expenditures in order to remain within appropriations, a state
1172 agency shall include the following revisions to the Medicaid
1173 state plan, in the priority order listed below:
1174 (a) Reduction in administrative costs.
1175 (b) Elimination of optional benefits.
1176 (c) Elimination of optional eligibility groups.
1177 (d) Reduction to institutional and provider reimbursement
1178 rates.
1179 (e) Reduction in the amount, duration, and scope of
1180 mandatory benefits.
1181
1182 The state agency may not implement any of these cost-containment
1183 measures until the amendment is approved by the Legislative
1184 Budget Commission.
1185 (4) In order to remedy a projected expenditure in excess of
1186 the amount appropriated in a specific appropriation within the
1187 Medicaid budget, a state agency may, consistent with chapter
1188 216:
1189 (a) Submit a budget amendment to transfer budget authority

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1190 between appropriation categories;
1191 (b) Submit a budget amendment to increase federal trust
1192 authority or grants and donations trust authority if additional
1193 federal or local funds are available; or
1194 (c) Submit any other budget amendment consistent with
1195 chapter 216.
1196 (5) The agency shall amend the Medicaid state plan to
1197 incorporate the provisions of this section.
1198 (6) Chapter 216 does not permit the transfer of funds from
1199 any other program into the Medicaid program or the transfer of
1200 funds out of the Medicaid program into any other program.
1201 Section 21. Section 409.903, Florida Statutes, is amended
1202 to read:
1203 409.903 Mandatory payments for eligible persons.—The agency
1204 shall make payments for medical assistance and related services
1205 on behalf of the following categories of persons who the
1206 Department of Children and Family Services, or the Social
1207 Security Administration by contract with the department ~~of~~
1208 ~~Children and Family Services~~, determines to be eligible for
1209 Medicaid, subject to the income, assets, and categorical
1210 eligibility tests set forth in federal and state law. Payment on
1211 behalf of these recipients ~~Medicaid eligible persons~~ is subject
1212 to the availability of moneys and any limitations established by
1213 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1214 (1) Low-income families with children if ~~are eligible for~~
1215 ~~Medicaid provided~~ they meet the following requirements:
1216 (a) The family includes a dependent child who is living
1217 with a caretaker relative.
1218 (b) The family's income does not exceed the gross income

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1219 test limit.
1220 (c) The family's countable income and resources do not
1221 exceed the applicable Aid to Families with Dependent Children
1222 (AFDC) income and resource standards under the AFDC state plan
1223 in effect on ~~in~~ July 1996, except as amended in the Medicaid
1224 state plan to conform as closely as possible to the requirements
1225 of the welfare transition program, to the extent permitted by
1226 federal law.
1227 (2) A person who receives payments from, who is determined
1228 eligible for, or who was eligible for but lost cash benefits
1229 from the federal program known as the Supplemental Security
1230 Income program (SSI). This ~~category~~ includes a low-income person
1231 age 65 or over and a low-income person under age 65 considered
1232 to be permanently and totally disabled.
1233 (3) A child under age 21 living in a low-income, two-parent
1234 family, and a child under age 7 living with a nonrelative~~,~~ if
1235 the income and assets of the family or child, as applicable, do
1236 not exceed the resource limits under the Temporary Cash
1237 Assistance Program.
1238 (4) A child who is eligible under Title IV-E of the Social
1239 Security Act for subsidized board payments, foster care, or
1240 adoption subsidies, and a child for whom the state has assumed
1241 temporary or permanent responsibility and who does not qualify
1242 for Title IV-E assistance but is in foster care, shelter or
1243 emergency shelter care, or subsidized adoption. This ~~category~~
1244 includes a young adult who is eligible to receive services under
1245 s. 409.1451(5), until the young adult reaches 21 years of age~~,~~
1246 without regard to any income, resource, or categorical
1247 eligibility test that is otherwise required. This ~~category~~ also

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1248 includes a person who as a child was eligible under Title IV-E
1249 of the Social Security Act for foster care or the state-provided
1250 foster care and who is a participant in the Road-to-Independence
1251 Program.
1252 (5) A pregnant woman for the duration of her pregnancy and
1253 for the postpartum period as defined in federal law and rule, or
1254 a child under age 1, if either is living in a family that has an
1255 income which is at or below ~~150 percent of the most current~~
1256 ~~federal poverty level, or, effective January 1, 1992, that has~~
1257 ~~an income which is at or below~~ 185 percent of the most current
1258 federal poverty level. Such a person is not subject to an assets
1259 test. ~~Further,~~ A pregnant woman who applies for eligibility for
1260 the Medicaid program through a qualified Medicaid provider must
1261 be offered the opportunity, subject to federal rules, to be made
1262 presumptively eligible for the Medicaid program.
1263 (6) A child ~~born after September 30, 1983,~~ living in a
1264 family that has an income which is at or below 100 percent of
1265 the current federal poverty level, who has attained the age of
1266 6, but has not attained the age of 19. In determining the
1267 eligibility of such a child, an assets test is not required. A
1268 child who is eligible ~~for Medicaid~~ under this subsection must be
1269 offered the opportunity, subject to federal rules, to be made
1270 presumptively eligible. A child who has been deemed
1271 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in
1272 a managed care plan until the child's full eligibility
1273 ~~determination~~ for Medicaid has been determined ~~completed~~.
1274 (7) A child living in a family that has an income that
1275 ~~which~~ is at or below 133 percent of the current federal poverty
1276 level, who has attained the age of 1, but has not attained the

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1277 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an
1278 assets test is not required. A child who is eligible ~~for~~
1279 ~~Medicaid~~ under this subsection must be offered the opportunity,
1280 subject to federal rules, to be made presumptively eligible. A
1281 child who has been deemed presumptively eligible may ~~for~~
1282 ~~Medicaid shall~~ not be enrolled in a managed care plan until the
1283 child's full eligibility ~~determination~~ for Medicaid has been
1284 determined ~~completed~~.
1285 (8) A person who is age 65 or over or is determined by the
1286 agency to be disabled, whose income is at or below 100 percent
1287 of the most current federal poverty level and whose assets do
1288 not exceed limitations established by the agency. However, the
1289 agency may only pay for premiums, coinsurance, and deductibles,
1290 as required by federal law, unless additional coverage is
1291 provided for any or all members of this group under ~~by~~ s.
1292 409.904(1).
1293 Section 22. Section 409.904, Florida Statutes, is amended
1294 to read:
1295 409.904 Optional payments for eligible persons.—The agency
1296 may make payments for medical assistance and related services on
1297 behalf of the following categories of persons who are determined
1298 to be eligible for Medicaid, subject to the income, assets, and
1299 categorical eligibility tests set forth in federal and state
1300 law. Payment on behalf of these ~~Medicaid eligible~~ persons is
1301 subject to the availability of moneys and any limitations
1302 established by the General Appropriations Act, ~~or~~ chapter 216,
1303 or s. 409.9022.
1304 (1) ~~Effective January 1, 2006, and~~ Subject to federal
1305 waiver approval, a person who is age 65 or older or is

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1306 determined to be disabled, whose income is at or below 88
1307 percent of the federal poverty level, whose assets do not exceed
1308 established limitations, and who is not eligible for Medicare
1309 or, if eligible for Medicare, is also eligible for and receiving
1310 Medicaid-covered institutional care services, hospice services,
1311 or home and community-based services. The agency shall seek
1312 federal authorization through a waiver to provide this coverage.
1313 This subsection expires June 30, 2011.
1314 (2) The following persons who are eligible for the Medicaid
1315 nonpoverty medical subsidy, which includes the same services as
1316 those provided to other Medicaid recipients, with the exception
1317 of services in skilled nursing facilities and intermediate care
1318 facilities for the developmentally disabled:
1319 (a) A family, a pregnant woman, a child under age 21, a
1320 person age 65 or over, or a blind or disabled person, who would
1321 be eligible under any group listed in s. 409.903(1), (2), or
1322 (3), except that the income or assets of such family or person
1323 exceed established limitations. For a family or person in one of
1324 these coverage groups, medical expenses are deductible from
1325 income in accordance with federal requirements in order to make
1326 a determination of eligibility. ~~A family or person eligible~~
1327 ~~under the coverage known as the "medically needy," is eligible~~
1328 ~~to receive the same services as other Medicaid recipients, with~~
1329 ~~the exception of services in skilled nursing facilities and~~
1330 ~~intermediate care facilities for the developmentally disabled.~~
1331 This paragraph expires June 30, 2011.
1332 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a
1333 child younger than 21 years of age who would be eligible under
1334 any group listed in s. 409.903, except that the income or assets

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1335 of such group exceed established limitations. For a person in
1336 one of these coverage groups, medical expenses are deductible
1337 from income in accordance with federal requirements in order to
1338 make a determination of eligibility. ~~A person eligible under the~~
1339 ~~coverage known as the "medically needy" is eligible to receive~~
1340 ~~the same services as other Medicaid recipients, with the~~
1341 ~~exception of services in skilled nursing facilities and~~
1342 ~~intermediate care facilities for the developmentally disabled.~~
1343 (c) A family, a person age 65 or older, or a blind or
1344 disabled person, who would be eligible under any group listed in
1345 s. 409.903(1), (2), or (3), except that the income or assets of
1346 such family or person exceed established limitations. For a
1347 family or person in one of these coverage groups, medical
1348 expenses are deductible from income in accordance with federal
1349 requirements in order to make a determination of eligibility. A
1350 family, a person age 65 or older, or a blind or disabled person,
1351 covered under the Medicaid nonpoverty medical subsidy, is
1352 eligible to receive physician services only.
1353 (3) A person who is in need of the services of a licensed
1354 nursing facility, a licensed intermediate care facility for the
1355 developmentally disabled, or a state mental hospital, whose
1356 income does not exceed 300 percent of the SSI income standard,
1357 and who meets the assets standards established under federal and
1358 state law. In determining the person's responsibility for the
1359 cost of care, the following amounts must be deducted from the
1360 person's income:
1361 (a) The monthly personal allowance for residents as set
1362 based on appropriations.
1363 (b) The reasonable costs of medically necessary services

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1364 and supplies that are not reimbursable by the Medicaid program.
1365 (c) The cost of premiums, copayments, coinsurance, and
1366 deductibles for supplemental health insurance.
1367 (4) A low-income person who meets all other requirements
1368 for Medicaid eligibility except citizenship and who is in need
1369 of emergency medical services. The eligibility of such a
1370 recipient is limited to the period of the emergency, in
1371 accordance with federal regulations.
1372 (5) Subject to specific federal authorization, a woman
1373 living in a family that has an income that is at or below 185
1374 percent of the most current federal poverty level. Coverage is
1375 limited to ~~is eligible for~~ family planning services as specified
1376 in s. 409.905(3) for a period of up to 24 months following a
1377 loss of Medicaid benefits.
1378 (6) A child who has not attained the age of 19 who has been
1379 determined eligible for the Medicaid program is deemed to be
1380 eligible for a total of 6 months, regardless of changes in
1381 circumstances other than attainment of the maximum age.
1382 ~~Effective January 1, 1999,~~ A child who has not attained the age
1383 of 5 and who has been determined eligible for the Medicaid
1384 program is deemed to be eligible for a total of 12 months
1385 regardless of changes in circumstances other than attainment of
1386 the maximum age.
1387 (7) A child under 1 year of age who lives in a family that
1388 has an income above 185 percent of the most recently published
1389 federal poverty level, but which is at or below 200 percent of
1390 such poverty level. In determining the eligibility ~~of such~~
1391 ~~child~~, an assets test is not required. A child who is eligible
1392 ~~for Medicaid~~ under this subsection must be offered the

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1393 opportunity, subject to federal rules, to be made presumptively
1394 eligible.
1395 (8) An eligible person ~~A Medicaid-eligible individual~~ for
1396 the individual's health insurance premiums, if the agency
1397 determines that such payments are cost-effective.
1398 (9) Eligible women with incomes at or below 200 percent of
1399 the federal poverty level and under age 65, for cancer treatment
1400 pursuant to the federal Breast and Cervical Cancer Prevention
1401 and Treatment Act of 2000, screened through the Mary Brogan
1402 Breast and Cervical Cancer Early Detection Program established
1403 under s. 381.93.
1404 Section 23. Section 409.905, Florida Statutes, is amended
1405 to read:
1406 409.905 Mandatory Medicaid services.—The agency shall ~~may~~
1407 make payments for the following services, which are required ~~of~~
1408 ~~the state~~ by Title XIX of the Social Security Act, furnished by
1409 Medicaid providers to recipients who are ~~determined to be~~
1410 eligible on the dates on which the services were provided. Any
1411 service under this section shall be provided only when medically
1412 necessary and in accordance with state and federal law.
1413 Mandatory services rendered by providers in mobile units to
1414 Medicaid recipients may be restricted by the agency. This
1415 section does not ~~Nothing in this section shall be construed to~~
1416 prevent or limit the agency from adjusting fees, reimbursement
1417 rates, lengths of stay, number of visits, number of services, or
1418 any other adjustments necessary to comply with the availability
1419 of moneys and any limitations or directions provided ~~for~~ in the
1420 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.
1421 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The

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1422 agency shall pay for services provided to a recipient by a
1423 licensed advanced registered nurse practitioner who has a valid
1424 collaboration agreement with a licensed physician on file with
1425 the Department of Health or who provides anesthesia services in
1426 accordance with established protocol required by state law and
1427 approved by the medical staff of the facility in which the
1428 ~~anesthetic~~ service is performed. Reimbursement for such services
1429 must be provided in an amount that equals at least ~~not less than~~
1430 80 percent of the reimbursement to a physician who provides the
1431 same services, unless otherwise provided ~~for~~ in the General
1432 Appropriations Act.
1433 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
1434 SERVICES.—The agency shall pay for early and periodic screening
1435 and diagnosis of a recipient under age 21 to ascertain physical
1436 and mental problems and conditions and ~~provide treatment to~~
1437 ~~correct or ameliorate these problems and conditions. These~~
1438 ~~services include~~ all services determined by the agency to be
1439 medically necessary for the treatment, correction, or
1440 amelioration of these problems and conditions, including
1441 personal care, private duty nursing, durable medical equipment,
1442 physical therapy, occupational therapy, speech therapy,
1443 respiratory therapy, and immunizations.
1444 (3) FAMILY PLANNING SERVICES.—The agency shall pay for
1445 services necessary to enable a recipient voluntarily to plan
1446 family size or to space children. These services include
1447 information; education; counseling regarding the availability,
1448 benefits, and risks of each method of pregnancy prevention;
1449 drugs and supplies; and necessary medical care and followup.
1450 Each recipient participating in ~~the~~ family planning ~~portion of~~

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1451 ~~the Medicaid program~~ must be provided the choice of ~~freedom to~~
1452 ~~choose~~ any alternative method of family planning, as required by
1453 federal law.
1454 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
1455 nursing and home health aide services, supplies, appliances, and
1456 durable medical equipment, necessary to assist a recipient
1457 living at home. An entity that provides such services must
1458 ~~pursuant to this subsection shall~~ be licensed under part III of
1459 chapter 400. These services, equipment, and supplies, or
1460 reimbursement therefor, may be limited as provided in the
1461 General Appropriations Act and do not include services,
1462 equipment, or supplies provided to a person residing in a
1463 hospital or nursing facility.
1464 (a) ~~In providing home health care services,~~ The agency
1465 shall ~~may~~ require prior authorization of home health services
1466 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing
1467 rates. ~~The agency shall require prior authorization for visits~~
1468 ~~for home health services that are not associated with a skilled~~
1469 ~~nursing visit when the home health agency billing rates exceed~~
1470 ~~the state average by 50 percent or more.~~ The home health agency
1471 must submit the recipient's plan of care and documentation that
1472 supports the recipient's diagnosis to the agency when requesting
1473 prior authorization.
1474 (b) The agency shall implement a comprehensive utilization
1475 management program ~~that requires prior authorization~~ of all
1476 private duty nursing services, an individualized treatment plan
1477 that includes information about medication and treatment orders,
1478 treatment goals, methods of care to be used, and plans for care
1479 coordination by nurses and other health professionals. The

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1480 utilization management program must ~~shall~~ also include a process
1481 for periodically reviewing the ongoing use of private duty
1482 nursing services. The assessment of need shall be based on a
1483 child's condition;~~,~~ family support and care supplements;~~,~~ a
1484 family's ability to provide care;~~, and~~ a family's and child's
1485 schedule regarding work, school, sleep, and care for other
1486 family dependents; and a determination of the medical necessity
1487 for private duty nursing instead of other more cost-effective
1488 in-home services. When implemented, the private duty nursing
1489 utilization management program shall replace the current
1490 authorization program used by the agency ~~for Health Care~~
1491 ~~Administration~~ and the Children's Medical Services program of
1492 the Department of Health. The agency may competitively bid ~~on~~ a
1493 contract to select a qualified organization to provide
1494 utilization management of private duty nursing services. The
1495 agency may ~~is authorized to~~ seek federal waivers to implement
1496 this initiative.
1497 (c) The agency may not pay for home health services unless
1498 the services are medically necessary and:
1499 1. The services are ordered by a physician.
1500 2. The written prescription for the services is signed and
1501 dated by the recipient's physician before the development of a
1502 plan of care and before any request requiring prior
1503 authorization.
1504 3. The physician ordering the services is not employed,
1505 under contract with, or otherwise affiliated with the home
1506 health agency rendering the services. However, this subparagraph
1507 does not apply to a home health agency affiliated with a
1508 retirement community, of which the parent corporation or a

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1509 related legal entity owns a rural health clinic certified under
1510 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
1511 under part II of chapter 400, or an apartment or single-family
1512 home for independent living. For purposes of this subparagraph,
1513 the agency may, on a case-by-case basis, provide an exception
1514 for medically fragile children who are younger than 21 years of
1515 age.
1516 4. The physician ordering the services has examined the
1517 recipient within the 30 days preceding the initial request for
1518 the services and biannually thereafter.
1519 5. The written prescription for the services includes the
1520 recipient's acute or chronic medical condition or diagnosis, the
1521 home health service required, and, for skilled nursing services,
1522 the frequency and duration of the services.
1523 6. The national provider identifier, Medicaid
1524 identification number, or medical practitioner license number of
1525 the physician ordering the services is listed on the written
1526 prescription for the services, the claim for home health
1527 reimbursement, and the prior authorization request.
1528 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
1529 all covered services provided for the medical care and treatment
1530 of a recipient who is admitted as an inpatient by a licensed
1531 physician or dentist to a hospital licensed under part I of
1532 chapter 395. However, the agency shall limit the payment for
1533 inpatient hospital services for a Medicaid recipient 21 years of
1534 age or older to 45 days or the number of days necessary to
1535 comply with the General Appropriations Act.
1536 (a) The agency may ~~is authorized to~~ implement reimbursement
1537 and utilization management reforms in order to comply with any

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1538 limitations or directions in the General Appropriations Act,
1539 which may include, but are not limited to~~:~~ prior authorization
1540 for inpatient psychiatric days; prior authorization for
1541 nonemergency hospital inpatient admissions for individuals 21
1542 years of age and older; authorization of emergency and urgent-
1543 care admissions within 24 hours after admission; enhanced
1544 utilization and concurrent review programs for highly utilized
1545 services; reduction or elimination of covered days of service;
1546 adjusting reimbursement ceilings for variable costs; adjusting
1547 reimbursement ceilings for fixed and property costs; and
1548 implementing target rates of increase. The agency may limit
1549 prior authorization for hospital inpatient services to selected
1550 diagnosis-related groups, based on an analysis of the cost and
1551 potential for unnecessary hospitalizations represented by
1552 certain diagnoses. Admissions for normal delivery and newborns
1553 are exempt from requirements for prior authorization. In
1554 implementing the provisions of this section related to prior
1555 authorization, the agency must ~~shall~~ ensure that the process for
1556 authorization is accessible 24 hours per day, 7 days per week
1557 and that authorization is automatically granted if ~~when~~ not
1558 denied within 4 hours after the request. Authorization
1559 procedures must include steps for reviewing ~~review of~~ denials.
1560 Upon implementing the prior authorization program for hospital
1561 inpatient services, the agency shall discontinue its hospital
1562 retrospective review program.
1563 (b) A licensed hospital maintained primarily for the care
1564 and treatment of patients having mental disorders or mental
1565 diseases may ~~is~~ not ~~eligible to~~ participate in the hospital
1566 inpatient portion of the Medicaid program except as provided in

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1567 federal law. However, the Department of Children and Family
1568 Services shall apply for a waiver~~, within 9 months after June 5,~~
1569 ~~1991,~~ designed to provide hospitalization services for mental
1570 health reasons to children and adults in the most cost-effective
1571 and lowest cost setting possible. Such waiver shall include a
1572 request for the opportunity to pay for care in hospitals known
1573 under federal law as "institutions for mental disease" or
1574 "IMD's." The waiver proposal shall propose no additional
1575 aggregate cost to the state or Federal Government, and shall be
1576 conducted in Hillsborough County, Highlands County, Hardee
1577 County, Manatee County, and Polk County. The waiver proposal may
1578 incorporate competitive bidding for hospital services,
1579 comprehensive brokering, prepaid capitated arrangements, or
1580 other mechanisms deemed by the department to show promise in
1581 reducing the cost of acute care and increasing the effectiveness
1582 of preventive care. When developing the waiver proposal, the
1583 department shall take into account price, quality,
1584 accessibility, linkages of the hospital to community services
1585 and family support programs, plans of the hospital to ensure the
1586 earliest discharge possible, and the comprehensiveness of the
1587 mental health and other health care services offered by
1588 participating providers.
1589 (c) The agency shall adjust a hospital's current inpatient
1590 per diem rate to reflect the cost of serving the Medicaid
1591 population at that institution if:
1592 1. The hospital experiences an increase in Medicaid
1593 caseload by more than 25 percent in any year, primarily
1594 resulting from the closure of a hospital in the same service
1595 area occurring after July 1, 1995;

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1596 2. The hospital's Medicaid per diem rate is at least 25
1597 percent below the Medicaid per patient cost for that year; or
1598 3. The hospital is located in a county that has six or
1599 fewer general acute care hospitals, began offering obstetrical
1600 services on or after September 1999, and has submitted a request
1601 in writing to the agency for a rate adjustment after July 1,
1602 2000, but before September 30, 2000, in which case such
1603 hospital's Medicaid inpatient per diem rate shall be adjusted to
1604 cost, effective July 1, 2002. By October 1 of each year, the
1605 agency must provide estimated costs for any adjustment in a
1606 hospital inpatient per diem rate to the Executive Office of the
1607 Governor, the House of Representatives General Appropriations
1608 Committee, and the Senate Appropriations Committee. Before the
1609 agency implements a change in a hospital's inpatient per diem
1610 rate pursuant to this paragraph, the Legislature must have
1611 specifically appropriated sufficient funds in the General
1612 Appropriations Act to support the increase in cost as estimated
1613 by the agency.
1614 (d) The agency shall implement a hospitalist program in
1615 nonteaching hospitals, select counties, or statewide. The
1616 program shall require hospitalists to manage Medicaid
1617 recipients' hospital admissions and lengths of stay. Individuals
1618 who are dually eligible for Medicare and Medicaid are exempted
1619 from this requirement. Medicaid participating physicians and
1620 other practitioners with hospital admitting privileges shall
1621 coordinate and review admissions of Medicaid recipients with the
1622 hospitalist. The agency may competitively bid a contract for
1623 selection of a single qualified organization to provide
1624 hospitalist services. The agency may procure hospitalist

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1625 services by individual county or may combine counties in a
1626 single procurement. The qualified organization shall contract
1627 with or employ board-eligible physicians in Miami-Dade, Palm
1628 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency
1629 may ~~is authorized to~~ seek federal waivers to implement this
1630 program.
1631 (e) The agency shall implement a comprehensive utilization
1632 management program for hospital neonatal intensive care stays in
1633 certain high-volume participating hospitals, select counties, or
1634 statewide, and shall replace existing hospital inpatient
1635 utilization management programs for neonatal intensive care
1636 admissions. The program shall be designed to manage the lengths
1637 of stay for children being treated in neonatal intensive care
1638 units and must seek the earliest medically appropriate discharge
1639 to the child's home or other less costly treatment setting. The
1640 agency may competitively bid a contract for selection of a
1641 qualified organization to provide neonatal intensive care
1642 utilization management services. The agency may ~~is authorized to~~
1643 seek any federal waivers to implement this initiative.
1644 (f) The agency may develop and implement a program to
1645 reduce the number of hospital readmissions among the non-
1646 Medicare population eligible in areas 9, 10, and 11.
1647 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for
1648 preventive, diagnostic, therapeutic, or palliative care and
1649 other services provided to a recipient in the outpatient portion
1650 of a hospital licensed under part I of chapter 395, and provided
1651 under the direction of a licensed physician or licensed dentist,
1652 except that payment for such care and services is limited to
1653 $1,500 per state fiscal year per recipient, unless an exception

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1654 has been made by the agency, and with the exception of a
1655 Medicaid recipient under age 21, in which case the only
1656 limitation is medical necessity.
1657 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay
1658 for medically necessary diagnostic laboratory procedures ordered
1659 by a licensed physician or other licensed health care
1660 practitioner ~~of the healing arts~~ which are provided for a
1661 recipient in a laboratory that meets the requirements for
1662 Medicare participation and is licensed under chapter 483, if
1663 required.
1664 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-
1665 hour-a-day nursing and rehabilitative services for a recipient
1666 in a nursing facility licensed under part II of chapter 400 or
1667 in a rural hospital, as defined in s. 395.602, or in a Medicare
1668 certified skilled nursing facility operated by a general
1669 hospital, as defined in ~~by~~ s. 395.002~~(10)~~, which ~~that~~ is
1670 licensed under part I of chapter 395, and in accordance with
1671 ~~provisions set forth in~~ s. 409.908(2)(a), which services are
1672 ordered by and provided under the direction of a licensed
1673 physician. However, if a nursing facility has been destroyed or
1674 otherwise made uninhabitable by natural disaster or other
1675 emergency and another nursing facility is not available, the
1676 agency must pay for similar services temporarily in a hospital
1677 licensed under part I of chapter 395 provided federal funding is
1678 approved and available. The agency shall pay only for bed-hold
1679 days if the facility has an occupancy rate of 95 percent or
1680 greater. The agency is authorized to seek any federal waivers to
1681 implement this policy.
1682 (9) PHYSICIAN SERVICES.—The agency shall pay for covered

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1683 services and procedures rendered to a Medicaid recipient by, or
1684 under the personal supervision of, a person licensed under state
1685 law to practice medicine or osteopathic medicine. These services
1686 may be furnished in the physician's office, the ~~Medicaid~~
1687 recipient's home, a hospital, a nursing facility, or elsewhere,
1688 but must ~~shall~~ be medically necessary for the treatment of a
1689 covered ~~an~~ injury or~~,~~ illness~~, or disease~~ within the scope of
1690 the practice of medicine or osteopathic medicine as defined by
1691 state law. The agency may ~~shall~~ not pay for services that are
1692 clinically unproven, experimental, or for purely cosmetic
1693 purposes.
1694 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for
1695 professional and technical portable radiological services
1696 ordered by a licensed physician or other licensed health care
1697 practitioner ~~of the healing arts~~ which are provided by a
1698 licensed professional in a setting other than a hospital,
1699 clinic, or office of a physician or practitioner ~~of the healing~~
1700 ~~arts~~, on behalf of a recipient.
1701 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for
1702 outpatient primary ~~health~~ care services for a recipient provided
1703 by a clinic certified by and participating in the Medicare
1704 program which is located in a federally designated, rural,
1705 medically underserved area and has on its staff one or more
1706 licensed primary care nurse practitioners or physician
1707 assistants, and a licensed staff supervising physician or a
1708 consulting supervising physician.
1709 (12) TRANSPORTATION SERVICES.—The agency shall ensure that
1710 appropriate transportation services are available for a Medicaid
1711 recipient in need of transport to a qualified Medicaid provider

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1712 for medically necessary ~~and Medicaid-compensable~~ services, if
1713 the recipient's ~~provided a client's~~ ability to choose a specific
1714 transportation provider is ~~shall be~~ limited to those options
1715 resulting from policies established by the agency to meet the
1716 fiscal limitations of the General Appropriations Act. The agency
1717 may pay for necessary transportation and other related travel
1718 expenses ~~as necessary~~ only if these services are not otherwise
1719 available.
1720 Section 24. Section 409.906, Florida Statutes, is amended
1721 to read:
1722 409.906 Optional Medicaid services.—Subject to specific
1723 appropriations, the agency may make payments for services which
1724 are optional to the state under Title XIX of the Social Security
1725 Act and are furnished by Medicaid providers to recipients who
1726 are determined to be eligible on the dates on which the services
1727 were provided. Any optional service that is provided shall be
1728 provided only when medically necessary and in accordance with
1729 state and federal law. Optional services rendered by providers
1730 in mobile units to Medicaid recipients may be restricted or
1731 prohibited by the agency. ~~Nothing in~~ This section does not ~~shall~~
1732 ~~be construed to~~ prevent or limit the agency from adjusting fees,
1733 reimbursement rates, lengths of stay, number of visits, or
1734 number of services, or making any other adjustments necessary to
1735 comply with the availability of moneys and any limitations or
1736 directions provided for in the General Appropriations Act, ~~or~~
1737 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~
1738 ~~state's systems of providing services to elderly and disabled~~
1739 ~~persons and subject to the notice and review provisions of s.~~
1740 ~~216.177, the Governor may direct the Agency for Health Care~~

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1741 ~~Administration to amend the Medicaid state plan to delete the~~
1742 ~~optional Medicaid service known as "Intermediate Care Facilities~~
1743 ~~for the Developmentally Disabled."~~ Optional services may
1744 include:
1745 (1) ADULT DENTAL SERVICES.—For a recipient who is 21 years
1746 of age or older:
1747 (a) The agency may pay for medically necessary, emergency
1748 dental procedures to alleviate pain or infection. Emergency
1749 dental care is ~~shall be~~ limited to emergency oral examinations,
1750 necessary radiographs, extractions, and incision and drainage of
1751 abscess~~, for a recipient who is 21 years of age or older~~.
1752 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or
1753 partial dentures, the procedures required to seat full or
1754 partial dentures, and the repair and reline of full or partial
1755 dentures, provided by or under the direction of a licensed
1756 dentist~~, for a recipient who is 21 years of age or older~~.
1757 (c) ~~However,~~ Medicaid will not provide reimbursement for
1758 dental services provided in a mobile dental unit, except for a
1759 mobile dental unit:
1760 1. Owned by, operated by, or having a contractual agreement
1761 with the Department of Health and complying with Medicaid's
1762 county health department clinic services program specifications
1763 as a county health department clinic services provider.
1764 2. Owned by, operated by, or having a contractual
1765 arrangement with a federally qualified health center and
1766 complying with Medicaid's federally qualified health center
1767 specifications as a federally qualified health center provider.
1768 3. Rendering dental services to Medicaid recipients, 21
1769 years of age and older, at nursing facilities.

