1 A bill to be entitled
2 An act relating to Medicaid; amending s. 393.0661, F.S.,
3 relating to the home and community-based services delivery
4 system for persons with developmental disabilities;
5 requiring the Agency for Persons with Disabilities to
6 establish a transition plan for current Medicaid
7 recipients under certain circumstances; providing for
8 expiration of the section on a specified date; creating s.
9 400.0713, F.S.; requiring the Agency for Health Care
10 Administration to establish a nursing home licensure
11 workgroup; amending s. 408.040, F.S.; providing for
12 suspension of conditions precedent to the issuance of a
13 certificate of need for a nursing home, effective on a
14 specified date; amending s. 408.0435, F.S.; extending the
15 certificate-of-need moratorium for additional community
16 nursing home beds; designating ss. 409.016-409.803, F.S.,
17 as pt. I of ch. 409, F.S., and entitling the part "Social
18 and Economic Assistance"; designating ss. 409.810-409.821,
19 F.S., as pt. II of ch. 409, F.S., and entitling the part
20 "Kidcare"; designating ss. 409.901-409.9205, F.S., as part
21 III of ch. 409, F.S., and entitling the part "Medicaid";
22 amending s. 409.907, F.S.; authorizing the Agency for
23 Health Care Administration to enroll entities as Medicare
24 crossover-only providers for payment purposes only;
25 specifying requirements for Medicare crossover-only
26 agreements; amending s. 409.908, F.S.; providing penalties
27 for providers that fail to report suspension or
28 disenrollment from Medicare within a specified time;

29 amending s. 409.912, F.S.; authorizing provider service
30 networks to provide comprehensive behavioral health care
31 services to certain Medicaid recipients; providing payment
32 requirements for provider service networks; providing for
33 the expiration of various provisions of the section on
34 specified dates to conform to the reorganization of
35 Medicaid managed care; eliminating obsolete provisions and
36 updating provisions within the section; amending ss.
37 409.91195 and 409.91196, F.S.; conforming cross-
38 references; amending s. 409.91207, F.S.; providing
39 authority of the Agency for Health Care Administration
40 with respect to the development of a method for
41 designating qualified plans as a medical home network;
42 providing purposes and principles for creating medical
43 home networks; providing criteria for designation of a
44 qualified plan as a medical home network; providing agency
45 duties with respect thereto; amending s. 409.91211, F.S.;
46 providing authority of the Agency for Health Care
47 Administration to implement a managed care pilot program
48 based on specified waiver authority with respect to the
49 Medicaid reform program; continuing the existing pilot
50 program in specified counties; requiring the agency to
51 seek an extension of the waiver; providing for monthly
52 reports; requiring approval of the Legislative Budget
53 Commission for changes to specified terms and conditions ;
54 providing for expansion of the managed care pilot program
55 to Miami-Dade County; specifying managed care plans that
56 are qualified to participate in the Medicaid managed care

57 pilot program; providing requirements for qualified
58 managed care plans; requiring the agency to develop and
59 seek federal approval to implement methodologies to
60 preserve intergovernmental transfers of funds and
61 certified public expenditures from Miami-Dade County;
62 requiring the agency to submit a plan and specified
63 amendment to the Legislative Budget Commission; providing
64 for a report; requiring Medicaid recipients in counties in
65 which the managed care pilot program has been implemented
66 to be enrolled in a qualified plan; providing a time limit
67 for enrollment; requiring the agency to provide choice
68 counseling; providing requirements with respect to choice
69 counseling information provided to Medicaid recipients;
70 providing for automatic enrollment of certain Medicaid
71 recipients; establishing criteria for automatic
72 enrollment; providing procedures and requirements with
73 respect to voluntary disenrollment of a recipient in a
74 qualified plan; providing for an enrollment period;
75 requiring qualified plans to establish a process for
76 review of and response to grievances of enrollees;
77 requiring qualified plans to submit quarterly reports;
78 specifying services to be covered by qualified plans;
79 authorizing qualified plans to offer specified
80 customizations, variances, and coverage for additional
81 services; requiring agency evaluation of proposed benefit
82 packages; requiring qualified plans to reimburse the
83 agency for the cost of specified enrollment changes;
84 providing for access to encounter data; requiring

85 participating plans to establish an incentive program to
86 reward healthy behaviors; requiring the agency to continue
87 budget-neutral adjustment of capitation rates for all
88 prepaid plans in existing managed care pilot program
89 counties; providing for transition to payment
90 methodologies for Miami-Dade County plans; providing a
91 phased schedule for risk-adjusted capitation rates;
92 requiring the establishment of a technical advisory panel;
93 providing for distribution of funds from a low-income
94 pool; specifying purposes for such distribution; requiring
95 the agency to maintain and operate the Medicaid Encounter
96 Data System; requiring the agency to contract with the
97 University of Florida for evaluation of the pilot program;
98 amending s. 409.9122, F.S.; eliminating outdated
99 provisions; providing for the expiration of various
100 provisions of the section on specified dates to conform to
101 the reorganization of Medicaid managed care; requiring the
102 Agency for Health Care Administration to begin a budget-
103 neutral adjustment of capitation rates for all Medicaid
104 prepaid plans in the state on a specified date; providing
105 the basis for the adjustment; providing a phased schedule
106 for risk adjusted capitation rates; providing for the
107 establishment of a technical advisory panel; requiring the
108 agency to develop a process to enable any recipient with
109 access to employer sponsored insurance to opt out of
110 qualified plans in the Medicaid program; requiring the
111 agency, contingent on federal approval, to enable
112 recipients with access to other insurance or related

113 products providing access to specified health care
114 services to opt out of qualified plans in the Medicaid
115 program; providing a limitation on the amount of financial
116 assistance provided for each recipient; requiring each
117 qualified plan to establish an incentive program that
118 rewards specific healthy behaviors; requiring plans to
119 maintain a specified reserve account; requiring the agency
120 to maintain and operate the Medicaid Encounter Data
121 System; requiring the agency to establish a designated
122 payment for specified Medicare Advantage Special Needs
123 members; authorizing the agency to develop a designated
124 payment for Medicaid-only covered services for which the
125 state is responsible; requiring the agency to establish,
126 and managed care plans to use, a uniform method of
127 accounting for and reporting of medical and nonmedical
128 costs; requiring reimbursement by Medicaid of school
129 districts participating in a certified school match
130 program for a Medicaid-eligible child participating in the
131 services, effective on a specified date; requiring the
132 agency, the Department of Health, and the Department of
133 Education to develop procedures for ensuring that a
134 student's managed care plan receives information relating
135 to services provided; authorizing the Agency for Health
136 Care Administration to create exceptions to mandatory
137 enrollment in managed care under specified circumstances;
138 amending s. 430.04, F.S.; eliminating outdated provisions;
139 requiring the Department of Elderly Affairs to develop a
140 transition plan for specified elder and disabled adults

141 receiving long-term care Medicaid services when qualified
142 plans become available; providing for expiration thereof;
143 amending s. 430.2053, F.S.; eliminating outdated
144 provisions; providing additional duties of aging resource
145 centers; providing an additional exception to direct
146 services that may not be provided by an aging resource
147 center; providing for the cessation of specified payments
148 by the department as qualified plans become available;
149 providing for a memorandum of understanding between the
150 Agency for Health Care Administration and aging resource
151 centers under certain circumstances; eliminating
152 provisions requiring reports; amending s. 641.386, F.S.;
153 conforming a cross-reference; repealing s. 430.701, F.S.,
154 relating to legislative findings and intent and approval
155 for action relating to provider enrollment levels;
156 repealing s. 430.702, F.S., relating to the Long-Term Care
157 Community Diversion Pilot Project Act; repealing s.
158 430.703, F.S., relating to definitions; repealing s.
159 430.7031, F.S., relating to nursing home transition
160 program; repealing s. 430.704, F.S., relating to
161 evaluation of long-term care through the pilot projects;
162 repealing s. 430.705, F.S., relating to implementation of
163 long-term care community diversion pilot projects;
164 repealing s. 430.706, F.S., relating to quality of care;
165 repealing s. 430.707, F.S., relating to contracts;
166 repealing s. 430.708, F.S., relating to certificate of
167 need; repealing s. 430.709, F.S., relating to reports and
168 evaluations; renumbering ss. 409.9301, 409.942, 409.944,

169 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.
170 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
171 402.87, F.S., respectively; amending s. 443.111, F.S.;
172 conforming a cross-reference; providing contingent
173 effective dates.
174
175 Be It Enacted by the Legislature of the State of Florida:
176
177 Section 1. Section 393.0661, Florida Statutes, is amended
178 to read:
179 393.0661 Home and community-based services delivery
180 system; comprehensive redesign.—The Legislature finds that the
181 home and community-based services delivery system for persons
182 with developmental disabilities and the availability of
183 appropriated funds are two of the critical elements in making
184 services available. Therefore, it is the intent of the
185 Legislature that the Agency for Persons with Disabilities shall
186 develop and implement a comprehensive redesign of the system.
187 (1) The redesign of the home and community-based services
188 system shall include, at a minimum, all actions necessary to
189 achieve an appropriate rate structure, client choice within a
190 specified service package, appropriate assessment strategies, an
191 efficient billing process that contains reconciliation and
192 monitoring components, a redefined role for support coordinators
193 that avoids potential conflicts of interest, and ensures that
194 family/client budgets are linked to levels of need.
195 (a) The agency shall use an assessment instrument that is
196 reliable and valid. The agency may contract with an external

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197 vendor or may use support coordinators to complete client
198 assessments if it develops sufficient safeguards and training to
199 ensure ongoing inter-rater reliability.
200 (b) The agency, with the concurrence of the Agency for
201 Health Care Administration, may contract for the determination
202 of medical necessity and establishment of individual budgets.
203 (2) A provider of services rendered to persons with
204 developmental disabilities pursuant to a federally approved
205 waiver shall be reimbursed according to a rate methodology based
206 upon an analysis of the expenditure history and prospective
207 costs of providers participating in the waiver program, or under
208 any other methodology developed by the Agency for Health Care
209 Administration, in consultation with the Agency for Persons with
210 Disabilities, and approved by the Federal Government in
211 accordance with the waiver.
212 (3) The Agency for Health Care Administration, in
213 consultation with the agency, shall seek federal approval and
214 implement a four-tiered waiver system to serve eligible clients
215 through the developmental disabilities and family and supported
216 living waivers. The agency shall assign all clients receiving
217 services through the developmental disabilities waiver to a tier
218 based on a valid assessment instrument, client characteristics,
219 and other appropriate assessment methods.
220 (a) Tier one is limited to clients who have service needs
221 that cannot be met in tier two, three, or four for intensive
222 medical or adaptive needs and that are essential for avoiding
223 institutionalization, or who possess behavioral problems that
224 are exceptional in intensity, duration, or frequency and present

225 a substantial risk of harm to themselves or others.
226 (b) Tier two is limited to clients whose service needs
227 include a licensed residential facility and who are authorized
228 to receive a moderate level of support for standard residential
229 habilitation services or a minimal level of support for behavior
230 focus residential habilitation services, or clients in supported
231 living who receive more than 6 hours a day of in-home support
232 services. Total annual expenditures under tier two may not
233 exceed $55,000 per client each year.
234 (c) Tier three includes, but is not limited to, clients
235 requiring residential placements, clients in independent or
236 supported living situations, and clients who live in their
237 family home. Total annual expenditures under tier three may not
238 exceed $35,000 per client each year.
239 (d) Tier four is the family and supported living waiver
240 and includes, but is not limited to, clients in independent or
241 supported living situations and clients who live in their family
242 home. Total annual expenditures under tier four may not exceed
243 $14,792 per client each year.
244 (e) The Agency for Health Care Administration shall also
245 seek federal approval to provide a consumer-directed option for
246 persons with developmental disabilities which corresponds to the
247 funding levels in each of the waiver tiers. The agency shall
248 implement the four-tiered waiver system beginning with tiers
249 one, three, and four and followed by tier two. The agency and
250 the Agency for Health Care Administration may adopt rules
251 necessary to administer this subsection.
252 (f) The agency shall seek federal waivers and amend

253 contracts as necessary to make changes to services defined in
254 federal waiver programs administered by the agency as follows:
255 1. Supported living coaching services may not exceed 20
256 hours per month for persons who also receive in-home support
257 services.
258 2. Limited support coordination services is the only type
259 of support coordination service that may be provided to persons
260 under the age of 18 who live in the family home.
261 3. Personal care assistance services are limited to 180
262 hours per calendar month and may not include rate modifiers.
263 Additional hours may be authorized for persons who have
264 intensive physical, medical, or adaptive needs if such hours are
265 essential for avoiding institutionalization.
266 4. Residential habilitation services are limited to 8
267 hours per day. Additional hours may be authorized for persons
268 who have intensive medical or adaptive needs and if such hours
269 are essential for avoiding institutionalization, or for persons
270 who possess behavioral problems that are exceptional in
271 intensity, duration, or frequency and present a substantial risk
272 of harming themselves or others. This restriction shall be in
273 effect until the four-tiered waiver system is fully implemented.
274 5. Chore services, nonresidential support services, and
275 homemaker services are eliminated. The agency shall expand the
276 definition of in-home support services to allow the service
277 provider to include activities previously provided in these
278 eliminated services.
279 6. Massage therapy, medication review, and psychological
280 assessment services are eliminated.

281 7. The agency shall conduct supplemental cost plan reviews
282 to verify the medical necessity of authorized services for plans
283 that have increased by more than 8 percent during either of the
284 2 preceding fiscal years.
285 8. The agency shall implement a consolidated residential
286 habilitation rate structure to increase savings to the state
287 through a more cost-effective payment method and establish
288 uniform rates for intensive behavioral residential habilitation
289 services.
290 9. Pending federal approval, the agency may extend current
291 support plans for clients receiving services under Medicaid
292 waivers for 1 year beginning July 1, 2007, or from the date
293 approved, whichever is later. Clients who have a substantial
294 change in circumstances which threatens their health and safety
295 may be reassessed during this year in order to determine the
296 necessity for a change in their support plan.
297 10. The agency shall develop a plan to eliminate
298 redundancies and duplications between in-home support services,
299 companion services, personal care services, and supported living
300 coaching by limiting or consolidating such services.
301 11. The agency shall develop a plan to reduce the
302 intensity and frequency of supported employment services to
303 clients in stable employment situations who have a documented
304 history of at least 3 years' employment with the same company or
305 in the same industry.
306 (4) The geographic differential for Miami-Dade, Broward,
307 and Palm Beach Counties for residential habilitation services
308 shall be 7.5 percent.

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309 (5) The geographic differential for Monroe County for
310 residential habilitation services shall be 20 percent.
311 (6) Effective January 1, 2010, and except as otherwise
312 provided in this section, a client served by the home and
313 community-based services waiver or the family and supported
314 living waiver funded through the agency shall have his or her
315 cost plan adjusted to reflect the amount of expenditures for the
316 previous state fiscal year plus 5 percent if such amount is less
317 than the client's existing cost plan. The agency shall use
318 actual paid claims for services provided during the previous
319 fiscal year that are submitted by October 31 to calculate the
320 revised cost plan amount. If the client was not served for the
321 entire previous state fiscal year or there was any single change
322 in the cost plan amount of more than 5 percent during the
323 previous state fiscal year, the agency shall set the cost plan
324 amount at an estimated annualized expenditure amount plus 5
325 percent. The agency shall estimate the annualized expenditure
326 amount by calculating the average of monthly expenditures,
327 beginning in the fourth month after the client enrolled,
328 interrupted services are resumed, or the cost plan was changed
329 by more than 5 percent and ending on August 31, 2009, and
330 multiplying the average by 12. In order to determine whether a
331 client was not served for the entire year, the agency shall
332 include any interruption of a waiver-funded service or services
333 lasting at least 18 days. If at least 3 months of actual
334 expenditure data are not available to estimate annualized
335 expenditures, the agency may not rebase a cost plan pursuant to
336 this subsection. The agency may not rebase the cost plan of any

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337 client who experiences a significant change in recipient
338 condition or circumstance which results in a change of more than
339 5 percent to his or her cost plan between July 1 and the date
340 that a rebased cost plan would take effect pursuant to this
341 subsection.
342 (7) Nothing in this section or in any administrative rule
343 shall be construed to prevent or limit the Agency for Health
344 Care Administration, in consultation with the Agency for Persons
345 with Disabilities, from adjusting fees, reimbursement rates,
346 lengths of stay, number of visits, or number of services, or
347 from limiting enrollment, or making any other adjustment
348 necessary to comply with the availability of moneys and any
349 limitations or directions provided for in the General
350 Appropriations Act.
351 (8) The Agency for Persons with Disabilities shall submit
352 quarterly status reports to the Executive Office of the
353 Governor, the chair of the Senate Ways and Means Committee or
354 its successor, and the chair of the House Fiscal Council or its
355 successor regarding the financial status of home and community-
356 based services, including the number of enrolled individuals who
357 are receiving services through one or more programs; the number
358 of individuals who have requested services who are not enrolled
359 but who are receiving services through one or more programs,
360 with a description indicating the programs from which the
361 individual is receiving services; the number of individuals who
362 have refused an offer of services but who choose to remain on
363 the list of individuals waiting for services; the number of
364 individuals who have requested services but who are receiving no

365 services; a frequency distribution indicating the length of time
366 individuals have been waiting for services; and information
367 concerning the actual and projected costs compared to the amount
368 of the appropriation available to the program and any projected
369 surpluses or deficits. If at any time an analysis by the agency,
370 in consultation with the Agency for Health Care Administration,
371 indicates that the cost of services is expected to exceed the
372 amount appropriated, the agency shall submit a plan in
373 accordance with subsection (7) to the Executive Office of the
374 Governor, the chair of the Senate Ways and Means Committee or
375 its successor, and the chair of the House Fiscal Council or its
376 successor to remain within the amount appropriated. The agency
377 shall work with the Agency for Health Care Administration to
378 implement the plan so as to remain within the appropriation.
379 (9) The agency shall develop a transition plan for
380 recipients who are receiving services in one of the four waiver
381 tiers at the time qualified plans are available in each
382 recipient's region pursuant to s. 409.989(3) to enroll those
383 recipients in qualified plans.
384 (10) This section expires October 1, 2015.
385 Section 2. Section 400.0713, Florida Statutes, is created
386 to read:
387 400.0713 Nursing home licensure workgroup.—The agency
388 shall establish a workgroup to develop a plan for licensure
389 flexibility to assist nursing homes in developing comprehensive
390 long-term care service capabilities.
391 Section 3. Paragraphs (b) and (d) of subsection (1) of
392 section 408.040, Florida Statutes, are amended to read:

393 408.040 Conditions and monitoring.—
394 (1)
395 (b) The agency may consider, in addition to the other
396 criteria specified in s. 408.035, a statement of intent by the
397 applicant that a specified percentage of the annual patient days
398 at the facility will be utilized by patients eligible for care
399 under Title XIX of the Social Security Act. Any certificate of
400 need issued to a nursing home in reliance upon an applicant's
401 statements that a specified percentage of annual patient days
402 will be utilized by residents eligible for care under Title XIX
403 of the Social Security Act must include a statement that such
404 certification is a condition of issuance of the certificate of
405 need. The certificate-of-need program shall notify the Medicaid
406 program office and the Department of Elderly Affairs when it
407 imposes conditions as authorized in this paragraph in an area in
408 which a community diversion pilot project is implemented.
409 Effective July 1, 2011, the agency shall not consider, or impose
410 conditions related to, patient day utilization by patients
411 eligible for care under Title XIX the Social Security Act in
412 making certificate-of-need determinations for nursing homes.
413 (d) If a nursing home is located in a county in which a
414 long-term care community diversion pilot project has been
415 implemented under s. 430.705 ~~or in a county in which an~~
416 ~~integrated, fixed-payment delivery program for Medicaid~~
417 ~~recipients who are 60 years of age or older or dually eligible~~
418 ~~for Medicare and Medicaid has been implemented under s.~~
419 ~~409.912(5)~~, the nursing home may request a reduction in the
420 percentage of annual patient days used by residents who are

421 eligible for care under Title XIX of the Social Security Act,
422 which is a condition of the nursing home's certificate of need.
423 The agency shall automatically grant the nursing home's request
424 if the reduction is not more than 15 percent of the nursing
425 home's annual Medicaid-patient-days condition. A nursing home
426 may submit only one request every 2 years for an automatic
427 reduction. A requesting nursing home must notify the agency in
428 writing at least 60 days in advance of its intent to reduce its
429 annual Medicaid-patient-days condition by not more than 15
430 percent. The agency must acknowledge the request in writing and
431 must change its records to reflect the revised certificate-of-
432 need condition. This paragraph expires June 30, 2011.
433 Section 4. Subsection (1) of section 408.0435, Florida
434 Statutes, is amended to read:
435 408.0435 Moratorium on nursing home certificates of need.—
436 (1) Notwithstanding the establishment of need as provided
437 for in this chapter, a certificate of need for additional
438 community nursing home beds may not be approved by the agency
439 until after Medicaid managed care is implemented statewide
440 pursuant to ss. 409.961-409.992, or October 1, 2015, whichever
441 is earlier ~~July 1, 2011~~.
442 Section 5. Sections 409.016 through 409.803, Florida
443 Statutes, are designated as part I of chapter 409, Florida
444 Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."
445 Section 6. Sections 409.810 through 409.821, Florida
446 Statutes, are designated as part II of chapter 409, Florida
447 Statutes, and entitled "KIDCARE."

448 Section 7. Sections 409.901 through 409.9205, Florida
449 Statutes, are designated as part III of chapter 409, Florida
450 Statutes, and entitled "MEDICAID."
451 Section 8. Subsection (5) of section 409.907, Florida
452 Statutes, is amended to read:
453 409.907 Medicaid provider agreements.—The agency may make
454 payments for medical assistance and related services rendered to
455 Medicaid recipients only to an individual or entity who has a
456 provider agreement in effect with the agency, who is performing
457 services or supplying goods in accordance with federal, state,
458 and local law, and who agrees that no person shall, on the
459 grounds of handicap, race, color, or national origin, or for any
460 other reason, be subjected to discrimination under any program
461 or activity for which the provider receives payment from the
462 agency.
463 (5) The agency:
464 (a) Is required to make timely payment at the established
465 rate for services or goods furnished to a recipient by the
466 provider upon receipt of a properly completed claim form. The
467 claim form shall require certification that the services or
468 goods have been completely furnished to the recipient and that,
469 with the exception of those services or goods specified by the
470 agency, the amount billed does not exceed the provider's usual
471 and customary charge for the same services or goods.
472 (b) Is prohibited from demanding repayment from the
473 provider in any instance in which the Medicaid overpayment is
474 attributable to error of the department in the determination of
475 eligibility of a recipient.

476 (c) May adopt, and include in the provider agreement, such
477 other requirements and stipulations on either party as the
478 agency finds necessary to properly and efficiently administer
479 the Medicaid program.
480 (d) May enroll entities as Medicare crossover-only
481 providers for payment purposes only. The provider agreement
482 shall:
483 1. Require that the provider is an eligible Medicare
484 provider, has a current provider agreement in place with the
485 Centers for Medicare and Medicaid Services, and provides
486 verification that the provider is currently in good standing
487 with the agency.
488 2. Require that the provider notify the agency
489 immediately, in writing, upon being suspended or disenrolled as
490 a Medicare provider. If a provider does not provide such
491 notification within 5 business days after suspension or
492 disenrollment, sanctions may be imposed pursuant to this chapter
493 and the provider may be required to return funds paid to the
494 provider during the period of time that the provider was
495 suspended or disenrolled as a Medicare provider.
496 3. Require that all records pertaining to health care
497 services provided to each of the provider's recipients be kept
498 for a minimum of 5 years. The agreement shall also require that
499 records and information relating to payments claimed by the
500 provider for services under the agreement be delivered to the
501 agency or the Office of the Attorney General Medicaid Fraud
502 Control Unit when requested. If a provider does not provide such
503 records and information when requested, sanctions may be imposed

504 pursuant to this chapter.
505 4. Disclose that the agreement is for the purposes of
506 paying Medicare crossover claims only.
507
508 This paragraph pertains solely to Medicare crossover-only
509 providers. In order to become a standard Medicaid provider, the
510 other requirements of this section and applicable rules must be
511 met.
512 Section 9. Subsection (24) is added to section 409.908,
513 Florida Statutes, to read:
514 409.908 Reimbursement of Medicaid providers.—Subject to
515 specific appropriations, the agency shall reimburse Medicaid
516 providers, in accordance with state and federal law, according
517 to methodologies set forth in the rules of the agency and in
518 policy manuals and handbooks incorporated by reference therein.
519 These methodologies may include fee schedules, reimbursement
520 methods based on cost reporting, negotiated fees, competitive
521 bidding pursuant to s. 287.057, and other mechanisms the agency
522 considers efficient and effective for purchasing services or
523 goods on behalf of recipients. If a provider is reimbursed based
524 on cost reporting and submits a cost report late and that cost
525 report would have been used to set a lower reimbursement rate
526 for a rate semester, then the provider's rate for that semester
527 shall be retroactively calculated using the new cost report, and
528 full payment at the recalculated rate shall be effected
529 retroactively. Medicare-granted extensions for filing cost
530 reports, if applicable, shall also apply to Medicaid cost
531 reports. Payment for Medicaid compensable services made on