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1770 4. Owned by, operated by, or having a contractual agreement
1771 with a state-approved dental educational institution.
1772 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for
1773 an annual routine physical examination, conducted by or under
1774 the direction of a licensed physician, for a recipient age 21 or
1775 older, without regard to medical necessity, in order to detect
1776 and prevent disease, disability, or other health condition or
1777 its progression.
1778 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay
1779 for services provided to a recipient in an ambulatory surgical
1780 center licensed under part I of chapter 395, by or under the
1781 direction of a licensed physician or dentist.
1782 (4) BIRTH CENTER SERVICES.—The agency may pay for
1783 examinations and delivery, recovery, ~~and~~ newborn assessment, and
1784 related services, provided in a licensed birth center staffed
1785 with licensed physicians, certified nurse midwives, and midwives
1786 licensed in accordance with chapter 467, to a recipient expected
1787 to experience a low-risk pregnancy and delivery.
1788 (5) CASE MANAGEMENT SERVICES.—The agency may pay for
1789 primary care case management services rendered to a recipient
1790 pursuant to a federally approved waiver~~,~~ and targeted case
1791 management services for specific groups of targeted recipients,
1792 for which funding has been provided and which are rendered
1793 pursuant to federal guidelines. The agency may ~~is authorized to~~
1794 limit reimbursement for targeted case management services in
1795 order to comply with any limitations or directions provided for
1796 in the General Appropriations Act.
1797 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
1798 diagnostic, preventive, or corrective procedures, including

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1799 orthodontia in severe cases, provided to a recipient under age
1800 21, by or under the supervision of a licensed dentist. Services
1801 ~~provided under this program~~ include treatment of the teeth and
1802 associated structures of the oral cavity, as well as treatment
1803 of disease, injury, or impairment that may affect the oral or
1804 general health of the individual. However, Medicaid may ~~will~~ not
1805 provide reimbursement for dental services provided in a mobile
1806 dental unit, except for a mobile dental unit:
1807 (a) Owned by, operated by, or having a contractual
1808 agreement with the Department of Health and complying with
1809 Medicaid's county health department clinic services program
1810 specifications as a county health department clinic services
1811 provider.
1812 (b) Owned by, operated by, or having a contractual
1813 arrangement with a federally qualified health center and
1814 complying with Medicaid's federally qualified health center
1815 specifications as a federally qualified health center provider.
1816 (c) Rendering dental services to Medicaid recipients, 21
1817 years of age and older, at nursing facilities.
1818 (d) Owned by, operated by, or having a contractual
1819 agreement with a state-approved dental educational institution.
1820 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
1821 manipulation of the spine and initial services, screening, and X
1822 rays provided to a recipient by a licensed chiropractic
1823 physician.
1824 (8) COMMUNITY MENTAL HEALTH SERVICES.—
1825 ~~(a)~~ The agency may pay for rehabilitative services provided
1826 to a recipient by a mental health or substance abuse provider
1827 under contract with the agency or the Department of Children and

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1828 Family Services to provide such services. ~~Those~~ Services that
1829 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or
1830 recommended by a psychiatrist, and ~~those~~ services that ~~which~~ are
1831 medical in nature must ~~shall~~ be rendered or recommended by a
1832 physician or psychiatrist.
1833 (a) The agency shall ~~must~~ develop a provider enrollment
1834 process for community mental health providers which bases
1835 provider enrollment on an assessment of service need. The
1836 provider enrollment process shall be designed to control costs,
1837 prevent fraud and abuse, consider provider expertise and
1838 capacity, and assess provider success in managing utilization of
1839 care and measuring treatment outcomes. Providers must ~~will~~ be
1840 selected through a competitive procurement or selective
1841 contracting process. In addition ~~to other community mental~~
1842 ~~health providers~~, the agency shall consider enrolling ~~for~~
1843 ~~enrollment~~ mental health programs licensed under chapter 395 and
1844 group practices licensed under chapter 458, chapter 459, chapter
1845 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~
1846 continue the operation of its behavioral health utilization
1847 management program and ~~may~~ develop new services, if ~~these~~
1848 ~~actions are~~ necessary, to ensure savings from the implementation
1849 of the utilization management system. The agency shall
1850 coordinate the implementation of this enrollment process with
1851 the Department of Children and Family Services and the
1852 Department of Juvenile Justice. The agency may use ~~is authorized~~
1853 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,
1854 ~~to~~ preauthorize certain high-cost or highly utilized services,
1855 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make
1856 any other adjustments necessary to comply with any limitations

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1857 or directions provided for in the General Appropriations Act.
1858 (b) The agency may ~~is authorized to~~ implement reimbursement
1859 and use management reforms in order to comply with any
1860 limitations or directions in the General Appropriations Act,
1861 which may include, but are not limited to~~:~~ prior authorization
1862 of treatment and service plans; prior authorization of services;
1863 enhanced use review programs for highly used services; and
1864 limits on services for recipients ~~those~~ determined to be abusing
1865 their benefit coverages.
1866 (9) DIALYSIS FACILITY SERVICES.—Subject to specific
1867 appropriations being provided for this purpose, the agency may
1868 pay a dialysis facility that is approved as a dialysis facility
1869 in accordance with Title XVIII of the Social Security Act, for
1870 dialysis services that are provided to a Medicaid recipient
1871 under the direction of a physician licensed to practice medicine
1872 or osteopathic medicine in this state, including dialysis
1873 services provided in the recipient's home by a hospital-based or
1874 freestanding dialysis facility.
1875 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize
1876 and pay for certain durable medical equipment and supplies
1877 provided to a Medicaid recipient as medically necessary.
1878 (11) HEALTHY START SERVICES.—The agency may pay for a
1879 continuum of risk-appropriate medical and psychosocial services
1880 for the Healthy Start program in accordance with a federal
1881 waiver. The agency may not implement the federal waiver unless
1882 the waiver permits the state to limit enrollment or the amount,
1883 duration, and scope of services to ensure that expenditures will
1884 not exceed funds appropriated by the Legislature or available
1885 from local sources. If ~~the Health Care Financing Administration~~

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1886 ~~does not approve~~ a federal waiver for Healthy Start services is
1887 not approved, the agency, in consultation with the Department of
1888 Health and the Florida Association of Healthy Start Coalitions,
1889 may ~~is authorized to~~ establish a Medicaid certified-match
1890 program for Healthy Start services. Participation in the Healthy
1891 Start certified-match program is ~~shall be~~ voluntary, and
1892 reimbursement is ~~shall be~~ limited to the federal Medicaid share
1893 provided to Medicaid-enrolled Healthy Start coalitions for
1894 services provided to Medicaid recipients. The agency may not
1895 ~~shall~~ take ~~no~~ action to implement a certified-match program
1896 without ensuring that the amendment and review requirements of
1897 ss. 216.177 and 216.181 have been met.
1898 (12) HEARING SERVICES.—The agency may pay for hearing and
1899 related services, including hearing evaluations, hearing aid
1900 devices, dispensing of the hearing aid, and related repairs~~, if~~
1901 provided to a recipient by a licensed hearing aid specialist,
1902 otolaryngologist, otologist, audiologist, or physician.
1903 (13) HOME AND COMMUNITY-BASED SERVICES.—
1904 (a) The agency may pay for home-based or community-based
1905 services that are rendered to a recipient in accordance with a
1906 federally approved waiver program. The agency may limit or
1907 eliminate coverage for certain services, preauthorize high-cost
1908 or highly utilized services, or make any other adjustments
1909 necessary to comply with any limitations or directions provided
1910 ~~for~~ in the General Appropriations Act.
1911 (b) The agency may consolidate types of services offered in
1912 the Aged and Disabled Waiver, the Channeling Waiver, the Project
1913 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury
1914 Waiver programs in order to group similar services under a

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1915 single service, or continue a service upon evidence of the need
1916 for including a particular service type in a particular waiver.
1917 The agency may ~~is authorized to~~ seek a Medicaid state plan
1918 amendment or federal waiver approval to implement this policy.
1919 (c) The agency may implement a utilization management
1920 program designed to prior-authorize home and community-based
1921 service plans which ~~and~~ includes, but is not limited to,
1922 assessing proposed quantity and duration of services and
1923 monitoring ongoing service use by participants in the program.
1924 The agency may ~~is authorized to~~ competitively procure a
1925 qualified organization to provide utilization management of home
1926 and community-based services. The agency may ~~is authorized to~~
1927 seek any federal waivers to implement this initiative.
1928 (d) The agency shall assess a fee against the parents of a
1929 child who is being served by a waiver under this subsection if
1930 the adjusted household income is greater than 100 percent of the
1931 federal poverty level. The amount of the fee shall be calculated
1932 using a sliding scale based on the size of the family, the
1933 amount of the parent's adjusted gross income, and the federal
1934 poverty guidelines. The agency shall seek a federal waiver to
1935 implement this provision.
1936 (14) HOSPICE CARE SERVICES.—The agency may pay for all
1937 reasonable and necessary services for the palliation or
1938 management of a recipient's terminal illness, if the services
1939 are provided by a hospice that is licensed under part IV of
1940 chapter 400 and meets Medicare certification requirements.
1941 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
1942 DISABLED SERVICES.—The agency may pay for health-related care
1943 and services provided on a 24-hour-a-day basis by a facility

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1944 licensed and certified as a Medicaid Intermediate Care Facility
1945 for the Developmentally Disabled, for a recipient who needs such
1946 care because of a developmental disability. Payment may ~~shall~~
1947 not include bed-hold days except in facilities with occupancy
1948 rates of 95 percent or greater. The agency may ~~is authorized to~~
1949 seek any federal waiver approvals to implement this policy. If
1950 necessary to safeguard the state's systems of providing services
1951 to elderly and disabled persons and subject to notice and review
1952 under s. 216.177, the Governor may direct the agency to amend
1953 the Medicaid state plan to delete these services.
1954 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-
1955 hour-a-day intermediate care nursing and rehabilitation services
1956 rendered to a recipient in a nursing facility licensed under
1957 part II of chapter 400~~,~~ if the services are ordered by and
1958 provided under the direction of a physician.
1959 (17) OPTOMETRIC SERVICES.—The agency may pay for services
1960 provided to a recipient, including examination, diagnosis,
1961 treatment, and management, related to ocular pathology~~,~~ if the
1962 services are provided by a licensed optometrist or physician.
1963 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for
1964 all services provided to a recipient by a physician assistant
1965 licensed under s. 458.347 or s. 459.022. Reimbursement for such
1966 services must be at least ~~not less than~~ 80 percent of the
1967 reimbursement that would be paid to a physician who provided the
1968 same services.
1969 (19) PODIATRIC SERVICES.—The agency may pay for services,
1970 including diagnosis and medical, surgical, palliative, and
1971 mechanical treatment, related to ailments of the human foot and
1972 lower leg, if provided to a recipient by a podiatric physician

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1973 licensed under state law.
1974 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for
1975 medications that are prescribed for a recipient by a physician
1976 or other licensed health care practitioner ~~of the healing arts~~
1977 authorized to prescribe medications and that are dispensed to
1978 the recipient by a licensed pharmacist or physician in
1979 accordance with applicable state and federal law. However, the
1980 agency may not pay for any psychotropic medication prescribed
1981 for a child younger than the age for which the federal Food and
1982 Drug Administration has approved its use.
1983 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency
1984 may pay for all services provided to a recipient by a registered
1985 nurse first assistant as described in s. 464.027. Reimbursement
1986 for such services must be at least ~~may not be less than~~ 80
1987 percent of the reimbursement that would be paid to a physician
1988 providing the same services.
1989 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-
1990 inclusive psychiatric inpatient hospital care provided to a
1991 recipient age 65 or older in a state mental hospital.
1992 (23) VISUAL SERVICES.—The agency may pay for visual
1993 examinations, eyeglasses, and eyeglass repairs for a recipient
1994 if they are prescribed by a licensed physician specializing in
1995 diseases of the eye or by a licensed optometrist. Eyeglass
1996 frames for adult recipients are ~~shall be~~ limited to one pair per
1997 recipient every 2 years, except a second pair may be provided
1998 ~~during that period~~ after prior authorization. Eyeglass lenses
1999 for adult recipients are ~~shall be~~ limited to one pair per year
2000 except a second pair may be provided ~~during that period~~ after
2001 prior authorization.

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2002 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~
2003 ~~Health Care Administration~~, in consultation with the Department
2004 of Children and Family Services, may establish a targeted case-
2005 management project in those counties identified by the
2006 department ~~of Children and Family Services~~ and for all counties
2007 with a community-based child welfare project, as authorized
2008 under s. 409.1671, which have been specifically approved by the
2009 department. The covered group that is ~~of individuals who are~~
2010 eligible for ~~to receive~~ targeted case management include
2011 children who are eligible for Medicaid; who are between the ages
2012 of birth through 21; and who are under protective supervision or
2013 postplacement supervision, under foster-care supervision, or in
2014 shelter care or foster care. The number of eligible children
2015 ~~individuals who are eligible to receive targeted case management~~
2016 is limited to the number for whom the department ~~of Children and~~
2017 ~~Family Services~~ has matching funds to cover the costs. The
2018 general revenue funds required to match the funds for services
2019 provided by the community-based child welfare projects are
2020 limited to funds available for services described under s.
2021 409.1671. The department ~~of Children and Family Services~~ may
2022 transfer the general revenue matching funds as billed by the
2023 agency ~~for Health Care Administration~~.
2024 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for
2025 assistive-care services provided to recipients with functional
2026 or cognitive impairments residing in assisted living facilities,
2027 adult family-care homes, or residential treatment facilities.
2028 These services may include health support, assistance with the
2029 activities of daily living and the instrumental acts of daily
2030 living, assistance with medication administration, and

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2031 arrangements for health care.
2032 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM
2033 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~
2034 ~~authorized to~~ seek federal approval through a Medicaid waiver or
2035 a state plan amendment for the provision of occupational
2036 therapy, speech therapy, physical therapy, behavior analysis,
2037 and behavior assistant services to individuals who are 5 years
2038 of age and under and have a diagnosed developmental disability
2039 as defined in s. 393.063, or autism spectrum disorder as defined
2040 in s. 627.6686~~, or Down syndrome, a genetic disorder caused by~~
2041 ~~the presence of extra chromosomal material on chromosome 21~~.
2042 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~
2043 ~~Robertsonian Translocation, and other duplications of a portion~~
2044 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited
2045 to $36,000 annually and may not exceed $108,000 in total
2046 lifetime benefits. The agency shall submit an annual report
2047 beginning ~~on~~ January 1, 2009, to the President of the Senate,
2048 the Speaker of the House of Representatives, and the relevant
2049 committees of the Senate and the House of Representatives
2050 regarding progress on obtaining federal approval and
2051 recommendations for the implementation of these home and
2052 community-based services. The agency may not implement this
2053 subsection without prior legislative approval.
2054 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may
2055 pay for all services provided to a recipient by an
2056 anesthesiologist assistant licensed under s. 458.3475 or s.
2057 459.023. Reimbursement for such services must be at least ~~not~~
2058 ~~less than~~ 80 percent of the reimbursement that would be paid to
2059 a physician who provided the same services.

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2060 Section 25. Section 409.9062, Florida Statutes, is amended
2061 to read:
2062 409.9062 Lung transplant services for Medicaid recipients.—
2063 Subject to the availability of funds and ~~subject to~~ any
2064 limitations or directions provided ~~for~~ in the General
2065 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~
2066 ~~for Health Care Administration~~ Medicaid program shall pay for
2067 medically necessary lung transplant services for Medicaid
2068 recipients. These payments must be used to reimburse approved
2069 lung transplant facilities a global fee for providing lung
2070 transplant services to Medicaid recipients.
2071 Section 26. Paragraph (h) of subsection (3) of section
2072 409.907, Florida Statutes, is amended to read:
2073 409.907 Medicaid provider agreements.—The agency may make
2074 payments for medical assistance and related services rendered to
2075 Medicaid recipients only to an individual or entity who has a
2076 provider agreement in effect with the agency, who is performing
2077 services or supplying goods in accordance with federal, state,
2078 and local law, and who agrees that no person shall, on the
2079 grounds of handicap, race, color, or national origin, or for any
2080 other reason, be subjected to discrimination under any program
2081 or activity for which the provider receives payment from the
2082 agency.
2083 (3) The provider agreement developed by the agency, in
2084 addition to the requirements specified in subsections (1) and
2085 (2), shall require the provider to:
2086 (h) Be liable for and indemnify, defend, and hold the
2087 agency harmless from all claims, suits, judgments, or damages,
2088 including court costs and attorney's fees, arising out of the

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2089 negligence or omissions of the provider in the course of
2090 providing services to a recipient or a person believed to be a
2091 recipient, subject to s. 766.1183 or s. 766.1184.
2092 Section 27. Section 409.908, Florida Statutes, is amended
2093 to read:
2094 409.908 Reimbursement of Medicaid providers.—Subject to
2095 specific appropriations, the agency shall reimburse Medicaid
2096 providers, in accordance with state and federal law, according
2097 to methodologies set forth in the rules of the agency and in
2098 policy manuals and handbooks incorporated by reference therein.
2099 These methodologies may include fee schedules, reimbursement
2100 methods based on cost reporting, negotiated fees, competitive
2101 bidding pursuant to s. 287.057, and other mechanisms the agency
2102 considers efficient and effective for purchasing services or
2103 goods on behalf of recipients. ~~If a provider is reimbursed based~~
2104 ~~on cost reporting and submits a cost report late and that cost~~
2105 ~~report would have been used to set a lower reimbursement rate~~
2106 ~~for a rate semester, then the provider's rate for that semester~~
2107 ~~shall be retroactively calculated using the new cost report, and~~
2108 ~~full payment at the recalculated rate shall be effected~~
2109 ~~retroactively. Medicare-granted extensions for filing cost~~
2110 ~~reports, if applicable, shall also apply to Medicaid cost~~
2111 ~~reports.~~ Payment for Medicaid compensable services made on
2112 behalf of Medicaid eligible persons is subject to the
2113 availability of moneys and any limitations or directions
2114 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,
2115 or s. 409.9022. ~~Further, nothing in~~ This section does not ~~shall~~
2116 ~~be construed to~~ prevent or limit the agency from adjusting fees,
2117 reimbursement rates, lengths of stay, number of visits, or

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2118 number of services, or making any other adjustments necessary to
2119 comply with the availability of moneys and any limitations or
2120 directions provided ~~for~~ in the General Appropriations Act if~~,~~
2121 ~~provided~~ the adjustment is consistent with legislative intent.
2122 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed
2123 under part I of chapter 395 must be made prospectively or on the
2124 basis of negotiation.
2125 (a) *Inpatient care.*—
2126 1. Reimbursement for inpatient care is limited as provided
2127 ~~for~~ in s. 409.905(5), except for:
2128 a.~~1.~~ The raising of rate reimbursement caps, excluding
2129 rural hospitals.
2130 b.~~2.~~ Recognition of the costs of graduate medical
2131 education.
2132 c.~~3.~~ Other methodologies recognized in the General
2133 Appropriations Act.
2134 2. If ~~During the years~~ funds are transferred from the
2135 Department of Health, any reimbursement supported by such funds
2136 is ~~shall be~~ subject to certification by the Department of Health
2137 that the hospital has complied with s. 381.0403. The agency may
2138 ~~is authorized to~~ receive funds from state entities, including,
2139 but not limited to, the Department of Health, local governments,
2140 and other local political subdivisions, for the purpose of
2141 making special exception payments, including federal matching
2142 funds, through the Medicaid inpatient reimbursement
2143 methodologies. Funds received from state entities or local
2144 governments for this purpose shall be separately accounted for
2145 and may ~~shall~~ not be commingled with other state or local funds
2146 in any manner. The agency may certify all local governmental

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2147 funds used as state match under Title XIX of the Social Security
2148 Act, to the extent that the identified local health care
2149 provider that is otherwise entitled to and is contracted to
2150 receive such local funds is the benefactor under the state's
2151 Medicaid program as determined under the General Appropriations
2152 Act and pursuant to an agreement between the agency ~~for Health~~
2153 ~~Care Administration~~ and the local governmental entity. The local
2154 governmental entity shall use a certification form prescribed by
2155 the agency. At a minimum, the certification form must ~~shall~~
2156 identify the amount being certified and describe the
2157 relationship between the certifying local governmental entity
2158 and the local health care provider. The agency shall prepare an
2159 annual statement of impact which documents the specific
2160 activities undertaken during the previous fiscal year pursuant
2161 to this paragraph, to be submitted to the Legislature annually
2162 by ~~no later than~~ January 1~~, annually~~.
2163 (b) *Outpatient care.*—
2164 1. Reimbursement for hospital outpatient care is limited to
2165 $1,500 per state fiscal year per recipient, except for:
2166 a.~~1.~~ ~~Such~~ Care provided to a Medicaid recipient under age
2167 21, in which case the only limitation is medical necessity.
2168 b.~~2.~~ Renal dialysis services.
2169 c.~~3.~~ Other exceptions made by the agency.
2170 2. The agency may ~~is authorized to~~ receive funds from state
2171 entities, including, but not limited to, the Department of
2172 Health, the Board of Governors of the State University System,
2173 local governments, and other local political subdivisions, for
2174 the purpose of making payments, including federal matching
2175 funds, through the Medicaid outpatient reimbursement

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2176 methodologies. Funds received ~~from state entities and local~~
2177 ~~governments~~ for this purpose shall be separately accounted for
2178 and may ~~shall~~ not be commingled with other state or local funds
2179 ~~in any manner~~.
2180 3. The agency may limit inflationary increases for
2181 outpatient hospital services as directed by the General
2182 Appropriations Act.
2183 (c) *Disproportionate share.*—Hospitals that provide services
2184 to a disproportionate share of low-income Medicaid recipients,
2185 ~~or~~ that participate in the regional perinatal intensive care
2186 center program under chapter 383, or that participate in the
2187 statutory teaching hospital disproportionate share program may
2188 receive additional reimbursement. The total amount of payment
2189 for disproportionate share hospitals shall be fixed by the
2190 General Appropriations Act. The computation of these payments
2191 must comply ~~be made in compliance~~ with all federal regulations
2192 and the methodologies described in ss. 409.911, 409.9112, and
2193 409.9113.
2194 ~~(d) The agency is authorized to limit inflationary~~
2195 ~~increases for outpatient hospital services as directed by the~~
2196 ~~General Appropriations Act.~~
2197 (2) NURSING HOME CARE.—
2198 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II
2199 of chapter 400 and state-owned-and-operated intermediate care
2200 facilities for the developmentally disabled licensed under part
2201 VIII of chapter 400 must be made prospectively.
2202 (a)~~2.~~ Unless otherwise limited or directed in the General
2203 Appropriations Act, reimbursement to hospitals licensed under
2204 part I of chapter 395 for ~~the provision of~~ swing-bed nursing

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2205 home services must be based ~~made~~ on ~~the basis of~~ the average
2206 statewide nursing home payment, and reimbursement to a hospital
2207 ~~licensed under part I of chapter 395~~ for ~~the provision of~~
2208 skilled nursing services must be based ~~made~~ on ~~the basis of~~ the
2209 average nursing home payment for those services in the county in
2210 which the hospital is located. If ~~When~~ a hospital is located in
2211 a county that does not have any community nursing homes,
2212 reimbursement shall be determined by averaging the nursing home
2213 payments in counties that surround the county in which the
2214 hospital is located. Reimbursement to hospitals, including
2215 Medicaid payment of Medicare copayments, for skilled nursing
2216 services is ~~shall be~~ limited to 30 days, unless a prior
2217 authorization has been obtained from the agency. Medicaid
2218 reimbursement may be extended by the agency beyond 30 days, and
2219 approval must be based upon verification by the patient's
2220 physician that the patient requires short-term rehabilitative
2221 and recuperative services only, in which case an extension of no
2222 more than 15 days may be approved. Reimbursement to a hospital
2223 ~~licensed under part I of chapter 395~~ for the temporary provision
2224 of skilled nursing services to nursing home residents who have
2225 been displaced as the result of a natural disaster or other
2226 emergency may not exceed the average county nursing home payment
2227 for those services in the county in which the hospital is
2228 located and is limited to the period of time which the agency
2229 considers necessary for continued placement of the nursing home
2230 residents in the hospital.
2231 (b) Subject to any limitations or directions provided ~~for~~
2232 in the General Appropriations Act, the agency shall establish
2233 and implement a Florida Title XIX Long-Term Care Reimbursement

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2234 Plan (Medicaid) for nursing home care in order to provide care
2235 and services that conform to ~~in conformance with the~~ applicable
2236 state and federal laws, rules, regulations, and quality and
2237 safety standards and to ensure that individuals eligible for
2238 medical assistance have reasonable geographic access to such
2239 care.
2240 1. The agency shall amend the long-term care reimbursement
2241 plan and cost reporting system to create direct care and
2242 indirect care subcomponents of the patient care component of the
2243 per diem rate. These two subcomponents together must ~~shall~~ equal
2244 the patient care component of the per diem rate. Separate cost-
2245 based ceilings shall be calculated for each patient care
2246 subcomponent. The direct care subcomponent of the per diem rate
2247 is ~~shall be~~ limited by the cost-based class ceiling, and the
2248 indirect care subcomponent may be limited by the lower of the
2249 cost-based class ceiling, the target rate class ceiling, or the
2250 individual provider target.
2251 2. The direct care subcomponent includes ~~shall include~~
2252 salaries and benefits of direct care staff providing nursing
2253 services, including registered nurses, licensed practical
2254 nurses, and certified nursing assistants who deliver care
2255 directly to residents in the nursing home facility. This
2256 excludes nursing administration, minimum data set, and care plan
2257 coordinators, staff development, and the staffing coordinator.
2258 The direct care subcomponent also includes medically necessary
2259 dental care, vision care, hearing care, and podiatric care.
2260 3. All other patient care costs are ~~shall be~~ included in
2261 the indirect care cost subcomponent of the patient care per diem
2262 rate. ~~There shall be no~~ Costs may not be directly or indirectly

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2263 allocated to the direct care subcomponent from a home office or
2264 management company.
2265 4. On July 1 of each year, the agency shall report to the
2266 Legislature direct and indirect care costs, including average
2267 direct and indirect care costs per resident per facility and
2268 direct care and indirect care salaries and benefits per category
2269 of staff member per facility.
2270 5. In order to offset the cost of general and professional
2271 liability insurance, the agency shall amend the plan to allow
2272 for interim rate adjustments to reflect increases in the cost of
2273 general or professional liability insurance for nursing homes.
2274 This provision shall be implemented to the extent existing
2275 appropriations are available.
2276
2277 It is the intent of the Legislature that the reimbursement plan
2278 achieve the goal of providing access to health care for nursing
2279 home residents who require large amounts of care while
2280 encouraging diversion services as an alternative to nursing home
2281 care for residents who can be served within the community. The
2282 agency shall base the establishment of any maximum rate of
2283 payment, whether overall or component, on the available moneys
2284 ~~as~~ provided ~~for~~ in the General Appropriations Act. The agency
2285 may base the maximum rate of payment on the results of
2286 scientifically valid analysis and conclusions derived from
2287 objective statistical data pertinent to the particular maximum
2288 rate of payment.
2289 (c) The agency shall request and implement Medicaid waivers
2290 approved by the federal Centers for Medicare and Medicaid
2291 Services to advance and treat a portion of the Medicaid nursing

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2292 home per diem as capital for creating and operating a risk-
2293 retention group for self-insurance purposes, consistent with
2294 federal and state laws and rules.
2295 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any
2296 limitations or directions provided ~~for~~ in the General
2297 Appropriations Act, the following Medicaid services and goods
2298 may be reimbursed on a fee-for-service basis. For each allowable
2299 service or goods furnished in accordance with Medicaid rules,
2300 policy manuals, handbooks, and state and federal law, the
2301 payment shall be the amount billed by the provider, the
2302 provider's usual and customary charge, or the maximum allowable
2303 fee established by the agency, whichever amount is less, with
2304 the exception of those services or goods for which the agency
2305 makes payment using a methodology based on capitation rates,
2306 average costs, or negotiated fees.
2307 (a) Advanced registered nurse practitioner services.
2308 (b) Birth center services.
2309 (c) Chiropractic services.
2310 (d) Community mental health services.
2311 (e) Dental services, including oral and maxillofacial
2312 surgery.
2313 (f) Durable medical equipment.
2314 (g) Hearing services.
2315 (h) Occupational therapy for Medicaid recipients under age
2316 21.
2317 (i) Optometric services.
2318 (j) Orthodontic services.
2319 (k) Personal care for Medicaid recipients under age 21.
2320 (l) Physical therapy for Medicaid recipients under age 21.

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2321 (m) Physician assistant services.
2322 (n) Podiatric services.
2323 (o) Portable X-ray services.
2324 (p) Private-duty nursing for Medicaid recipients under age
2325 21.
2326 (q) Registered nurse first assistant services.
2327 (r) Respiratory therapy for Medicaid recipients under age
2328 21.
2329 (s) Speech therapy for Medicaid recipients under age 21.
2330 (t) Visual services.
2331 (4) MANAGED CARE SERVICES.—Subject to any limitations or
2332 directions provided ~~for~~ in the General Appropriations Act,
2333 alternative health plans, health maintenance organizations, and
2334 prepaid health plans shall be reimbursed a fixed, prepaid amount
2335 negotiated, or competitively bid pursuant to s. 287.057, by the
2336 agency and prospectively paid to the provider monthly for each
2337 Medicaid recipient enrolled. The amount may not exceed the
2338 average amount the agency determines it would have paid, based
2339 on claims experience, for recipients in the same or similar
2340 category of eligibility. The agency shall calculate capitation
2341 rates on a regional basis and~~, beginning September 1, 1995,~~
2342 ~~shall~~ include age-band differentials in such calculations.
2343 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical
2344 center shall be reimbursed the lesser of the amount billed by
2345 the provider or the Medicare-established allowable amount for
2346 the facility.
2347 (6) EPSDT SERVICES.—A provider of early and periodic
2348 screening, diagnosis, and treatment services to Medicaid
2349 recipients who are ~~children~~ under age 21 shall be reimbursed

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2350 using an all-inclusive rate stipulated in a fee schedule
2351 established by the agency. A provider of the visual, dental, and
2352 hearing components of such services shall be reimbursed the
2353 lesser of the amount billed by the provider or the Medicaid
2354 maximum allowable fee established by the agency.
2355 (7) FAMILY PLANNING SERVICES.—A provider of family planning
2356 services shall be reimbursed the lesser of the amount billed by
2357 the provider or an all-inclusive amount per type of visit for
2358 physicians and advanced registered nurse practitioners, as
2359 established by the agency in a fee schedule.
2360 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-
2361 based or community-based services rendered pursuant to a
2362 federally approved waiver shall be reimbursed based on an
2363 established or negotiated rate for each service. These rates
2364 shall be established according to an analysis of the expenditure
2365 history and prospective budget developed by each contract
2366 provider participating in the waiver program, or under any other
2367 methodology adopted by the agency and approved by the Federal
2368 Government in accordance with the waiver. Privately owned and
2369 operated community-based residential facilities that ~~which~~ meet
2370 agency requirements and ~~which~~ formerly received Medicaid
2371 reimbursement for the optional intermediate care facility for
2372 the mentally retarded service may participate in the
2373 developmental services waiver as part of a home-and-community-
2374 based continuum of care for Medicaid recipients who receive
2375 waiver services.
2376 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider
2377 of home health care services or of medical supplies and
2378 appliances shall be reimbursed on the basis of competitive

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2379 bidding or for the lesser of the amount billed by the provider
2380 or the agency's established maximum allowable amount, except
2381 that~~, in the case of the rental of durable medical equipment,~~
2382 the total rental payments for durable medical equipment may not
2383 exceed the purchase price of the equipment over its expected
2384 useful life or the agency's established maximum allowable
2385 amount, whichever amount is less.
2386 (10) HOSPICE.—A hospice shall be reimbursed through a
2387 prospective system for each Medicaid hospice patient at Medicaid
2388 rates using the methodology established for hospice
2389 reimbursement pursuant to Title XVIII of the federal Social
2390 Security Act.
2391 (11) LABORATORY SERVICES.—A provider of independent
2392 laboratory services shall be reimbursed on the basis of
2393 competitive bidding or for the least of the amount billed by the
2394 provider, the provider's usual and customary charge, or the
2395 Medicaid maximum allowable fee established by the agency.
2396 (12) PHYSICIAN SERVICES.—
2397 (a) A physician shall be reimbursed the lesser of the
2398 amount billed by the provider or the Medicaid maximum allowable
2399 fee established by the agency.
2400 (b) The agency shall adopt a fee schedule, subject to any
2401 limitations or directions provided ~~for~~ in the General
2402 Appropriations Act, based on a resource-based relative value
2403 scale for pricing Medicaid physician services. Under the ~~this~~
2404 fee schedule, physicians shall be paid a dollar amount for each
2405 service based on the average resources required to provide the
2406 service, including, but not limited to, estimates of average
2407 physician time and effort, practice expense, and the costs of

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2408 professional liability insurance. The fee schedule must ~~shall~~
2409 provide increased reimbursement for preventive and primary care
2410 services and lowered reimbursement for specialty services by
2411 using at least two conversion factors, one for cognitive
2412 services and another for procedural services. The fee schedule
2413 may ~~shall~~ not increase total Medicaid physician expenditures
2414 unless moneys are available. The agency ~~for Health Care~~
2415 ~~Administration~~ shall seek the advice of a 16-member advisory
2416 panel in formulating and adopting the fee schedule. The panel
2417 shall consist of Medicaid physicians licensed under chapters 458
2418 and 459 and ~~shall~~ be composed of 50 percent primary care
2419 physicians and 50 percent specialty care physicians.
2420 (c) Notwithstanding paragraph (b), reimbursement fees to
2421 physicians for providing total obstetrical services to Medicaid
2422 recipients, which include prenatal, delivery, and postpartum
2423 care, must ~~shall~~ be at least $1,500 per delivery for a pregnant
2424 woman with low medical risk and at least $2,000 per delivery for
2425 a pregnant woman with high medical risk. However, reimbursement
2426 to physicians working in regional perinatal intensive care
2427 centers designated pursuant to chapter 383, for services to
2428 ~~certain~~ pregnant Medicaid recipients with a high medical risk,
2429 may be made according to obstetrical care and neonatal care
2430 groupings and rates established by the agency. Nurse midwives
2431 licensed under part I of chapter 464 or midwives licensed under
2432 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent
2433 of the low medical risk fee. The agency shall by rule determine,
2434 for the purpose of this paragraph, what constitutes a high or
2435 low medical risk pregnant woman and may ~~shall~~ not pay more based
2436 solely on the fact that a caesarean section was performed,

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2437 rather than a vaginal delivery. The agency shall by rule
2438 determine a prorated payment for obstetrical services ~~in cases~~
2439 where only part of the total prenatal, delivery, or postpartum
2440 care was performed. The Department of Health shall adopt rules
2441 for appropriate insurance coverage for midwives licensed under
2442 chapter 467. Before issuing and renewing ~~Prior to the issuance~~
2443 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~
2444 ~~of~~ an inactive license for midwives licensed under chapter 467,
2445 such licensees must ~~shall~~ submit proof of coverage with each
2446 application.
2447 (d) Effective January 1, 2013, Medicaid fee-for-service
2448 payments to primary care physicians for primary care services
2449 must be at least 100 percent of the Medicare payment rate for
2450 such services.
2451 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for
2452 persons eligible for both Medicare and Medicaid coverage shall
2453 be paid at the rates established by Title XVIII of the Social
2454 Security Act. For Medicare services rendered to Medicaid-
2455 eligible persons, Medicaid shall pay Medicare deductibles and
2456 coinsurance as follows:
2457 (a) Medicaid’s financial obligation for deductibles and
2458 coinsurance payments shall be based on Medicare allowable fees,
2459 not on a provider’s billed charges.
2460 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare
2461 deductibles and coinsurance if ~~when~~ payment that Medicare has
2462 made for the service equals or exceeds what Medicaid would have
2463 paid if it had been the sole payor. The combined payment of
2464 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid
2465 would have paid had it been the sole payor. The Legislature

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2466 finds that there has been confusion regarding the reimbursement
2467 for services rendered to dually eligible Medicare beneficiaries.
2468 Accordingly, the Legislature clarifies that it has always been
2469 the intent of the Legislature before and after 1991 that, in
2470 reimbursing in accordance with fees established by Title XVIII
2471 for premiums, deductibles, and coinsurance for Medicare services
2472 rendered by physicians to Medicaid eligible persons, physicians
2473 be reimbursed at the lesser of the amount billed by the
2474 physician or the Medicaid maximum allowable fee established by
2475 the agency ~~for Health Care Administration~~, as is permitted by
2476 federal law. It has never been the intent of the Legislature
2477 ~~with regard to such services rendered by physicians~~ that
2478 Medicaid be required to provide any payment for deductibles,
2479 coinsurance, or copayments for Medicare cost sharing, or any
2480 expenses incurred relating thereto, in excess of the payment
2481 amount provided for under the State Medicaid plan for physician
2482 services ~~such service~~. This payment methodology is applicable
2483 even in those situations in which the payment for Medicare cost
2484 sharing for a qualified Medicare beneficiary with respect to an
2485 item or service is reduced or eliminated. This expression of the
2486 Legislature clarifies ~~is in clarification of~~ existing law and
2487 applies ~~shall apply~~ to payment for, and with respect to provider
2488 agreements with respect to, items or services furnished on or
2489 after July 1, 2000 ~~the effective date of this act~~. This
2490 paragraph applies to payment by Medicaid for items and services
2491 furnished before July 1, 2000, ~~the effective date of this act~~ if
2492 such payment is the subject of a lawsuit that is based on ~~the~~
2493 ~~provisions of~~ this section, and that is pending as of, or is
2494 initiated after that date~~, the effective date of this act~~.

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2495 (c) Notwithstanding paragraphs (a) and (b):
2496 1. Medicaid payments for Nursing Home Medicare part A
2497 coinsurance are limited to the Medicaid nursing home per diem
2498 rate less any amounts paid by Medicare, but only up to the
2499 amount of Medicare coinsurance. The Medicaid per diem rate is
2500 ~~shall be~~ the rate in effect for the dates of service of the
2501 crossover claims and may not be subsequently adjusted due to
2502 subsequent per diem rate adjustments.
2503 2. Medicaid shall pay all deductibles and coinsurance for
2504 Medicare-eligible recipients receiving freestanding end stage
2505 renal dialysis center services.
2506 3. Medicaid payments for general and specialty hospital
2507 inpatient services are limited to the Medicare deductible and
2508 coinsurance per spell of illness. Medicaid payments for hospital
2509 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid
2510 hospital per diem rate less any amounts paid by Medicare, but
2511 only up to the amount of Medicare coinsurance. Medicaid payments
2512 for coinsurance are ~~shall be~~ limited to the Medicaid per diem
2513 rate in effect for the dates of service of the crossover claims
2514 and may not be subsequently adjusted due to subsequent per diem
2515 adjustments.
2516 4. Medicaid shall pay all deductibles and coinsurance for
2517 Medicare emergency transportation services provided by
2518 ambulances licensed pursuant to chapter 401.
2519 5. Medicaid shall pay all deductibles and coinsurance for
2520 portable X-ray Medicare Part B services provided in a nursing
2521 home.
2522 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall
2523 be reimbursed the least of the amount billed by the provider,

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2524 the provider's usual and customary charge, or the Medicaid
2525 maximum allowable fee established by the agency, plus a
2526 dispensing fee. The Medicaid maximum allowable fee for
2527 ingredient cost must ~~will~~ be based on the lower of the~~:~~ average
2528 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition
2529 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the
2530 state maximum allowable cost (SMAC), or the usual and customary
2531 (UAC) charge billed by the provider.
2532 (a) Medicaid providers must ~~are required to~~ dispense
2533 generic drugs if available at lower cost and the agency has not
2534 determined that the branded product is more cost-effective,
2535 unless the prescriber has requested and received approval to
2536 require the branded product.
2537 (b) The agency shall ~~is directed to~~ implement a variable
2538 dispensing fee for ~~payments for~~ prescribed medicines while
2539 ensuring continued access for Medicaid recipients. The variable
2540 dispensing fee may be based upon, but not limited to, either or
2541 both the volume of prescriptions dispensed by a specific
2542 pharmacy provider, the volume of prescriptions dispensed to an
2543 individual recipient, and dispensing of preferred-drug-list
2544 products.
2545 (c) The agency may increase the pharmacy dispensing fee
2546 authorized by statute and in the ~~annual~~ General Appropriations
2547 Act by $0.50 for the dispensing of a Medicaid preferred-drug-
2548 list product and reduce the pharmacy dispensing fee by $0.50 for
2549 the dispensing of a Medicaid product that is not included on the
2550 preferred drug list.
2551 (d) The agency may establish a supplemental pharmaceutical
2552 dispensing fee to be paid to providers returning unused unit-

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2553 dose packaged medications to stock and crediting the Medicaid
2554 program for the ingredient cost of those medications if the
2555 ingredient costs to be credited exceed the value of the
2556 supplemental dispensing fee.
2557 (e) The agency may ~~is authorized to~~ limit reimbursement for
2558 prescribed medicine in order to comply with any limitations or
2559 directions provided ~~for~~ in the General Appropriations Act, which
2560 may include implementing a prospective or concurrent utilization
2561 review program.
2562 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary
2563 care case management services rendered pursuant to a federally
2564 approved waiver shall be reimbursed by payment of a fixed,
2565 prepaid monthly sum for each Medicaid recipient enrolled with
2566 the provider.
2567 (16) RURAL HEALTH CLINICS.—A provider of rural health
2568 clinic services and federally qualified health center services
2569 shall be reimbursed a rate per visit based on total reasonable
2570 costs of the clinic, as determined by the agency in accordance
2571 with federal regulations.
2572 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case
2573 management services shall be reimbursed pursuant to an
2574 established fee, except where the Federal Government requires a
2575 public provider be reimbursed on the basis of average actual
2576 costs.
2577 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the
2578 General Appropriations Act, a provider of transportation
2579 services shall be reimbursed the lesser of the amount billed by
2580 the provider or the Medicaid maximum allowable fee established
2581 by the agency, except if ~~when~~ the agency has entered into a

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2582 direct contract with the provider, or with a community
2583 transportation coordinator, for the provision of an all-
2584 inclusive service, or if ~~when~~ services are provided pursuant to
2585 an agreement negotiated between the agency and the provider. ~~The~~
2586 ~~agency, as provided for in s. 427.0135, shall purchase~~
2587 ~~transportation services through the community coordinated~~
2588 ~~transportation system, if available, unless the agency, after~~
2589 ~~consultation with the commission, determines that it cannot~~
2590 ~~reach mutually acceptable contract terms with the commission.~~
2591 ~~The agency may then contract for the same transportation~~
2592 ~~services provided in a more cost-effective manner and of~~
2593 ~~comparable or higher quality and standards. Nothing in~~
2594 (a) This subsection does not ~~shall be construed to~~ limit or
2595 preclude the agency from contracting for services using a
2596 prepaid capitation rate or from establishing maximum fee
2597 schedules, individualized reimbursement policies by provider
2598 type, negotiated fees, prior authorization, competitive bidding,
2599 increased use of mass transit, or any other mechanism that the
2600 agency considers efficient and effective for the purchase of
2601 services on behalf of Medicaid clients, including implementing a
2602 transportation eligibility process.
2603 (b) The agency may ~~shall~~ not ~~be required to~~ contract with
2604 any community transportation coordinator or transportation
2605 operator that has been determined by the agency, the Department
2606 of Legal Affairs Medicaid Fraud Control Unit, or any other state
2607 or federal agency to have engaged in any abusive or fraudulent
2608 billing activities.
2609 (c) The agency shall ~~is authorized to~~ competitively procure
2610 transportation services or make other changes necessary to

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2611 secure approval of federal waivers needed to permit federal
2612 financing of Medicaid transportation services at the service
2613 matching rate rather than the administrative matching rate.
2614 ~~Notwithstanding chapter 427, the agency is authorized to~~
2615 ~~continue contracting for Medicaid nonemergency transportation~~
2616 ~~services in agency service area 11 with managed care plans that~~
2617 ~~were under contract for those services before July 1, 2004.~~
2618 (d) Transportation to access covered services provided by a
2619 qualified plan pursuant to part IV of this chapter shall be
2620 contracted for by the plan. A qualified plan is not required to
2621 purchase such services through a coordinated transportation
2622 system established pursuant to part I of chapter 427.
2623 (19) COUNTY HEALTH DEPARTMENTS.—County health department
2624 services shall be reimbursed a rate per visit based on total
2625 reasonable costs of the clinic, as determined by the agency in
2626 accordance with federal regulations under the authority of 42
2627 C.F.R. s. 431.615.
2628 (20) DIALYSIS.—A renal dialysis facility that provides
2629 dialysis services under s. 409.906(9) must be reimbursed the
2630 lesser of the amount billed by the provider, the provider's
2631 usual and customary charge, or the maximum allowable fee
2632 established by the agency, whichever ~~amount~~ is less.
2633 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse
2634 school districts that ~~which~~ certify the state match pursuant to
2635 ss. 409.9071 and 1011.70 for the federal portion of the school
2636 district's allowable costs to deliver the services, based on the
2637 reimbursement schedule. The school district shall determine the
2638 costs for delivering services as authorized in ss. 409.9071 and
2639 1011.70 for which the state match will be certified.

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2640 Reimbursement of school-based providers is contingent on such
2641 providers being enrolled as Medicaid providers and meeting the
2642 qualifications contained in 42 C.F.R. s. 440.110, unless
2643 otherwise waived by the federal Centers for Medicare and
2644 Medicaid Services ~~Health Care Financing Administration~~. Speech
2645 therapy providers who are certified through the Department of
2646 Education pursuant to rule 6A-4.0176, Florida Administrative
2647 Code, are eligible for reimbursement for services that are
2648 provided on school premises. Any employee of the school district
2649 who has been fingerprinted and has received a criminal
2650 background check in accordance with Department of Education
2651 rules and guidelines is ~~shall be~~ exempt from any agency
2652 requirements relating to criminal background checks.
2653 ~~(22) The agency shall request and implement Medicaid~~
2654 ~~waivers from the federal Health Care Financing Administration to~~
2655 ~~advance and treat a portion of the Medicaid nursing home per~~
2656 ~~diem as capital for creating and operating a risk-retention~~
2657 ~~group for self-insurance purposes, consistent with federal and~~
2658 ~~state laws and rules.~~
2659 (22)~~(23)(a)~~ LIMITATION ON REIMBURSEMENT RATES.—The agency
2660 shall establish rates at a level that ensures no increase in
2661 statewide expenditures resulting from a change in unit costs for
2662 2 fiscal years effective July 1, 2009. Reimbursement rates for
2663 the 2 fiscal years shall be as provided in the General
2664 Appropriations Act.
2665 (a)~~(b)~~ This subsection applies to the following provider
2666 types:
2667 1. Inpatient hospitals.
2668 2. Outpatient hospitals.

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2669 3. Nursing homes.
2670 4. County health departments.
2671 5. Community intermediate care facilities for the
2672 developmentally disabled.
2673 6. Prepaid health plans.
2674 (b) The agency shall apply ~~the effect of~~ this subsection to
2675 the reimbursement rates for nursing home diversion programs.
2676 ~~(c) The agency shall create a workgroup on hospital~~
2677 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
2678 ~~and a workgroup on managed care plan payment. The workgroups~~
2679 ~~shall evaluate alternative reimbursement and payment~~
2680 ~~methodologies for hospitals, nursing facilities, and managed~~
2681 ~~care plans, including prospective payment methodologies for~~
2682 ~~hospitals and nursing facilities. The nursing facility workgroup~~
2683 ~~shall also consider price-based methodologies for indirect care~~
2684 ~~and acuity adjustments for direct care. The agency shall submit~~
2685 ~~a report on the evaluated alternative reimbursement~~
2686 ~~methodologies to the relevant committees of the Senate and the~~
2687 ~~House of Representatives by November 1, 2009.~~
2688 (c) ~~(d)~~ This subsection expires June 30, 2011.
2689 (23) PAYMENT METHODOLOGIES.—If a provider is reimbursed
2690 based on cost reporting and submits a cost report late and that
2691 cost report would have been used to set a lower reimbursement
2692 rate for a rate semester, the provider's rate for that semester
2693 shall be retroactively calculated using the new cost report, and
2694 full payment at the recalculated rate shall be applied
2695 retroactively. Medicare-granted extensions for filing cost
2696 reports, if applicable, also apply to Medicaid cost reports.
2697 (24) RETURN OF PAYMENTS.—If a provider fails to notify the

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2698 agency within 5 business days after suspension or disenrollment
2699 from Medicare, sanctions may be imposed pursuant to this
2700 chapter, and the provider may be required to return funds paid
2701 to the provider during the period of time that the provider was
2702 suspended or disenrolled ~~as a Medicare provider~~.
2703 Section 28. Subsection (1) of section 409.9081, Florida
2704 Statutes, is amended to read:
2705 409.9081 Copayments.—
2706 (1) ~~The agency shall require,~~ Subject to federal
2707 regulations and limitations, each Medicaid recipient must ~~to~~ pay
2708 at the time of service a nominal copayment for the following
2709 Medicaid services:
2710 (a) Hospital outpatient services: up to $3 for each
2711 hospital outpatient visit.
2712 (b) Physician services: up to $2 copayment for each visit
2713 with a primary care physician and up to $3 copayment for each
2714 visit with a specialty care physician ~~licensed under chapter~~
2715 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463~~.
2716 (c) Hospital emergency department visits for nonemergency
2717 care: 5 percent of up to the first $300 of the Medicaid payment
2718 for emergency room services, not to exceed $15. The agency shall
2719 seek a federal waiver of the requirement that cost-sharing
2720 amounts for nonemergency services and care furnished in a
2721 hospital emergency department be nominal. Upon waiver approval,
2722 a Medicaid recipient who requests such services and care, must
2723 pay a $100 copayment to the hospital for the nonemergency
2724 services and care provided in the hospital emergency department.
2725 (d) Prescription drugs: a coinsurance equal to 2.5 percent
2726 of the Medicaid cost of the prescription drug at the time of

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2727 purchase. The maximum coinsurance is ~~shall be~~ $7.50 per
2728 prescription drug purchased.
2729 Section 29. Paragraphs (b) and (d) of subsection (4) and
2730 subsections (8), (34), (44), (47), and (53) of section 409.912,
2731 Florida Statutes, are amended, and subsections (48) through (52)
2732 of that section are renumbered as subsections (47) through (51)
2733 respectively, to read:
2734 409.912 Cost-effective purchasing of health care.—The
2735 agency shall purchase goods and services for Medicaid recipients
2736 in the most cost-effective manner consistent with the delivery
2737 of quality medical care. To ensure that medical services are
2738 effectively utilized, the agency may, in any case, require a
2739 confirmation or second physician's opinion of the correct
2740 diagnosis for purposes of authorizing future services under the
2741 Medicaid program. This section does not restrict access to
2742 emergency services or poststabilization care services as defined
2743 in 42 C.F.R. part 438.114. Such confirmation or second opinion
2744 shall be rendered in a manner approved by the agency. The agency
2745 shall maximize the use of prepaid per capita and prepaid
2746 aggregate fixed-sum basis services when appropriate and other
2747 alternative service delivery and reimbursement methodologies,
2748 including competitive bidding pursuant to s. 287.057, designed
2749 to facilitate the cost-effective purchase of a case-managed
2750 continuum of care. The agency shall also require providers to
2751 minimize the exposure of recipients to the need for acute
2752 inpatient, custodial, and other institutional care and the
2753 inappropriate or unnecessary use of high-cost services. The
2754 agency shall contract with a vendor to monitor and evaluate the
2755 clinical practice patterns of providers in order to identify

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2756 trends that are outside the normal practice patterns of a
2757 provider’s professional peers or the national guidelines of a
2758 provider’s professional association. The vendor must be able to
2759 provide information and counseling to a provider whose practice
2760 patterns are outside the norms, in consultation with the agency,
2761 to improve patient care and reduce inappropriate utilization.
2762 The agency may mandate prior authorization, drug therapy
2763 management, or disease management participation for certain
2764 populations of Medicaid beneficiaries, certain drug classes, or
2765 particular drugs to prevent fraud, abuse, overuse, and possible
2766 dangerous drug interactions. The Pharmaceutical and Therapeutics
2767 Committee shall make recommendations to the agency on drugs for
2768 which prior authorization is required. The agency shall inform
2769 the Pharmaceutical and Therapeutics Committee of its decisions
2770 regarding drugs subject to prior authorization. The agency is
2771 authorized to limit the entities it contracts with or enrolls as
2772 Medicaid providers by developing a provider network through
2773 provider credentialing. The agency may competitively bid single-
2774 source-provider contracts if procurement of goods or services
2775 results in demonstrated cost savings to the state without
2776 limiting access to care. The agency may limit its network based
2777 on the assessment of beneficiary access to care, provider
2778 availability, provider quality standards, time and distance
2779 standards for access to care, the cultural competence of the
2780 provider network, demographic characteristics of Medicaid
2781 beneficiaries, practice and provider-to-beneficiary standards,
2782 appointment wait times, beneficiary use of services, provider
2783 turnover, provider profiling, provider licensure history,
2784 previous program integrity investigations and findings, peer

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2785 review, provider Medicaid policy and billing compliance records,
2786 clinical and medical record audits, and other factors. Providers
2787 shall not be entitled to enrollment in the Medicaid provider
2788 network. The agency shall determine instances in which allowing
2789 Medicaid beneficiaries to purchase durable medical equipment and
2790 other goods is less expensive to the Medicaid program than long-
2791 term rental of the equipment or goods. The agency may establish
2792 rules to facilitate purchases in lieu of long-term rentals in
2793 order to protect against fraud and abuse in the Medicaid program
2794 as defined in s. 409.913. The agency may seek federal waivers
2795 necessary to administer these policies.
2796 (4) The agency may contract with:
2797 (b) An entity that is providing comprehensive behavioral
2798 health care services to ~~certain~~ Medicaid recipients through a
2799 capitated, prepaid arrangement pursuant to the federal waiver
2800 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.
2801 Such entity must be licensed under chapter 624, chapter 636, or
2802 chapter 641, or authorized under paragraph (c) or paragraph (d),
2803 and must possess the clinical systems and operational competence
2804 to manage risk and provide comprehensive behavioral health care
2805 to Medicaid recipients. As used in this paragraph, the term
2806 “comprehensive behavioral health care services” means covered
2807 mental health and substance abuse treatment services that are
2808 available to Medicaid recipients. The Secretary ~~of the~~
2809 ~~Department~~ of Children and Family Services must ~~shall~~ approve
2810 ~~provisions of~~ procurements related to children in the
2811 department’s care or custody before enrolling such children in a
2812 prepaid behavioral health plan. Any contract awarded under this
2813 paragraph must be competitively procured. ~~In developing~~ The

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2814 behavioral health care prepaid plan procurement document must
2815 require~~, the agency shall ensure that the procurement document~~
2816 ~~requires~~ the contractor to develop and implement a plan to
2817 ensure compliance with s. 394.4574 related to services provided
2818 to residents of licensed assisted living facilities that hold a
2819 limited mental health license. Except as provided in
2820 subparagraph 5. ~~8.~~, and except in counties where the Medicaid
2821 managed care pilot program is authorized pursuant to s. 409.986
2822 ~~409.91211~~, the agency shall seek federal approval to contract
2823 with a single entity ~~meeting these requirements~~ to provide
2824 comprehensive behavioral health care services to all Medicaid
2825 recipients not enrolled in a Medicaid managed care plan
2826 authorized under s. 409.986 ~~409.91211~~, a provider service
2827 network authorized under paragraph (d), or a Medicaid health
2828 maintenance organization in an AHCA area. In an AHCA area where
2829 the Medicaid managed care pilot program is authorized pursuant
2830 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may
2831 procure a contract with a single entity to serve the remaining
2832 counties as an AHCA area or the remaining counties may be
2833 included with an adjacent AHCA area and are subject to this
2834 paragraph. Each entity must offer a ~~sufficient~~ choice of
2835 providers in its network to ensure recipient access to care and
2836 the opportunity to select a provider with whom they are
2837 satisfied. The network shall include all public mental health
2838 hospitals. To ensure unimpaired access to behavioral health care
2839 services by Medicaid recipients, all contracts issued pursuant
2840 to this paragraph must require that 90 ~~80~~ percent of the
2841 capitation paid to the managed care plan, including health
2842 maintenance organizations and capitated provider service

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2843 networks, ~~to~~ be expended for the provision of behavioral health
2844 care services. If the managed care plan expends less than 90 ~~80~~
2845 percent ~~of the capitation paid~~ for the provision of behavioral
2846 health care services, the difference shall be returned to the
2847 agency. The agency shall provide the plan with a certification
2848 letter indicating the amount of capitation paid during each
2849 calendar year for behavioral health care services pursuant to
2850 this section. The agency may reimburse ~~for~~ substance abuse
2851 treatment services on a fee-for-service basis until the agency
2852 finds that adequate funds are available for capitated, prepaid
2853 arrangements.
2854 1. ~~By January 1, 2001,~~ The agency shall modify the
2855 contracts with the entities providing comprehensive inpatient
2856 and outpatient mental health care services to Medicaid
2857 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
2858 Counties, to include substance abuse treatment services.
2859 ~~2. By July 1, 2003, the agency and the Department of~~
2860 ~~Children and Family Services shall execute a written agreement~~
2861 ~~that requires collaboration and joint development of all policy,~~
2862 ~~budgets, procurement documents, contracts, and monitoring plans~~
2863 ~~that have an impact on the state and Medicaid community mental~~
2864 ~~health and targeted case management programs.~~
2865 2.~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~
2866 ~~2006,~~ the agency and the Department of Children and Family
2867 Services shall contract with managed care entities in each AHCA
2868 area ~~except area 6~~ or arrange to provide comprehensive inpatient
2869 and outpatient mental health and substance abuse services
2870 through capitated prepaid arrangements to all Medicaid
2871 recipients who are eligible to participate in such plans under

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2872 federal law and regulation. In AHCA areas where there are fewer
2873 than 150,000 eligible individuals ~~number less than 150,000~~, the
2874 agency shall contract with a single managed care plan to provide
2875 comprehensive behavioral health services to all recipients who
2876 are not enrolled in a Medicaid health maintenance organization,
2877 a provider service network authorized under paragraph (d), or a
2878 Medicaid capitated managed care plan authorized under s. 409.986
2879 ~~409.91211~~. The agency may contract with more than one
2880 comprehensive behavioral health provider to provide care to
2881 recipients who are not enrolled in a Medicaid capitated managed
2882 care plan authorized under s. 409.986 ~~409.91211~~, a provider
2883 service network authorized under paragraph (d), or a Medicaid
2884 health maintenance organization in AHCA areas where the eligible
2885 population exceeds 150,000. In an AHCA area where the Medicaid
2886 managed care pilot program is authorized pursuant to s. 409.986
2887 ~~409.91211~~ in one or more counties, the agency may procure a
2888 contract with a single entity to serve the remaining counties as
2889 an AHCA area or the remaining counties may be included with an
2890 adjacent AHCA area and shall be subject to this paragraph.
2891 Contracts for comprehensive behavioral health providers awarded
2892 pursuant to this section must ~~shall~~ be competitively procured.
2893 Both for-profit and not-for-profit corporations are eligible to
2894 compete. Managed care plans contracting with the agency under
2895 subsection (3) or paragraph (d), shall provide and receive
2896 payment for the same comprehensive behavioral health benefits as
2897 provided in AHCA rules, including handbooks incorporated by
2898 reference. In AHCA area 11, the agency shall contract with at
2899 least two comprehensive behavioral health care providers to
2900 provide behavioral health care to recipients ~~in that area~~ who

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2901 are enrolled in, or assigned to, the MediPass program. One of
2902 the ~~behavioral health care~~ contracts must be with the existing
2903 provider service network pilot project, as described in
2904 paragraph (d), for the purpose of demonstrating the cost-
2905 effectiveness of the provision of quality mental health services
2906 through a public hospital-operated managed care model. Payment
2907 shall be at an agreed-upon capitated rate to ensure cost
2908 savings. Of the recipients in area 11 who are assigned to
2909 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those
2910 MediPass-enrolled recipients shall be assigned to the existing
2911 provider service network in area 11 for their behavioral care.
2912 ~~4. By October 1, 2003, the agency and the department shall~~
2913 ~~submit a plan to the Governor, the President of the Senate, and~~
2914 ~~the Speaker of the House of Representatives which provides for~~
2915 ~~the full implementation of capitated prepaid behavioral health~~
2916 ~~care in all areas of the state.~~
2917 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
2918 ~~of the state where the agency is able to establish sufficient~~
2919 ~~capitation rates.~~
2920 ~~b. If the agency determines that the proposed capitation~~
2921 ~~rate in any area is insufficient to provide appropriate~~
2922 ~~services, the agency may adjust the capitation rate to ensure~~
2923 ~~that care will be available. The agency and the department may~~
2924 ~~use existing general revenue to address any additional required~~
2925 ~~match but may not over-obligate existing funds on an annualized~~
2926 ~~basis.~~
2927 ~~c. Subject to any limitations provided in the General~~
2928 ~~Appropriations Act, the agency, in compliance with appropriate~~
2929 ~~federal authorization, shall develop policies and procedures~~

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2930 ~~that allow for certification of local and state funds.~~
2931 3.~~5.~~ Children residing in a statewide inpatient psychiatric
2932 program, or in a Department of Juvenile Justice or a Department
2933 of Children and Family Services residential program approved as
2934 a Medicaid behavioral health overlay services provider may not
2935 be included in a behavioral health care prepaid health plan or
2936 any other Medicaid managed care plan pursuant to this paragraph.
2937 ~~6. In converting to a prepaid system of delivery, the~~
2938 ~~agency shall in its procurement document require an entity~~
2939 ~~providing only comprehensive behavioral health care services to~~
2940 ~~prevent the displacement of indigent care patients by enrollees~~
2941 ~~in the Medicaid prepaid health plan providing behavioral health~~
2942 ~~care services from facilities receiving state funding to provide~~
2943 ~~indigent behavioral health care, to facilities licensed under~~
2944 ~~chapter 395 which do not receive state funding for indigent~~
2945 ~~behavioral health care, or reimburse the unsubsidized facility~~
2946 ~~for the cost of behavioral health care provided to the displaced~~
2947 ~~indigent care patient.~~
2948 4.~~7.~~ Traditional community mental health providers under
2949 contract with the Department of Children and Family Services
2950 pursuant to part IV of chapter 394, ~~child welfare providers~~
2951 ~~under contract with the Department of Children and Family~~
2952 ~~Services in areas 1 and 6,~~ and inpatient mental health providers
2953 licensed pursuant to chapter 395 must be offered an opportunity
2954 to accept or decline a contract to participate in any provider
2955 network for prepaid behavioral health services.
2956 5.~~8.~~ All Medicaid-eligible children, except children in
2957 area 1 and children in ~~Highlands County, Hardee County, Polk~~
2958 ~~County, or~~ Manatee County in ~~of~~ area 6, whose cases ~~that~~ are

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2959 open for child welfare services in the statewide automated child
2960 welfare information ~~HomeSafeNet~~ system, shall receive their
2961 behavioral health care services through a specialty prepaid plan
2962 operated by community-based lead agencies through a single
2963 agency or formal agreements among several agencies. The
2964 specialty prepaid plan must result in savings to the state
2965 comparable to savings achieved in other Medicaid managed care
2966 and prepaid programs. Such plan must provide mechanisms to
2967 maximize state and local revenues. The specialty prepaid plan
2968 shall be developed by the agency and the Department of Children
2969 and Family Services. The agency may seek federal waivers to
2970 implement this initiative. Medicaid-eligible children whose
2971 cases are open for child welfare services in the statewide
2972 automated child welfare information ~~HomeSafeNet~~ system and who
2973 reside in AHCA area 10 shall be enrolled in a capitated managed
2974 care plan, which includes provider service networks, which, in
2975 coordination with available community-based care providers
2976 specified in s. 409.1671, shall provide sufficient medical,
2977 developmental, behavioral, and emotional services to meet the
2978 needs of these children, subject to funding as provided in the
2979 General Appropriations Act ~~are exempt from the specialty prepaid~~
2980 ~~plan upon the development of a service delivery mechanism for~~
2981 ~~children who reside in area 10 as specified in s.~~
2982 ~~409.91211(3)(dd)~~.
2983 (d) A provider service network, which may be reimbursed on
2984 a fee-for-service or prepaid basis.
2985 1. A provider service network that ~~which~~ is reimbursed by
2986 the agency on a prepaid basis is ~~shall be~~ exempt from parts I
2987 and III of chapter 641, but must comply with the solvency

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2988 requirements in s. 641.2261(2) and meet appropriate financial
2989 reserve, quality assurance, and patient rights requirements ~~as~~
2990 established by the agency.
2991 2. ~~Medicaid recipients assigned to a provider service~~
2992 ~~network shall be chosen equally from those who would otherwise~~
2993 ~~have been assigned to prepaid plans and MediPass.~~ The agency may
2994 ~~is authorized to~~ seek federal Medicaid waivers as necessary to
2995 implement ~~the provisions of~~ this section. ~~Any contract~~
2996 ~~previously awarded to a provider service network operated by a~~
2997 ~~hospital pursuant to this subsection shall remain in effect for~~
2998 ~~a period of 3 years following the current contract expiration~~
2999 ~~date, regardless of any contractual provisions to the contrary.~~
3000 3. A provider service network is a network established or
3001 organized and operated by a health care provider, or group of
3002 affiliated health care providers, including minority physician
3003 networks and emergency room diversion programs that meet the
3004 requirements of s. 409.986 ~~409.91211~~, which provides a
3005 substantial proportion of the health care items and services
3006 under a contract directly through the provider or affiliated
3007 group of providers and may make arrangements with physicians or
3008 other health care professionals, health care institutions, or
3009 any combination of such individuals or institutions to assume
3010 all or part of the financial risk on a prospective basis for the
3011 provision of basic health services by the physicians, by other
3012 health professionals, or through the institutions. The health
3013 care providers must have a controlling interest in the governing
3014 body of the provider service network organization.
3015 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum
3016 basis with an exclusive provider organization to provide health