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532 behalf of Medicaid eligible persons is subject to the
533 availability of moneys and any limitations or directions
534 provided for in the General Appropriations Act or chapter 216.
535 Further, nothing in this section shall be construed to prevent
536 or limit the agency from adjusting fees, reimbursement rates,
537 lengths of stay, number of visits, or number of services, or
538 making any other adjustments necessary to comply with the
539 availability of moneys and any limitations or directions
540 provided for in the General Appropriations Act, provided the
541 adjustment is consistent with legislative intent.
542 (24) If a provider fails to notify the agency within 5
543 business days after suspension or disenrollment from Medicare,
544 sanctions may be imposed pursuant to this chapter and the
545 provider may be required to return funds paid to the provider
546 during the period of time that the provider was suspended or
547 disenrolled as a Medicare provider.
548 Section 10. Section 409.912, Florida Statutes, is amended
549 to read:
550 409.912 Cost-effective purchasing of health care.—The
551 agency shall purchase goods and services for Medicaid recipients
552 in the most cost-effective manner consistent with the delivery
553 of quality medical care. To ensure that medical services are
554 effectively utilized, the agency may, in any case, require a
555 confirmation or second physician's opinion of the correct
556 diagnosis for purposes of authorizing future services under the
557 Medicaid program. This section does not restrict access to
558 emergency services or poststabilization care services as defined
559 in 42 C.F.R. part 438.114. Such confirmation or second opinion

560 shall be rendered in a manner approved by the agency. The agency
561 shall maximize the use of prepaid per capita and prepaid
562 aggregate fixed-sum basis services when appropriate and other
563 alternative service delivery and reimbursement methodologies,
564 including competitive bidding pursuant to s. 287.057, designed
565 to facilitate the cost-effective purchase of a case-managed
566 continuum of care. The agency shall also require providers to
567 minimize the exposure of recipients to the need for acute
568 inpatient, custodial, and other institutional care and the
569 inappropriate or unnecessary use of high-cost services. The
570 agency shall contract with a vendor to monitor and evaluate the
571 clinical practice patterns of providers in order to identify
572 trends that are outside the normal practice patterns of a
573 provider's professional peers or the national guidelines of a
574 provider's professional association. The vendor must be able to
575 provide information and counseling to a provider whose practice
576 patterns are outside the norms, in consultation with the agency,
577 to improve patient care and reduce inappropriate utilization.
578 The agency may mandate prior authorization, drug therapy
579 management, or disease management participation for certain
580 populations of Medicaid beneficiaries, certain drug classes, or
581 particular drugs to prevent fraud, abuse, overuse, and possible
582 dangerous drug interactions. The Pharmaceutical and Therapeutics
583 Committee shall make recommendations to the agency on drugs for
584 which prior authorization is required. The agency shall inform
585 the Pharmaceutical and Therapeutics Committee of its decisions
586 regarding drugs subject to prior authorization. The agency is
587 authorized to limit the entities it contracts with or enrolls as

588 Medicaid providers by developing a provider network through
589 provider credentialing. The agency may competitively bid single-
590 source-provider contracts if procurement of goods or services
591 results in demonstrated cost savings to the state without
592 limiting access to care. The agency may limit its network based
593 on the assessment of beneficiary access to care, provider
594 availability, provider quality standards, time and distance
595 standards for access to care, the cultural competence of the
596 provider network, demographic characteristics of Medicaid
597 beneficiaries, practice and provider-to-beneficiary standards,
598 appointment wait times, beneficiary use of services, provider
599 turnover, provider profiling, provider licensure history,
600 previous program integrity investigations and findings, peer
601 review, provider Medicaid policy and billing compliance records,
602 clinical and medical record audits, and other factors. Providers
603 shall not be entitled to enrollment in the Medicaid provider
604 network. The agency shall determine instances in which allowing
605 Medicaid beneficiaries to purchase durable medical equipment and
606 other goods is less expensive to the Medicaid program than long-
607 term rental of the equipment or goods. The agency may establish
608 rules to facilitate purchases in lieu of long-term rentals in
609 order to protect against fraud and abuse in the Medicaid program
610 as defined in s. 409.913. The agency may seek federal waivers
611 necessary to administer these policies.
612 (1) The agency shall work with the Department of Children
613 and Family Services to ensure access of children and families in
614 the child protection system to needed and appropriate mental
615 health and substance abuse services. This subsection expires

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616 October 1, 2013.
617 (2) The agency may enter into agreements with appropriate
618 agents of other state agencies or of any agency of the Federal
619 Government and accept such duties in respect to social welfare
620 or public aid as may be necessary to implement the provisions of
621 Title XIX of the Social Security Act and ss. 409.901-409.920.
622 This subsection expires October 1, 2015.
623 (3) The agency may contract with health maintenance
624 organizations certified pursuant to part I of chapter 641 for
625 the provision of services to recipients. This subsection expires
626 October 1, 2013.
627 (4) The agency may contract with:
628 (a) An entity that provides no prepaid health care
629 services other than Medicaid services under contract with the
630 agency and which is owned and operated by a county, county
631 health department, or county-owned and operated hospital to
632 provide health care services on a prepaid or fixed-sum basis to
633 recipients, which entity may provide such prepaid services
634 either directly or through arrangements with other providers.
635 Such prepaid health care services entities must be licensed
636 under parts I and III of chapter 641. An entity recognized under
637 this paragraph which demonstrates to the satisfaction of the
638 Office of Insurance Regulation of the Financial Services
639 Commission that it is backed by the full faith and credit of the
640 county in which it is located may be exempted from s. 641.225.
641 This paragraph expires October 1, 2013.
642 (b) An entity that is providing comprehensive behavioral
643 health care services to certain Medicaid recipients through a

644 capitated, prepaid arrangement pursuant to the federal waiver
645 provided for by s. 409.905(5). Such entity must be licensed
646 under chapter 624, chapter 636, or chapter 641, or authorized
647 under paragraph (c) or paragraph (d), and must possess the
648 clinical systems and operational competence to manage risk and
649 provide comprehensive behavioral health care to Medicaid
650 recipients. As used in this paragraph, the term "comprehensive
651 behavioral health care services" means covered mental health and
652 substance abuse treatment services that are available to
653 Medicaid recipients. The secretary of the Department of Children
654 and Family Services shall approve provisions of procurements
655 related to children in the department's care or custody before
656 enrolling such children in a prepaid behavioral health plan. Any
657 contract awarded under this paragraph must be competitively
658 procured. In developing the behavioral health care prepaid plan
659 procurement document, the agency shall ensure that the
660 procurement document requires the contractor to develop and
661 implement a plan to ensure compliance with s. 394.4574 related
662 to services provided to residents of licensed assisted living
663 facilities that hold a limited mental health license. Except as
664 provided in subparagraph 5. ~~8.~~, and except in counties where the
665 Medicaid managed care pilot program is authorized pursuant to s.
666 409.91211, the agency shall seek federal approval to contract
667 with a single entity meeting these requirements to provide
668 comprehensive behavioral health care services to all Medicaid
669 recipients not enrolled in a Medicaid managed care plan
670 authorized under s. 409.91211, a provider service network as
671 described in paragraph (d), or a Medicaid health maintenance

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672 organization in an AHCA area. In an AHCA area where the Medicaid
673 managed care pilot program is authorized pursuant to s.
674 409.91211 in one or more counties, the agency may procure a
675 contract with a single entity to serve the remaining counties as
676 an AHCA area or the remaining counties may be included with an
677 adjacent AHCA area and are subject to this paragraph. Each
678 entity must offer a sufficient choice of providers in its
679 network to ensure recipient access to care and the opportunity
680 to select a provider with whom they are satisfied. The network
681 shall include all public mental health hospitals. To ensure
682 unimpaired access to behavioral health care services by Medicaid
683 recipients, all contracts issued pursuant to this paragraph must
684 require 80 percent of the capitation paid to the managed care
685 plan, including health maintenance organizations and capitated
686 provider service networks, to be expended for the provision of
687 behavioral health care services. If the managed care plan
688 expends less than 80 percent of the capitation paid for the
689 provision of behavioral health care services, the difference
690 shall be returned to the agency. The agency shall provide the
691 plan with a certification letter indicating the amount of
692 capitation paid during each calendar year for behavioral health
693 care services pursuant to this section. The agency may reimburse
694 for substance abuse treatment services on a fee-for-service
695 basis until the agency finds that adequate funds are available
696 for capitated, prepaid arrangements.
697 1. By January 1, 2001, The agency shall modify the
698 contracts with the entities providing comprehensive inpatient
699 and outpatient mental health care services to Medicaid

700 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
701 Counties, to include substance abuse treatment services.
702 ~~2. By July 1, 2003, the agency and the Department of~~
703 ~~Children and Family Services shall execute a written agreement~~
704 ~~that requires collaboration and joint development of all policy,~~
705 ~~budgets, procurement documents, contracts, and monitoring plans~~
706 ~~that have an impact on the state and Medicaid community mental~~
707 ~~health and targeted case management programs.~~
708 2.~~3.~~ Except as provided in subparagraph 5. ~~8.~~, ~~by July 1,~~
709 ~~2006,~~ the agency and the Department of Children and Family
710 Services shall contract with managed care entities in each AHCA
711 area except area 6 or arrange to provide comprehensive inpatient
712 and outpatient mental health and substance abuse services
713 through capitated prepaid arrangements to all Medicaid
714 recipients who are eligible to participate in such plans under
715 federal law and regulation. In AHCA areas where eligible
716 individuals number less than 150,000, the agency shall contract
717 with a single managed care plan to provide comprehensive
718 behavioral health services to all recipients who are not
719 enrolled in a Medicaid health maintenance organization, a
720 provider service network as described in paragraph (d), or a
721 Medicaid capitated managed care plan authorized under s.
722 409.91211. The agency may contract with more than one
723 comprehensive behavioral health provider to provide care to
724 recipients who are not enrolled in a Medicaid capitated managed
725 care plan authorized under s. 409.91211, a provider service
726 network as described in paragraph (d), or a Medicaid health
727 maintenance organization in AHCA areas where the eligible

728 population exceeds 150,000. In an AHCA area where the Medicaid
729 managed care pilot program is authorized pursuant to s.
730 409.91211 in one or more counties, the agency may procure a
731 contract with a single entity to serve the remaining counties as
732 an AHCA area or the remaining counties may be included with an
733 adjacent AHCA area and shall be subject to this paragraph.
734 Contracts for comprehensive behavioral health providers awarded
735 pursuant to this section shall be competitively procured. Both
736 for-profit and not-for-profit corporations are eligible to
737 compete. Managed care plans contracting with the agency under
738 subsection (3) or paragraph (d), shall provide and receive
739 payment for the same comprehensive behavioral health benefits as
740 provided in AHCA rules, including handbooks incorporated by
741 reference. In AHCA area 11, the agency shall contract with at
742 least two comprehensive behavioral health care providers to
743 provide behavioral health care to recipients in that area who
744 are enrolled in, or assigned to, the MediPass program. One of
745 the behavioral health care contracts must be with the existing
746 provider service network pilot project, as described in
747 paragraph (d), for the purpose of demonstrating the cost-
748 effectiveness of the provision of quality mental health services
749 through a public hospital-operated managed care model. Payment
750 shall be at an agreed-upon capitated rate to ensure cost
751 savings. Of the recipients in area 11 who are assigned to
752 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
753 MediPass-enrolled recipients shall be assigned to the existing
754 provider service network in area 11 for their behavioral care.
755 ~~4. By October 1, 2003, the agency and the department shall~~

756 ~~submit a plan to the Governor, the President of the Senate, and~~
757 ~~the Speaker of the House of Representatives which provides for~~
758 ~~the full implementation of capitated prepaid behavioral health~~
759 ~~care in all areas of the state.~~
760 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
761 ~~of the state where the agency is able to establish sufficient~~
762 ~~capitation rates.~~
763 ~~b. If the agency determines that the proposed capitation~~
764 ~~rate in any area is insufficient to provide appropriate~~
765 ~~services, the agency may adjust the capitation rate to ensure~~
766 ~~that care will be available. The agency and the department may~~
767 ~~use existing general revenue to address any additional required~~
768 ~~match but may not over-obligate existing funds on an annualized~~
769 ~~basis.~~
770 ~~c. Subject to any limitations provided in the General~~
771 ~~Appropriations Act, the agency, in compliance with appropriate~~
772 ~~federal authorization, shall develop policies and procedures~~
773 ~~that allow for certification of local and state funds.~~
774 3.~~5.~~ Children residing in a statewide inpatient
775 psychiatric program, or in a Department of Juvenile Justice or a
776 Department of Children and Family Services residential program
777 approved as a Medicaid behavioral health overlay services
778 provider may not be included in a behavioral health care prepaid
779 health plan or any other Medicaid managed care plan pursuant to
780 this paragraph.
781 ~~6. In converting to a prepaid system of delivery, the~~
782 ~~agency shall in its procurement document require an entity~~
783 ~~providing only comprehensive behavioral health care services to~~

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784 ~~prevent the displacement of indigent care patients by enrollees~~
785 ~~in the Medicaid prepaid health plan providing behavioral health~~
786 ~~care services from facilities receiving state funding to provide~~
787 ~~indigent behavioral health care, to facilities licensed under~~
788 ~~chapter 395 which do not receive state funding for indigent~~
789 ~~behavioral health care, or reimburse the unsubsidized facility~~
790 ~~for the cost of behavioral health care provided to the displaced~~
791 ~~indigent care patient.~~
792 4.~~7.~~ Traditional community mental health providers under
793 contract with the Department of Children and Family Services
794 pursuant to part IV of chapter 394, child welfare providers
795 under contract with the Department of Children and Family
796 Services in areas 1 and 6, and inpatient mental health providers
797 licensed pursuant to chapter 395 must be offered an opportunity
798 to accept or decline a contract to participate in any provider
799 network for prepaid behavioral health services.
800 5.~~8.~~ All Medicaid-eligible children, except children in
801 area 1 and children in Highlands County, Hardee County, Polk
802 County, or Manatee County of area 6, that are open for child
803 welfare services in the HomeSafeNet system, shall receive their
804 behavioral health care services through a specialty prepaid plan
805 operated by community-based lead agencies through a single
806 agency or formal agreements among several agencies. The
807 specialty prepaid plan must result in savings to the state
808 comparable to savings achieved in other Medicaid managed care
809 and prepaid programs. Such plan must provide mechanisms to
810 maximize state and local revenues. The specialty prepaid plan
811 shall be developed by the agency and the Department of Children

812 and Family Services. The agency may seek federal waivers to
813 implement this initiative. Medicaid-eligible children whose
814 cases are open for child welfare services in the HomeSafeNet
815 system and who reside in AHCA area 10 are exempt from the
816 specialty prepaid plan upon the development of a service
817 delivery mechanism for children who reside in area 10 as
818 specified in s. 409.91211(3)(dd).
819
820 This paragraph expires October 1, 2013.
821 (c) A federally qualified health center or an entity owned
822 by one or more federally qualified health centers or an entity
823 owned by other migrant and community health centers receiving
824 non-Medicaid financial support from the Federal Government to
825 provide health care services on a prepaid or fixed-sum basis to
826 recipients. A federally qualified health center or an entity
827 that is owned by one or more federally qualified health centers
828 and is reimbursed by the agency on a prepaid basis is exempt
829 from parts I and III of chapter 641, but must comply with the
830 solvency requirements in s. 641.2261(2) and meet the appropriate
831 requirements governing financial reserve, quality assurance, and
832 patients' rights established by the agency. This paragraph
833 expires October 1, 2013.
834 (d)1. A provider service network may be reimbursed on a
835 fee-for-service or prepaid basis. Prepaid provider service
836 networks receive per-member per-month payments. Provider service
837 networks that do not choose to be prepaid plans shall receive
838 fee-for-service rates with a shared savings settlement. The fee-
839 for-service option shall be available to a provider service

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840 network only for the first 5 years of the plan's operation in a
841 given region or until the contract year beginning October 1,
842 2015, whichever is later. The agency shall annually conduct cost
843 reconciliations to determine the amount of cost savings achieved
844 by fee-for-service provider service networks for the dates of
845 service in the period being reconciled. Only payments for
846 covered services for dates of service within the reconciliation
847 period and paid within 6 months after the last date of service
848 in the reconciliation period shall be included. The agency shall
849 perform the necessary adjustments for the inclusion of claims
850 incurred but not reported within the reconciliation for claims
851 that could be received and paid by the agency after the 6-month
852 claims processing time lag. The agency shall provide the results
853 of the reconciliations to the fee-for-service provider service
854 networks within 45 days after the end of the reconciliation
855 period. The fee-for-service provider service networks shall
856 review and provide written comments or a letter of concurrence
857 to the agency within 45 days after receipt of the reconciliation
858 results. This reconciliation shall be considered final.
859 2. A provider service network which is reimbursed by the
860 agency on a prepaid basis shall be exempt from parts I and III
861 of chapter 641, but must comply with the solvency requirements
862 in s. 641.2261(2) and meet appropriate financial reserve,
863 quality assurance, and patient rights requirements as
864 established by the agency.
865 3. Medicaid recipients assigned to a provider service
866 network shall be chosen equally from those who would otherwise
867 have been assigned to prepaid plans and MediPass. The agency is

868 authorized to seek federal Medicaid waivers as necessary to
869 implement the provisions of this section. This subparagraph
870 expires October 1, 2013. Any contract previously awarded to a
871 provider service network operated by a hospital pursuant to this
872 subsection shall remain in effect for a period of 3 years
873 following the current contract expiration date, regardless of
874 any contractual provisions to the contrary.
875 4. A provider service network is a network established or
876 organized and operated by a health care provider, or group of
877 affiliated health care providers, including minority physician
878 networks and emergency room diversion programs that meet the
879 requirements of s. 409.91211, which provides a substantial
880 proportion of the health care items and services under a
881 contract directly through the provider or affiliated group of
882 providers and may make arrangements with physicians or other
883 health care professionals, health care institutions, or any
884 combination of such individuals or institutions to assume all or
885 part of the financial risk on a prospective basis for the
886 provision of basic health services by the physicians, by other
887 health professionals, or through the institutions. The health
888 care providers must have a controlling interest in the governing
889 body of the provider service network organization.
890 (e) An entity that provides only comprehensive behavioral
891 health care services to certain Medicaid recipients through an
892 administrative services organization agreement. Such an entity
893 must possess the clinical systems and operational competence to
894 provide comprehensive health care to Medicaid recipients. As
895 used in this paragraph, the term "comprehensive behavioral

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896 health care services" means covered mental health and substance
897 abuse treatment services that are available to Medicaid
898 recipients. Any contract awarded under this paragraph must be
899 competitively procured. The agency must ensure that Medicaid
900 recipients have available the choice of at least two managed
901 care plans for their behavioral health care services. This
902 paragraph expires October 1, 2013.
903 ~~(f) An entity that provides in-home physician services to~~
904 ~~test the cost-effectiveness of enhanced home-based medical care~~
905 ~~to Medicaid recipients with degenerative neurological diseases~~
906 ~~and other diseases or disabling conditions associated with high~~
907 ~~costs to Medicaid. The program shall be designed to serve very~~
908 ~~disabled persons and to reduce Medicaid reimbursed costs for~~
909 ~~inpatient, outpatient, and emergency department services. The~~
910 ~~agency shall contract with vendors on a risk-sharing basis.~~
911 ~~(g) Children's provider networks that provide care~~
912 ~~coordination and care management for Medicaid-eligible pediatric~~
913 ~~patients, primary care, authorization of specialty care, and~~
914 ~~other urgent and emergency care through organized providers~~
915 ~~designed to service Medicaid eligibles under age 18 and~~
916 ~~pediatric emergency departments' diversion programs. The~~
917 ~~networks shall provide after-hour operations, including evening~~
918 ~~and weekend hours, to promote, when appropriate, the use of the~~
919 ~~children's networks rather than hospital emergency departments.~~
920 (f) ~~(h)~~ An entity authorized in s. 430.205 to contract with
921 the agency and the Department of Elderly Affairs to provide
922 health care and social services on a prepaid or fixed-sum basis
923 to elderly recipients. Such prepaid health care services

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924 entities are exempt from the provisions of part I of chapter 641
925 for the first 3 years of operation. An entity recognized under
926 this paragraph that demonstrates to the satisfaction of the
927 Office of Insurance Regulation that it is backed by the full
928 faith and credit of one or more counties in which it operates
929 may be exempted from s. 641.225. This paragraph expires October
930 1, 2012.
931 (g) ~~(i)~~ A Children's Medical Services Network, as defined
932 in s. 391.021. This paragraph expires October 1, 2013.
933 ~~(5) The Agency for Health Care Administration, in~~
934 ~~partnership with the Department of Elderly Affairs, shall create~~
935 ~~an integrated, fixed-payment delivery program for Medicaid~~
936 ~~recipients who are 60 years of age or older or dually eligible~~
937 ~~for Medicare and Medicaid. The Agency for Health Care~~
938 ~~Administration shall implement the integrated program initially~~
939 ~~on a pilot basis in two areas of the state. The pilot areas~~
940 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
941 ~~Administration. Enrollment in the pilot areas shall be on a~~
942 ~~voluntary basis and in accordance with approved federal waivers~~
943 ~~and this section. The agency and its program contractors and~~
944 ~~providers shall not enroll any individual in the integrated~~
945 ~~program because the individual or the person legally responsible~~
946 ~~for the individual fails to choose to enroll in the integrated~~
947 ~~program. Enrollment in the integrated program shall be~~
948 ~~exclusively by affirmative choice of the eligible individual or~~
949 ~~by the person legally responsible for the individual. The~~
950 ~~integrated program must transfer all Medicaid services for~~
951 ~~eligible elderly individuals who choose to participate into an~~

952 ~~integrated-care management model designed to serve Medicaid~~
953 ~~recipients in the community. The integrated program must combine~~
954 ~~all funding for Medicaid services provided to individuals who~~
955 ~~are 60 years of age or older or dually eligible for Medicare and~~
956 ~~Medicaid into the integrated program, including funds for~~
957 ~~Medicaid home and community-based waiver services; all Medicaid~~
958 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
959 ~~for Medicaid nursing home services unless the agency is able to~~
960 ~~demonstrate how the integration of the funds will improve~~
961 ~~coordinated care for these services in a less costly manner; and~~
962 ~~Medicare coinsurance and deductibles for persons dually eligible~~
963 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~
964 ~~(a) Individuals who are 60 years of age or older or dually~~
965 ~~eligible for Medicare and Medicaid and enrolled in the~~
966 ~~developmental disabilities waiver program, the family and~~
967 ~~supported-living waiver program, the project AIDS care waiver~~
968 ~~program, the traumatic brain injury and spinal cord injury~~
969 ~~waiver program, the consumer-directed care waiver program, and~~
970 ~~the program of all-inclusive care for the elderly program, and~~
971 ~~residents of institutional care facilities for the~~
972 ~~developmentally disabled, must be excluded from the integrated~~
973 ~~program.~~
974 ~~(b) Managed care entities who meet or exceed the agency's~~
975 ~~minimum standards are eligible to operate the integrated~~
976 ~~program. Entities eligible to participate include managed care~~
977 ~~organizations licensed under chapter 641, including entities~~
978 ~~eligible to participate in the nursing home diversion program,~~
979 ~~other qualified providers as defined in s. 430.703(7), community~~

980 ~~care for the elderly lead agencies, and other state-certified~~
981 ~~community service networks that meet comparable standards as~~
982 ~~defined by the agency, in consultation with the Department of~~
983 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~
984 ~~financially solvent and able to take on financial risk for~~
985 ~~managed care. Community service networks that are certified~~
986 ~~pursuant to the comparable standards defined by the agency are~~
987 ~~not required to be licensed under chapter 641. Managed care~~
988 ~~entities who operate the integrated program shall be subject to~~
989 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
990 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~
991 ~~are 60 years of age or older, or both.~~
992 ~~(c) The agency must ensure that the capitation-rate-~~
993 ~~setting methodology for the integrated program is actuarially~~
994 ~~sound and reflects the intent to provide quality care in the~~
995 ~~least restrictive setting. The agency must also require~~
996 ~~integrated-program providers to develop a credentialing system~~
997 ~~for service providers and to contract with all Gold Seal nursing~~
998 ~~homes, where feasible, and exclude, where feasible, chronically~~
999 ~~poor-performing facilities and providers as defined by the~~
1000 ~~agency. The integrated program must develop and maintain an~~
1001 ~~informal provider grievance system that addresses provider~~
1002 ~~payment and contract problems. The agency shall also establish a~~
1003 ~~formal grievance system to address those issues that were not~~
1004 ~~resolved through the informal grievance system. The integrated~~
1005 ~~program must provide that if the recipient resides in a~~
1006 ~~noncontracted residential facility licensed under chapter 400 or~~
1007 ~~chapter 429 at the time of enrollment in the integrated program,~~