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3017 care services to Medicaid recipients if ~~provided that~~ the
3018 exclusive provider organization meets applicable managed care
3019 plan requirements in this section, ss. 409.987, 409.988
3020 ~~409.9122, 409.9123~~, 409.9128, and 627.6472, and other applicable
3021 provisions of law.
3022 ~~(b) For a period of no longer than 24 months after the~~
3023 ~~effective date of this paragraph, when a member of an exclusive~~
3024 ~~provider organization that is contracted by the agency to~~
3025 ~~provide health care services to Medicaid recipients in rural~~
3026 ~~areas without a health maintenance organization obtains services~~
3027 ~~from a provider that participates in the Medicaid program in~~
3028 ~~this state, the provider shall be paid in accordance with the~~
3029 ~~appropriate fee schedule for services provided to eligible~~
3030 ~~Medicaid recipients. The agency may seek waiver authority to~~
3031 ~~implement this paragraph.~~
3032 (34) The agency and entities that contract with the agency
3033 to provide health care services to Medicaid recipients under
3034 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~
3035 must comply with the provisions of s. 641.513 in providing
3036 emergency services and care to Medicaid recipients and MediPass
3037 recipients. Where feasible, safe, and cost-effective, the agency
3038 shall encourage hospitals, emergency medical services providers,
3039 and other public and private health care providers to work
3040 together in their local communities to enter into agreements or
3041 arrangements to ensure access to alternatives to emergency
3042 services and care for those Medicaid recipients who need
3043 nonemergent care. The agency shall coordinate with hospitals,
3044 emergency medical services providers, private health plans,
3045 capitated managed care networks as established in s. 409.986

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3046 ~~409.91211~~, and other public and private health care providers to
3047 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),
3048 627.6405, and 641.31097 to develop and implement emergency
3049 department diversion programs for Medicaid recipients.
3050 (44) The agency ~~for Health Care Administration~~ shall ensure
3051 that any Medicaid managed care plan as defined in s.
3052 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis
3053 or a shared savings basis, is cost-effective. For purposes of
3054 this subsection, the term "cost-effective" means that a
3055 network's per-member, per-month costs to the state, including,
3056 but not limited to, fee-for-service costs, administrative costs,
3057 and case-management fees, if any, must be no greater than the
3058 state's costs associated with contracts for Medicaid services
3059 established under subsection (3), which may be adjusted for
3060 health status. The agency shall conduct actuarially sound
3061 adjustments for health status in order to ensure such cost-
3062 effectiveness and shall annually publish the results on its
3063 Internet website. Contracts established pursuant to this
3064 subsection which are not cost-effective may not be renewed.
3065 ~~(47) The agency shall conduct a study of available~~
3066 ~~electronic systems for the purpose of verifying the identity and~~
3067 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
3068 ~~to the Legislature a plan to implement an electronic~~
3069 ~~verification system for Medicaid recipients by January 31, 2005.~~
3070 ~~(53) Before seeking an amendment to the state plan for~~
3071 ~~purposes of implementing programs authorized by the Deficit~~
3072 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~
3073 Section 30. Paragraph (a) of subsection (1) of section
3074 409.915, Florida Statutes, is amended to read:

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3075 409.915 County contributions to Medicaid.—Although the
3076 state is responsible for the full portion of the state share of
3077 the matching funds required for the Medicaid program, in order
3078 to acquire a certain portion of these funds, the state shall
3079 charge the counties for certain items of care and service as
3080 provided in this section.
3081 (1) Each county shall participate in the following items of
3082 care and service:
3083 (a) For both health maintenance members and fee-for-service
3084 beneficiaries, payments for inpatient hospitalization in excess
3085 of 10 days, but not in excess of 45 days, with the exception of
3086 pregnant women and children whose income is greater than ~~in~~
3087 ~~excess of~~ the federal poverty level and who do not receive a
3088 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~
3089 ~~medically needy Program~~, and for adult lung transplant services.
3090 Section 31. Section 409.9301, Florida Statutes, is
3091 transferred, renumbered as section 409.9067, Florida Statutes,
3092 and subsections (1) and (2) of that section are amended, to
3093 read:
3094 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—
3095 (1) PROGRAM ESTABLISHED.—A program is established in the
3096 agency ~~for Health Care Administration~~ to provide pharmaceutical
3097 expense assistance to individuals diagnosed with cancer or
3098 individuals who have obtained ~~received~~ organ transplants who
3099 received a Medicaid nonpoverty medical subsidy before ~~were~~
3100 ~~medically needy recipients prior to~~ January 1, 2006.
3101 (2) ELIGIBILITY.—Eligibility for the program is limited to
3102 an individual who:
3103 (a) Is a resident of this state;

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3104 (b) Was a Medicaid recipient who received a nonpoverty
3105 medical subsidy before ~~under the Florida Medicaid medically~~
3106 ~~needy program prior to~~ January 1, 2006;
3107 (c) Is eligible for Medicare;
3108 (d) Is a cancer patient or an organ transplant recipient;
3109 and
3110 (e) Requests to be enrolled in the program.
3111 Section 32. Subsection (1) of section 409.9126, Florida
3112 Statutes, is amended to read:
3113 409.9126 Children with special health care needs.—
3114 (1) Except as provided in subsection (4), children eligible
3115 for Children's Medical Services who receive Medicaid benefits,
3116 and other Medicaid-eligible children with special health care
3117 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987
3118 ~~409.9122~~ and shall be served through the Children's Medical
3119 Services network established in chapter 391.
3120 Section 33. The Division of Statutory Revision is requested
3121 to create part IV of chapter 409, Florida Statutes, consisting
3122 of sections 409.961-409.978, Florida Statutes, entitled
3123 "MEDICAID MANAGED CARE."
3124 Section 34. Section 409.961, Florida Statutes, is created
3125 to read:
3126 409.961 Construction; applicability.—It is the intent of
3127 the Legislature that if any conflict exists between ss. 409.961-
3128 409.978 and other parts or sections of this chapter, the
3129 provisions in ss. 409.961-409.978 control. Sections 409.961-
3130 409.978 apply only to the Medicaid managed care program, as
3131 provided in this part.
3132 Section 35. Section 409.962, Florida Statutes, is created

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3133 to read:
3134 409.962 Definitions.—As used in this part, and including
3135 the terms defined in s. 409.901, the term:
3136 (1) "Direct care management" means care management
3137 activities that involve direct interaction between providers and
3138 patients.
3139 (2) "Home and community-based services" means a specific
3140 set of services designed to assist recipients qualifying under
3141 s. 409.974 in avoiding institutionalization.
3142 (3) "Medicaid managed care program" means the integrated,
3143 statewide Medicaid program created in this part, which includes
3144 the provision of managed care medical assistance services
3145 described in ss. 409.971 and 409.972 and managed long-term care
3146 services described in ss. 409.973-409.978.
3147 (4) "Provider service network" means an entity of which a
3148 controlling interest is owned by, or a controlling interest in
3149 the governing body of the entity is composed of, a health care
3150 provider, a group of affiliated providers, or a public agency or
3151 entity that delivers health services. For purposes of this
3152 chapter, health care providers include Florida-licensed health
3153 care professionals, Florida-licensed health care facilities,
3154 federally qualified health centers, and home health care
3155 agencies.
3156 (5) "Qualified plan" means a managed care plan that is
3157 determined eligible to participate in the Medicaid managed care
3158 program pursuant to s. 409.965.
3159 (6) "Specialty plan" means a qualified plan that serves
3160 Medicaid recipients who meet specified criteria based on age,
3161 medical condition, or diagnosis.

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3162 Section 36. Section 409.963, Florida Statutes, is created
3163 to read:
3164 409.963 Medicaid managed care program.—The Medicaid managed
3165 care program is established as a statewide, integrated managed
3166 care program for all covered medical assistance services and
3167 long-term care services as provided under this part. Pursuant to
3168 s. 409.902, the program shall be administered by the agency, and
3169 eligibility for the program shall be determined by the
3170 Department of Children and Family Services.
3171 (1) The agency shall submit amendments to the Medicaid
3172 state plan or to existing waivers, or submit new waiver requests
3173 under section 1115 or other applicable sections of the Social
3174 Security Act, by August 1, 2011, as needed to implement the
3175 managed care program. At a minimum, the waiver requests must
3176 include a waiver that allows home and community-based services
3177 to be preferred over nursing home services for persons who can
3178 be safely managed in the home and community, and a waiver that
3179 requires dually eligible recipients to participate in the
3180 Medicaid managed care program. The waiver requests must also
3181 include provisions authorizing the state to limit enrollment in
3182 managed long-term care, establish waiting lists, and limit the
3183 amount, duration, and scope of home and community-based services
3184 to ensure that expenditures for persons eligible for managed
3185 long-term care services do not exceed funds provided in the
3186 General Appropriations Act.
3187 (a) The agency shall initiate any necessary procurements
3188 required to implement the managed care program as soon as
3189 practicable, but no later than July 1, 2011, in anticipation of
3190 prompt approval of the waivers needed for the managed care

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3191 program by the United States Department of Health and Human
3192 Services.
3193 (b) In submitting waivers, the agency shall work with the
3194 federal Centers for Medicare and Medicaid Services to accomplish
3195 approval of all waivers by December 1, 2011, in order to begin
3196 implementation of the managed care program by December 31, 2011.
3197 (c) Before seeking a waiver, the agency shall provide
3198 public notice and the opportunity for public comment and include
3199 public feedback in the waiver application.
3200 (2) The agency shall begin implementation of the Medicaid
3201 managed care program on December 31, 2011. If waiver approval is
3202 obtained, the program shall be implemented in accordance with
3203 the terms and conditions of the waiver. If necessary waivers
3204 have not been timely received, the agency shall notify the
3205 Centers for Medicare and Medicaid Services of the state's
3206 implementation of the managed care program and request the
3207 federal agency to continue providing federal funds equivalent to
3208 the funding level provided under the Federal Medical Assistance
3209 Percentage in order to implement the managed care program.
3210 (a) If the Centers for Medicare and Medicaid Services
3211 refuses to continue providing federal funds, the managed care
3212 program shall be implemented as a state-only funded program to
3213 the extent state funds are available.
3214 (b) If implemented as a state-only funded program, priority
3215 shall be given to providing:
3216 1. Nursing home services to persons eligible for nursing
3217 home care.
3218 2. Medical services to persons served by the Agency for
3219 Persons with Disabilities.

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3220 3. Medical services to pregnant women.
3221 4. Physician and hospital services to persons who are
3222 determined to be eligible for Medicaid subject to the income,
3223 assets, and categorical eligibility tests set forth in federal
3224 and state law.
3225 5. Services provided under the Healthy Start waiver.
3226 6. Medical services provided to persons in the Nursing Home
3227 Diversion waiver.
3228 7. Medical services provided to persons in intermediate
3229 care facilities for the developmentally disabled.
3230 8. Services to children in the child welfare system whose
3231 medical care is provided in accordance with s. 409.16713, as
3232 authorized by the General Appropriations Act.
3233 (c) If implemented as a state-only funded program pursuant
3234 to paragraph (b), provisions related to the eligibility
3235 standards of the state and federally funded Medicaid program
3236 remain in effect, except as otherwise provided under the managed
3237 care program.
3238 (d) If implemented as a state-only funded program pursuant
3239 to paragraph (a), provider agreements and other contracts that
3240 provide for Medicaid services to recipients identified in
3241 paragraph (b) continue in effect.
3242 Section 37. Section 409.964, Florida Statutes, is created
3243 to read:
3244 409.964 Enrollment.—All Medicaid recipients shall receive
3245 medical services through the Medicaid managed care program
3246 established under this part unless excluded under this section.
3247 (1) The following recipients are excluded from
3248 participation in the Medicaid managed care program:

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3249 (a) Women who are eligible only for family planning
3250 services.
3251 (b) Women who are eligible only for breast and cervical
3252 cancer services.
3253 (c) Persons who have a developmental disability as defined
3254 in s. 393.063.
3255 (d) Persons who are eligible for a Medicaid nonpoverty
3256 medical subsidy.
3257 (e) Persons who receive eligible services under emergency
3258 Medicaid for aliens.
3259 (f) Persons who are residing in a nursing home facility or
3260 are considered residents under the nursing home's bed-hold
3261 policy on or before July 1, 2011.
3262 (g) Persons who are eligible for and receiving prescribed
3263 pediatric extended care.
3264 (h) Persons who are dependent on a respirator by medical
3265 necessity and who meet the definition of a medically dependent
3266 or technologically dependent child under s. 400.902.
3267 (i) Persons who select the Medicaid hospice benefit and are
3268 receiving hospice services from a hospice licensed under part IV
3269 of chapter 400.
3270 (j) Children residing in a statewide inpatient psychiatric
3271 program.
3272 (k) A person who is eligible for services under the
3273 Medicaid program who has access to health care coverage through
3274 an employer-sponsored health plan. Such person may not receive
3275 Medicaid services under the fee-for-service program but may use
3276 Medicaid financial assistance to pay the cost of premiums for
3277 the employer-sponsored health plan. For purposes of this

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3278 paragraph, access to health care coverage through an employer-
3279 sponsored health plan means that the Medicaid financial
3280 assistance available to the person is sufficient to pay the
3281 premium for the employer-sponsored health plan for the eligible
3282 person and his or her Medicaid eligible family members.
3283 1. The agency shall develop a process that allows a
3284 recipient who has access to employer-sponsored health coverage
3285 to use Medicaid financial assistance to pay the cost of the
3286 premium for the recipient and the recipient's Medicaid-eligible
3287 family members for such coverage. The amount of financial
3288 assistance may not exceed the Medicaid capitated rate that would
3289 have been paid to a qualified plan for that recipient and the
3290 recipient's family members.
3291 2. Contingent upon federal approval, the agency shall also
3292 allow recipients who have access to other insurance or coverage
3293 created pursuant to state or federal law to opt out of Medicaid
3294 managed care and apply the Medicaid capitated rate that would
3295 have been paid to a qualified plan for that recipient and the
3296 recipient's family to pay for the other insurance product.
3297 (2) The following Medicaid recipients are exempt from
3298 mandatory enrollment in the managed care program but may
3299 volunteer to participate in the program:
3300 (a) Recipients residing in residential commitment
3301 facilities operated through the Department of Juvenile Justice,
3302 group care facilities operated by the Department of Children and
3303 Family Services, or treatment facilities funded through the
3304 substance abuse and mental health program of the Department of
3305 Children and Family Services.
3306 (b) Persons eligible for refugee assistance.

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3307 (3) Medicaid recipients who are exempt from mandatory
3308 participation under this section and who do not choose to enroll
3309 in the Medicaid managed care program shall be served though the
3310 Medicaid fee-for-service program as provided under part III of
3311 this chapter.
3312 Section 38. Section 409.965, Florida Statutes, is created
3313 to read:
3314 409.965 Qualified plans; regions; selection criteria.—
3315 Services in the Medicaid managed care program shall be provided
3316 by qualified plans.
3317 (1) The agency shall select qualified plans to participate
3318 in the Medicaid managed care program using an invitation to
3319 negotiate issued pursuant to s. 287.057.
3320 (a) The agency shall notice separate invitations to
3321 negotiate for the managed medical assistance component and the
3322 managed long-term care component of the managed care program.
3323 (b) At least 30 days before noticing the invitation to
3324 negotiate and annually thereafter, the agency shall compile and
3325 publish a databook consisting of a comprehensive set of
3326 utilization and spending data for the 3 most recent contract
3327 years, consistent with the rate-setting periods for all Medicaid
3328 recipients by region and county. Pursuant to s. 409.970, the
3329 source of the data must include both historic fee-for-service
3330 claims and validated data from the Medicaid Encounter Data
3331 System. The report shall be made available electronically and
3332 must delineate utilization by age, gender, eligibility group,
3333 geographic area, and acuity level.
3334 (2) Separate and simultaneous procurements shall be
3335 conducted in each of the following regions:

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3336 (a) Region 1, which consists of Escambia, Okaloosa, Santa
3337 Rosa, and Walton counties.
3338 (b) Region 2, which consists of Franklin, Gadsden,
3339 Jefferson, Leon, Liberty, and Wakulla counties.
3340 (c) Region 3, which consists of Columbia, Dixie, Hamilton,
3341 Lafayette, Madison, Suwannee, and Taylor counties.
3342 (d) Region 4, which consists of Baker, Clay, Duval, and
3343 Nassau counties.
3344 (e) Region 5, which consists of Citrus, Hernando, Lake,
3345 Marion, and Sumter counties.
3346 (f) Region 6, which consists of Pasco and Pinellas
3347 counties.
3348 (g) Region 7, which consists of Flagler, Putnam, St. Johns,
3349 and Volusia counties.
3350 (h) Region 8, which consists of Alachua, Bradford,
3351 Gilchrist, Levy, and Union counties.
3352 (i) Region 9, which consists of Orange and Osceola
3353 counties.
3354 (j) Region 10, which consists of Hardee, Highlands, and
3355 Polk counties.
3356 (k) Region 11, which consists of Miami-Dade and Monroe
3357 counties.
3358 (l) Region 12, which consists of DeSoto, Manatee, and
3359 Sarasota counties.
3360 (m) Region 13, which consists of Hillsborough County.
3361 (n) Region 14, which consists of Bay, Calhoun, Gulf,
3362 Holmes, Jackson, and Washington counties.
3363 (o) Region 15, which consists of Palm Beach County.
3364 (p) Region 16, which consists of Broward County.

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3365 (q) Region 17, which consists of Brevard and Seminole
3366 counties.
3367 (r) Region 18, which consists of Indian River, Martin,
3368 Okeechobee, and St. Lucie counties.
3369 (s) Region 19, which consists of Charlotte, Collier,
3370 Glades, Hendry, and Lee counties.
3371 (3) The invitation to negotiate must specify the criteria
3372 and the relative weight of the criteria to be used for
3373 determining the acceptability of a reply and guiding the
3374 selection of qualified plans with which the agency shall
3375 contract. In addition to other criteria developed by the agency,
3376 the agency shall give preference to the following factors in
3377 selecting qualified plans:
3378 (a) Accreditation by the National Committee for Quality
3379 Assurance or another nationally recognized accrediting body.
3380 (b) Experience serving similar populations, including the
3381 organization’s record in achieving specific quality standards
3382 for similar populations.
3383 (c) Availability and accessibility of primary care and
3384 specialty physicians in the provider network.
3385 (d) Establishment of partnerships with community providers
3386 that provide community-based services.
3387 (e) The organization’s commitment to quality improvement
3388 and documentation of achievements in specific quality-
3389 improvement projects, including active involvement by the
3390 organization’s leadership.
3391 (f) Provision of additional benefits, particularly dental
3392 care for all recipients, disease management, and other programs
3393 offering additional benefits.

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3394 (g) Establishment of incentive programs that reward
3395 specific behaviors with health-related benefits not otherwise
3396 covered by the organizations' benefit plan. Such behaviors may
3397 include participation in smoking-cessation programs, weight-loss
3398 programs, or other activities designed to mitigate lifestyle
3399 choices and avoid behaviors associated with the use of high-cost
3400 medical services.
3401 (h) Organizations without a history of voluntary or
3402 involuntary withdrawal from any state Medicaid program or
3403 program area.
3404 (i) Evidence that an organization has written agreements or
3405 signed contracts or has made substantial progress in
3406 establishing relationships with providers before the
3407 organization submits a reply. The agency shall evaluate such
3408 evidence based on the following factors:
3409 1. Contracts with primary care and specialty physicians in
3410 sufficient numbers to meet the specific performance standards
3411 established pursuant to s. 409.966(2)(b).
3412 2. Specific arrangements that provide evidence that the
3413 compensation offered by the plan is sufficient to retain primary
3414 care and specialty physicians in sufficient numbers to comply
3415 with the performance standards established pursuant to s.
3416 409.966(2) throughout the 5-year contract term. The agency shall
3417 give preference to plans that provide evidence that primary care
3418 physicians within the plan's provider network will be
3419 compensated for primary care services with payments equivalent
3420 to or greater than payments for such services under the Medicare
3421 program, whether compensation is made on a fee-for-service basis
3422 or by sub-capitation.

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3423 3. Contracts with community pharmacies located in rural
3424 areas; contracts with community pharmacies serving specialty
3425 disease populations, including, but not limited to, HIV/AIDS
3426 patients, hemophiliacs, patients suffering from end-stage renal
3427 disease, diabetes, or cancer; community pharmacies located
3428 within distinct cultural communities that reflect the unique
3429 cultural dynamics of such communities, including, but not
3430 limited to, languages spoken, ethnicities served, unique disease
3431 states serviced, and geographic location within the
3432 neighborhoods of culturally distinct populations; and community
3433 pharmacies providing value-added services to patients, such as
3434 free delivery, immunizations, disease management, diabetes
3435 education, and medication utilization review.
3436 4. Contracts with cancer disease management programs that
3437 have a proven record of clinical efficiencies and cost savings.
3438 5. Contracts with diabetes disease management programs that
3439 have a proven record of clinical efficiencies and cost savings.
3440 (j) The capitated rates provided in the reply to the
3441 invitation to negotiate.
3442 (k) Establishment of a claims payment process to ensure
3443 that claims that are not contested or denied will be paid within
3444 20 days after receipt.
3445 (l) Utilizing a tiered approach, organizations that are
3446 based in Florida and have operational functions performed in
3447 Florida, either performed in-house or through contractual
3448 arrangements, by Florida-employed staff. The highest number of
3449 points shall be awarded to any plan with all or substantially
3450 all of its operational functions performed in the state. The
3451 second highest number of points shall be awarded to any plan

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3452 with a majority of its operational functions performed in the
3453 state. The agency may establish a third tier; however, no
3454 preference points shall be awarded to plans that perform only
3455 community outreach, medical director functions, and state
3456 administrative functions in the state. For purposes of this
3457 paragraph, operational functions include claims processing,
3458 member services, provider relations, utilization and prior
3459 authorization, case management, disease and quality functions,
3460 and finance and administration. For purposes of this paragraph,
3461 "based in Florida" means that the entity's principal office is
3462 in Florida and the plan is not a subsidiary, directly or
3463 indirectly through one or more subsidiaries of, or a joint
3464 venture with, any other entity whose principal office is not
3465 located in the state.
3466 (m) For long-term care plans, additional criteria as
3467 specified in s. 409.976(3).
3468 (4) Acceptable replies to the invitation to negotiate for
3469 each region shall be ranked, and the agency shall select the
3470 number of qualified plans with which to contract in each region.
3471 (a) The agency may not select more than one plan per 20,000
3472 Medicaid recipients residing in the region who are subject to
3473 mandatory managed care enrollment, except that, in addition to
3474 the Children's Medical Services Network, a region may not have
3475 fewer than three or more than 10 qualified plans for the managed
3476 medical assistance or the managed long-term care components of
3477 the program.
3478 (b) If the funding available in the General Appropriations
3479 Act is not adequate to meet the proposed statewide requirement
3480 under the Medicaid managed care program, the agency shall enter

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3481 into negotiations with qualified plans that responded to the
3482 invitation to negotiate. The negotiation process may alter the
3483 rank of a qualified plan. If negotiations are conducted, the
3484 agency shall select qualified plans that are responsive and
3485 provide the best value to the state.
3486 (5) The agency may issue a new invitation to negotiate in
3487 any region:
3488 (a) At any time if:
3489 1. Data becomes available to the agency indicating that the
3490 population of recipients residing in the region who are subject
3491 to mandatory managed care enrollment cannot be served by the
3492 plans under contract with the agency in that region or has
3493 increased by more than 20,000 since the most recent invitation
3494 to negotiate was issued in that region; and
3495 2. The agency has not contracted with the maximum number of
3496 plans authorized for that region.
3497 (b) At any time during the first 2 years after the initial
3498 contract period and upon the request of a qualified plan under
3499 contract in one or more regions if:
3500 1. Data becomes available to the agency indicating that the
3501 population of Medicaid recipients residing in the region who are
3502 subject to mandatory managed care enrollment has increased by
3503 more than 20,000 since the initial invitation to negotiate was
3504 issued for the contract period; and
3505 2. The agency has not contracted with the maximum number of
3506 plans authorized for that region.
3507
3508 The term of a contract executed under this subsection shall be
3509 for the remainder of the 5-year contract cycle.

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3510 (6) The Children's Medical Services Network authorized
3511 under chapter 391 is a qualified plan for purposes of the
3512 managed care medical assistance component of the Medicaid
3513 managed care program. Participation by the network shall be
3514 pursuant to a single statewide contract with the agency which is
3515 not subject to the procurement requirements of this section. The
3516 network must meet all other plan requirements for the managed
3517 care medical assistance component of the program.
3518 (7) In order to allow a provider service network in rural
3519 areas sufficient time to develop an adequate provider network to
3520 participate in the Medicaid managed care program on a capitated
3521 basis, the network may submit an application or invitation to
3522 negotiate after July 1, 2011, as required by the agency, for a
3523 region where there was no Medicaid-contracted health maintenance
3524 organization or provider service network on July 1, 2011. For
3525 the first 12 months that the network operates in the region, the
3526 agency shall assign existing Medicaid provider agreements to the
3527 provider service network for purposes of administering managed
3528 care services and building an adequate provider network to meet
3529 the access standards established by the agency.
3530 Section 39. Section 409.966, Florida Statutes, is created
3531 to read:
3532 409.966 Plan contracts.—
3533 (1) The agency shall execute a 5-year contract with each
3534 qualified plan selected through the procurement process
3535 described in s. 409.965. A contract between the agency and the
3536 qualified plan may be amended annually, or as needed, to reflect
3537 capitated rate adjustments due to funding availability pursuant
3538 to the General Appropriations Act and ss. 409.9022, 409.972, and

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3539 409.975(2).
3540 (a) A plan contract may not be renewed; however, the agency
3541 may extend the term of a contract, keeping intact all
3542 operational provisions in the contract, including capitation
3543 rates, to cover any delays in transitioning to a new plan.
3544 (b) If a plan applies for a rate increase that is not the
3545 result of a solicitation from the agency and the application for
3546 rate increase is not timely withdrawn, the plan will be deemed
3547 to have submitted a notice of intent to leave the region before
3548 the end of the contract term.
3549 (2) The agency shall establish such contract requirements
3550 as are necessary for the operation of the Medicaid managed care
3551 program. In addition to any other provisions the agency may deem
3552 necessary, the contract must require:
3553 (a) *Access.*—The agency shall establish specific standards
3554 for the number, type, and regional distribution of providers in
3555 plan networks in order to ensure access to care. Each qualified
3556 plan shall:
3557 1. Maintain a network of providers in sufficient numbers to
3558 meet the access standards for specified services for all
3559 recipients enrolled in the plan.
3560 2. Establish and maintain an accurate and complete
3561 electronic database of contracted providers, including
3562 information about licensure or registration, locations and hours
3563 of operation, specialty credentials and other certifications,
3564 specific performance indicators, and such other information as
3565 the agency deems necessary. The provider database must be
3566 available online to both the agency and the public and allow
3567 comparison of the availability of providers to network adequacy

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3568 standards, and accept and display feedback from each provider's
3569 patients.
3570 3. Provide for reasonable and adequate hours of operation,
3571 including 24-hour availability of information, referral, and
3572 treatment for emergency medical conditions.
3573 4. Assign each new enrollee to a primary care provider and
3574 ensure that an appointment with that provider has been scheduled
3575 within 30 days after the enrollment in the plan.
3576 5. Submit quarterly reports to the agency identifying the
3577 number of enrollees assigned to each primary care provider.
3578 (b) *Performance standards.*—The agency shall establish
3579 specific performance standards and expected milestones or
3580 timelines for improving plan performance over the term of the
3581 contract.
3582 1. Each plan shall establish an internal health care
3583 quality improvement system that includes enrollee satisfaction
3584 and disenrollment surveys and incentives and disincentives for
3585 network providers.
3586 2. Each plan must collect and report the Health Plan
3587 Employer Data and Information Set (HEDIS) measures, as specified
3588 by the agency. These measures must be published on the plan's
3589 website in a manner that allows recipients to reliably compare
3590 the performance of plans. The agency shall use the HEDIS
3591 measures as a tool to monitor plan performance.
3592 3. A qualified plan that is not accredited when the
3593 contract is executed with the agency must become accredited or
3594 have initiated the accreditation process within 1 year after the
3595 contract is executed. If the plan is not accredited within 18
3596 months after executing the contract, the plan shall be suspended

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3597 from automated enrollments pursuant to s. 409.969(2).
3598 4. In addition to agency standards, a qualified plan must
3599 ensure that the agency is notified of the impending birth of a
3600 child to an enrollee or as soon as practicable after the child's
3601 birth. Upon the birth, the child is deemed enrolled with the
3602 qualified plan, regardless of the administrative enrollment
3603 procedures, and the qualified plan is responsible for providing
3604 Medicaid services to the child on a capitated basis.
3605 (c) *Program integrity.*—Each plan shall establish program
3606 integrity functions and activities in order to reduce the
3607 incidence of fraud and abuse, including, at a minimum:
3608 1. A provider credentialing system and ongoing provider
3609 monitoring. Each plan must verify at least annually that all
3610 providers have a valid and unencumbered license or permit to
3611 provide services to Medicaid recipients, and shall establish a
3612 procedure for providers to notify the plan when the provider has
3613 been notified by a licensing or regulatory agency that the
3614 provider's license or permit is to be revoked or suspended, or
3615 when an event has occurred which would prevent the provider from
3616 renewing its license or permit. The provider must also notify
3617 the plan if the license or permit is revoked or suspended, if
3618 renewal of the license or permit is denied or expires by
3619 operation of law, or if the provider requests that the license
3620 or permit be inactivated. The plan must immediately exclude a
3621 provider from the plan's provider network if the provider's
3622 license is suspended or invalid. However, this section does not
3623 preclude a plan from contracting with a provider that is
3624 approved via a final order, has commenced construction, and will
3625 be licensed and operational within 18 months after the effective

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3626 date of this act;
3627 2. An effective prepayment and postpayment review process
3628 that includes, at a minimum, data analysis, system editing, and
3629 auditing of network providers;
3630 3. Procedures for reporting instances of fraud and abuse
3631 pursuant to s. 409.91212;
3632 4. The establishment of an anti-fraud plan pursuant to s.
3633 409.91212; and
3634 5. Designation of a program integrity compliance officer.
3635 (d) *Encounter data.*—Each plan must comply with the agency's
3636 reporting requirements for the Medicaid Encounter Data System
3637 under s. 409.970. The agency shall assess a fine of $5,000 per
3638 day against a qualified plan for failing to comply with this
3639 requirement. If a plan fails to comply for more than 30 days,
3640 the agency shall assess a fine of $10,000 per day beginning on
3641 the 31st day. If a plan is fined $300,000 or more for failing to
3642 comply, in addition to paying the fine, the plan shall be
3643 disqualified from the Medicaid managed care program for 3 years.
3644 If the plan is disqualified, the plan shall be deemed to have
3645 terminated its contract before the scheduled end date and shall
3646 also be subject to applicable penalties under paragraph (l).
3647 However, the agency may waive or reduce the fine upon a showing
3648 of good cause for the failure to comply.
3649 (e) *Electronic claims and prior authorization requests.*—
3650 Plans shall accept electronic claims that are in compliance with
3651 federal standards and accept electronic prior authorization
3652 requests from prescribers and pharmacists for medication
3653 exceptions to the preferred drug list or formulary. The criteria
3654 for the approval and the reasons for denial of prior

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3655 authorization requests shall be made readily available to
3656 prescribers and pharmacists submitting the request.
3657 (f) *Prompt payment.*—All qualified plans must comply with
3658 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay
3659 nursing homes by the 10th day of the month for enrollees who are
3660 residing in the nursing home on the 1st day of the month.
3661 Payment for the month in which an enrollee initiates residency
3662 in a nursing home shall be in accordance with s. 641.3155. On an
3663 annual basis, qualified plans shall submit a report certifying
3664 compliance with the prompt payment requirements for the plan
3665 year.
3666 (g) *Emergency services.*—Qualified plans must pay for
3667 emergency services and care required under ss. 395.1041 and
3668 401.45 and rendered by a noncontracted provider in accordance
3669 with the prompt payment standards established in s. 641.3155.
3670 The payment rate shall be the fee-for-service rate the agency
3671 would pay the noncontracted provider for such services, unless
3672 the agency has developed an average rate for the noncontracted
3673 provider for such services under s. 409.967(3)(c). If the agency
3674 has developed an average rate for the noncontracted provider for
3675 such services under s. 409.967(3)(c), the payment rate for such
3676 services under this paragraph shall be the average rate
3677 developed by the agency for the noncontracted provider for such
3678 services under s. 409.967(3)(c).
3679 (h) *Surety bond.*—A qualified plan shall post and maintain a
3680 surety bond with the agency, payable to the agency, or in lieu
3681 of a surety bond, establish and maintain an irrevocable letter
3682 of credit or a deposit in a trust account in a financial
3683 institution, payable to the agency.