1008 ~~the recipient must be permitted to continue to reside in the~~
1009 ~~noncontracted facility as long as the recipient desires. The~~
1010 ~~integrated program must also provide that, in the absence of a~~
1011 ~~contract between the integrated-program provider and the~~
1012 ~~residential facility licensed under chapter 400 or chapter 429,~~
1013 ~~current Medicaid rates must prevail. The integrated-program~~
1014 ~~provider must ensure that electronic nursing home claims that~~
1015 ~~contain sufficient information for processing are paid within 10~~
1016 ~~business days after receipt. Alternately, the integrated-program~~
1017 ~~provider may establish a capitated payment mechanism to~~
1018 ~~prospectively pay nursing homes at the beginning of each month.~~
1019 ~~The agency and the Department of Elderly Affairs must jointly~~
1020 ~~develop procedures to manage the services provided through the~~
1021 ~~integrated program in order to ensure quality and recipient~~
1022 ~~choice.~~
1023 ~~(d) The Office of Program Policy Analysis and Government~~
1024 ~~Accountability, in consultation with the Auditor General, shall~~
1025 ~~comprehensively evaluate the pilot project for the integrated,~~
1026 ~~fixed-payment delivery program for Medicaid recipients created~~
1027 ~~under this subsection. The evaluation shall begin as soon as~~
1028 ~~Medicaid recipients are enrolled in the managed care pilot~~
1029 ~~program plans and shall continue for 24 months thereafter. The~~
1030 ~~evaluation must include assessments of each managed care plan in~~
1031 ~~the integrated program with regard to cost savings; consumer~~
1032 ~~education, choice, and access to services; coordination of care;~~
1033 ~~and quality of care. The evaluation must describe administrative~~
1034 ~~or legal barriers to the implementation and operation of the~~
1035 ~~pilot program and include recommendations regarding statewide~~

1036 ~~expansion of the pilot program. The office shall submit its~~
1037 ~~evaluation report to the Governor, the President of the Senate,~~
1038 ~~and the Speaker of the House of Representatives no later than~~
1039 ~~December 31, 2009.~~
1040 ~~(e) The agency may seek federal waivers or Medicaid state~~
1041 ~~plan amendments and adopt rules as necessary to administer the~~
1042 ~~integrated program. The agency may implement the approved~~
1043 ~~federal waivers and other provisions as specified in this~~
1044 ~~subsection.~~
1045 ~~(f) No later than December 31, 2007, the agency shall~~
1046 ~~provide a report to the Governor, the President of the Senate,~~
1047 ~~and the Speaker of the House of Representatives containing an~~
1048 ~~analysis of the merits and challenges of seeking a waiver to~~
1049 ~~implement a voluntary program that integrates payments and~~
1050 ~~services for dually enrolled Medicare and Medicaid recipients~~
1051 ~~who are 65 years of age or older.~~
1052 ~~(g) The implementation of the integrated, fixed-payment~~
1053 ~~delivery program created under this subsection is subject to an~~
1054 ~~appropriation in the General Appropriations Act.~~
1055 (5) ~~(6)~~ The agency may contract with any public or private
1056 entity otherwise authorized by this section on a prepaid or
1057 fixed-sum basis for the provision of health care services to
1058 recipients. An entity may provide prepaid services to
1059 recipients, either directly or through arrangements with other
1060 entities, if each entity involved in providing services:
1061 (a) Is organized primarily for the purpose of providing
1062 health care or other services of the type regularly offered to
1063 Medicaid recipients;

1064 (b) Ensures that services meet the standards set by the
1065 agency for quality, appropriateness, and timeliness;
1066 (c) Makes provisions satisfactory to the agency for
1067 insolvency protection and ensures that neither enrolled Medicaid
1068 recipients nor the agency will be liable for the debts of the
1069 entity;
1070 (d) Submits to the agency, if a private entity, a
1071 financial plan that the agency finds to be fiscally sound and
1072 that provides for working capital in the form of cash or
1073 equivalent liquid assets excluding revenues from Medicaid
1074 premium payments equal to at least the first 3 months of
1075 operating expenses or $200,000, whichever is greater;
1076 (e) Furnishes evidence satisfactory to the agency of
1077 adequate liability insurance coverage or an adequate plan of
1078 self-insurance to respond to claims for injuries arising out of
1079 the furnishing of health care;
1080 (f) Provides, through contract or otherwise, for periodic
1081 review of its medical facilities and services, as required by
1082 the agency; and
1083 (g) Provides organizational, operational, financial, and
1084 other information required by the agency.
1085
1086 This subsection expires October 1, 2013.
1087 (6) (7) The agency may contract on a prepaid or fixed-sum
1088 basis with any health insurer that:
1089 (a) Pays for health care services provided to enrolled
1090 Medicaid recipients in exchange for a premium payment paid by
1091 the agency;

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1092 (b) Assumes the underwriting risk; and
1093 (c) Is organized and licensed under applicable provisions
1094 of the Florida Insurance Code and is currently in good standing
1095 with the Office of Insurance Regulation.
1096
1097 This subsection expires October 1, 2013.
1098 (7) ~~(8)(a)~~ The agency may contract on a prepaid or fixed-
1099 sum basis with an exclusive provider organization to provide
1100 health care services to Medicaid recipients provided that the
1101 exclusive provider organization meets applicable managed care
1102 plan requirements in this section, ss. 409.9122, 409.9123,
1103 409.9128, and 627.6472, and other applicable provisions of law.
1104 This subsection expires October 1, 2013.
1105 ~~(b) For a period of no longer than 24 months after the~~
1106 ~~effective date of this paragraph, when a member of an exclusive~~
1107 ~~provider organization that is contracted by the agency to~~
1108 ~~provide health care services to Medicaid recipients in rural~~
1109 ~~areas without a health maintenance organization obtains services~~
1110 ~~from a provider that participates in the Medicaid program in~~
1111 ~~this state, the provider shall be paid in accordance with the~~
1112 ~~appropriate fee schedule for services provided to eligible~~
1113 ~~Medicaid recipients. The agency may seek waiver authority to~~
1114 ~~implement this paragraph.~~
1115 (8) ~~(9)~~ The Agency for Health Care Administration may
1116 provide cost-effective purchasing of chiropractic services on a
1117 fee-for-service basis to Medicaid recipients through
1118 arrangements with a statewide chiropractic preferred provider
1119 organization incorporated in this state as a not-for-profit

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1120 corporation. The agency shall ensure that the benefit limits and
1121 prior authorization requirements in the current Medicaid program
1122 shall apply to the services provided by the chiropractic
1123 preferred provider organization. This subsection expires October
1124 1, 2013.
1125 (9) ~~(10)~~ The agency shall not contract on a prepaid or
1126 fixed-sum basis for Medicaid services with an entity which knows
1127 or reasonably should know that any officer, director, agent,
1128 managing employee, or owner of stock or beneficial interest in
1129 excess of 5 percent common or preferred stock, or the entity
1130 itself, has been found guilty of, regardless of adjudication, or
1131 entered a plea of nolo contendere, or guilty, to:
1132 (a) Fraud;
1133 (b) Violation of federal or state antitrust statutes,
1134 including those proscribing price fixing between competitors and
1135 the allocation of customers among competitors;
1136 (c) Commission of a felony involving embezzlement, theft,
1137 forgery, income tax evasion, bribery, falsification or
1138 destruction of records, making false statements, receiving
1139 stolen property, making false claims, or obstruction of justice;
1140 or
1141 (d) Any crime in any jurisdiction which directly relates
1142 to the provision of health services on a prepaid or fixed-sum
1143 basis.
1144
1145 This subsection expires October 1, 2013.
1146 (10) ~~(11)~~ The agency, after notifying the Legislature, may
1147 apply for waivers of applicable federal laws and regulations as

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1148 necessary to implement more appropriate systems of health care
1149 for Medicaid recipients and reduce the cost of the Medicaid
1150 program to the state and federal governments and shall implement
1151 such programs, after legislative approval, within a reasonable
1152 period of time after federal approval. These programs must be
1153 designed primarily to reduce the need for inpatient care,
1154 custodial care and other long-term or institutional care, and
1155 other high-cost services. Prior to seeking legislative approval
1156 of such a waiver as authorized by this subsection, the agency
1157 shall provide notice and an opportunity for public comment.
1158 Notice shall be provided to all persons who have made requests
1159 of the agency for advance notice and shall be published in the
1160 Florida Administrative Weekly not less than 28 days prior to the
1161 intended action. This subsection expires October 1, 2015.
1162 (11) ~~(12)~~ The agency shall establish a postpayment
1163 utilization control program designed to identify recipients who
1164 may inappropriately overuse or underuse Medicaid services and
1165 shall provide methods to correct such misuse. This subsection
1166 expires October 1, 2013.
1167 (12) ~~(13)~~ The agency shall develop and provide coordinated
1168 systems of care for Medicaid recipients and may contract with
1169 public or private entities to develop and administer such
1170 systems of care among public and private health care providers
1171 in a given geographic area. This subsection expires October 1,
1172 2013.
1173 (13) ~~(14)(a)~~ The agency shall operate or contract for the
1174 operation of utilization management and incentive systems
1175 designed to encourage cost-effective use of services and to

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1176 eliminate services that are medically unnecessary. The agency
1177 shall track Medicaid provider prescription and billing patterns
1178 and evaluate them against Medicaid medical necessity criteria
1179 and coverage and limitation guidelines adopted by rule. Medical
1180 necessity determination requires that service be consistent with
1181 symptoms or confirmed diagnosis of illness or injury under
1182 treatment and not in excess of the patient's needs. The agency
1183 shall conduct reviews of provider exceptions to peer group norms
1184 and shall, using statistical methodologies, provider profiling,
1185 and analysis of billing patterns, detect and investigate
1186 abnormal or unusual increases in billing or payment of claims
1187 for Medicaid services and medically unnecessary provision of
1188 services. Providers that demonstrate a pattern of submitting
1189 claims for medically unnecessary services shall be referred to
1190 the Medicaid program integrity unit for investigation. In its
1191 annual report, required in s. 409.913, the agency shall report
1192 on its efforts to control overutilization as described in this
1193 subsection ~~paragraph~~. This subsection expires October 1, 2013.
1194 ~~(b) The agency shall develop a procedure for determining~~
1195 ~~whether health care providers and service vendors can provide~~
1196 ~~the Medicaid program using a business case that demonstrates~~
1197 ~~whether a particular good or service can offset the cost of~~
1198 ~~providing the good or service in an alternative setting or~~
1199 ~~through other means and therefore should receive a higher~~
1200 ~~reimbursement. The business case must include, but need not be~~
1201 ~~limited to:~~
1202 ~~1. A detailed description of the good or service to be~~
1203 ~~provided, a description and analysis of the agency's current~~

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1204 ~~performance of the service, and a rationale documenting how~~
1205 ~~providing the service in an alternative setting would be in the~~
1206 ~~best interest of the state, the agency, and its clients.~~
1207 ~~2. A cost-benefit analysis documenting the estimated~~
1208 ~~specific direct and indirect costs, savings, performance~~
1209 ~~improvements, risks, and qualitative and quantitative benefits~~
1210 ~~involved in or resulting from providing the service. The cost-~~
1211 ~~benefit analysis must include a detailed plan and timeline~~
1212 ~~identifying all actions that must be implemented to realize~~
1213 ~~expected benefits. The Secretary of Health Care Administration~~
1214 ~~shall verify that all costs, savings, and benefits are valid and~~
1215 ~~achievable.~~
1216 ~~(c) If the agency determines that the increased~~
1217 ~~reimbursement is cost-effective, the agency shall recommend a~~
1218 ~~change in the reimbursement schedule for that particular good or~~
1219 ~~service. If, within 12 months after implementing any rate change~~
1220 ~~under this procedure, the agency determines that costs were not~~
1221 ~~offset by the increased reimbursement schedule, the agency may~~
1222 ~~revert to the former reimbursement schedule for the particular~~
1223 ~~good or service.~~
1224 (14) ~~(15)~~(a) The agency shall operate the Comprehensive
1225 Assessment and Review for Long-Term Care Services (CARES)
1226 nursing facility preadmission screening program to ensure that
1227 Medicaid payment for nursing facility care is made only for
1228 individuals whose conditions require such care and to ensure
1229 that long-term care services are provided in the setting most
1230 appropriate to the needs of the person and in the most
1231 economical manner possible. The CARES program shall also ensure

1232 that individuals participating in Medicaid home and community-
1233 based waiver programs meet criteria for those programs,
1234 consistent with approved federal waivers.
1235 (b) The agency shall operate the CARES program through an
1236 interagency agreement with the Department of Elderly Affairs.
1237 The agency, in consultation with the Department of Elderly
1238 Affairs, may contract for any function or activity of the CARES
1239 program, including any function or activity required by 42
1240 C.F.R. part 483.20, relating to preadmission screening and
1241 resident review.
1242 (c) Prior to making payment for nursing facility services
1243 for a Medicaid recipient, the agency must verify that the
1244 nursing facility preadmission screening program has determined
1245 that the individual requires nursing facility care and that the
1246 individual cannot be safely served in community-based programs.
1247 The nursing facility preadmission screening program shall refer
1248 a Medicaid recipient to a community-based program if the
1249 individual could be safely served at a lower cost and the
1250 recipient chooses to participate in such program. For
1251 individuals whose nursing home stay is initially funded by
1252 Medicare and Medicare coverage is being terminated for lack of
1253 progress towards rehabilitation, CARES staff shall consult with
1254 the person making the determination of progress toward
1255 rehabilitation to ensure that the recipient is not being
1256 inappropriately disqualified from Medicare coverage. If, in
1257 their professional judgment, CARES staff believes that a
1258 Medicare beneficiary is still making progress toward
1259 rehabilitation, they may assist the Medicare beneficiary with an

1260 appeal of the disqualification from Medicare coverage. The use
1261 of CARES teams to review Medicare denials for coverage under
1262 this section is authorized only if it is determined that such
1263 reviews qualify for federal matching funds through Medicaid. The
1264 agency shall seek or amend federal waivers as necessary to
1265 implement this section.
1266 (d) For the purpose of initiating immediate prescreening
1267 and diversion assistance for individuals residing in nursing
1268 homes and in order to make families aware of alternative long-
1269 term care resources so that they may choose a more cost-
1270 effective setting for long-term placement, CARES staff shall
1271 conduct an assessment and review of a sample of individuals
1272 whose nursing home stay is expected to exceed 20 days,
1273 regardless of the initial funding source for the nursing home
1274 placement. CARES staff shall provide counseling and referral
1275 services to these individuals regarding choosing appropriate
1276 long-term care alternatives. This paragraph does not apply to
1277 continuing care facilities licensed under chapter 651 or to
1278 retirement communities that provide a combination of nursing
1279 home, independent living, and other long-term care services.
1280 (e) By January 15 of each year, the agency shall submit a
1281 report to the Legislature describing the operations of the CARES
1282 program. The report must describe:
1283 1. Rate of diversion to community alternative programs;
1284 2. CARES program staffing needs to achieve additional
1285 diversions;
1286 3. Reasons the program is unable to place individuals in
1287 less restrictive settings when such individuals desired such

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1288 services and could have been served in such settings;
1289 4. Barriers to appropriate placement, including barriers
1290 due to policies or operations of other agencies or state-funded
1291 programs; and
1292 5. Statutory changes necessary to ensure that individuals
1293 in need of long-term care services receive care in the least
1294 restrictive environment.
1295 (f) The Department of Elderly Affairs shall track
1296 individuals over time who are assessed under the CARES program
1297 and who are diverted from nursing home placement. By January 15
1298 of each year, the department shall submit to the Legislature a
1299 longitudinal study of the individuals who are diverted from
1300 nursing home placement. The study must include:
1301 1. The demographic characteristics of the individuals
1302 assessed and diverted from nursing home placement, including,
1303 but not limited to, age, race, gender, frailty, caregiver
1304 status, living arrangements, and geographic location;
1305 2. A summary of community services provided to individuals
1306 for 1 year after assessment and diversion;
1307 3. A summary of inpatient hospital admissions for
1308 individuals who have been diverted; and
1309 4. A summary of the length of time between diversion and
1310 subsequent entry into a nursing home or death.
1311 ~~(g) By July 1, 2005, the department and the Agency for~~
1312 ~~Health Care Administration shall report to the President of the~~
1313 ~~Senate and the Speaker of the House of Representatives regarding~~
1314 ~~the impact to the state of modifying level-of-care criteria to~~
1315 ~~eliminate the Intermediate II level of care.~~

1316

1317 This subsection expires October 1, 2012.

1318 (15) ~~(16)~~ (a) The agency shall identify health care
1319 utilization and price patterns within the Medicaid program which
1320 are not cost-effective or medically appropriate and assess the
1321 effectiveness of new or alternate methods of providing and
1322 monitoring service, and may implement such methods as it
1323 considers appropriate. Such methods may include disease
1324 management initiatives, an integrated and systematic approach
1325 for managing the health care needs of recipients who are at risk
1326 of or diagnosed with a specific disease by using best practices,
1327 prevention strategies, clinical-practice improvement, clinical
1328 interventions and protocols, outcomes research, information
1329 technology, and other tools and resources to reduce overall
1330 costs and improve measurable outcomes.

1331 (b) The responsibility of the agency under this subsection
1332 shall include the development of capabilities to identify actual
1333 and optimal practice patterns; patient and provider educational
1334 initiatives; methods for determining patient compliance with
1335 prescribed treatments; fraud, waste, and abuse prevention and
1336 detection programs; and beneficiary case management programs.

1337 1. The practice pattern identification program shall
1338 evaluate practitioner prescribing patterns based on national and
1339 regional practice guidelines, comparing practitioners to their
1340 peer groups. The agency and its Drug Utilization Review Board
1341 shall consult with the Department of Health and a panel of
1342 practicing health care professionals consisting of the
1343 following: the Speaker of the House of Representatives and the

1344 President of the Senate shall each appoint three physicians
1345 licensed under chapter 458 or chapter 459; and the Governor
1346 shall appoint two pharmacists licensed under chapter 465 and one
1347 dentist licensed under chapter 466 who is an oral surgeon. Terms
1348 of the panel members shall expire at the discretion of the
1349 appointing official. The advisory panel shall be responsible for
1350 evaluating treatment guidelines and recommending ways to
1351 incorporate their use in the practice pattern identification
1352 program. Practitioners who are prescribing inappropriately or
1353 inefficiently, as determined by the agency, may have their
1354 prescribing of certain drugs subject to prior authorization or
1355 may be terminated from all participation in the Medicaid
1356 program.

1357 2. The agency shall also develop educational interventions
1358 designed to promote the proper use of medications by providers
1359 and beneficiaries.

1360 3. The agency shall implement a pharmacy fraud, waste, and
1361 abuse initiative that may include a surety bond or letter of
1362 credit requirement for participating pharmacies, enhanced
1363 provider auditing practices, the use of additional fraud and
1364 abuse software, recipient management programs for beneficiaries
1365 inappropriately using their benefits, and other steps that will
1366 eliminate provider and recipient fraud, waste, and abuse. The
1367 initiative shall address enforcement efforts to reduce the
1368 number and use of counterfeit prescriptions.

1369 4. By September 30, 2002, the agency shall contract with
1370 an entity in the state to implement a wireless handheld clinical
1371 pharmacology drug information database for practitioners. The

1372 initiative shall be designed to enhance the agency's efforts to
1373 reduce fraud, abuse, and errors in the prescription drug benefit
1374 program and to otherwise further the intent of this paragraph.
1375 5. By April 1, 2006, the agency shall contract with an
1376 entity to design a database of clinical utilization information
1377 or electronic medical records for Medicaid providers. This
1378 system must be web-based and allow providers to review on a
1379 real-time basis the utilization of Medicaid services, including,
1380 but not limited to, physician office visits, inpatient and
1381 outpatient hospitalizations, laboratory and pathology services,
1382 radiological and other imaging services, dental care, and
1383 patterns of dispensing prescription drugs in order to coordinate
1384 care and identify potential fraud and abuse.
1385 6. The agency may apply for any federal waivers needed to
1386 administer this paragraph.
1387
1388 This subsection expires October 1, 2013.
1389 (16) (17) An entity contracting on a prepaid or fixed-sum
1390 basis shall meet the surplus requirements of s. 641.225. If an
1391 entity's surplus falls below an amount equal to the surplus
1392 requirements of s. 641.225, the agency shall prohibit the entity
1393 from engaging in marketing and preenrollment activities, shall
1394 cease to process new enrollments, and may not renew the entity's
1395 contract until the required balance is achieved. The
1396 requirements of this subsection do not apply:
1397 (a) Where a public entity agrees to fund any deficit
1398 incurred by the contracting entity; or
1399 (b) Where the entity's performance and obligations are

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1400 guaranteed in writing by a guaranteeing organization which:
1401 1. Has been in operation for at least 5 years and has
1402 assets in excess of $50 million; or
1403 2. Submits a written guarantee acceptable to the agency
1404 which is irrevocable during the term of the contracting entity's
1405 contract with the agency and, upon termination of the contract,
1406 until the agency receives proof of satisfaction of all
1407 outstanding obligations incurred under the contract.
1408
1409 This subsection expires October 1, 2013.
1410 (17) ~~(18)~~ (a) The agency may require an entity contracting
1411 on a prepaid or fixed-sum basis to establish a restricted
1412 insolvency protection account with a federally guaranteed
1413 financial institution licensed to do business in this state. The
1414 entity shall deposit into that account 5 percent of the
1415 capitation payments made by the agency each month until a
1416 maximum total of 2 percent of the total current contract amount
1417 is reached. The restricted insolvency protection account may be
1418 drawn upon with the authorized signatures of two persons
1419 designated by the entity and two representatives of the agency.
1420 If the agency finds that the entity is insolvent, the agency may
1421 draw upon the account solely with the two authorized signatures
1422 of representatives of the agency, and the funds may be disbursed
1423 to meet financial obligations incurred by the entity under the
1424 prepaid contract. If the contract is terminated, expired, or not
1425 continued, the account balance must be released by the agency to
1426 the entity upon receipt of proof of satisfaction of all
1427 outstanding obligations incurred under this contract.

1428 (b) The agency may waive the insolvency protection account
1429 requirement in writing when evidence is on file with the agency
1430 of adequate insolvency insurance and reinsurance that will
1431 protect enrollees if the entity becomes unable to meet its
1432 obligations.
1433
1434 This subsection expires October 1, 2013.
1435 (18) ~~(19)~~ An entity that contracts with the agency on a
1436 prepaid or fixed-sum basis for the provision of Medicaid
1437 services shall reimburse any hospital or physician that is
1438 outside the entity's authorized geographic service area as
1439 specified in its contract with the agency, and that provides
1440 services authorized by the entity to its members, at a rate
1441 negotiated with the hospital or physician for the provision of
1442 services or according to the lesser of the following:
1443 (a) The usual and customary charges made to the general
1444 public by the hospital or physician; or
1445 (b) The Florida Medicaid reimbursement rate established
1446 for the hospital or physician.
1447
1448 This subsection expires October 1, 2013.
1449 (19) ~~(20)~~ When a merger or acquisition of a Medicaid
1450 prepaid contractor has been approved by the Office of Insurance
1451 Regulation pursuant to s. 628.4615, the agency shall approve the
1452 assignment or transfer of the appropriate Medicaid prepaid
1453 contract upon request of the surviving entity of the merger or
1454 acquisition if the contractor and the other entity have been in
1455 good standing with the agency for the most recent 12-month

1456 period, unless the agency determines that the assignment or
1457 transfer would be detrimental to the Medicaid recipients or the
1458 Medicaid program. To be in good standing, an entity must not
1459 have failed accreditation or committed any material violation of
1460 the requirements of s. 641.52 and must meet the Medicaid
1461 contract requirements. For purposes of this section, a merger or
1462 acquisition means a change in controlling interest of an entity,
1463 including an asset or stock purchase. This subsection expires
1464 October 1, 2013.
1465 (20) ~~(21)~~ Any entity contracting with the agency pursuant
1466 to this section to provide health care services to Medicaid
1467 recipients is prohibited from engaging in any of the following
1468 practices or activities:
1469 (a) Practices that are discriminatory, including, but not
1470 limited to, attempts to discourage participation on the basis of
1471 actual or perceived health status.
1472 (b) Activities that could mislead or confuse recipients,
1473 or misrepresent the organization, its marketing representatives,
1474 or the agency. Violations of this paragraph include, but are not
1475 limited to:
1476 1. False or misleading claims that marketing
1477 representatives are employees or representatives of the state or
1478 county, or of anyone other than the entity or the organization
1479 by whom they are reimbursed.
1480 2. False or misleading claims that the entity is
1481 recommended or endorsed by any state or county agency, or by any
1482 other organization which has not certified its endorsement in
1483 writing to the entity.