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3684 1. The amount of the surety bond, letter of credit, or
3685 trust account shall be 125 percent of the estimated annual
3686 guaranteed savings for each qualified plan, and at least $2
3687 million but no more than $15 million for each qualified plan.
3688 The estimated guaranteed savings shall be calculated before the
3689 execution of the contract as follows:
3690 a. The agreed-upon monthly contractual capitated rate for
3691 each level of acuity multiplied by the estimated population in
3692 the region for the plan for each level of acuity, multiplied by
3693 12 months, multiplied by 7 percent, multiplied by 125 percent.
3694 b. The estimated population in the region for the plan
3695 under sub-subparagraph a. shall be based on the maximum enrollee
3696 level that the agency initially authorizes. The factors that the
3697 agency may consider in determining the maximum enrollee level
3698 include, but are not limited to, requested capacity, projected
3699 enrollment, network adequacy, and the available budget in the
3700 General Appropriations Act.
3701 2. The purpose of the surety bond, letter of credit, or
3702 trust account is to protect the agency if the entity terminates
3703 its contract with the agency before the scheduled end date for
3704 the contract, if the plan fails to comply with the terms of the
3705 contract, including, but not limited to, the timely submission
3706 of encounter data, if the agency imposes fines or penalties for
3707 noncompliance, or if the plan fails to achieve the guaranteed
3708 savings. If any of those events occurs, the agency shall first
3709 request payment from the qualified plan. If the qualified plan
3710 does not pay all costs, fines, penalties, or the differential in
3711 the guaranteed savings in full within 30 days, the agency shall
3712 pursue a claim against the surety bond, letter of credit, or

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3713 trust account for all applicable moneys and the legal and
3714 administrative costs associated with pursuing such claim.
3715 (i) *Grievance resolution.*—Each plan shall establish and the
3716 agency shall approve an internal process for reviewing and
3717 responding to grievances from enrollees consistent with s.
3718 641.511. Each plan shall submit quarterly reports to the agency
3719 on the number, description, and outcome of grievances filed by
3720 enrollees.
3721 (j) *Solvency.*—A qualified plan must meet and maintain the
3722 surplus and solvency requirements under s. 409.912(17) and (18).
3723 A provider service network may satisfy the surplus and solvency
3724 requirements if the network's performance and financial
3725 obligations are guaranteed in writing by an entity licensed by
3726 the Office of Insurance Regulation which meets the surplus and
3727 solvency requirements of s. 624.408 or s. 641.225.
3728 (k) *Guaranteed savings.*—During the first contract period, a
3729 qualified plan must agree to provide a guaranteed minimum
3730 savings of 7 percent to the state. The agency shall conduct a
3731 cost reconciliation to determine the amount of cost savings
3732 achieved by the qualified plan compared with the reimbursements
3733 the agency would have incurred under fee-for-service provisions.
3734 (l) *Costs and penalties.*—Plans that reduce enrollment
3735 levels or leave a region before the end of the contract term
3736 must reimburse the agency for the cost of enrollment changes and
3737 other transition activities. If more than one plan leaves a
3738 region at the same time, costs shall be shared by the departing
3739 plans proportionate to their enrollment. In addition to the
3740 payment of costs, departing plans must pay a penalty of 1
3741 month's payment calculated as an average of the past 12 months

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3742 of payments, or since inception if the plan has not contracted
3743 with the agency for 12 months, plus the differential of the
3744 guaranteed savings based on the original contract term and the
3745 corresponding termination date. Plans must provide the agency
3746 with at least 180 days' notice before withdrawing from a region.
3747 (m) *Formulary.*—Upon recommendation of the Medicaid
3748 Pharmaceutical and Therapeutics Committee as defined in s.
3749 409.91195, all qualified plans must adopt a standard minimum
3750 preferred drug list as described in s. 409.912(39). A plan may
3751 offer additional products on its formulary. Each plan must
3752 publish an up-to-date listing of its formulary on a publicly
3753 available website.
3754 (3) If the agency terminates more than one regional
3755 contract with a qualified plan due to the plan's noncompliance
3756 with one or more requirements of this section, the agency shall
3757 terminate all regional contracts with the plan under the
3758 Medicaid managed care program, as well as any other contracts or
3759 agreements for other programs or services, and the plan may not
3760 be awarded new contracts for 3 years.
3761 Section 40. Section 409.967, Florida Statutes, is created
3762 to read:
3763 409.967 Plan accountability.—In addition to the contract
3764 requirements of s. 409.966, plans and providers participating in
3765 the Medicaid managed care program must comply with this section.
3766 (1) The agency shall require qualified plans to use a
3767 uniform method of reporting and accounting for medical, direct
3768 care management, and nonmedical costs and shall evaluate plan-
3769 spending patterns after the plan completes 2 full years of
3770 operation and at least annually thereafter.

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3771 (2) The agency shall establish and the qualified plans
3772 shall use a uniform method for annually reporting premium
3773 revenue, medical and administrative costs, and income or losses
3774 across all state Medicaid prepaid plan lines of business in all
3775 regions. The reports are due to the agency within 270 days after
3776 the conclusion of the reporting period, and the agency may audit
3777 the reports. Achieved savings rebates are due within 30 days
3778 after the report is submitted.
3779 (a) Except as provided in paragraph (b), the achieved
3780 savings rebate is established by determining pretax income as a
3781 percentage of revenues and applying the following income sharing
3782 ratios:
3783 1. One hundred percent of income up to and including 5
3784 percent of revenue shall be retained by the plan.
3785 2. Fifty percent of income above 5 percent and up to 10
3786 percent shall be retained by the plan, with the other 50 percent
3787 refunded to the state.
3788 3. One hundred percent of income above 10 percent of
3789 revenue shall be refunded to the state.
3790 (b) A plan that meets or exceeds agency defined quality
3791 measures in the reporting period may retain an additional 1
3792 percent of revenue.
3793 (c) The following expenses may not be included in
3794 calculating income to the plan:
3795 1. Payment of achieved savings rebates.
3796 2. Any financial incentive payments made to the plan
3797 outside of the capitation rate.
3798 3. Any financial disincentive payments levied by the state
3799 or federal governments.

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3800 4. Expenses associated with lobbying activities.
3801 5. Administrative, reinsurance, and outstanding claims
3802 expenses in excess of actuarially sound maximum amounts set by
3803 the agency.
3804 (d) Qualified plans that incur a loss in the first contract
3805 year may apply the full amount of the loss as an offset to
3806 income in the second contract year.
3807 (e) If, after an audit or other reconciliation, the agency
3808 determines that a qualified plan owes an additional rebate, the
3809 plan has 30 days after notification to make payment. Upon
3810 failure to timely pay the rebate, the agency shall withhold
3811 future payments to the plan until the entire amount is recouped.
3812 If the agency determines that a plan has made an overpayment,
3813 the agency shall return the overpayment within 30 days.
3814 (3) Plans may limit the providers in their networks.
3815 (a) However, during the first year in which a qualified
3816 plan is operating in a region after the initial plan procurement
3817 for that region, the plan must offer a network contract to the
3818 following providers in the region:
3819 1. Federally qualified health centers.
3820 2. Nursing homes if the plan is providing managed long-term
3821 care services.
3822 3. Aging network service providers that have previously
3823 participated in home and community-based waivers serving elders,
3824 or community-service programs administered by the Department of
3825 Elderly Affairs if the plan is providing managed long-term care
3826 services.
3827 (b) After 12 months of active participation in a plan's
3828 network, the plan may exclude any of the providers listed in

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3829 paragraph (a) from the network while maintaining the network
3830 performance standards required under s. 409.966(2)(b). If the
3831 plan excludes a nursing home that meets the standards for
3832 ongoing Medicaid certification, the plan must provide an
3833 alternative residence in that community for Medicaid recipients
3834 residing in that nursing home. If a Medicaid recipient residing
3835 in an excluded nursing home does not choose to change residence,
3836 the plan must continue to pay for the recipient's care in that
3837 nursing home. If the plan excludes a provider, the plan must
3838 provide written notice to all enrollees who have chosen that
3839 provider for care. Notice to excluded providers must be
3840 delivered at least 30 days before the effective date of the
3841 exclusion.
3842 (c) Notwithstanding the limitation provided in this
3843 subsection, qualified plans must include the following essential
3844 providers in their networks:
3845 1. Faculty plans of state medical schools;
3846 2. Regional perinatal intensive care centers as defined in
3847 s. 383.16; and
3848 3. Hospitals licensed as a children's specialty hospital as
3849 defined in s. 395.002.
3850
3851 Qualified plans that have not contracted with all statewide
3852 essential providers as of the first date of recipient enrollment
3853 must continue to negotiate in good faith. Payments to physicians
3854 on the faculty of nonparticipating state medical schools must be
3855 made at the applicable Medicaid rate. Payments for services
3856 rendered by a regional perinatal intensive care center must be
3857 at the applicable Medicaid rate as of the first day of the

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3858 contract between the agency and the plan. Payments to a
3859 nonparticipating specialty children's hospital must equal the
3860 highest rate established by contract between that provider and
3861 any other Medicaid managed care plan.
3862 (d) Qualified plans and providers shall engage in good
3863 faith negotiations to reach contract terms.
3864 1. If a qualified plan seeks to develop a provider network
3865 in a county or region that, as of June 30, 2011, does not have a
3866 capitated managed care plan providing comprehensive acute care
3867 for Medicaid recipients, and the qualified plan has made at
3868 least three documented, unsuccessful, good faith attempts to
3869 contract with a specific provider, the plan may request the
3870 agency to examine the negotiation process. During the
3871 examination, the agency shall consider similar counties or
3872 regions in which qualified plans have contracted with providers
3873 under similar circumstances, as well as the contracted rates
3874 between qualified plans and that provider and similar providers
3875 in the same region. If the agency determines that the plan has
3876 made three good faith attempts to contract with the provider,
3877 the agency shall consider that provider to be part of the
3878 qualified plan's provider network for the purpose of determining
3879 network adequacy, and the plan shall pay the provider for
3880 services to Medicaid recipients on a noncontracted basis at a
3881 rate or rates determined by the agency to be the average of
3882 rates for corresponding services paid by the qualified plan and
3883 other qualified plans in the region and in similar counties or
3884 regions under similar circumstances.
3885 2. The agency may continue to calculate Medicaid hospital
3886 inpatient per diem rates and outpatient rates. However, these

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3887 rates may not be the basis for contract negotiations between a
3888 managed care plan and a hospital.
3889 (4) Each qualified plan shall monitor the quality and
3890 performance of each provider within its network based on metrics
3891 established by the agency for evaluating and documenting
3892 provider performance and determining continued participation in
3893 the network. However, qualified plans are not required to
3894 conduct surveys of health care facilities that the agency
3895 surveys periodically for licensure or certification purposes and
3896 shall accept the results of such surveys. The agency shall
3897 establish requirements for qualified plans to report, at least
3898 annually, provider performance data compiled under this
3899 subsection. If a plan uses additional metrics to evaluate the
3900 provider's performance and to determine continued participation
3901 in the network, the plan must notify the network providers of
3902 these metrics at the beginning of the contract period.
3903 (a) At a minimum, a qualified plan shall hold primary care
3904 physicians responsible for the following activities:
3905 1. Supervision, coordination, and provision of care to each
3906 assigned enrollee.
3907 2. Initiation of referrals for medically necessary
3908 specialty care and other services.
3909 3. Maintaining continuity of care for each assigned
3910 enrollee.
3911 4. Maintaining the enrollee's medical record, including
3912 documentation of all medical services provided to the enrollee
3913 by the primary care physician, as well as any specialty or
3914 referral services.
3915 (b) Qualified plans shall establish and implement policies

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3916 and procedures to monitor primary care physician activities and
3917 ensure that primary care physicians are adequately notified and
3918 receive documentation of specialty and referral services
3919 provided to enrollees by specialty physicians and other health
3920 care providers within the plan's provider network.
3921 (5) Each qualified plan shall establish specific programs
3922 and procedures to improve pregnancy outcomes and infant health,
3923 including, but not limited to, coordination with the Healthy
3924 Start program, immunization programs, and referral to the
3925 Special Supplemental Nutrition Program for Women, Infants, and
3926 Children, and the Children's Medical Services Program for
3927 children with special health care needs.
3928 (a) Qualified plans must ensure that primary care
3929 physicians who provide obstetrical care are available to
3930 pregnant recipients and that an obstetrical care provider is
3931 assigned to each pregnant recipient for the duration of her
3932 pregnancy and postpartum care, by referral of the recipient's
3933 primary care physician if necessary.
3934 (b) Qualified plans within the managed long-term care
3935 component are exempt from this subsection.
3936 (6) Each qualified plan shall achieve an annual screening
3937 rate for early and periodic screening, diagnosis, and treatment
3938 services of at least 80 percent of those recipients continuously
3939 enrolled for at least 8 months. Qualified plans within the
3940 managed long-term care component are exempt from this
3941 requirement.
3942 (7) Effective January 1, 2013, qualified plans must
3943 compensate primary care physicians for primary care services at
3944 payment rates that are equivalent to or greater than payments

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3945 under the federal Medicare program, whether compensation is made
3946 on a fee-for-service basis or by sub-capitation.
3947 (8) In order to protect the continued operation of the
3948 Medicaid managed care program, unresolved disputes, including
3949 claim and other types of disputes, between a qualified plan and
3950 a provider shall proceed in accordance with s. 408.7057. This
3951 process may not be used to review or reverse a decision by a
3952 qualified plan to exclude a provider from its network if the
3953 decision does not conflict with s. 409.967(3).
3954 Section 41. Section 409.968, Florida Statutes, is created
3955 to read:
3956 409.968 Plan payment.—Payments for managed medical
3957 assistance and managed long-term care services under this part
3958 shall be made in accordance with a capitated managed care model.
3959 Qualified plans shall receive per-member, per-month payments
3960 pursuant to the procurements described in s. 409.965 and annual
3961 adjustments as described in s. 409.966(1). Payment rates must be
3962 based on the acuity level for each member pursuant to ss.
3963 409.972 and 409.978. Payment rates for managed long-term care
3964 plans shall be combined with rates for managed medical
3965 assistance plans.
3966 (1) The agency shall develop a methodology and request a
3967 waiver that ensures the availability of intergovernmental
3968 transfers and certified public expenditures in the Medicaid
3969 managed care program to support providers that have historically
3970 served Medicaid recipients. Such providers include, but are not
3971 limited to, safety net providers, trauma hospitals, children's
3972 hospitals, statutory teaching hospitals, and medical and
3973 osteopathic physicians employed by or under contract with a

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3974 medical school in this state. The agency may develop a
3975 supplemental capitation rate, risk pool, or incentive payment
3976 for plans that contract with these providers. A plan is eligible
3977 for a supplemental payment only if there are sufficient
3978 intergovernmental transfers or certified public expenditures
3979 available from allowable sources.
3980 (2) The agency shall evaluate the development of the rate
3981 cell to accurately reflect the underlying utilization to the
3982 maximum extent possible. This methodology may include interim
3983 rate adjustments as permitted under federal regulations. Any
3984 such methodology must preserve federal funding to these entities
3985 and be actuarially sound. In the absence of federal approval of
3986 the methodology, the agency may set an enhanced rate and require
3987 that plans pay the rate if the agency determines the enhanced
3988 rate is necessary to ensure access to care by the providers
3989 described in this subsection.
3990 (3) The amount paid to the plans to make supplemental
3991 payments or to enhance provider rates pursuant to this
3992 subsection must be reconciled to the exact amounts the plans are
3993 required to pay providers. The plans shall make the designated
3994 payments to providers within 15 business days after notification
3995 by the agency regarding provider-specific distributions.
3996 (4) The agency shall develop a methodology and request a
3997 state plan amendment or waiver that ensures the availability of
3998 certified public expenditures in the Medicaid managed care
3999 program to support noninstitutional teaching faculty providers
4000 that have historically served Medicaid recipients. Such
4001 providers include allopathic and osteopathic physicians employed
4002 by or under contract with a medical school in this state. The

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4003 agency shall directly make supplemental payments to teaching
4004 faculty providers or to a statewide entity acting on behalf of
4005 state medical schools and teaching faculty providers that
4006 contract with qualified plans and provide care to Medicaid
4007 recipients in recognition of the costs associated with graduate
4008 medical education and training, educating medical school
4009 students, and access to primary and specialty care provided to
4010 Medicaid recipients. Physicians employed by or under contract
4011 with a medical school in this state are eligible for a
4012 supplemental payment only if there are sufficient certified
4013 public expenditures available from allowable sources. The agency
4014 shall evaluate the development of teaching faculty provider
4015 payments for managed care to accurately reflect the historical
4016 and underlying as well as current and prospective utilization to
4017 the maximum extent possible. Any such methodology must preserve
4018 federal funding to these entities.
4019 Section 42. Section 409.969, Florida Statutes, is created
4020 to read:
4021 409.969 Enrollment; disenrollment; grievance procedure.—
4022 (1) Each Medicaid recipient may choose any available plan
4023 within the region in which the recipient resides unless that
4024 plan is a specialty plan for which the recipient does not
4025 qualify. The agency may not provide or contract for choice
4026 counseling services for persons enrolling in the Medicaid
4027 managed care program.
4028 (2) If a recipient has not made a choice of plans within 30
4029 days after having been notified to choose a plan, the agency
4030 shall assign the recipient to a plan in accordance with the
4031 following:

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4032 (a) A recipient who was previously enrolled in a plan
4033 within the preceding 90 days shall automatically be enrolled in
4034 the same plan, if available.
4035 (b) Newborns of eligible mothers enrolled in a plan at the
4036 time of the child's birth shall be enrolled in the mother's
4037 plan; however, the mother may choose another plan for the
4038 newborn within 90 days after the child's birth.
4039 (c) If the recipient is diagnosed with HIV/AIDS and resides
4040 in region 11, region 15, or region 16, the agency shall assign
4041 the recipient to a plan that:
4042 1. Is a specialty plan under contract with the agency
4043 pursuant to s. 409.965; and
4044 2. Offers a delivery system through a teaching- and
4045 research-oriented organization that specializes in providing
4046 health care services and treatment for individuals diagnosed
4047 with HIV/AIDS.
4048
4049 The agency shall assign recipients under this paragraph on an
4050 even basis among all such plans within a region under contract
4051 with the agency.
4052 (d) A recipient who is currently receiving Medicare
4053 services from an entity qualified under 42 C.F.R. part 422 as a
4054 Medicare Advantage preferred provider organization, Medicare
4055 Advantage provider-sponsored organization, or Medicare Advantage
4056 special needs plan that is under contract with the agency shall
4057 be assigned to that plan for the Medicaid services not covered
4058 by Medicare for which the recipient is eligible.
4059 (e) Other recipients shall be enrolled into a qualified
4060 plan in accordance with an auto-assignment enrollment algorithm

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4061 that the agency develops by rule. The algorithm must heavily
4062 weigh family continuity.
4063 1. Automatic enrollment of recipients in plans must be
4064 based on the following criteria:
4065 a. Whether the plan has sufficient network capacity to meet
4066 the needs of recipients.
4067 b. Whether the recipient has previously received services
4068 from one of the plan's primary care providers.
4069 c. Whether primary care providers in one plan are more
4070 geographically accessible to the recipient's residence than
4071 providers in other plans.
4072 d. If a recipient is eligible for long-term care services,
4073 whether the recipient has previously received services from one
4074 of the plan's home and community-based service providers.
4075 e. If a recipient is eligible for long-term care services,
4076 whether the home and community-based providers in one plan are
4077 more geographically accessible to the recipient's residence than
4078 providers in other plans.
4079 2. The agency shall automatically enroll recipients in
4080 plans that meet or exceed the performance or quality standards
4081 established pursuant to s. 409.967, and may not automatically
4082 enroll recipients in a plan that is not meeting those standards.
4083 Except as provided by law or rule, the agency may not engage in
4084 practices that favor one qualified plan over another.
4085 (3) After a recipient has enrolled in a qualified plan, the
4086 enrollee shall have 90 days to voluntarily disenroll and select
4087 another plan. After 90 days, no further changes may be made
4088 except for good cause. Good cause includes, but is not limited
4089 to, poor quality of care, lack of access to necessary specialty

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4090 services, an unreasonable delay or denial of service, or
4091 fraudulent enrollment. The agency shall determine whether good
4092 cause exists. The agency may require an enrollee to use the
4093 plan's grievance process before the agency makes a determination
4094 of good cause, unless an immediate risk of permanent damage to
4095 the enrollee's health is alleged.
4096 (a) If used, the qualified plan's internal grievance
4097 process must be completed in time to allow the enrollee to
4098 disenroll by the first day of the second month after the month
4099 the disenrollment request was made. If the grievance process
4100 approves an enrollee's request to disenroll, the agency is not
4101 required to make a determination of good cause.
4102 (b) The agency must make a determination of good cause and
4103 take final action on an enrollee's request so that disenrollment
4104 occurs by the first day of the second month after the month the
4105 request was made. If the agency fails to act within this
4106 timeframe, the enrollee's request to disenroll is deemed
4107 approved as of the date agency action was required. Enrollees
4108 who disagree with the agency's finding that good cause for
4109 disenrollment does not exist shall be advised of their right to
4110 pursue a Medicaid fair hearing to dispute the agency's finding.
4111 (c) Medicaid recipients enrolled in a qualified plan after
4112 the 90-day period must remain in the plan for the remainder of
4113 the 12-month period. After 12 months, the enrollee may select
4114 another plan. However, a recipient who is referred for nursing
4115 home or assisted living facility services may change plans
4116 within 30 days after such referral. An enrollee may change
4117 primary care providers within the plan at any time.
4118 (d) On the first day of the next month after receiving

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4119 notice from a recipient that the recipient has moved to another
4120 region, the agency shall automatically disenroll the recipient
4121 from the plan the recipient is currently enrolled in and treat
4122 the recipient as if the recipient is a new enrollee. At that
4123 time, the recipient may choose another plan pursuant to the
4124 enrollment process established in this section.
4125 Section 43. Section 409.970, Florida Statutes, is created
4126 to read:
4127 409.970 Medicaid Encounter Data System.—The agency shall
4128 maintain and operate the Medicaid Encounter Data System to
4129 collect, process, and report on covered services provided to all
4130 Medicaid recipients enrolled in qualified plans.
4131 (1) Qualified plans shall submit encounter data
4132 electronically in a format that complies with provisions of the
4133 federal Health Insurance Portability and Accountability Act for
4134 electronic claims and in accordance with deadlines established
4135 by the agency. Plans must certify that the data reported is
4136 accurate and complete. The agency is responsible for validating
4137 the data submitted by the plans.
4138 (2) The agency shall develop methods and protocols for
4139 ongoing analysis of the encounter data, which must adjust for
4140 differences in the characteristics of enrollees in order to
4141 allow for the comparison of service utilization among plans. The
4142 analysis shall be used to identify possible cases of systemic
4143 overutilization, underutilization, inappropriate denials of
4144 claims, and inappropriate utilization of covered services, such
4145 as higher than expected emergency department and pharmacy
4146 encounters. One of the primary focus areas for the analysis
4147 shall be the use of prescription drugs.

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4148 (3) The agency shall provide periodic feedback to the plans
4149 based on the analysis and establish corrective action plans if
4150 necessary.
4151 (4) The agency shall make encounter data available to plans
4152 accepting enrollees who are reassigned to them from other plans
4153 leaving a region.
4154 (5) Beginning July 1, 2011, the agency shall conduct
4155 appropriate tests and establish specific criteria for
4156 determining whether the Medicaid Encounter Data System has
4157 valid, complete, and sound data for a sufficient period of time
4158 to provide qualified plans with a reliable basis for determining
4159 and proposing actuarially sound payment rates.
4160 Section 44. Section 409.971, Florida Statutes, is created
4161 to read:
4162 409.971 Managed care medical assistance.—Pursuant to s.
4163 409.902, the agency shall administer the managed care medical
4164 assistance component of the Medicaid managed care program
4165 described in this section and s. 409.972. Unless otherwise
4166 specified, the provisions of ss. 409.961-409.970 apply to the
4167 provision of managed care medical assistance. By December 31,
4168 2011, the agency shall begin implementation of managed care
4169 medical assistance, and full implementation in all regions must
4170 be completed by December 31, 2012.
4171 Section 45. Section 409.972, Florida Statutes, is created
4172 to read:
4173 409.972 Managed care medical assistance services.—
4174 (1) Qualified plans providing managed care medical
4175 assistance must, at a minimum, cover the following services:
4176 (a) Ambulatory patient services.

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4177 (b) Dental services for a recipient who is under age 21.
4178 (c) Dental services as provided in s. 627.419(7) for a
4179 recipient who is 21 years of age or older.
4180 (d) Dialysis services.
4181 (e) Durable medical equipment and supplies.
4182 (f) Early periodic screening diagnosis and treatment
4183 services, hearing services and hearing aids, and vision services
4184 and eyeglasses for enrollees under age 21.
4185 (g) Emergency services.
4186 (h) Family planning services.
4187 (i) Hearing services for a recipient who is under age 21.
4188 (j) Hearing services that are medically indicated for a
4189 recipient who is 21 years of age or older.
4190 (k) Home health services.
4191 (l) Hospital inpatient services.
4192 (m) Hospital outpatient services.
4193 (n) Laboratory and imaging services.
4194 (o) Maternity and newborn care and birth center services.
4195 (p) Mental health services, substance abuse disorder
4196 services, and behavioral health treatment.
4197 (q) Prescription drugs.
4198 (r) Primary care service, referred specialty care services,
4199 preventive services, and wellness services.
4200 (s) Skilled nursing facility or inpatient rehabilitation
4201 facility services.
4202 (t) Transplant services.
4203 (u) Transportation to access covered services.
4204 (v) Vision services for a recipient who is under age 21.
4205 (w) Vision services that are medically indicated for a

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4206 recipient who is 21 years of age or older.
4207 (2) Subject to specific appropriations, the agency may make
4208 payments for services that are optional.
4209 (3) Qualified plans may customize benefit packages for
4210 nonpregnant adults, vary cost-sharing provisions, and provide
4211 coverage for additional services. The agency shall evaluate the
4212 proposed benefit packages to ensure that services are sufficient
4213 to meet the needs of the plans' enrollees and to verify
4214 actuarial equivalence.
4215 (4) For Medicaid recipients diagnosed with hemophilia who
4216 have been prescribed anti-hemophilic-factor replacement
4217 products, the agency shall provide for those products and
4218 hemophilia overlay services through the agency's hemophilia
4219 disease management program authorized under s. 409.912.
4220 (5) Managed care medical assistance services provided under
4221 this section must be medically necessary and provided in
4222 accordance with state and federal law. This section does not
4223 prevent the agency from adjusting fees, reimbursement rates,
4224 lengths of stay, number of visits, or number of services, or
4225 from making any other adjustments necessary to comply with the
4226 availability of funding and any limitations or directions
4227 provided in the General Appropriations Act, chapter 216, or s.
4228 409.9022.
4229 Section 46. Section 409.973, Florida Statutes, is created
4230 to read:
4231 409.973 Managed long-term care.—
4232 (1) Qualified plans providing managed care medical
4233 assistance may also participate in the managed long-term care
4234 component of the Medicaid managed care program. Unless otherwise

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4235 specified, the provisions of ss. 409.961-409.970 apply to the
4236 managed long-term care component of the managed care program.
4237 (2) Pursuant to s. 409.902, the agency shall administer the
4238 managed long-term care component described in this section and
4239 ss. 409.974-409.978, but may delegate specific duties and
4240 responsibilities to the Department of Elderly Affairs and other
4241 state agencies. By March 31, 2012, the agency shall begin
4242 implementation of the managed long-term care component, with
4243 full implementation in all regions by March 31, 2013.
4244 (3) The Department of Elderly Affairs shall assist the
4245 agency in developing specifications for use in the invitation to
4246 negotiate and the model contract, determining clinical
4247 eligibility for enrollment in managed long-term care plans,
4248 monitoring plan performance and measuring quality of service
4249 delivery, assisting clients and families in order to address
4250 complaints with the plans, facilitating working relationships
4251 between plans and providers serving elders and disabled adults,
4252 and performing other functions specified in a memorandum of
4253 agreement.
4254 Section 47. Section 409.974, Florida Statutes, is created
4255 to read:
4256 409.974 Recipient eligibility for managed long-term care.—
4257 (1) Medicaid recipients shall receive covered long-term
4258 care services through the managed long-term care component of
4259 the Medicaid managed care program unless excluded pursuant to s.
4260 409.964. In order to participate in the managed long-term care
4261 component, the recipient must be:
4262 (a) Sixty-five years of age or older or eligible for
4263 Medicaid by reason of a disability; and

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4264 (b) Determined by the Comprehensive Assessment and Review
4265 for Long-Term Care Services (CARES) Program to meet the criteria
4266 for nursing facility care.
4267 (2) Medicaid recipients who are enrolled in one of the
4268 following Medicaid long-term care waiver programs on the date
4269 that a managed long-term care plan becomes available in the
4270 recipient's region may remain in that program if it is
4271 operational on that date:
4272 (a) The Assisted Living for the Frail Elderly Waiver.
4273 (b) The Aged and Disabled Adult Waiver.
4274 (c) The Adult Day Health Care Waiver.
4275 (d) The Consumer-Directed Care Program as described in s.
4276 409.221.
4277 (e) The Program of All-inclusive Care for the Elderly.
4278 (f) The Long-Term Care Community Diversion Pilot Project as
4279 described in s. 430.705.
4280 (g) The Channeling Services Waiver for Frail Elders.
4281 (3) If a long-term care waiver program in which the
4282 recipient is enrolled ceases to operate, the Medicaid recipient
4283 may transfer to another long-term care waiver program or to the
4284 Medicaid managed long-term care component of the Medicaid
4285 managed care program. If no waivers are operational in the
4286 recipient's region and the recipient continues to participate in
4287 Medicaid, the recipient must transfer to the managed long-term
4288 care component of the Medicaid managed care program.
4289 (4) New enrollment in a waiver program ends on the date
4290 that a managed long-term care plan becomes available in a
4291 region.
4292 (5) Medicaid recipients who are residing in a nursing home

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4293 facility on the date that a managed long-term care plan becomes
4294 available in the recipient's region are eligible for the long-
4295 term care Medicaid waiver programs.
4296 (6) This section does not create an entitlement to any home
4297 and community-based services provided under the managed long-
4298 term care component.
4299 Section 48. Section 409.975, Florida Statutes, is created
4300 to read:
4301 409.975 Managed long-term care services.—
4302 (1) Qualified plans participating in the managed long-term
4303 care component of the Medicaid managed care program, at a
4304 minimum, shall cover the following services:
4305 (a) The services listed in s. 409.972.
4306 (b) Nursing facility services.
4307 (c) Home and community-based services, including, but not
4308 limited to, assisted living facility services.
4309 (2) Services provided under this section must be medically
4310 necessary and provided in accordance with state and federal law.
4311 This section does not prevent the agency from adjusting fees,
4312 reimbursement rates, lengths of stay, number of visits, or
4313 number of services, or from making any other adjustments
4314 necessary to comply with the availability of funding and any
4315 limitations or directions provided in the General Appropriations
4316 Act, chapter 216, or s. 409.9022.
4317 Section 49. Section 409.976, Florida Statutes, is created
4318 to read:
4319 409.976 Qualified managed long-term care plans.—
4320 (1) For purposes of managed long-term care, qualified plans
4321 also include:

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4322 (a) Entities who are qualified under 42 C.F.R. part 422 as
4323 Medicare Advantage Preferred Provider Organizations, Medicare
4324 Advantage Provider-sponsored Organizations, and Medicare
4325 Advantage Special Needs Plans. Such plans may participate in the
4326 managed long-term care component. A plan submitting a response
4327 to the invitation to negotiate for the managed long-term care
4328 component may reference one or more of these entities as part of
4329 its demonstration of network adequacy for the provision of
4330 services required under s. 409.972 for dually eligible
4331 enrollees.
4332 (b) The Program of All-inclusive Care for the Elderly
4333 (PACE). Participation by PACE shall be pursuant to a contract
4334 with the agency and is not subject to the procurement
4335 requirements of this section. PACE plans may continue to provide
4336 services to recipients at such levels and enrollment caps as
4337 authorized by the General Appropriations Act.
4338 (2) The agency shall select qualified plans through the
4339 procurement described in s. 409.965. The agency shall notice the
4340 invitation to negotiate by November 14, 2011.
4341 (3) In addition to the criteria established in s. 409.965,
4342 the agency shall give preference to the following factors in
4343 selecting qualified plans:
4344 (a) The plan’s employment of executive managers having
4345 expertise and experience in serving aged and disabled persons
4346 who require long-term care.
4347 (b) The plan’s establishment of a network of service
4348 providers dispersed throughout the region and in sufficient
4349 numbers to meet specific service standards established by the
4350 agency for a continuum of care, beginning from the provision of

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4351 assistance with the activities of daily living at a recipient's
4352 home and the provision of other home and community-based care
4353 through the provision of nursing home care. These providers
4354 include:
4355 1. Adult day centers.
4356 2. Adult family care homes.
4357 3. Assisted living facilities.
4358 4. Health care services pools.
4359 5. Home health agencies.
4360 6. Homemaker and companion services.
4361 7. Community Care for the Elderly lead agencies.
4362 8. Nurse registries.
4363 9. Nursing homes.
4364
4365 All providers are not required to be located within the region;
4366 however, the provider network must be sufficient to ensure that
4367 services are available throughout the region.
4368 (c) Whether a plan offers consumer-directed care services
4369 to enrollees pursuant to s. 409.221 or includes attendant care
4370 or paid family caregivers in the benefit package. Consumer-
4371 directed care services must provide a flexible budget, which is
4372 managed by enrollees and their families or representatives, and
4373 allows them to choose service providers, determine provider
4374 rates of payment, and direct the delivery of services to best
4375 meet their special long-term care needs. If all other factors
4376 are equal among competing qualified plans, the agency shall give
4377 preference to such plans.
4378 (d) Evidence that a qualified plan has written agreements
4379 or signed contracts or has made substantial progress in

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4380 establishing relationships with providers before the plan
4381 submits a response.
4382 (e) The availability and accessibility of case managers in
4383 the plan and provider network.
4384 Section 50. Section 409.977, Florida Statutes, is created
4385 to read:
4386 409.977 Managed long-term plan and provider
4387 accountability.—In addition to the requirements of ss. 409.966
4388 and 409.967, plans and providers participating in managed long-
4389 term care must comply with s. 641.31(25) and with the specific
4390 standards established by the agency for the number, type, and
4391 regional distribution of the following providers in the plan's
4392 network, which must include:
4393 (1) Adult day centers.
4394 (2) Adult family care homes.
4395 (3) Assisted living facilities.
4396 (4) Health care services pools.
4397 (5) Home health agencies.
4398 (6) Homemaker and companion services.
4399 (7) Community Care for the Elderly lead agencies.
4400 (8) Nurse registries.
4401 (9) Nursing homes.
4402 Section 51. Section 409.978, Florida Statutes, is created
4403 to read:
4404 409.978 CARES program screening; levels of care.—
4405 (1) The agency shall operate the Comprehensive Assessment
4406 and Review for Long-Term Care Services (CARES) preadmission
4407 screening program to ensure that only recipients whose
4408 conditions require long-term care services are enrolled in

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4409 managed long-term care plans.
4410 (2) The agency shall operate the CARES program through an
4411 interagency agreement with the Department of Elderly Affairs.
4412 The agency, in consultation with the department, may contract
4413 for any function or activity of the CARES program, including any
4414 function or activity required by 42 C.F.R. part 483.20, relating
4415 to preadmission screening and review.
4416 (3) The CARES program shall determine if a recipient
4417 requires nursing facility care and, if so, assign the recipient
4418 to one of the following levels of care:
4419 (a) Level of care 1 consists of enrollees who require the
4420 constant availability of routine medical and nursing treatment
4421 and care, have a limited need for health-related care and
4422 services, are mildly medically or physically incapacitated, and
4423 cannot be managed at home due to inadequacy of home-based
4424 services.
4425 (b) Level of care 2 consists of enrollees who require the
4426 constant availability of routine medical and nursing treatment
4427 and care, and require extensive health-related care and services
4428 because of mental or physical incapacitation. Current enrollees
4429 in home and community-based waiver programs for persons who are
4430 elderly or adults with physical disability, or both, who remain
4431 financially eligible for Medicaid are not required to meet new
4432 level-of-care criteria except for immediate placement in a
4433 nursing home.
4434 (c) Level of care 3 consists of enrollees residing in
4435 nursing homes, or needing immediate placement in a nursing home,
4436 and who have a priority score of 5 or above as determined by
4437 CARES.

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4438 (4) For recipients whose nursing home stay is initially
4439 funded by Medicare and Medicare coverage is being terminated for
4440 lack of progress towards rehabilitation, CARES staff shall
4441 consult with the person determining the recipient's progress
4442 toward rehabilitation in order to ensure that the recipient is
4443 not being inappropriately disqualified from Medicare coverage.
4444 If, in their professional judgment, CARES staff believes that a
4445 Medicare beneficiary is still making progress, they may assist
4446 the Medicare beneficiary with appealing the disqualification
4447 from Medicare coverage. The CARES teams may review Medicare
4448 denials for coverage under this section only if it is determined
4449 that such reviews qualify for federal matching funds through
4450 Medicaid. The agency shall seek or amend federal waivers as
4451 necessary to implement this section.
4452 Section 52. Section 409.91207, Florida Statutes, is
4453 transferred, renumbered as section 409.985, Florida Statutes,
4454 and subsection (1) of that section is amended to read:
4455 409.985 ~~409.91207~~ Medical home pilot project.—
4456 (1) The agency shall develop a plan to implement a medical
4457 home pilot project that uses ~~utilizes~~ primary care case
4458 management enhanced by medical home networks to provide
4459 coordinated and cost-effective care that is reimbursed on a fee-
4460 for-service basis and to compare the performance of the medical
4461 home networks with other existing Medicaid managed care models.
4462 The agency may ~~is authorized to~~ seek a federal Medicaid waiver
4463 or an amendment to any existing Medicaid waiver, except for the
4464 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,
4465 as needed, to develop the pilot project created in this section
4466 but must obtain approval of the Legislature before ~~prior to~~

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4467 implementing the pilot project.
4468 Section 53. Section 409.91211, Florida Statutes, is
4469 transferred, renumbered as section 409.986, Florida Statutes,
4470 and paragraph (aa) of subsection (3) and paragraph (a) of
4471 subsection (4) of that section are amended, to read:
4472 409.986 ~~409.91211~~ Medicaid managed care pilot program.—
4473 (3) The agency shall have the following powers, duties, and
4474 responsibilities with respect to the pilot program:
4475 (aa) To implement a mechanism whereby Medicaid recipients
4476 who are already enrolled in a managed care plan or the MediPass
4477 program in the pilot areas are ~~shall be~~ offered the opportunity
4478 to change to capitated managed care plans on a staggered basis,
4479 as defined by the agency. All Medicaid recipients shall have 30
4480 days in which to make a choice of capitated managed care plans.
4481 Those Medicaid recipients who do not make a choice shall be
4482 assigned to a capitated managed care plan in accordance with
4483 paragraph (4)(a) and shall be exempt from s. 409.987 ~~409.9122~~.
4484 To facilitate continuity of care for a Medicaid recipient who is
4485 also a recipient of Supplemental Security Income (SSI), prior to
4486 assigning the SSI recipient to a capitated managed care plan,
4487 the agency shall determine whether the SSI recipient has an
4488 ongoing relationship with a provider or capitated managed care
4489 plan, and, if so, the agency shall assign the SSI recipient to
4490 that provider or capitated managed care plan where feasible.
4491 Those SSI recipients who do not have such a provider
4492 relationship shall be assigned to a capitated managed care plan
4493 provider in accordance with paragraph (4)(a) and shall be exempt
4494 from s. 409.987 ~~409.9122~~.
4495 (4)(a) A Medicaid recipient in the pilot area who is not

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4496 currently enrolled in a capitated managed care plan upon
4497 implementation is not eligible for services as specified in ss.
4498 409.905 and 409.906, for the amount of time that the recipient
4499 does not enroll in a capitated managed care network. If a
4500 Medicaid recipient has not enrolled in a capitated managed care
4501 plan within 30 days after eligibility, the agency shall assign
4502 the Medicaid recipient to a capitated managed care plan based on
4503 the assessed needs of the recipient as determined by the agency
4504 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When
4505 making assignments, the agency shall take into account the
4506 following criteria:
4507 1. A capitated managed care network has sufficient network
4508 capacity to meet the needs of members.
4509 2. The capitated managed care network has previously
4510 enrolled the recipient as a member, or one of the capitated
4511 managed care network's primary care providers has previously
4512 provided health care to the recipient.
4513 3. The agency has knowledge that the member has previously
4514 expressed a preference for a particular capitated managed care
4515 network as indicated by Medicaid fee-for-service claims data,
4516 but has failed to make a choice.
4517 4. The capitated managed care network's primary care
4518 providers are geographically accessible to the recipient's
4519 residence.
4520 Section 54. Section 409.9122, Florida Statutes, is
4521 transferred, renumbered as section 409.987, and paragraph (a) of
4522 subsection (2) of that section is amended to read:
4523 409.987 ~~409.9122~~ Mandatory Medicaid managed care
4524 enrollment; programs and procedures.—

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4525 (2)(a) The agency shall enroll all Medicaid recipients in a
4526 managed care plan or MediPass ~~all Medicaid recipients~~, except
4527 ~~those Medicaid~~ recipients who are~~:~~ in an institution, receiving
4528 a Medicaid nonpoverty medical subsidy,~~; enrolled in the Medicaid~~
4529 ~~medically needy Program;~~ or eligible for both Medicaid and
4530 Medicare. Upon enrollment, recipients may ~~individuals will be~~
4531 ~~able to~~ change their managed care option during the 90-day opt
4532 out period required by federal Medicaid regulations. The agency
4533 may ~~is authorized to~~ seek the necessary Medicaid state plan
4534 amendment to implement this policy. ~~However, to the extent~~
4535 1. If permitted by federal law, the agency may enroll ~~in a~~
4536 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
4537 from mandatory managed care enrollment in a managed care plan or
4538 MediPass if~~, provided that~~:
4539 a.~~1.~~ The recipient's decision to enroll in a managed care
4540 plan or MediPass is voluntary;
4541 b.~~2.~~ ~~If~~ The recipient chooses to enroll in a managed care
4542 plan, the agency has determined that the ~~managed care~~ plan
4543 provides specific programs and services that ~~which~~ address the
4544 special health needs of the recipient; and
4545 c.~~3.~~ The agency receives the ~~any~~ necessary waivers from the
4546 federal Centers for Medicare and Medicaid Services.
4547 2. The agency shall develop rules to establish policies by
4548 which exceptions to the mandatory managed care enrollment
4549 requirement may be made on a case-by-case basis. The rules must
4550 ~~shall~~ include the specific criteria to be applied when
4551 determining ~~making a determination as to~~ whether to exempt a
4552 recipient from mandatory enrollment ~~in a managed care plan or~~
4553 ~~MediPass~~.

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4554 3. School districts participating in the certified school
4555 match program pursuant to ss. 409.908(21) and 1011.70 shall be
4556 reimbursed by Medicaid, subject to the limitations of s.
4557 1011.70(1), for a Medicaid-eligible child participating in the
4558 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
4559 409.9071, regardless of whether the child is enrolled in
4560 MediPass or a managed care plan. Managed care plans must ~~shall~~
4561 make a good faith effort to execute agreements with school
4562 districts regarding the coordinated provision of services
4563 authorized under s. 1011.70.
4564 4. County health departments delivering school-based
4565 services pursuant to ss. 381.0056 and 381.0057 shall be
4566 reimbursed by Medicaid for the federal share for a Medicaid-
4567 eligible child who receives Medicaid-covered services in a
4568 school setting, regardless of whether the child is enrolled in
4569 MediPass or a managed care plan. Managed care plans shall make a
4570 good faith effort to execute agreements with county health
4571 departments that coordinate the ~~regarding the coordinated~~
4572 provision of services to a Medicaid-eligible child. To ensure
4573 continuity of care for Medicaid patients, the agency, the
4574 Department of Health, and the Department of Education shall
4575 develop procedures for ensuring that a student's managed care
4576 plan or MediPass provider receives information relating to
4577 services provided in accordance with ss. 381.0056, 381.0057,
4578 409.9071, and 1011.70.
4579 Section 55. Section 409.9123, Florida Statutes, is
4580 transferred and renumbered as section 409.988, Florida Statutes.
4581 Section 56. Section 409.9124, Florida Statutes, is
4582 transferred and renumbered as section 409.989.

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4583 Section 57. Subsection (15) of section 430.04, Florida
4584 Statutes, is amended to read:
4585 430.04 Duties and responsibilities of the Department of
4586 Elderly Affairs.—The Department of Elderly Affairs shall:
4587 (15) Administer all Medicaid waivers and programs relating
4588 to elders and their appropriations. The waivers include, but are
4589 not limited to:
4590 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
4591 ~~established in s. 430.502(7), (8), and (9).~~
4592 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.
4593 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.
4594 (c) ~~(d)~~ The Adult Day Health Care Waiver.
4595 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined
4596 in s. 409.221.
4597 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.
4598 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
4599 Project as described in s. 430.705.
4600 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.
4601
4602 The department shall develop a transition plan for recipients
4603 receiving services under long-term care Medicaid waivers for
4604 elders or disabled adults on the date qualified plans become
4605 available in each recipient's region pursuant to s. 409.973(2)
4606 in order to enroll those recipients in qualified plans.
4607 Section 58. Section 430.2053, Florida Statutes, is amended
4608 to read:
4609 430.2053 Aging resource centers.—
4610 (1) The department, in consultation with the Agency for
4611 Health Care Administration and the Department of Children and

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4612 Family Services, shall develop pilot projects for aging resource
4613 centers. ~~By October 31, 2004, the department, in consultation~~
4614 ~~with the agency and the Department of Children and Family~~
4615 ~~Services, shall develop an implementation plan for aging~~
4616 ~~resource centers and submit the plan to the Governor, the~~
4617 ~~President of the Senate, and the Speaker of the House of~~
4618 ~~Representatives. The plan must include qualifications for~~
4619 ~~designation as a center, the functions to be performed by each~~
4620 ~~center, and a process for determining that a current area agency~~
4621 ~~on aging is ready to assume the functions of an aging resource~~
4622 ~~center.~~
4623 ~~(2) Each area agency on aging shall develop, in~~
4624 ~~consultation with the existing community care for the elderly~~
4625 ~~lead agencies within their planning and service areas, a~~
4626 ~~proposal that describes the process the area agency on aging~~
4627 ~~intends to undertake to transition to an aging resource center~~
4628 ~~prior to July 1, 2005, and that describes the area agency's~~
4629 ~~compliance with the requirements of this section. The proposals~~
4630 ~~must be submitted to the department prior to December 31, 2004.~~
4631 ~~The department shall evaluate all proposals for readiness and,~~
4632 ~~prior to March 1, 2005, shall select three area agencies on~~
4633 ~~aging which meet the requirements of this section to begin the~~
4634 ~~transition to aging resource centers. Those area agencies on~~
4635 ~~aging which are not selected to begin the transition to aging~~
4636 ~~resource centers shall, in consultation with the department and~~
4637 ~~the existing community care for the elderly lead agencies within~~
4638 ~~their planning and service areas, amend their proposals as~~
4639 ~~necessary and resubmit them to the department prior to July 1,~~
4640 ~~2005. The department may transition additional area agencies to~~

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4641 ~~aging resource centers as it determines that area agencies are~~
4642 ~~in compliance with the requirements of this section.~~
4643 ~~(3) The Auditor General and the Office of Program Policy~~
4644 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
4645 ~~review and assess the department's process for determining an~~
4646 ~~area agency's readiness to transition to an aging resource~~
4647 ~~center.~~
4648 ~~(a) The review must, at a minimum, address the~~
4649 ~~appropriateness of the department's criteria for selection of an~~
4650 ~~area agency to transition to an aging resource center, the~~
4651 ~~instruments applied, the degree to which the department~~
4652 ~~accurately determined each area agency's compliance with the~~
4653 ~~readiness criteria, the quality of the technical assistance~~
4654 ~~provided by the department to an area agency in correcting any~~
4655 ~~weaknesses identified in the readiness assessment, and the~~
4656 ~~degree to which each area agency overcame any identified~~
4657 ~~weaknesses.~~
4658 ~~(b) Reports of these reviews must be submitted to the~~
4659 ~~appropriate substantive and appropriations committees in the~~
4660 ~~Senate and the House of Representatives on March 1 and September~~
4661 ~~1 of each year until full transition to aging resource centers~~
4662 ~~has been accomplished statewide, except that the first report~~
4663 ~~must be submitted by February 1, 2005, and must address all~~
4664 ~~readiness activities undertaken through December 31, 2004. The~~
4665 ~~perspectives of all participants in this review process must be~~
4666 ~~included in each report.~~
4667 (2)~~(4)~~ The purposes of an aging resource center are ~~shall~~
4668 ~~be~~:
4669 (a) To provide Florida's elders and their families with a

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4670 locally focused, coordinated approach to integrating information
4671 and referral for all available services for elders with the
4672 eligibility determination entities for state and federally
4673 funded long-term-care services.
4674 (b) To provide for easier access to long-term-care services
4675 by Florida's elders and their families by creating multiple
4676 access points to the long-term-care network that flow through
4677 one established entity with wide community recognition.
4678 (3) ~~(5)~~ The duties of an aging resource center are to:
4679 (a) Develop referral agreements with local community
4680 service organizations, such as senior centers, existing elder
4681 service providers, volunteer associations, and other similar
4682 organizations, to better assist clients who do not need or do
4683 not wish to enroll in programs funded by the department or the
4684 agency. The referral agreements must also include a protocol,
4685 developed and approved by the department, which provides
4686 specific actions that an aging resource center and local
4687 community service organizations must take when an elder or an
4688 elder's representative seeking information on long-term-care
4689 services contacts a local community service organization prior
4690 to contacting the aging resource center. The protocol shall be
4691 designed to ensure that elders and their families are able to
4692 access information and services in the most efficient and least
4693 cumbersome manner possible.
4694 (b) Provide an initial screening of all clients who request
4695 long-term-care services to determine whether the person would be
4696 most appropriately served through any combination of federally
4697 funded programs, state-funded programs, locally funded or
4698 community volunteer programs, or private funding for services.

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4699 (c) Determine eligibility for the programs and services
4700 listed in subsection (9) ~~(11)~~ for persons residing within the
4701 geographic area served by the aging resource center and
4702 determine a priority ranking for services which is based upon
4703 the potential recipient's frailty level and likelihood of
4704 institutional placement without such services.
4705 (d) Manage the availability of financial resources for the
4706 programs and services listed in subsection (9) ~~(11)~~ for persons
4707 residing within the geographic area served by the aging resource
4708 center.
4709 (e) If ~~When~~ financial resources become available, refer a
4710 client to the most appropriate entity to begin receiving
4711 services. The aging resource center shall make referrals to lead
4712 agencies for service provision that ensure that individuals who
4713 are vulnerable adults in need of services pursuant to s.
4714 415.104(3)(b), or who are victims of abuse, neglect, or
4715 exploitation in need of immediate services to prevent further
4716 harm and are referred by the adult protective services program,
4717 are given primary consideration for receiving community-care-
4718 for-the-elderly services in compliance with the requirements of
4719 s. 430.205(5)(a) and that other referrals for services are in
4720 compliance with s. 430.205(5)(b).
4721 (f) Convene a work group to advise in the planning,
4722 implementation, and evaluation of the aging resource center. The
4723 work group shall be composed ~~comprised~~ of representatives of
4724 local service providers, Alzheimer's Association chapters,
4725 housing authorities, social service organizations, advocacy
4726 groups, representatives of clients receiving services through
4727 the aging resource center, and ~~any~~ other persons or groups as

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4728 determined by the department. The aging resource center, in
4729 consultation with the work group, must develop annual program
4730 improvement plans that shall be submitted to the department for
4731 consideration. The department shall review each annual
4732 improvement plan and make recommendations on how to implement
4733 the components of the plan.
4734 (g) Enhance the existing area agency on aging in each
4735 planning and service area by integrating, ~~either~~ physically or
4736 virtually, the staff and services of the area agency on aging
4737 with the staff of the department's local CARES Medicaid ~~nursing~~
4738 ~~home~~ preadmission screening unit and a sufficient number of
4739 staff from the Department of Children and Family Services'
4740 Economic Self-Sufficiency Unit necessary to determine the
4741 financial eligibility for all persons age 60 and older residing
4742 within the area served by the aging resource center who ~~that~~ are
4743 seeking Medicaid services, Supplemental Security Income, and
4744 food assistance.
4745 (h) Assist clients who request long-term care services in
4746 being evaluated for eligibility for the long-term care managed
4747 care component of the Medicaid managed care program as qualified
4748 plans become available in each of the regions pursuant to s.
4749 409.973(2).
4750 (i) Provide enrollment and coverage information to Medicaid
4751 managed long-term care enrollees as qualified plans become
4752 available in each of the regions pursuant to s. 409.973(2).
4753 (j) Assist enrollees in the Medicaid long-term care managed
4754 care program with informally resolving grievances with a managed
4755 care network and in accessing the managed care network's formal
4756 grievance process as qualified plans become available in each of

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4757 the regions pursuant to s. 409.973(2).
4758 (4) ~~(6)~~ The department shall select the entities to become
4759 aging resource centers based on each entity's readiness and
4760 ability to perform the duties listed in subsection (3) ~~(5)~~ and
4761 the entity's:
4762 (a) Expertise in the needs of each target population the
4763 center proposes to serve and a thorough knowledge of the
4764 providers that serve these populations.
4765 (b) Strong connections to service providers, volunteer
4766 agencies, and community institutions.
4767 (c) Expertise in information and referral activities.
4768 (d) Knowledge of long-term-care resources, including
4769 resources designed to provide services in the least restrictive
4770 setting.
4771 (e) Financial solvency and stability.
4772 (f) Ability to collect, monitor, and analyze data in a
4773 timely and accurate manner, along with systems that meet the
4774 department's standards.
4775 (g) Commitment to adequate staffing by qualified personnel
4776 to effectively perform all functions.
4777 (h) Ability to meet all performance standards established
4778 by the department.
4779 (5) ~~(7)~~ The aging resource center shall have a governing
4780 body which shall be the same entity described in s. 20.41(7),
4781 and an executive director who may be the same person as
4782 described in s. 20.41(7). The governing body shall annually
4783 evaluate the performance of the executive director.
4784 (6) ~~(8)~~ The aging resource center may not be a provider of
4785 direct services other than information and referral services,

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4786 and screening.
4787 (7) ~~(9)~~ The aging resource center must agree to allow the
4788 department to review any financial information the department
4789 determines is necessary for monitoring or reporting purposes,
4790 including financial relationships.
4791 (8) ~~(10)~~ The duties and responsibilities of the community
4792 care for the elderly lead agencies within each area served by an
4793 aging resource center shall be to:
4794 (a) Develop strong community partnerships to maximize the
4795 use of community resources for the purpose of assisting elders
4796 to remain in their community settings for as long as it is
4797 safely possible.
4798 (b) Conduct comprehensive assessments of clients that have
4799 been determined eligible and develop a care plan consistent with
4800 established protocols that ensures that the unique needs of each
4801 client are met.
4802 (9) ~~(11)~~ The services to be administered through the aging
4803 resource center shall include those funded by the following
4804 programs:
4805 (a) Community care for the elderly.
4806 (b) Home care for the elderly.
4807 (c) Contracted services.
4808 (d) Alzheimer’s disease initiative.
4809 (e) Aged and disabled adult Medicaid waiver.
4810 (f) Assisted living for the frail elderly Medicaid waiver.
4811 (g) Older Americans Act.
4812 (10) ~~(12)~~ The department shall, prior to designation of an
4813 aging resource center, develop by rule operational and quality
4814 assurance standards and outcome measures to ensure that clients

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4815 receiving services through all long-term-care programs
4816 administered through an aging resource center are receiving the
4817 appropriate care they require and that contractors and
4818 subcontractors are adhering to the terms of their contracts and
4819 are acting in the best interests of the clients they are
4820 serving, consistent with the intent of the Legislature to reduce
4821 the use of and cost of nursing home care. The department shall
4822 by rule provide operating procedures for aging resource centers,
4823 which shall include:
4824 (a) Minimum standards for financial operation, including
4825 audit procedures.
4826 (b) Procedures for monitoring and sanctioning of service
4827 providers.
4828 (c) Minimum standards for technology utilized by the aging
4829 resource center.
4830 (d) Minimum staff requirements which shall ensure that the
4831 aging resource center employs sufficient quality and quantity of
4832 staff to adequately meet the needs of the elders residing within
4833 the area served by the aging resource center.
4834 (e) Minimum accessibility standards, including hours of
4835 operation.
4836 (f) Minimum oversight standards for the governing body of
4837 the aging resource center to ensure its continuous involvement
4838 in, and accountability for, all matters related to the
4839 development, implementation, staffing, administration, and
4840 operations of the aging resource center.
4841 (g) Minimum education and experience requirements for
4842 executive directors and other executive staff positions of aging
4843 resource centers.

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4844 (h) Minimum requirements regarding any executive staff
4845 positions that the aging resource center must employ and minimum
4846 requirements that a candidate must meet in order to be eligible
4847 for appointment to such positions.
4848 (11) ~~(13)~~ In an area in which the department has designated
4849 an area agency on aging as an aging resource center, the
4850 department and the agency may ~~shall~~ not make payments for the
4851 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
4852 Community Diversion Project for ~~such~~ persons who were not
4853 screened and enrolled through the aging resource center. The
4854 department shall cease making these payments for enrollees in
4855 qualified plans as qualified plans become available in each of
4856 the regions pursuant to s. 409.973(2).
4857 (12) ~~(14)~~ Each aging resource center shall enter into a
4858 memorandum of understanding with the department for
4859 collaboration with the CARES unit staff. The memorandum of
4860 understanding must ~~shall~~ outline the staff person responsible
4861 for each function and ~~shall~~ provide the staffing levels
4862 necessary to carry out the functions of the aging resource
4863 center.
4864 (13) ~~(15)~~ Each aging resource center shall enter into a
4865 memorandum of understanding with the Department of Children and
4866 Family Services for collaboration with the Economic Self-
4867 Sufficiency Unit staff. The memorandum of understanding must
4868 ~~shall~~ outline which staff persons are responsible for which
4869 functions and ~~shall~~ provide the staffing levels necessary to
4870 carry out the functions of the aging resource center.
4871 (14) ~~(16)~~ If any of the state activities described in this
4872 section are outsourced, ~~either~~ in part or in whole, the contract

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4873 executing the outsourcing must ~~shall~~ mandate that the contractor
4874 or its subcontractors shall, ~~either~~ physically or virtually,
4875 execute the provisions of the memorandum of understanding
4876 instead of the state entity whose function the contractor or
4877 subcontractor now performs.
4878 (15) ~~(17)~~ In order to be eligible to begin transitioning to
4879 an aging resource center, an area agency on aging board must
4880 ensure that the area agency on aging which it oversees meets all
4881 of the minimum requirements set by law and in rule.
4882 ~~(18) The department shall monitor the three initial~~
4883 ~~projects for aging resource centers and report on the progress~~
4884 ~~of those projects to the Governor, the President of the Senate,~~
4885 ~~and the Speaker of the House of Representatives by June 30,~~
4886 ~~2005. The report must include an evaluation of the~~
4887 ~~implementation process.~~
4888 (16) ~~(19)~~(a) Once an aging resource center is operational,
4889 the department, in consultation with the agency, may develop
4890 capitation rates for any of the programs administered through
4891 the aging resource center. Capitation rates for programs must
4892 ~~shall~~ be based on the historical cost experience of the state in
4893 providing those same services to the population age 60 or older
4894 residing within each area served by an aging resource center.
4895 Each capitated rate may vary by geographic area as determined by
4896 the department.
4897 (b) The department and the agency may determine for each
4898 area served by an aging resource center whether it is
4899 appropriate, consistent with federal and state laws and
4900 regulations, to develop and pay separate capitated rates for
4901 each program administered through the aging resource center or

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4902 to develop and pay capitated rates for service packages which
4903 include more than one program or service administered through
4904 the aging resource center.
4905 (c) Once capitation rates have been developed and certified
4906 as actuarially sound, the department and the agency may pay
4907 service providers the capitated rates for services if ~~when~~
4908 appropriate.
4909 (d) The department, in consultation with the agency, shall
4910 annually reevaluate and recertify the capitation rates,
4911 adjusting forward to account for inflation, programmatic
4912 changes.
4913 ~~(20) The department, in consultation with the agency, shall~~
4914 ~~submit to the Governor, the President of the Senate, and the~~
4915 ~~Speaker of the House of Representatives, by December 1, 2006, a~~
4916 ~~report addressing the feasibility of administering the following~~
4917 ~~services through aging resource centers beginning July 1, 2007:~~
4918 ~~(a) Medicaid nursing home services.~~
4919 ~~(b) Medicaid transportation services.~~
4920 ~~(c) Medicaid hospice care services.~~
4921 ~~(d) Medicaid intermediate care services.~~
4922 ~~(e) Medicaid prescribed drug services.~~
4923 ~~(f) Medicaid assistive care services.~~
4924 ~~(g) Any other long-term-care program or Medicaid service.~~
4925 (17) ~~(21)~~ This section does ~~shall~~ not ~~be construed to~~ allow
4926 an aging resource center to restrict, manage, or impede the
4927 local fundraising activities of service providers.
4928 Section 59. Paragraphs (c) and (d) of subsection (3) of
4929 section 39.407, Florida Statutes, are amended to read:
4930 39.407 Medical, psychiatric, and psychological examination

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4931 and treatment of child; physical, mental, or substance abuse
4932 examination of person with or requesting child custody.—
4933 (3)
4934 (c) Except as provided in paragraphs (b) and (e), the
4935 department must file a motion seeking the court's authorization
4936 to initially provide or continue to provide psychotropic
4937 medication to a child in its legal custody. The motion must be
4938 supported by a written report prepared by the department which
4939 describes the efforts made to enable the prescribing physician
4940 to obtain express and informed consent to provide ~~for providing~~
4941 the medication to the child and other treatments considered or
4942 recommended for the child. ~~In addition,~~ The motion must also be
4943 supported by the prescribing physician's signed medical report
4944 providing:
4945 1. The name of the child, the name and range of the dosage
4946 of the psychotropic medication, and the ~~that there is a~~ need to
4947 prescribe psychotropic medication to the child based upon a
4948 diagnosed condition for which such medication is being
4949 prescribed.
4950 2. A statement indicating that the physician has reviewed
4951 all medical information concerning the child which has been
4952 provided.
4953 3. A statement indicating that the psychotropic medication,
4954 at its prescribed dosage, is appropriate for treating the
4955 child's diagnosed medical condition, as well as the behaviors
4956 and symptoms the medication, at its prescribed dosage, is
4957 expected to address.
4958 4. An explanation of the nature and purpose of the
4959 treatment; the recognized side effects, risks, and

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4960 contraindications of the medication; drug-interaction
4961 precautions; the possible effects of stopping the medication;
4962 and how the treatment will be monitored, followed by a statement
4963 indicating that this explanation was provided to the child if
4964 age appropriate and to the child's caregiver.
4965 5. Documentation addressing whether the psychotropic
4966 medication will replace or supplement any other currently
4967 prescribed medications or treatments; the length of time the
4968 child is expected to be taking the medication; and any
4969 additional medical, mental health, behavioral, counseling, or
4970 other services that the prescribing physician recommends.
4971 6. For a child 10 years of age or younger who is in an out-
4972 of-home placement, the results of a review of the administration
4973 of the medication by a child psychiatrist who is licensed under
4974 chapter 458 or chapter 459. The review must be provided to the
4975 child and the parent or legal guardian before final express and
4976 informed consent is given. The review must include a
4977 determination of the following:
4978 a. The presence of a genetic psychiatric disorder or a
4979 family history of a psychiatric disorder;
4980 b. Whether the cause of a psychiatric disorder is physical
4981 or environmental; and
4982 c. The likelihood of the child being an imminent danger to
4983 self or others.
4984 (d)~~1.~~ The department must notify all parties of the
4985 proposed action taken under paragraph (c) in writing or by
4986 whatever other method best ensures that all parties receive
4987 notification of the proposed action within 48 hours after the
4988 motion is filed. If any party objects to the department's

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4989 motion, that party shall file the objection within 2 working
4990 days after being notified of the department's motion. If any
4991 party files an objection to the authorization of the proposed
4992 psychotropic medication, the court shall hold a hearing as soon
4993 as possible before authorizing the department to initially
4994 provide or to continue providing psychotropic medication to a
4995 child in the legal custody of the department.
4996 1. At such hearing and notwithstanding s. 90.803, the
4997 medical report described in paragraph (c) is admissible in
4998 evidence. The prescribing physician need not attend the hearing
4999 or testify unless the court specifically orders such attendance
5000 or testimony, or a party subpoenas the physician to attend the
5001 hearing or provide testimony.
5002 2. If, after considering any testimony received, the court
5003 finds that the department's motion and the physician's medical
5004 report meet the requirements of this subsection and that it is
5005 in the child's best interests, the court may order that the
5006 department provide or continue to provide the psychotropic
5007 medication to the child without additional testimony or
5008 evidence.
5009 3. At any hearing held under this paragraph, the court
5010 shall ~~further~~ inquire of the department as to whether additional
5011 medical, mental health, behavioral, counseling, or other
5012 services are being provided to the child by the department which
5013 the prescribing physician considers to be necessary or
5014 beneficial in treating the child's medical condition and which
5015 the physician recommends or expects to provide to the child in
5016 concert with the medication. The court may order additional
5017 medical consultation, including consultation with the MedConsult