1484 3. False or misleading claims that the state or county
1485 recommends that a Medicaid recipient enroll with an entity.
1486 4. Claims that a Medicaid recipient will lose benefits
1487 under the Medicaid program, or any other health or welfare
1488 benefits to which the recipient is legally entitled, if the
1489 recipient does not enroll with the entity.
1490 (c) Granting or offering of any monetary or other valuable
1491 consideration for enrollment, except as authorized by subsection
1492 (23) ~~(24)~~.
1493 (d) Door-to-door solicitation of recipients who have not
1494 contacted the entity or who have not invited the entity to make
1495 a presentation.
1496 (e) Solicitation of Medicaid recipients by marketing
1497 representatives stationed in state offices unless approved and
1498 supervised by the agency or its agent and approved by the
1499 affected state agency when solicitation occurs in an office of
1500 the state agency. The agency shall ensure that marketing
1501 representatives stationed in state offices shall market their
1502 managed care plans to Medicaid recipients only in designated
1503 areas and in such a way as to not interfere with the recipients'
1504 activities in the state office.
1505 (f) Enrollment of Medicaid recipients.
1506
1507 This subsection expires October 1, 2013.
1508 (21) ~~(22)~~ The agency may impose a fine for a violation of
1509 this section or the contract with the agency by a person or
1510 entity that is under contract with the agency. With respect to
1511 any nonwillful violation, such fine shall not exceed $2,500 per

1512 violation. In no event shall such fine exceed an aggregate
1513 amount of $10,000 for all nonwillful violations arising out of
1514 the same action. With respect to any knowing and willful
1515 violation of this section or the contract with the agency, the
1516 agency may impose a fine upon the entity in an amount not to
1517 exceed $20,000 for each such violation. In no event shall such
1518 fine exceed an aggregate amount of $100,000 for all knowing and
1519 willful violations arising out of the same action. This
1520 subsection expires October 1, 2013.
1521 (22) (23) A health maintenance organization or a person or
1522 entity exempt from chapter 641 that is under contract with the
1523 agency for the provision of health care services to Medicaid
1524 recipients may not use or distribute marketing materials used to
1525 solicit Medicaid recipients, unless such materials have been
1526 approved by the agency. The provisions of this subsection do not
1527 apply to general advertising and marketing materials used by a
1528 health maintenance organization to solicit both non-Medicaid
1529 subscribers and Medicaid recipients. This subsection expires
1530 October 1, 2013.
1531 (23) (24) Upon approval by the agency, health maintenance
1532 organizations and persons or entities exempt from chapter 641
1533 that are under contract with the agency for the provision of
1534 health care services to Medicaid recipients may be permitted
1535 within the capitation rate to provide additional health benefits
1536 that the agency has found are of high quality, are practicably
1537 available, provide reasonable value to the recipient, and are
1538 provided at no additional cost to the state. This subsection
1539 expires October 1, 2013.

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1540 (24) ~~(25)~~ The agency shall utilize the statewide health
1541 maintenance organization complaint hotline for the purpose of
1542 investigating and resolving Medicaid and prepaid health plan
1543 complaints, maintaining a record of complaints and confirmed
1544 problems, and receiving disenrollment requests made by
1545 recipients. This subsection expires October 1, 2013.
1546 (25) ~~(26)~~ The agency shall require the publication of the
1547 health maintenance organization's and the prepaid health plan's
1548 consumer services telephone numbers and the "800" telephone
1549 number of the statewide health maintenance organization
1550 complaint hotline on each Medicaid identification card issued by
1551 a health maintenance organization or prepaid health plan
1552 contracting with the agency to serve Medicaid recipients and on
1553 each subscriber handbook issued to a Medicaid recipient. This
1554 subsection expires October 1, 2013.
1555 (26) ~~(27)~~ The agency shall establish a health care quality
1556 improvement system for those entities contracting with the
1557 agency pursuant to this section, incorporating all the standards
1558 and guidelines developed by the Medicaid Bureau of the Health
1559 Care Financing Administration as a part of the quality assurance
1560 reform initiative. The system shall include, but need not be
1561 limited to, the following:
1562 (a) Guidelines for internal quality assurance programs,
1563 including standards for:
1564 1. Written quality assurance program descriptions.
1565 2. Responsibilities of the governing body for monitoring,
1566 evaluating, and making improvements to care.
1567 3. An active quality assurance committee.

1568 4. Quality assurance program supervision.
1569 5. Requiring the program to have adequate resources to
1570 effectively carry out its specified activities.
1571 6. Provider participation in the quality assurance
1572 program.
1573 7. Delegation of quality assurance program activities.
1574 8. Credentialing and recredentialing.
1575 9. Enrollee rights and responsibilities.
1576 10. Availability and accessibility to services and care.
1577 11. Ambulatory care facilities.
1578 12. Accessibility and availability of medical records, as
1579 well as proper recordkeeping and process for record review.
1580 13. Utilization review.
1581 14. A continuity of care system.
1582 15. Quality assurance program documentation.
1583 16. Coordination of quality assurance activity with other
1584 management activity.
1585 17. Delivering care to pregnant women and infants; to
1586 elderly and disabled recipients, especially those who are at
1587 risk of institutional placement; to persons with developmental
1588 disabilities; and to adults who have chronic, high-cost medical
1589 conditions.
1590 (b) Guidelines which require the entities to conduct
1591 quality-of-care studies which:
1592 1. Target specific conditions and specific health service
1593 delivery issues for focused monitoring and evaluation.
1594 2. Use clinical care standards or practice guidelines to
1595 objectively evaluate the care the entity delivers or fails to

1596 deliver for the targeted clinical conditions and health services
1597 delivery issues.
1598 3. Use quality indicators derived from the clinical care
1599 standards or practice guidelines to screen and monitor care and
1600 services delivered.
1601 (c) Guidelines for external quality review of each
1602 contractor which require: focused studies of patterns of care;
1603 individual care review in specific situations; and followup
1604 activities on previous pattern-of-care study findings and
1605 individual-care-review findings. In designing the external
1606 quality review function and determining how it is to operate as
1607 part of the state's overall quality improvement system, the
1608 agency shall construct its external quality review organization
1609 and entity contracts to address each of the following:
1610 1. Delineating the role of the external quality review
1611 organization.
1612 2. Length of the external quality review organization
1613 contract with the state.
1614 3. Participation of the contracting entities in designing
1615 external quality review organization review activities.
1616 4. Potential variation in the type of clinical conditions
1617 and health services delivery issues to be studied at each plan.
1618 5. Determining the number of focused pattern-of-care
1619 studies to be conducted for each plan.
1620 6. Methods for implementing focused studies.
1621 7. Individual care review.
1622 8. Followup activities.
1623

1624 This subsection expires October 1, 2015.
1625 (27) ~~(28)~~ In order to ensure that children receive health
1626 care services for which an entity has already been compensated,
1627 an entity contracting with the agency pursuant to this section
1628 shall achieve an annual Early and Periodic Screening, Diagnosis,
1629 and Treatment (EPSDT) Service screening rate of at least 60
1630 percent for those recipients continuously enrolled for at least
1631 8 months. The agency shall develop a method by which the EPSDT
1632 screening rate shall be calculated. For any entity which does
1633 not achieve the annual 60 percent rate, the entity must submit a
1634 corrective action plan for the agency's approval. If the entity
1635 does not meet the standard established in the corrective action
1636 plan during the specified timeframe, the agency is authorized to
1637 impose appropriate contract sanctions. At least annually, the
1638 agency shall publicly release the EPSDT Services screening rates
1639 of each entity it has contracted with on a prepaid basis to
1640 serve Medicaid recipients. This subsection expires October 1,
1641 2013.
1642 (28) ~~(29)~~ The agency shall perform enrollments and
1643 disenrollments for Medicaid recipients who are eligible for
1644 MediPass or managed care plans. Notwithstanding the prohibition
1645 contained in paragraph (20) ~~(21)~~ (f), managed care plans may
1646 perform preenrollments of Medicaid recipients under the
1647 supervision of the agency or its agents. For the purposes of
1648 this section, "preenrollment" means the provision of marketing
1649 and educational materials to a Medicaid recipient and assistance
1650 in completing the application forms, but shall not include
1651 actual enrollment into a managed care plan. An application for

1652 enrollment shall not be deemed complete until the agency or its
1653 agent verifies that the recipient made an informed, voluntary
1654 choice. The agency, in cooperation with the Department of
1655 Children and Family Services, may test new marketing initiatives
1656 to inform Medicaid recipients about their managed care options
1657 at selected sites. The agency shall report to the Legislature on
1658 the effectiveness of such initiatives. The agency may contract
1659 with a third party to perform managed care plan and MediPass
1660 enrollment and disenrollment services for Medicaid recipients
1661 and is authorized to adopt rules to implement such services. The
1662 agency may adjust the capitation rate only to cover the costs of
1663 a third-party enrollment and disenrollment contract, and for
1664 agency supervision and management of the managed care plan
1665 enrollment and disenrollment contract. This subsection expires
1666 October 1, 2013.
1667 (29) (30) Any lists of providers made available to Medicaid
1668 recipients, MediPass enrollees, or managed care plan enrollees
1669 shall be arranged alphabetically showing the provider's name and
1670 specialty and, separately, by specialty in alphabetical order.
1671 This subsection expires October 1, 2013.
1672 (30) (31) The agency shall establish an enhanced managed
1673 care quality assurance oversight function, to include at least
1674 the following components:
1675 (a) At least quarterly analysis and followup, including
1676 sanctions as appropriate, of managed care participant
1677 utilization of services.
1678 (b) At least quarterly analysis and followup, including
1679 sanctions as appropriate, of quality findings of the Medicaid

1680 peer review organization and other external quality assurance
1681 programs.
1682 (c) At least quarterly analysis and followup, including
1683 sanctions as appropriate, of the fiscal viability of managed
1684 care plans.
1685 (d) At least quarterly analysis and followup, including
1686 sanctions as appropriate, of managed care participant
1687 satisfaction and disenrollment surveys.
1688 (e) The agency shall conduct regular and ongoing Medicaid
1689 recipient satisfaction surveys.
1690
1691 The analyses and followup activities conducted by the agency
1692 under its enhanced managed care quality assurance oversight
1693 function shall not duplicate the activities of accreditation
1694 reviewers for entities regulated under part III of chapter 641,
1695 but may include a review of the finding of such reviewers. This
1696 subsection expires October 1, 2013.
1697 (31) ~~(32)~~ Each managed care plan that is under contract
1698 with the agency to provide health care services to Medicaid
1699 recipients shall annually conduct a background check with the
1700 Florida Department of Law Enforcement of all persons with
1701 ownership interest of 5 percent or more or executive management
1702 responsibility for the managed care plan and shall submit to the
1703 agency information concerning any such person who has been found
1704 guilty of, regardless of adjudication, or has entered a plea of
1705 nolo contendere or guilty to, any of the offenses listed in s.
1706 435.03. This subsection expires October 1, 2013.
1707 (32) ~~(33)~~ The agency shall, by rule, develop a process

1708 whereby a Medicaid managed care plan enrollee who wishes to
1709 enter hospice care may be disenrolled from the managed care plan
1710 within 24 hours after contacting the agency regarding such
1711 request. The agency rule shall include a methodology for the
1712 agency to recoup managed care plan payments on a pro rata basis
1713 if payment has been made for the enrollment month when
1714 disenrollment occurs. This subsection expires October 1, 2013.
1715 (33) ~~(34)~~ The agency and entities that contract with the
1716 agency to provide health care services to Medicaid recipients
1717 under this section or ss. 409.91211 and 409.9122 must comply
1718 with the provisions of s. 641.513 in providing emergency
1719 services and care to Medicaid recipients and MediPass
1720 recipients. Where feasible, safe, and cost-effective, the agency
1721 shall encourage hospitals, emergency medical services providers,
1722 and other public and private health care providers to work
1723 together in their local communities to enter into agreements or
1724 arrangements to ensure access to alternatives to emergency
1725 services and care for those Medicaid recipients who need
1726 nonemergent care. The agency shall coordinate with hospitals,
1727 emergency medical services providers, private health plans,
1728 capitated managed care networks as established in s. 409.91211,
1729 and other public and private health care providers to implement
1730 the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
1731 and 641.31097 to develop and implement emergency department
1732 diversion programs for Medicaid recipients. This subsection
1733 expires October 1, 2013.
1734 (34) ~~(35)~~ All entities providing health care services to
1735 Medicaid recipients shall make available, and encourage all