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5018 line at the University of Florida, if available, or require the
5019 department to obtain a second opinion within a reasonable
5020 timeframe as established by the court, not to exceed 21 calendar
5021 days, ~~after such order~~ based upon consideration of the best
5022 interests of the child. The department must make a referral for
5023 an appointment for a second opinion with a physician within 1
5024 working day.
5025 4. The court may not order the discontinuation of
5026 prescribed psychotropic medication if such order is contrary to
5027 the decision of the prescribing physician unless the court first
5028 obtains an opinion from a licensed psychiatrist, if available,
5029 or, if not available, a physician licensed under chapter 458 or
5030 chapter 459, stating that more likely than not, discontinuing
5031 the medication would not cause significant harm to the child.
5032 If, however, the prescribing psychiatrist specializes in mental
5033 health care for children and adolescents, the court may not
5034 order the discontinuation of prescribed psychotropic medication
5035 unless the required opinion is also from a psychiatrist who
5036 specializes in mental health care for children and adolescents.
5037 The court may also order the discontinuation of prescribed
5038 psychotropic medication if a child's treating physician,
5039 licensed under chapter 458 or chapter 459, states that
5040 continuing the prescribed psychotropic medication would cause
5041 significant harm to the child due to a diagnosed nonpsychiatric
5042 medical condition.
5043 5. If a child who is in out-of-home placement is 10 years
5044 of age or younger, psychotropic medication may not be authorized
5045 by the court absent a finding of a compelling governmental
5046 interest. In making such finding, the court shall review the

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5047 psychiatric review described in subparagraph (c)6.
5048 6.~~2.~~ The burden of proof at any hearing held under this
5049 paragraph shall be by a preponderance of the evidence.
5050 Section 60. Paragraph (a) of subsection (1) of section
5051 216.262, Florida Statutes, is amended to read:
5052 216.262 Authorized positions.—
5053 (1)(a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by
5054 law, the total number of authorized positions may not exceed the
5055 total provided in the appropriations acts. If a ~~In the event any~~
5056 state agency or entity of the judicial branch finds that the
5057 number of positions so provided is not sufficient to administer
5058 its authorized programs, it may file an application with the
5059 Executive Office of the Governor or the Chief Justice~~,~~ and, if
5060 the Executive Office of the Governor or Chief Justice certifies
5061 that there are no authorized positions available for addition,
5062 deletion, or transfer within the agency or entity as provided in
5063 paragraph (c), may recommend ~~and recommends~~ an increase in the
5064 number of positions.~~,~~
5065 1. The Governor or the Chief Justice may recommend an
5066 increase in the number of positions for the following reasons
5067 only:
5068 a.~~1.~~ To implement or provide for continuing federal grants
5069 or changes in grants not previously anticipated.
5070 b.~~2.~~ To meet emergencies pursuant to s. 252.36.
5071 c.~~3.~~ To satisfy new federal regulations or changes therein.
5072 d.~~4.~~ To take advantage of opportunities to reduce operating
5073 expenditures or to increase the revenues of the state or local
5074 government.
5075 e.~~5.~~ To authorize positions that were not fixed by the

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5076 Legislature due to ~~through~~ error in drafting the appropriations
5077 acts.
5078 2. Actions recommended pursuant to this paragraph are
5079 subject to approval by the Legislative Budget Commission. The
5080 certification and the final authorization shall be provided to
5081 the Legislative Budget Commission, the legislative
5082 appropriations committees, and the Auditor General.
5083 3. The provisions of this paragraph do not apply to
5084 positions in the Department of Health which are funded by the
5085 County Health Department Trust Fund.
5086 Section 61. Section 381.06014, Florida Statutes, is amended
5087 to read:
5088 381.06014 Blood establishments.—
5089 (1) As used in this section, the term:
5090 (a) "Blood establishment" means any person, entity, or
5091 organization, operating within the state, which examines an
5092 individual for the purpose of blood donation or which collects,
5093 processes, stores, tests, or distributes blood or blood
5094 components collected from the human body for the purpose of
5095 transfusion, for any other medical purpose, or for the
5096 production of any biological product. A person, entity, or
5097 organization that uses a mobile unit to conduct such activities
5098 within the state is also a blood establishment.
5099 (b) "Volunteer donor" means a person who does not receive
5100 remuneration, other than an incentive, for a blood donation
5101 intended for transfusion, and the product container of the
5102 donation from the person qualifies for labeling with the
5103 statement "volunteer donor" under 21 C.F.R. s. 606.121.
5104 (2) An entity or organization may not hold itself out and

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5105 engage in the activities of a ~~Any~~ blood establishment in this
5106 state ~~operating in the state may not conduct any activity~~
5107 ~~defined in subsection (1)~~ unless it operates in accordance ~~that~~
5108 ~~blood establishment is operated in a manner consistent~~ with ~~the~~
5109 ~~provisions of~~ Title 21 C.F.R. parts 211 and 600-640~~, Code of~~
5110 ~~Federal Regulations~~.
5111 (3) A ~~Any~~ blood establishment determined to be operating in
5112 the state in a manner not consistent with ~~the provisions of~~
5113 Title 21 C.F.R. parts 211 and 600-640, ~~Code of Federal~~
5114 ~~Regulations,~~ and in a manner that constitutes a danger to the
5115 health or well-being of donors or recipients as evidenced by the
5116 federal Food and Drug Administration's inspection reports and
5117 the revocation of the blood establishment's license or
5118 registration is ~~shall be~~ in violation of this chapter, ~~and shall~~
5119 ~~immediately cease all operations in the state.~~
5120 ~~(4) The operation of a blood establishment in a manner not~~
5121 ~~consistent with the provisions of Title 21 parts 211 and 600-~~
5122 ~~640, Code of Federal Regulations, and in a manner that~~
5123 ~~constitutes a danger to the health or well-being of blood donors~~
5124 ~~or recipients as evidenced by the federal Food and Drug~~
5125 ~~Administration's inspection process~~ is declared a nuisance and
5126 inimical to the public health, welfare, and safety, and must
5127 immediately cease all operations in this state. The Agency for
5128 Health Care Administration or any state attorney may bring an
5129 action for an injunction to restrain such operations or enjoin
5130 the future operation of the blood establishment.
5131 (4) A local government may not restrict access to or the
5132 use of any public facility or infrastructure for the collection
5133 of blood or blood components from volunteer donors based on

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5134 whether the blood establishment is operating as a for-profit or
5135 not-for-profit organization.
5136 (5) In determining the service fee of blood or blood
5137 components received from volunteer donors and sold to hospitals
5138 or other health care providers, a blood establishment may not
5139 base the service fee of the blood or blood component solely on
5140 whether the purchasing entity is a for-profit or not-for-profit
5141 organization.
5142 (6) A blood establishment that collects blood or blood
5143 components from volunteer donors must disclose the following
5144 information on its Internet website in order to educate and
5145 inform donors and the public about the blood establishment's
5146 activities, and the information required to be disclosed may be
5147 cumulative for all blood establishments within a business
5148 entity:
5149 (a) A description of the steps involved in collecting,
5150 processing, and distributing volunteer donations.
5151 (b) By March 1 of each year, the number of units of blood
5152 components which were:
5153 1. Produced by the blood establishment during the preceding
5154 calendar year;
5155 2. Obtained from other sources during the preceding
5156 calendar year;
5157 3. Distributed during the preceding calendar year to health
5158 care providers located outside this state. However, if the blood
5159 establishment collects donations in a county outside this state,
5160 distributions to health care providers in that county are
5161 excluded. Such information shall be reported in the aggregate
5162 for health care providers located within the United States and

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5163 its territories or outside the United States and its
5164 territories; and
5165 4. Distributed during the preceding calendar year to
5166 entities that are not health care providers. Such information
5167 shall be reported in the aggregate for purchasers located within
5168 the United States and its territories or outside the United
5169 States and its territories.
5170 (c) The blood establishment's conflict-of-interest policy,
5171 policy concerning related-party transactions, whistleblower
5172 policy, and policy for determining executive compensation. If a
5173 change occurs to any of these documents, the revised document
5174 must be available on the blood establishment's website by the
5175 following March 1.
5176 (d) Except for a hospital that collects blood or blood
5177 components from volunteer donors:
5178 1. The most recent 3 years of the Return of Organization
5179 Exempt from Income Tax, Internal Revenue Service Form 990, if
5180 the business entity for the blood establishment is eligible to
5181 file such return. The Form 990 must be available on the blood
5182 establishment's website within 60 calendar days after it is
5183 filed with the Internal Revenue Service; or
5184 2. If the business entity for the blood establishment is
5185 not eligible to file the Form 990 return, a balance sheet,
5186 income statement, and statement of changes in cash flow, along
5187 with the expression of an opinion thereon by an independent
5188 certified public accountant who audited or reviewed such
5189 financial statements. Such documents must be available on the
5190 blood establishment's website within 120 days after the end of
5191 the blood establishment's fiscal year and must remain on the

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5192 blood establishment's website for at least 36 months.
5193
5194 A hospital that collects blood or blood components to be used
5195 only by that hospital's licensed facilities or by a health care
5196 provider that is a part of the hospital's business entity is
5197 exempt from the disclosure requirements of this subsection.
5198 (7) A blood establishment is liable for a civil penalty for
5199 failing to make the disclosures required under subsection (6).
5200 The Department of Legal Affairs may assess a civil penalty
5201 against the blood establishment for each day that it fails to
5202 make such required disclosures, but the penalty may not exceed
5203 $10,000 per year. If multiple blood establishments operated by a
5204 single business entity fail to meet such disclosure
5205 requirements, the civil penalty may be assessed against only one
5206 of the business entity's blood establishments. The Department of
5207 Legal Affairs may terminate an action if the blood establishment
5208 agrees to pay a stipulated civil penalty. A civil penalty so
5209 collected accrues to the state and shall be deposited as
5210 received into the General Revenue Fund unallocated. The
5211 Department of Legal Affairs may terminate the action and waive
5212 the civil penalty upon a showing of good cause by the blood
5213 establishment as to why the required disclosures were not made.
5214 Section 62. Subsection (9) of section 393.063, Florida
5215 Statutes, is amended, present subsections (13) through (40) of
5216 that section are redesignated as subsections (14) through (41),
5217 respectively, and a new subsection (13) is added to that
5218 section, to read:
5219 393.063 Definitions.—For the purposes of this chapter, the
5220 term:

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5221 (9) “Developmental disability” means a disorder or syndrome
5222 that is attributable to retardation, cerebral palsy, autism,
5223 spina bifida, Down syndrome, or Prader-Willi syndrome; that
5224 manifests before the age of 18; and that constitutes a
5225 substantial handicap that can reasonably be expected to continue
5226 indefinitely.
5227 (13) “Down syndrome” means a disorder that is caused by the
5228 presence of an extra chromosome 21.
5229 Section 63. Section 400.023, Florida Statutes, is reordered
5230 and amended to read:
5231 400.023 Civil enforcement.—
5232 (1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a
5233 violation of rights as specified in this part has ~~are violated~~
5234 ~~shall have~~ a cause of action against the licensee or its
5235 management company, as identified in the state application for
5236 nursing home licensure. However, the cause of action may not be
5237 asserted individually against an officer, director, owner,
5238 including an owner designated as having a controlling interest
5239 on the state application for nursing home licensure, or agent of
5240 a licensee or management company unless, following an
5241 evidentiary hearing, the court determines there is sufficient
5242 evidence in the record or proffered by the claimant which
5243 establishes a reasonable basis for finding that the person or
5244 entity breached, failed to perform, or acted outside the scope
5245 of duties as an officer, director, owner, or agent, and that the
5246 breach, failure to perform, or action outside the scope of
5247 duties is a legal cause of actual loss, injury, death, or damage
5248 to the resident.
5249 (2) The action may be brought by the resident or his or her

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5250 guardian, by a person or organization acting on behalf of a
5251 resident with the consent of the resident or his or her
5252 guardian, or by the personal representative of the estate of a
5253 deceased resident regardless of the cause of death.
5254 (5) If the action alleges a claim for the resident's rights
5255 or for negligence that:
5256 (a) Caused the death of the resident, the claimant must
5257 ~~shall be required to~~ elect ~~either~~ survival damages pursuant to
5258 s. 46.021 or wrongful death damages pursuant to s. 768.21. If
5259 the claimant elects wrongful death damages, total noneconomic
5260 damages may not exceed $250,000, regardless of the number of
5261 claimants.
5262 (b) ~~If the action alleges a claim for the resident's rights~~
5263 ~~or for negligence that~~ Did not cause the death of the resident,
5264 the personal representative of the estate may recover damages
5265 for the negligence that caused injury to the resident.
5266 (3) The action may be brought in any court of competent
5267 jurisdiction to enforce such rights and to recover actual and
5268 punitive damages for any violation of the rights of a resident
5269 or for negligence.
5270 (10) Any resident who prevails in seeking injunctive relief
5271 or a claim for an administrative remedy may ~~is entitled to~~
5272 recover the costs of the action, and a reasonable attorney's fee
5273 assessed against the defendant not to exceed $25,000. Fees shall
5274 be awarded solely for the injunctive or administrative relief
5275 and not for any claim or action for damages whether such claim
5276 or action is brought together with a request for an injunction
5277 or administrative relief or as a separate action, except as
5278 provided under s. 768.79 or the Florida Rules of Civil

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5279 Procedure. Sections 400.023-400.0238 provide the exclusive
5280 remedy for a cause of action for recovery of damages for the
5281 personal injury or death of a nursing home resident arising out
5282 of negligence or a violation of rights specified in s. 400.022.
5283 This section does not preclude theories of recovery not arising
5284 out of negligence or s. 400.022 which are available to a
5285 resident or to the agency. The provisions of chapter 766 do not
5286 apply to any cause of action brought under ss. 400.023-400.0238.
5287 (6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part
5288 alleges ~~alleging~~ a violation of resident's rights or negligence
5289 causing injury to or the death of a resident, the claimant shall
5290 have the burden of proving, by a preponderance of the evidence,
5291 that:
5292 (a) The defendant owed a duty to the resident;
5293 (b) The defendant breached the duty to the resident;
5294 (c) The breach of the duty is a legal cause of loss,
5295 injury, death, or damage to the resident; and
5296 (d) The resident sustained loss, injury, death, or damage
5297 as a result of the breach.
5298 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~
5299 create strict liability. A violation of the rights set forth in
5300 s. 400.022 or in any other standard or guidelines specified in
5301 this part or in any applicable administrative standard or
5302 guidelines of this state or a federal regulatory agency is ~~shall~~
5303 ~~be~~ evidence of negligence but may ~~shall~~ not be considered
5304 negligence per se.
5305 (7) ~~(3)~~ In any claim brought pursuant to this section, a
5306 licensee, person, or entity has ~~shall have~~ a duty to exercise
5307 reasonable care. Reasonable care is that degree of care which a

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5308 reasonably careful licensee, person, or entity would use under
5309 like circumstances.
5310 (9) ~~(4)~~ In any claim for resident's rights violation or
5311 negligence by a nurse licensed under part I of chapter 464, such
5312 nurse has a ~~shall have the~~ duty to exercise care consistent with
5313 the prevailing professional standard of care for a nurse. The
5314 prevailing professional standard of care for a nurse is ~~shall be~~
5315 that level of care, skill, and treatment which, in light of all
5316 relevant surrounding circumstances, is recognized as acceptable
5317 and appropriate by reasonably prudent similar nurses.
5318 (8) ~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical
5319 negligence of any physician rendering care or treatment to the
5320 resident except for the administrative services of a medical
5321 director as required in this part. ~~Nothing in~~ This subsection
5322 does not ~~shall be construed to~~ protect a licensee, person, or
5323 entity from liability for failure to provide a resident with
5324 appropriate observation, assessment, nursing diagnosis,
5325 planning, intervention, and evaluation of care by nursing staff.
5326 (4) ~~(6)~~ The resident or the resident's legal representative
5327 shall serve a copy of any complaint alleging in whole or in part
5328 a violation of any rights specified in this part to the agency
5329 ~~for Health Care Administration~~ at the time of filing the initial
5330 complaint with the clerk of the court for the county in which
5331 the action is pursued. ~~The requirement of~~ Providing a copy of
5332 the complaint to the agency does not impair the resident's legal
5333 rights or ability to seek relief for his or her claim.
5334 (11) ~~(7)~~ An action under this part for a violation of rights
5335 or negligence ~~recognized herein~~ is not a claim for medical
5336 malpractice, and the provisions of s. 768.21(8) do not apply to

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5337 a claim alleging death of the resident.
5338 Section 64. Subsections (1), (2), and (3) of section
5339 400.0237, Florida Statutes, are amended to read:
5340 400.0237 Punitive damages; pleading; burden of proof.—
5341 (1) In any action ~~for damages~~ brought under this part, a ~~no~~
5342 claim for punitive damages is not ~~shall be~~ permitted unless,
5343 based on admissible ~~there is a reasonable showing by~~ evidence ~~in~~
5344 ~~the record or~~ proffered by the claimant, ~~which would provide~~ a
5345 reasonable basis for recovery of such damages is demonstrated
5346 upon applying the criteria set forth in this section. The
5347 defendant may proffer admissible evidence to refute the
5348 claimant's proffer of evidence to recover punitive damages. The
5349 trial judge shall conduct an evidentiary hearing and weigh the
5350 admissible evidence proffered by the claimant and the defendant
5351 to ensure that there is a reasonable basis to believe that the
5352 claimant, at trial, will be able to demonstrate by clear and
5353 convincing evidence that the recovery of such damages is
5354 warranted. The claimant may move to amend her or his complaint
5355 to assert a claim for punitive damages as allowed by the rules
5356 of civil procedure. ~~The rules of civil procedure shall be~~
5357 ~~liberally construed so as to allow the claimant discovery of~~
5358 ~~evidence which appears reasonably calculated to lead to~~
5359 ~~admissible evidence on the issue of punitive damages.~~ ~~No~~
5360 Discovery of financial worth may not ~~shall~~ proceed until after
5361 the trial judge approves the pleading on ~~concerning~~ punitive
5362 damages ~~is permitted~~.
5363 (2) A defendant, including the licensee or management
5364 company, against whom punitive damages is sought may be held
5365 liable for punitive damages only if the trier of fact, based on

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5366 clear and convincing evidence, finds that a specific individual
5367 or corporate defendant actively and knowingly participated in
5368 intentional misconduct, or engaged in conduct that constituted
5369 gross negligence, and that conduct contributed to the loss,
5370 damages, or injury suffered by the claimant ~~the defendant was~~
5371 ~~personally guilty of intentional misconduct or gross negligence~~.
5372 As used in this section, the term:
5373 (a) "Intentional misconduct" means that the defendant
5374 against whom a claim for punitive damages is sought had actual
5375 knowledge of the wrongfulness of the conduct and the high
5376 probability that injury or damage to the claimant would result
5377 and, despite that knowledge, intentionally pursued that course
5378 of conduct, resulting in injury or damage.
5379 (b) "Gross negligence" means that the defendant's conduct
5380 was so reckless or wanting in care that it constituted a
5381 conscious disregard or indifference to the life, safety, or
5382 rights of persons exposed to such conduct.
5383 (3) In the case of vicarious liability of an employer,
5384 principal, corporation, or other legal entity, punitive damages
5385 may not be imposed for the conduct of an identified employee or
5386 agent unless ~~only if~~ the conduct of the employee or agent meets
5387 the criteria specified in subsection (2) and officers,
5388 directors, or managers of the actual employer corporation or
5389 legal entity condoned, ratified, or consented to the specific
5390 conduct as alleged by the claimant in subsection (2).~~:~~
5391 ~~(a) The employer, principal, corporation, or other legal~~
5392 ~~entity actively and knowingly participated in such conduct;~~
5393 ~~(b) The officers, directors, or managers of the employer,~~
5394 ~~principal, corporation, or other legal entity condoned,~~

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5395 ~~ratified, or consented to such conduct; or~~
5396 ~~(c) The employer, principal, corporation, or other legal~~
5397 ~~entity engaged in conduct that constituted gross negligence and~~
5398 ~~that contributed to the loss, damages, or injury suffered by the~~
5399 ~~claimant.~~
5400 Section 65. Subsections (3) and (4) of section 408.7057,
5401 Florida Statutes, are amended, present subsection (7) of that
5402 section is redesignated as subsection (8), and a new subsection
5403 (7) is added to that section, to read:
5404 408.7057 Statewide provider and health plan claim dispute
5405 resolution program.—
5406 (3) The agency shall adopt rules to establish a process to
5407 be used by the resolution organization in considering claim
5408 disputes submitted by a provider or health plan which must
5409 include a hearing, if requested by the respondent, and the
5410 issuance by the resolution organization of a written
5411 recommendation, supported by findings of fact and conclusions of
5412 law, to the agency within 60 days after the requested
5413 information is received by the resolution organization within
5414 the timeframes specified by the resolution organization. ~~In no~~
5415 ~~event shall~~ The review time may not exceed 90 days following
5416 receipt of the initial claim dispute submission by the
5417 resolution organization.
5418 (4) Within 30 days after receipt of the recommendation of
5419 the resolution organization, the agency shall adopt the
5420 recommendation as a final order subject to chapter 120.
5421 (7) This section creates a procedure for dispute resolution
5422 and not an independent right of recovery. The conclusions of law
5423 contained in the written recommendation of the resolution

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5424 organization must identify the provisions of law or contract
5425 which, under the particular facts and circumstances of the case,
5426 entitle the provider or health plan to the amount awarded, if
5427 any.
5428 Section 66. Section 458.3167, Florida Statutes, is created
5429 to read:
5430 458.3167 Expert witness certificate.—
5431 (1) A physician who holds an active and valid license to
5432 practice allopathic medicine in any other state or in Canada,
5433 who submits an application form prescribed by the board to
5434 obtain a certificate to provide expert testimony and pays the
5435 application fee, and who has not had a previous expert witness
5436 certificate revoked by the board shall be issued a certificate
5437 to provide expert testimony.
5438 (2) A physician possessing an expert witness certificate
5439 may use the certificate only to give a verified written medical
5440 expert opinion as provided in s. 766.203 and to provide expert
5441 testimony concerning the prevailing professional standard of
5442 care for medical negligence litigation pending in this state
5443 against a physician licensed under this chapter or chapter 459.
5444 (3) An application for an expert witness certificate must
5445 be approved or denied within 5 business days after receipt of a
5446 completed application. An application that is not approved or
5447 denied within the required time period is deemed approved. An
5448 applicant seeking to claim certification by default shall notify
5449 the board, in writing, of the intent to rely on the default
5450 certification provision of this subsection. In such case, s.
5451 458.327 does not apply, and the applicant may provide expert
5452 testimony as provided in subsection (2).

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5453 (4) All licensure fees, other than the initial certificate
5454 application fee, including the neurological injury compensation
5455 assessment, are waived for those persons obtaining an expert
5456 witness certificate. The possession of an expert witness
5457 certificate alone does not entitle the physician to engage in
5458 the practice of medicine as defined in s. 458.305.
5459 (5) The board shall adopt rules to administer this section,
5460 including rules setting the amount of the expert witness
5461 certificate application fee, which may not exceed $50. An expert
5462 witness certificate expires 2 years after the date of issuance.
5463 Section 67. Subsection (11) is added to section 458.331,
5464 Florida Statutes, present paragraphs (oo) through (qq) of
5465 subsection (1) of that section are redesignated as paragraphs
5466 (pp) through (rr), respectively, and a new paragraph (oo) is
5467 added to that subsection, to read:
5468 458.331 Grounds for disciplinary action; action by the
5469 board and department.—
5470 (1) The following acts constitute grounds for denial of a
5471 license or disciplinary action, as specified in s. 456.072(2):
5472 (oo) Providing misleading, deceptive, or fraudulent expert
5473 witness testimony related to the practice of medicine.
5474 (11) The purpose of this section is to facilitate uniform
5475 discipline for those acts made punishable under this section
5476 and, to this end, a reference to this section constitutes a
5477 general reference under the doctrine of incorporation by
5478 reference.
5479 Section 68. Section 459.0078, Florida Statutes, is created
5480 to read:
5481 459.0078 Expert witness certificate.—

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5482 (1) A physician who holds an active and valid license to
5483 practice osteopathic medicine in any other state or in Canada,
5484 who submits an application form prescribed by the board to
5485 obtain a certificate to provide expert testimony and pays the
5486 application fee, and who has not had a previous expert witness
5487 certificate revoked by the board shall be issued a certificate
5488 to provide expert testimony.
5489 (2) A physician possessing an expert witness certificate
5490 may use the certificate only to give a verified written medical
5491 expert opinion as provided in s. 766.203 and to provide expert
5492 testimony concerning the prevailing professional standard of
5493 care for medical negligence litigation pending in this state
5494 against a physician licensed under this chapter or chapter 458.
5495 (3) An application for an expert witness certificate must
5496 be approved or denied within 5 business days after receipt of a
5497 completed application. An application that is not approved or
5498 denied within the required time period is deemed approved. An
5499 applicant seeking to claim certification by default shall notify
5500 the board, in writing, of the intent to rely on the default
5501 certification provision of this subsection. In such case, s.
5502 459.013 does not apply, and the applicant may provide expert
5503 testimony as provided in subsection (2).
5504 (4) All licensure fees, other than the initial certificate
5505 application fee, including the neurological injury compensation
5506 assessment, are waived for those persons obtaining an expert
5507 witness certificate. The possession of an expert witness
5508 certificate alone does not entitle the physician to engage in
5509 the practice of osteopathic medicine as defined in s. 459.003.
5510 (5) The board shall adopt rules to administer this section,

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5511 including rules setting the amount of the expert witness
5512 certificate application fee, which may not exceed $50. An expert
5513 witness certificate expires 2 years after the date of issuance.
5514 Section 69. Subsection (11) is added to section 459.015,
5515 Florida Statutes, present paragraphs (qq) through (ss) of
5516 subsection (1) of that section are redesignated as paragraphs
5517 (rr) through (tt), respectively, and a new paragraph (qq) is
5518 added to that subsection, to read:
5519 459.015 Grounds for disciplinary action; action by the
5520 board and department.—
5521 (1) The following acts constitute grounds for denial of a
5522 license or disciplinary action, as specified in s. 456.072(2):
5523 (qq) Providing misleading, deceptive, or fraudulent expert
5524 witness testimony related to the practice of osteopathic
5525 medicine.
5526 (11) The purpose of this section is to facilitate uniform
5527 discipline for those acts made punishable under this section
5528 and, to this end, a reference to this section constitutes a
5529 general reference under the doctrine of incorporation by
5530 reference.
5531 Section 70. Subsection (23) of section 499.003, Florida
5532 Statutes, is amended to read:
5533 499.003 Definitions of terms used in this part.—As used in
5534 this part, the term:
5535 (23) “Health care entity” means a closed pharmacy or any
5536 person, organization, or business entity that provides
5537 diagnostic, medical, surgical, or dental treatment or care, or
5538 chronic or rehabilitative care, but does not include any
5539 wholesale distributor or retail pharmacy licensed under state

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5540 law to deal in prescription drugs. However, a blood
5541 establishment is a health care entity that may engage in the
5542 wholesale distribution of prescription drugs under s.
5543 499.01(2)(g)1.c.
5544 Section 71. Subsection (21) of section 499.005, Florida
5545 Statutes, is amended to read:
5546 499.005 Prohibited acts.—It is unlawful for a person to
5547 perform or cause the performance of any of the following acts in
5548 this state:
5549 (21) The wholesale distribution of any prescription drug
5550 that was:
5551 (a) Purchased by a public or private hospital or other
5552 health care entity; or
5553 (b) Donated or supplied at a reduced price to a charitable
5554 organization,
5555
5556 unless the wholesale distribution of the prescription drug is
5557 authorized in s. 499.01(2)(g)1.c.
5558 Section 72. Paragraphs (a) and (g) of subsection (2) of
5559 section 499.01, Florida Statutes, are amended to read:
5560 499.01 Permits.—
5561 (2) The following permits are established:
5562 (a) *Prescription drug manufacturer permit.*—A prescription
5563 drug manufacturer permit is required for any person that is a
5564 manufacturer of a prescription drug and that manufactures or
5565 distributes such prescription drugs in this state.
5566 1. A person that operates an establishment permitted as a
5567 prescription drug manufacturer may engage in wholesale
5568 distribution of prescription drugs manufactured at that

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5569 establishment and must comply with all of the provisions of this
5570 part, except s. 499.01212, and the rules adopted under this
5571 part, except s. 499.01212, which ~~that~~ apply to a wholesale
5572 distributor.
5573 2. A prescription drug manufacturer must comply with all
5574 appropriate state and federal good manufacturing practices.
5575 3. A blood establishment, as defined in s. 381.06014,
5576 operating in a manner consistent with the provisions of Title 21
5577 C.F.R. parts 211 and 600-640 and manufacturing only the
5578 prescription drugs described in s. 499.003(54)(d) is not
5579 required to be permitted as a prescription drug manufacturer
5580 under this paragraph or to register its products under s.
5581 499.015.
5582 (g) *Restricted prescription drug distributor permit.*—
5583 1. A restricted prescription drug distributor permit is
5584 required for:
5585 a. Any person located in this state that engages in the
5586 distribution of a prescription drug, which distribution is not
5587 considered "wholesale distribution" under s. 499.003(54)(a).
5588 b.~~1.~~ Any ~~A~~ person located in this state who engages in the
5589 receipt or distribution of a prescription drug in this state for
5590 the purpose of processing its return or its destruction ~~must~~
5591 ~~obtain a permit as a restricted prescription drug distributor~~ if
5592 such person is not the person initiating the return, the
5593 prescription drug wholesale supplier of the person initiating
5594 the return, or the manufacturer of the drug.
5595 c. A blood establishment located in this state which
5596 collects blood and blood components only from volunteer donors
5597 as defined in s. 381.06014 or pursuant to an authorized

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5598 practitioner's order for medical treatment or therapy and
5599 engages in the wholesale distribution of a prescription drug not
5600 described in s. 499.003(54)(d) to a health care entity. The
5601 health care entity receiving a prescription drug distributed
5602 under this sub-subparagraph must be licensed as a closed
5603 pharmacy or provide health care services at that establishment.
5604 The blood establishment must operate in accordance with s.
5605 381.06014 and may distribute only:
5606 (I) Prescription drugs indicated for a bleeding or clotting
5607 disorder or anemia;
5608 (II) Blood-collection containers approved under s. 505 of
5609 the federal act;
5610 (III) Drugs that are blood derivatives, or a recombinant or
5611 synthetic form of a blood derivative;
5612 (IV) Prescription drugs that are identified in rules
5613 adopted by the department and that are essential to services
5614 performed or provided by blood establishments and authorized for
5615 distribution by blood establishments under federal law; or
5616 (V) To the extent authorized by federal law, drugs
5617 necessary to collect blood or blood components from volunteer
5618 blood donors; for blood establishment personnel to perform
5619 therapeutic procedures under the direction and supervision of a
5620 licensed physician; and to diagnose, treat, manage, and prevent
5621 any reaction of either a volunteer blood donor or a patient
5622 undergoing a therapeutic procedure performed under the direction
5623 and supervision of a licensed physician,
5624
5625 as long as all of the health care services provided by the blood
5626 establishment are related to its activities as a registered

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5627 blood establishment or the health care services consist of
5628 collecting, processing, storing, or administering human
5629 hematopoietic stem cells or progenitor cells or performing
5630 diagnostic testing of specimens if such specimens are tested
5631 together with specimens undergoing routine donor testing.
5632 2. Storage, handling, and recordkeeping of these
5633 distributions by a person required to be permitted as a
5634 restricted prescription drug distributor must comply with the
5635 requirements for wholesale distributors under s. 499.0121, but
5636 not those set forth in s. 499.01212 if the distribution occurs
5637 pursuant to sub-subparagraph 1.a. or sub-subparagraph 1.b.
5638 3. A person who applies for a permit as a restricted
5639 prescription drug distributor, or for the renewal of such a
5640 permit, must provide to the department the information required
5641 under s. 499.012.
5642 4. The department may adopt rules regarding the
5643 distribution of prescription drugs by hospitals, health care
5644 entities, charitable organizations, ~~or~~ other persons not
5645 involved in wholesale distribution, and blood establishments,
5646 which rules are necessary for the protection of the public
5647 health, safety, and welfare.
5648 Section 73. Subsection (4) is added to section 626.9541,
5649 Florida Statutes, to read:
5650 626.9541 Unfair methods of competition and unfair or
5651 deceptive acts or practices defined.—
5652 (4) WELLNESS OR HEALTH IMPROVEMENT PROGRAMS.—
5653 (a) An insurer issuing a group or individual health benefit
5654 plan may offer a voluntary wellness or health improvement
5655 program and may encourage or reward participation in the program

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5656 by authorizing rewards or incentives, including, but not limited
5657 to, merchandise, gift cards, debit cards, premium discounts or
5658 rebates, contributions to a member's health savings account, or
5659 modifications to copayment, deductible, or coinsurance amounts.
5660 (b) An insurer may require a health benefit plan member to
5661 provide verification, such as an affirming statement from the
5662 member's physician, that the member's medical condition makes it
5663 unreasonably difficult or inadvisable to participate in the
5664 wellness or health improvement program.
5665 (c) A reward or incentive offered under this subsection is
5666 not an insurance benefit or violation of this section if it is
5667 disclosed in the policy or certificate. This subsection does not
5668 prohibit insurers from offering other incentives or rewards for
5669 adherence to a wellness or health improvement program if
5670 otherwise authorized by state or federal law.
5671 Section 74. Paragraph (b) of subsection (1) of section
5672 627.4147, Florida Statutes, is amended to read:
5673 627.4147 Medical malpractice insurance contracts.—
5674 (1) In addition to any other requirements imposed by law,
5675 each self-insurance policy ~~as~~ authorized under s. 627.357 or s.
5676 624.462 or insurance policy providing coverage for claims
5677 arising out of the rendering of, or the failure to render,
5678 medical care or services, including those of the Florida Medical
5679 Malpractice Joint Underwriting Association, must ~~shall~~ include:
5680 (b)~~1. Except as provided in subparagraph 2., a clause~~
5681 ~~authorizing the insurer or self-insurer to determine, to make,~~
5682 ~~and to conclude, without the permission of the insured, any~~
5683 ~~offer of admission of liability and for arbitration pursuant to~~
5684 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~

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5685 ~~is within the policy limits. It is against public policy for any~~
5686 ~~insurance or self-insurance policy to contain a clause giving~~
5687 ~~the insured the exclusive right to veto any offer for admission~~
5688 ~~of liability and for arbitration made pursuant to s. 766.106,~~
5689 ~~settlement offer, or offer of judgment, when such offer is~~
5690 ~~within the policy limits. However, any offer of admission of~~
5691 ~~liability, settlement offer, or offer of judgment made by an~~
5692 ~~insurer or self-insurer shall be made in good faith and in the~~
5693 ~~best interests of the insured.~~
5694 1.~~2.a.~~ With respect to dentists licensed under chapter 466,
5695 a clause clearly stating whether or not the insured has the
5696 exclusive right to veto any offer of admission of liability and
5697 for arbitration pursuant to s. 766.106, settlement offer, or
5698 offer of judgment if the offer is within policy limits. An
5699 insurer or self-insurer may ~~shall~~ not make or conclude, without
5700 the permission of the insured, any offer of admission of
5701 liability and for arbitration pursuant to s. 766.106, settlement
5702 offer, or offer of judgment, if such offer is outside the policy
5703 limits. However, any offer for admission of liability and for
5704 arbitration made under s. 766.106, settlement offer, or offer of
5705 judgment made by an insurer or self-insurer must ~~shall~~ be made
5706 in good faith and in the best interest of the insured.
5707 2.~~b.~~ If the policy contains a clause stating the insured
5708 does not have the exclusive right to veto any offer or admission
5709 of liability and for arbitration made pursuant to s. 766.106,
5710 settlement offer or offer of judgment, the insurer or self-
5711 insurer shall provide to the insured or the insured’s legal
5712 representative by certified mail, return receipt requested, a
5713 copy of the final offer of admission of liability and for

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5714 arbitration made pursuant to s. 766.106, settlement offer or
5715 offer of judgment and at the same time such offer is provided to
5716 the claimant. A copy of any final agreement reached between the
5717 insurer and claimant shall also be provided to the insurer or
5718 his or her legal representative by certified mail, return
5719 receipt requested within ~~not more than~~ 10 days after affecting
5720 such agreement.
5721 Section 75. Present subsection (12) of section 766.102,
5722 Florida Statutes, is redesignated as subsection (13), and a new
5723 subsection (12) is added to that section, to read:
5724 766.102 Medical negligence; standards of recovery; expert
5725 witness.—
5726 (12) If a physician licensed under chapter 458 or chapter
5727 459 is a party against whom, or on whose behalf, expert
5728 testimony about the prevailing professional standard of care is
5729 offered, the expert witness must otherwise meet the requirements
5730 of this section and be licensed as a physician under chapter 458
5731 or chapter 459, or must possess a valid expert witness
5732 certificate issued under s. 458.3167 or s. 459.0078.
5733 Section 76. Subsection (1) of section 766.104, Florida
5734 Statutes, is amended to read:
5735 766.104 Pleading in medical negligence cases; claim for
5736 punitive damages; authorization for release of records for
5737 investigation.—
5738 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or
5739 wrongful death arising out of medical negligence, whether in
5740 tort or in contract, may not be filed unless the attorney filing
5741 the action has made a reasonable investigation, as permitted by
5742 the circumstances, to determine that there are grounds for a

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5743 good faith belief that there has been negligence in the care or
5744 treatment of the claimant.
5745 (a) The complaint or initial pleading must ~~shall~~ contain a
5746 certificate of counsel that such reasonable investigation gave
5747 rise to a good faith belief that grounds exist for an action
5748 against each named defendant. For purposes of this section, good
5749 faith may be shown ~~to exist~~ if the claimant or his or her
5750 counsel has received a written opinion, ~~which shall~~ not ~~be~~
5751 subject to discovery by an opposing party, of an expert as
5752 defined in s. 766.102 that there appears to be evidence of
5753 medical negligence. If the court determines that the ~~such~~
5754 certificate of counsel was not made in good faith and that no
5755 justiciable issue was presented against a health care provider
5756 that fully cooperated in providing informal discovery, the court
5757 shall award attorney's fees and taxable costs against claimant's
5758 counsel~~,~~ and ~~shall~~ submit the matter to The Florida Bar for
5759 disciplinary review of the attorney.
5760 (b) If the cause of action requires the plaintiff to
5761 establish the breach of a standard of care other than negligence
5762 in order to impose liability or secure specified damages arising
5763 out of the rendering of, or the failure to render, medical care
5764 or services, and the plaintiff intends to pursue such liability
5765 or damages, the investigation and certification required by this
5766 subsection must demonstrate grounds for a good faith belief that
5767 the requirement is satisfied.
5768 Section 77. Subsection (5) of section 766.106, Florida
5769 Statutes, is amended to read:
5770 766.106 Notice before filing action for medical negligence;
5771 presuit screening period; offers for admission of liability and

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5772 for arbitration; informal discovery; review.—
5773 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,
5774 written document, report, or other work product generated by the
5775 presuit screening process is discoverable or admissible in any
5776 civil action for any purpose by the opposing party. All
5777 participants, including, but not limited to, physicians,
5778 investigators, witnesses, and employees or associates of the
5779 defendant, are immune from civil liability arising from
5780 participation in the presuit screening process. This subsection
5781 does not prohibit a physician licensed under chapter 458 or
5782 chapter 459, or a physician who holds a certificate to provide
5783 expert testimony under s. 458.3167 or s. 459.0078, who submits a
5784 verified written expert medical opinion from being subject to
5785 disciplinary action pursuant to s. 456.073.
5786 Section 78. Subsection (11) of section 766.1115, Florida
5787 Statutes, is amended to read:
5788 766.1115 Health care providers; creation of agency
5789 relationship with governmental contractors.—
5790 (11) APPLICABILITY.—
5791 (a) This section applies to incidents occurring on or after
5792 April 17, 1992.
5793 (b) This section does not apply to any health care contract
5794 entered into by the Department of Corrections which is subject
5795 to s. 768.28(10)(a).
5796 (c) This section does not apply to any affiliation
5797 agreement or other contract subject to s. 768.28(10)(f).
5798 (d) ~~Nothing in~~ This section does not reduce or limit ~~in any~~
5799 ~~way reduces or limits~~ the rights of the state or any of its
5800 agencies or subdivisions to any benefit currently provided under

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5801 s. 768.28.
5802 Section 79. Section 766.1183, Florida Statutes, is created
5803 to read:
5804 766.1183 Standard of care for Medicaid providers.—
5805 (1) As used in this section:
5806 (a) The terms “applicant,” “medical assistance,” “medical
5807 services,” and “Medicaid recipient” have the same meaning as in
5808 s. 409.901.
5809 (b) The term “provider” means a health care provider as
5810 defined in s. 766.202, an ambulance provider licensed under
5811 chapter 401, or an entity that qualifies for an exemption under
5812 s. 400.9905(4)(e). The term includes:
5813 1. Any person or entity for whom a provider is vicariously
5814 liable; and
5815 2. Any person or entity whose liability is based solely on
5816 such person or entity being vicariously liable for the actions
5817 of a provider.
5818 (c) The term “wrongful manner” means in bad faith or with
5819 malicious purpose or in a manner exhibiting wanton and willful
5820 disregard of human rights, safety, or property, and shall be
5821 construed in conformity with the standard set forth in s.
5822 768.28(9)(a).
5823 (2) A provider is not liable in excess of $200,000 per
5824 claimant or $300,000 per occurrence for any cause of action
5825 arising out of the rendering of, or the failure to render,
5826 medical services to a Medicaid recipient, except as provided
5827 under subsection (3). However, a judgment may be claimed and
5828 rendered in excess of the amounts set forth in this subsection.
5829 That portion of the judgment that exceeds these amounts may be

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5830 reported to the Legislature, but may be paid in part or in whole
5831 by the state only by further act of the Legislature.
5832 (3) A provider may be liable for an amount in excess of
5833 $200,000 per claimant or $300,000 per occurrence only if the
5834 claimant pleads and proves, by clear and convincing evidence,
5835 that the provider acted in a wrongful manner. If the claimant so
5836 pleads, the court, after a reasonable opportunity for discovery,
5837 shall conduct a hearing before trial to determine if there is a
5838 reasonable basis in evidence to conclude that the provider acted
5839 in a wrongful manner. A claim for wrongful conduct is not
5840 permitted, to the extent it exceeds the amounts set forth in
5841 subsection (2), unless the claimant makes the showing required
5842 by this subsection.
5843 (4) At the time an application for medical assistance is
5844 submitted, the Department of Children and Family Services shall
5845 furnish the applicant with written notice of the provisions of
5846 this section.
5847 (5) This section does not limit or exclude the application
5848 of any law, including s. 766.118, which places limitations upon
5849 the recovery of civil damages.
5850 (6) This section does not apply to any claim for damages to
5851 which s. 768.28 applies.
5852 Section 80. Section 766.1184, Florida Statutes, is created
5853 to read:
5854 766.1184 Standard of care; low-income pool recipient.—
5855 (1) As used in this section, the term:
5856 (a) “Low-income pool recipient” means a low-income
5857 individual who is uninsured or underinsured and who receives
5858 primary care services from a provider which are delivered

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5859 exclusively using funding received by that provider under
5860 proviso language accompanying specific appropriation 191 of the
5861 2010-2011 fiscal year General Appropriations Act to establish
5862 new or expand existing primary care clinics for low-income
5863 persons who are uninsured or underinsured.
5864 (b) "Provider" means a health care provider, as defined in
5865 s. 766.202, which received funding under proviso language
5866 accompanying specific appropriation 191 of the fiscal year 2010-
5867 11 General Appropriations Act to establish new or expand
5868 existing primary care clinics for low-income persons who are
5869 uninsured or underinsured. The term includes:
5870 1. Any person or entity for whom a provider is vicariously
5871 liable; and
5872 2. Any person or entity whose liability is based solely on
5873 such person or entity being vicariously liable for the actions
5874 of a provider.
5875 (c) "Wrongful manner" means in bad faith or with malicious
5876 purpose or in a manner exhibiting wanton and willful disregard
5877 of human rights, safety, or property, and shall be construed in
5878 conformity with the standard set forth in s. 768.28(9)(a).
5879
5880 The funding of the provider's primary care clinic must have been
5881 awarded pursuant to a plan approved by the Legislative Budget
5882 Commission, and must be the subject of an agreement between the
5883 provider and the Agency for Health Care Administration,
5884 following the competitive solicitation of proposals to use low-
5885 income pool grant funds to provide primary care services in
5886 general acute hospitals, county health departments, faith-based
5887 and community clinics, and federally qualified health centers to

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5888 uninsured or underinsured persons.
5889 (2) A provider is not liable in excess of $200,000 per
5890 claimant or $300,000 per occurrence for any cause of action
5891 arising out of the rendering of, or the failure to render,
5892 primary care services to a low-income pool recipient, except as
5893 provided under subsection (3). However, a judgment may be
5894 claimed and rendered in excess of the amounts set forth in this
5895 subsection. That portion of the judgment that exceeds these
5896 amounts may be reported to the Legislature, but may be paid in
5897 part or in whole by the state only by further act of the
5898 Legislature.
5899 (3) A provider may be liable for an amount in excess of
5900 $200,000 per claimant or $300,000 per occurrence only if the
5901 claimant pleads and proves, by clear and convincing evidence,
5902 that the provider acted in a wrongful manner. If the claimant so
5903 pleads, the court, after a reasonable opportunity for discovery,
5904 shall conduct a hearing before trial to determine if there is a
5905 reasonable basis in evidence to conclude that the provider acted
5906 in a wrongful manner. A claim for wrongful conduct is not
5907 permitted, to the extent it exceeds the amounts set forth in
5908 subsection (2), unless the claimant makes the showing required
5909 by this subsection.
5910 (4) In order for this section to apply, the provider must:
5911 (a) Develop, implement, and maintain policies and
5912 procedures to:
5913 1. Ensure that funds described in subsection (1) are used
5914 exclusively to serve low-income persons who are uninsured or
5915 underinsured;
5916 2. Determine whether funds described in subsection (1) are

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5917 being used to provide primary care services to a particular
5918 person; and
5919 3. Identify whether an individual receiving primary care
5920 services is a low-income pool recipient to whom the provisions
5921 of this section apply.
5922 (b) Furnish a low-income pool recipient with written notice
5923 of the provisions of this section before providing primary care
5924 services to the recipient.
5925 (c) Be in compliance with the terms of any agreement
5926 between the provider and the Agency for Health Care
5927 Administration governing the receipt of the funds described in
5928 subsection (1).
5929 (5) This section does not limit or exclude the application
5930 of any law, including s. 766.118, which places limitations upon
5931 the recovery of civil damages.
5932 (6) This section does not apply to any claim for damages to
5933 which s. 768.28 applies.
5934 Section 81. Subsection (5) is added to section 766.203,
5935 Florida Statutes, to read:
5936 766.203 Presuit investigation of medical negligence claims
5937 and defenses by prospective parties.—
5938 (5) STANDARDS OF CARE.—If the cause of action that is the
5939 basis for the litigation requires the plaintiff to establish the
5940 breach of a standard of care other than negligence in order to
5941 impose liability or secure specified damages arising out of the
5942 rendering of, or the failure to render, medical care or
5943 services, and the plaintiff intends to pursue such liability or
5944 damages, the presuit investigations required of the claimant and
5945 the prospective defendant by this section must ascertain that

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5946 there are reasonable grounds to believe that the requirement is
5947 satisfied.
5948 Section 82. Paragraph (b) of subsection (9) of section
5949 768.28, Florida Statutes, is amended, and paragraphs (f) and (g)
5950 are added to subsection (10) of that section, to read:
5951 768.28 Waiver of sovereign immunity in tort actions;
5952 recovery limits; limitation on attorney fees; statute of
5953 limitations; exclusions; indemnification; risk management
5954 programs.—
5955 (9)
5956 (b) As used in this subsection, the term:
5957 1. "Employee" includes any volunteer firefighter.
5958 2. "Officer, employee, or agent" includes, but is not
5959 limited to, any health care provider when providing services
5960 pursuant to s. 766.1115;~~,~~ any member of the Florida Health
5961 Services Corps, as defined in s. 381.0302, who provides
5962 uncompensated care to medically indigent persons referred by the
5963 Department of Health; any nonprofit independent college or
5964 university located and chartered in this state which owns or
5965 operates an accredited medical school, and its employees or
5966 agents, when providing patient services pursuant to paragraph
5967 (10)(f);~~,~~ and any public defender or her or his employee or
5968 agent, including, among others, an assistant public defender and
5969 an investigator.
5970 (10)
5971 (f) For purposes of this section, any nonprofit independent
5972 college or university located and chartered in this state which
5973 owns or operates an accredited medical school, or any of its
5974 employees or agents, and which has agreed in an affiliation

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5975 agreement or other contract to provide, or to permit its
5976 employees or agents to provide, patient services as agents of a
5977 teaching hospital, is considered an agent of the teaching
5978 hospital while acting within the scope of and pursuant to
5979 guidelines established in the contract. To the extent allowed by
5980 law, the contract must provide for the indemnification of the
5981 state, up to the limits set out in this chapter, by the agent
5982 for any liability incurred which was caused by the negligence of
5983 the college or university or its employees or agents.
5984 1. For purposes of this paragraph, the term:
5985 a. "Employee or agent" means an officer, employee, agent,
5986 or servant of a nonprofit independent college or university
5987 located and chartered in this state which owns or operates an
5988 accredited medical school, including, but not limited to, the
5989 faculty of the medical school, any health care practitioner or
5990 licensee as defined in s. 456.001 for which the college or
5991 university is vicariously liable, and the staff or administrator
5992 of the medical school.
5993 b. "Patient services" mean:
5994 (I) Comprehensive health care services as defined in s.
5995 641.19, including any related administrative service, provided
5996 to patients in a teaching hospital or in a health care facility
5997 that is a part of a nonprofit independent college or university
5998 located and chartered in this state which owns or operates an
5999 accredited medical school, pursuant to an affiliation agreement
6000 or other contract with a teaching hospital;
6001 (II) Training and supervision of interns, residents, and
6002 fellows providing patient services in a teaching hospital or in
6003 a health care facility that is a part of a nonprofit independent

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6004 college or university located and chartered in this state which
6005 owns or operates an accredited medical school, pursuant to an
6006 affiliation agreement or other contract with a teaching
6007 hospital;
6008 (III) Participation in medical research protocols; or
6009 (IV) Training and supervision of medical students in a
6010 teaching hospital or in a health care facility owned by a not-
6011 for-profit college or university that owns or operates an
6012 accredited medical school, pursuant to an affiliation agreement
6013 or other contract with a teaching hospital.
6014 c. "Teaching hospital" means a teaching hospital as defined
6015 in s. 408.07 which is owned or operated by the state, a county
6016 or municipality, a public health trust, a special taxing
6017 district, a governmental entity having health care
6018 responsibilities, or a not-for-profit entity that operates such
6019 facilities as an agent of the state or a political subdivision
6020 of the state under a lease or other contract.
6021 2. The teaching hospital or the medical school, or its
6022 employees or agents, must provide written notice to each
6023 patient, or the patient's legal representative, receipt of which
6024 must be acknowledged in writing, that the college or university
6025 that owns or operates the medical school and the employees or
6026 agents of that college or university are acting as agents of the
6027 teaching hospital and that the exclusive remedy for injury or
6028 damage suffered as the result of any act or omission of the
6029 teaching hospital, the college or university that owns or
6030 operates the medical school, or the employees or agents of the
6031 college or university while acting within the scope of duties
6032 pursuant to the affiliation agreement or other contract with a

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6033 teaching hospital, is by commencement of an action pursuant to
6034 the provisions of this section.
6035 3. This paragraph does not designate any employee providing
6036 contracted patient services in a teaching hospital as an
6037 employee or agent of the state for purposes of chapter 440.
6038 (g) Providers or vendors, 75 percent of whose client
6039 population consists of individuals with a developmental
6040 disability as defined in ss. 393.063 and 400.960, individuals
6041 who are blind or severely handicapped individuals as defined in
6042 s. 413.033, individuals who have a mental illness as defined
6043 under s. 394.455, or individuals who have any combination of
6044 these conditions, which have contractually agreed to act on
6045 behalf of the Agency for Persons with Disabilities, the Agency
6046 for Health Care Administration, the Division of Blind Services
6047 in the Department of Education, or the Mental Health Program
6048 Office of the Department of Children and Family Services to
6049 provide services to such individuals, and their employees or
6050 agents, are considered agents of the state, solely with respect
6051 to the provision of such services while acting within the scope
6052 of and pursuant to guidelines established by contract, a
6053 Medicaid waiver agreement, or rule. The contracts for such
6054 services must provide for the indemnification of the state by
6055 the agent for any liabilities incurred up to the limits
6056 specified in this section.
6057 Section 83. Legislative findings and intent.—
6058 (1) The Legislature finds that:
6059 (a) Access to high-quality, comprehensive, and affordable
6060 health care for all persons in this state is a necessary state
6061 goal and that teaching hospitals play an intrinsic and essential

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

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6091 such sovereign immunity protections.
6092 (e) The employees or agents of nonprofit independent
6093 colleges and universities located and chartered in this state
6094 which enter into affiliation agreements or contracts with
6095 teaching hospitals to provide patient services do not have the
6096 same level of protection against liability claims as teaching
6097 hospitals and their employees and agents that provide the same
6098 patient services to the same patients. Thus, these colleges and
6099 universities and their employees and agents are
6100 disproportionately affected by claims arising out of alleged
6101 medical malpractice and other allegedly negligent acts. Given
6102 the recent growth in medical schools and medical education
6103 programs and ongoing efforts to support, strengthen, and
6104 increase physician residency training positions and medical
6105 faculty in both existing and newly designated teaching
6106 hospitals, this exposure and the consequent disparity in
6107 liability exposure will continue to increase. The vulnerability
6108 of these colleges and universities to claims of medical
6109 malpractice will only add to the current physician workforce
6110 crisis in Florida and can be alleviated only through legislative
6111 action.
6112 (f) Ensuring that the employees and agents of nonprofit
6113 independent colleges and universities located and chartered in
6114 this state which own or operated medical schools are able to
6115 continue to treat patients, provide graduate medical education,
6116 supervise medical students, engage in research, and provide
6117 administrative support and services in teaching hospitals is an
6118 overwhelming public necessity.
6119 (2) The Legislature intends that:

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

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6149 Section 84. Section 1004.41, Florida Statutes, is amended
6150 to read:
6151 1004.41 University of Florida; J. Hillis Miller Health
6152 Center.—
6153 (1) There is established the J. Hillis Miller Health Center
6154 at the University of Florida, including campuses at Gainesville
6155 and Jacksonville and affiliated teaching hospitals, which shall
6156 include the following colleges:
6157 (a) College of Dentistry.
6158 (b) College of Public Health and Health Professions.
6159 (c) College of Medicine.
6160 (d) College of Nursing.
6161 (e) College of Pharmacy.
6162 (f) College of Veterinary Medicine and related teaching
6163 hospitals.
6164 (2) Each college of the health center shall be ~~so~~
6165 maintained and operated so as to comply with the standards
6166 approved by a nationally recognized association for
6167 accreditation.
6168 (3)(a) The University of Florida Health Center Operations
6169 and Maintenance Trust Fund shall be administered by the
6170 University of Florida Board of Trustees. Funds shall be credited
6171 to the trust fund from the sale of goods and services performed
6172 by the University of Florida Veterinary Medicine Teaching
6173 Hospital. The purpose of the trust fund is to support the
6174 instruction, research, and service missions of the University of
6175 Florida College of Veterinary Medicine.
6176 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and
6177 pursuant to s. 216.351, any balance in the trust fund at the end

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6178 of any fiscal year shall remain in the trust fund and ~~shall~~ be
6179 available for carrying out the purposes of the trust fund.
6180 (4)(a) The University of Florida Board of Trustees shall
6181 lease the hospital facilities of the health center known as the
6182 Shands Teaching Hospital and Clinics on the Gainesville campus
6183 of the University of Florida and all furnishings, equipment, and
6184 other chattels or choses in action used in the operation of the
6185 hospital, to Shands Teaching Hospital and Clinics, Inc., a
6186 private not-for-profit corporation organized ~~solely~~ for the
6187 primary purpose of supporting ~~operating~~ the University of
6188 Florida Board of Trustees' health affairs mission of community
6189 service and patient care, education and training of health
6190 professionals, and clinical research. In furtherance of that
6191 purpose, Shands Teaching Hospital and Clinics, Inc., shall
6192 operate the hospital and ancillary health care facilities as
6193 deemed ~~of the health center and other health care facilities and~~
6194 ~~programs determined to be~~ necessary by the board of Shands
6195 Teaching Hospital and Clinics, Inc. ~~the nonprofit corporation.~~
6196 The rental for the hospital facilities shall be an amount equal
6197 to the debt service on bonds or revenue certificates issued
6198 solely for capital improvements to the hospital facilities or as
6199 otherwise provided by law.
6200 (b) The University of Florida Board of Trustees shall
6201 provide in the lease or by separate contract or agreement with
6202 Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6203 ~~corporation~~ for the following:
6204 1. Approval of the articles of incorporation of Shands
6205 Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~
6206 ~~corporation~~ by the University of Florida Board of Trustees and

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6207 the governance of that ~~the~~ not-for-profit corporation by a board
6208 of directors appointed, subject to removal, and chaired by the
6209 President of the University of Florida, or his or her designee,
6210 and vice chaired by the Vice President for Health Affairs of the
6211 University of Florida, or his or her designee.
6212 2. The use of hospital facilities and personnel in support
6213 of community service and patient care, ~~the~~ research programs,
6214 and ~~of the~~ teaching roles ~~role~~ of the health center.
6215 3. The continued recognition of the collective bargaining
6216 units and collective bargaining agreements as currently composed
6217 and recognition of the certified labor organizations
6218 representing those units and agreements.
6219 4. The use of hospital facilities and personnel in
6220 connection with research programs conducted by the health
6221 center.
6222 5. Reimbursement to the hospital for indigent patients,
6223 state-mandated programs, underfunded state programs, and costs
6224 to the hospital for support of the teaching and research
6225 programs of the health center. Such reimbursement shall be
6226 appropriated to either the health center or the hospital each
6227 year by the Legislature after review and approval of the request
6228 for funds.
6229 (c) The University of Florida Board of Trustees may, with
6230 the approval of the Legislature, increase the hospital
6231 facilities or remodel or renovate them, provided that the rental
6232 paid by the hospital for such new, remodeled, or renovated
6233 facilities is sufficient to amortize the costs thereof over a
6234 reasonable period of time or fund the debt service for any bonds
6235 or revenue certificates issued to finance such improvements.

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6236 (d) The University of Florida Board of Trustees is
6237 authorized to provide to Shands Teaching Hospital and Clinics,
6238 Inc., ~~the not-for-profit corporation leasing the hospital~~
6239 ~~facilities~~ and its not-for-profit subsidiaries and affiliates
6240 comprehensive general liability insurance including professional
6241 liability from a self-insurance trust program established
6242 pursuant to s. 1004.24.
6243 (e) Shands Teaching Hospital and Clinics, Inc., may, in
6244 support of the health affairs mission of the University of
6245 Florida Board of Trustees and with its prior approval, create
6246 for-profit or not-for-profit corporate subsidiaries and
6247 affiliates, or both. The University of Florida Board of
6248 Trustees, which may act through the President of the University
6249 of Florida or his or her designee, has the right to control
6250 Shands Teaching Hospital and Clinics, Inc. Shands Teaching
6251 Hospital and Clinics, Inc., and any not-for-profit subsidiaries
6252 are conclusively deemed corporations primarily acting as
6253 instrumentalities of the state, pursuant to s. 768.28(2), for
6254 purposes of sovereign immunity.
6255 (f) ~~(e)~~ If ~~In the event that~~ the lease of the hospital
6256 facilities to Shands Teaching Hospital and Clinics, Inc., ~~the~~
6257 ~~not-for-profit corporation~~ is terminated for any reason, the
6258 University of Florida Board of Trustees shall resume management
6259 and operation of the hospital facilities. In such event, the
6260 University of Florida Board of Trustees is authorized to utilize
6261 revenues generated from the operation of the hospital facilities
6262 to pay the costs and expenses of operating the hospital facility
6263 for the remainder of the fiscal year in which such termination
6264 occurs.

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6265 (5) ~~(f)~~ Shands Jacksonville Medical Center, Inc., and its
6266 parent Shands Jacksonville Healthcare, Inc., are private not-
6267 for-profit corporations organized primarily to support the
6268 health affairs mission of the University of Florida Board of
6269 Trustees in community service and patient care, education and
6270 training of health affairs professionals, and clinical research.
6271 Shands Jacksonville Medical Center, Inc., is a teaching hospital
6272 affiliated with the University of Florida Board of Trustees,
6273 located on the Jacksonville Campus of the University of Florida.
6274 Shands Jacksonville Medical Center, Inc., and Shands
6275 Jacksonville Healthcare, Inc., may, in support of the health
6276 affairs mission of the University of Florida Board of Trustees
6277 and with its prior approval, create for-profit or not-for-profit
6278 corporate subsidiaries and affiliates, or both.
6279 (a) The University of Florida Board of Trustees, which may
6280 act through the President of the University of Florida or his or
6281 her designee, has the right to control Shands Jacksonville
6282 Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.
6283 Shands Jacksonville Medical Center, Inc., Shands Jacksonville
6284 Healthcare, Inc., and any not-for-profit subsidiary of Shands
6285 Jacksonville Medical Center, Inc., are conclusively deemed
6286 corporations primarily acting as instrumentalities of the state,
6287 pursuant to s. 768.28(2), for purposes of sovereign immunity.
6288 (b) The University of Florida Board of Trustees is
6289 authorized to provide to Shands Jacksonville Healthcare, Inc.,
6290 and its not-for-profit subsidiaries and affiliates and any
6291 successor corporation that acts in support of the board of
6292 trustees, comprehensive general liability coverage, including
6293 professional liability, from the self-insurance programs

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6294 established pursuant to s. 1004.24.
6295 Section 85. Sections 409.9121, 409.919, and 624.915,
6296 Florida Statutes, are repealed.
6297 Section 86. Section 409.942, Florida Statutes, is
6298 transferred and renumbered as section 414.29, Florida Statutes.
6299 Section 87. Paragraph (a) of subsection (1) of section
6300 443.111, Florida Statutes, is amended to read:
6301 443.111 Payment of benefits.—
6302 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
6303 in accordance with rules adopted by the Agency for Workforce
6304 Innovation, subject to the following requirements:
6305 (a) Benefits are payable by mail or electronically.
6306 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a
6307 system for the payment of benefits by electronic funds transfer,
6308 including, but not limited to, debit cards, electronic payment
6309 cards, or any other means of electronic payment that the agency
6310 deems to be commercially viable or cost-effective. Commodities
6311 or services related to the development of such a system shall be
6312 procured by competitive solicitation, unless they are purchased
6313 from a state term contract pursuant to s. 287.056. The agency
6314 shall adopt rules necessary to administer the system.
6315 Section 88. Sections 409.944, 409.945, and 409.946, Florida
6316 Statutes, are transferred and renumbered as sections 163.464,
6317 163.465, and 163.466, Florida Statutes, respectively.
6318 Section 89. Sections 409.953 and 409.9531, Florida
6319 Statutes, are transferred and renumbered as sections 402.81 and
6320 402.82, Florida Statutes, respectively.
6321 Section 90. The Agency for Health Care Administration shall
6322 submit a reorganizational plan to the Governor, the Speaker of

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6323 the House of Representatives, and the President of the Senate by
6324 January 1, 2012, which converts the agency from a check-writing
6325 and fraud-chasing agency into a contract compliance and
6326 monitoring agency.
6327 Section 91. Effective December 1, 2011, if the Legislature
6328 has not received a letter from the Governor stating that the
6329 federal Centers for Medicare and Medicaid has approved the
6330 waivers necessary to implement the Medicaid managed care reforms
6331 contained in this act, the State of Florida shall withdraw from
6332 the Medicaid program effective December 31, 2011.
6333 Section 92. If any provision of this act or its application
6334 to any person or circumstance is held invalid, the invalidity
6335 does not affect other provisions or applications of the act
6336 which can be given effect without the invalid provision or
6337 application, and to this end the provisions of this act are
6338 severable.
6339 Section 93. This act shall take effect upon becoming a law.

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