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1736 pregnant women and mothers with infants to receive, and provide
1737 documentation in the medical records to reflect, the following:
1738 (a) Healthy Start prenatal or infant screening.
1739 (b) Healthy Start care coordination, when screening or
1740 other factors indicate need.
1741 (c) Healthy Start enhanced services in accordance with the
1742 prenatal or infant screening results.
1743 (d) Immunizations in accordance with recommendations of
1744 the Advisory Committee on Immunization Practices of the United
1745 States Public Health Service and the American Academy of
1746 Pediatrics, as appropriate.
1747 (e) Counseling and services for family planning to all
1748 women and their partners.
1749 (f) A scheduled postpartum visit for the purpose of
1750 voluntary family planning, to include discussion of all methods
1751 of contraception, as appropriate.
1752 (g) Referral to the Special Supplemental Nutrition Program
1753 for Women, Infants, and Children (WIC).
1754
1755 This subsection expires October 1, 2013.
1756 (35) ~~(36)~~ Any entity that provides Medicaid prepaid health
1757 plan services shall ensure the appropriate coordination of
1758 health care services with an assisted living facility in cases
1759 where a Medicaid recipient is both a member of the entity's
1760 prepaid health plan and a resident of the assisted living
1761 facility. If the entity is at risk for Medicaid targeted case
1762 management and behavioral health services, the entity shall
1763 inform the assisted living facility of the procedures to follow

1764 should an emergent condition arise. This subsection expires
1765 October 1, 2013.
1766 ~~(37) The agency may seek and implement federal waivers~~
1767 ~~necessary to provide for cost-effective purchasing of home~~
1768 ~~health services, private duty nursing services, transportation,~~
1769 ~~independent laboratory services, and durable medical equipment~~
1770 ~~and supplies through competitive bidding pursuant to s. 287.057.~~
1771 ~~The agency may request appropriate waivers from the federal~~
1772 ~~Health Care Financing Administration in order to competitively~~
1773 ~~bid such services. The agency may exclude providers not selected~~
1774 ~~through the bidding process from the Medicaid provider network.~~
1775 (36) ~~(38)~~ The agency shall enter into agreements with not-
1776 for-profit organizations based in this state for the purpose of
1777 providing vision screening. This subsection expires October 1,
1778 2013.
1779 (37) ~~(39)~~(a) The agency shall implement a Medicaid
1780 prescribed-drug spending-control program that includes the
1781 following components:
1782 1. A Medicaid preferred drug list, which shall be a
1783 listing of cost-effective therapeutic options recommended by the
1784 Medicaid Pharmacy and Therapeutics Committee established
1785 pursuant to s. 409.91195 and adopted by the agency for each
1786 therapeutic class on the preferred drug list. At the discretion
1787 of the committee, and when feasible, the preferred drug list
1788 should include at least two products in a therapeutic class. The
1789 agency may post the preferred drug list and updates to the
1790 preferred drug list on an Internet website without following the
1791 rulemaking procedures of chapter 120. Antiretroviral agents are

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1792 excluded from the preferred drug list. The agency shall also
1793 limit the amount of a prescribed drug dispensed to no more than
1794 a 34-day supply unless the drug products' smallest marketed
1795 package is greater than a 34-day supply, or the drug is
1796 determined by the agency to be a maintenance drug in which case
1797 a 100-day maximum supply may be authorized. The agency is
1798 authorized to seek any federal waivers necessary to implement
1799 these cost-control programs and to continue participation in the
1800 federal Medicaid rebate program, or alternatively to negotiate
1801 state-only manufacturer rebates. The agency may adopt rules to
1802 implement this subparagraph. The agency shall continue to
1803 provide unlimited contraceptive drugs and items. The agency must
1804 establish procedures to ensure that:
1805 a. There is a response to a request for prior consultation
1806 by telephone or other telecommunication device within 24 hours
1807 after receipt of a request for prior consultation; and
1808 b. A 72-hour supply of the drug prescribed is provided in
1809 an emergency or when the agency does not provide a response
1810 within 24 hours as required by sub-subparagraph a.
1811 2. Reimbursement to pharmacies for Medicaid prescribed
1812 drugs shall be set at the lesser of: the average wholesale price
1813 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
1814 plus 4.75 percent, the federal upper limit (FUL), the state
1815 maximum allowable cost (SMAC), or the usual and customary (UAC)
1816 charge billed by the provider.
1817 3. The agency shall develop and implement a process for
1818 managing the drug therapies of Medicaid recipients who are using
1819 significant numbers of prescribed drugs each month. The

1820 management process may include, but is not limited to,
1821 comprehensive, physician-directed medical-record reviews, claims
1822 analyses, and case evaluations to determine the medical
1823 necessity and appropriateness of a patient's treatment plan and
1824 drug therapies. The agency may contract with a private
1825 organization to provide drug-program-management services. The
1826 Medicaid drug benefit management program shall include
1827 initiatives to manage drug therapies for HIV/AIDS patients,
1828 patients using 20 or more unique prescriptions in a 180-day
1829 period, and the top 1,000 patients in annual spending. The
1830 agency shall enroll any Medicaid recipient in the drug benefit
1831 management program if he or she meets the specifications of this
1832 provision and is not enrolled in a Medicaid health maintenance
1833 organization.
1834 4. The agency may limit the size of its pharmacy network
1835 based on need, competitive bidding, price negotiations,
1836 credentialing, or similar criteria. The agency shall give
1837 special consideration to rural areas in determining the size and
1838 location of pharmacies included in the Medicaid pharmacy
1839 network. A pharmacy credentialing process may include criteria
1840 such as a pharmacy's full-service status, location, size,
1841 patient educational programs, patient consultation, disease
1842 management services, and other characteristics. The agency may
1843 impose a moratorium on Medicaid pharmacy enrollment when it is
1844 determined that it has a sufficient number of Medicaid-
1845 participating providers. The agency must allow dispensing
1846 practitioners to participate as a part of the Medicaid pharmacy
1847 network regardless of the practitioner's proximity to any other

1848 entity that is dispensing prescription drugs under the Medicaid
1849 program. A dispensing practitioner must meet all credentialing
1850 requirements applicable to his or her practice, as determined by
1851 the agency.
1852 5. The agency shall develop and implement a program that
1853 requires Medicaid practitioners who prescribe drugs to use a
1854 counterfeit-proof prescription pad for Medicaid prescriptions.
1855 The agency shall require the use of standardized counterfeit-
1856 proof prescription pads by Medicaid-participating prescribers or
1857 prescribers who write prescriptions for Medicaid recipients. The
1858 agency may implement the program in targeted geographic areas or
1859 statewide.
1860 6. The agency may enter into arrangements that require
1861 manufacturers of generic drugs prescribed to Medicaid recipients
1862 to provide rebates of at least 15.1 percent of the average
1863 manufacturer price for the manufacturer's generic products.
1864 These arrangements shall require that if a generic-drug
1865 manufacturer pays federal rebates for Medicaid-reimbursed drugs
1866 at a level below 15.1 percent, the manufacturer must provide a
1867 supplemental rebate to the state in an amount necessary to
1868 achieve a 15.1-percent rebate level.
1869 7. The agency may establish a preferred drug list as
1870 described in this subsection, and, pursuant to the establishment
1871 of such preferred drug list, it is authorized to negotiate
1872 supplemental rebates from manufacturers that are in addition to
1873 those required by Title XIX of the Social Security Act and at no
1874 less than 14 percent of the average manufacturer price as
1875 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless

1876 the federal or supplemental rebate, or both, equals or exceeds
1877 29 percent. There is no upper limit on the supplemental rebates
1878 the agency may negotiate. The agency may determine that specific
1879 products, brand-name or generic, are competitive at lower rebate
1880 percentages. Agreement to pay the minimum supplemental rebate
1881 percentage will guarantee a manufacturer that the Medicaid
1882 Pharmaceutical and Therapeutics Committee will consider a
1883 product for inclusion on the preferred drug list. However, a
1884 pharmaceutical manufacturer is not guaranteed placement on the
1885 preferred drug list by simply paying the minimum supplemental
1886 rebate. Agency decisions will be made on the clinical efficacy
1887 of a drug and recommendations of the Medicaid Pharmaceutical and
1888 Therapeutics Committee, as well as the price of competing
1889 products minus federal and state rebates. The agency is
1890 authorized to contract with an outside agency or contractor to
1891 conduct negotiations for supplemental rebates. For the purposes
1892 of this section, the term "supplemental rebates" means cash
1893 rebates. Effective July 1, 2004, value-added programs as a
1894 substitution for supplemental rebates are prohibited. The agency
1895 is authorized to seek any federal waivers to implement this
1896 initiative.
1897 8. The Agency for Health Care Administration shall expand
1898 home delivery of pharmacy products. To assist Medicaid patients
1899 in securing their prescriptions and reduce program costs, the
1900 agency shall expand its current mail-order-pharmacy diabetes-
1901 supply program to include all generic and brand-name drugs used
1902 by Medicaid patients with diabetes. Medicaid recipients in the
1903 current program may obtain nondiabetes drugs on a voluntary

1904 basis. This initiative is limited to the geographic area covered
1905 by the current contract. The agency may seek and implement any
1906 federal waivers necessary to implement this subparagraph.
1907 9. The agency shall limit to one dose per month any drug
1908 prescribed to treat erectile dysfunction.
1909 10.a. The agency may implement a Medicaid behavioral drug
1910 management system. The agency may contract with a vendor that
1911 has experience in operating behavioral drug management systems
1912 to implement this program. The agency is authorized to seek
1913 federal waivers to implement this program.
1914 b. The agency, in conjunction with the Department of
1915 Children and Family Services, may implement the Medicaid
1916 behavioral drug management system that is designed to improve
1917 the quality of care and behavioral health prescribing practices
1918 based on best practice guidelines, improve patient adherence to
1919 medication plans, reduce clinical risk, and lower prescribed
1920 drug costs and the rate of inappropriate spending on Medicaid
1921 behavioral drugs. The program may include the following
1922 elements:
1923 (I) Provide for the development and adoption of best
1924 practice guidelines for behavioral health-related drugs such as
1925 antipsychotics, antidepressants, and medications for treating
1926 bipolar disorders and other behavioral conditions; translate
1927 them into practice; review behavioral health prescribers and
1928 compare their prescribing patterns to a number of indicators
1929 that are based on national standards; and determine deviations
1930 from best practice guidelines.
1931 (II) Implement processes for providing feedback to and

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1932 educating prescribers using best practice educational materials
1933 and peer-to-peer consultation.
1934 (III) Assess Medicaid beneficiaries who are outliers in
1935 their use of behavioral health drugs with regard to the numbers
1936 and types of drugs taken, drug dosages, combination drug
1937 therapies, and other indicators of improper use of behavioral
1938 health drugs.
1939 (IV) Alert prescribers to patients who fail to refill
1940 prescriptions in a timely fashion, are prescribed multiple same-
1941 class behavioral health drugs, and may have other potential
1942 medication problems.
1943 (V) Track spending trends for behavioral health drugs and
1944 deviation from best practice guidelines.
1945 (VI) Use educational and technological approaches to
1946 promote best practices, educate consumers, and train prescribers
1947 in the use of practice guidelines.
1948 (VII) Disseminate electronic and published materials.
1949 (VIII) Hold statewide and regional conferences.
1950 (IX) Implement a disease management program with a model
1951 quality-based medication component for severely mentally ill
1952 individuals and emotionally disturbed children who are high
1953 users of care.
1954 11.a. The agency shall implement a Medicaid prescription
1955 drug management system. The agency may contract with a vendor
1956 that has experience in operating prescription drug management
1957 systems in order to implement this system. Any management system
1958 that is implemented in accordance with this subparagraph must
1959 rely on cooperation between physicians and pharmacists to

1960 determine appropriate practice patterns and clinical guidelines
1961 to improve the prescribing, dispensing, and use of drugs in the
1962 Medicaid program. The agency may seek federal waivers to
1963 implement this program.
1964 b. The drug management system must be designed to improve
1965 the quality of care and prescribing practices based on best
1966 practice guidelines, improve patient adherence to medication
1967 plans, reduce clinical risk, and lower prescribed drug costs and
1968 the rate of inappropriate spending on Medicaid prescription
1969 drugs. The program must:
1970 (I) Provide for the development and adoption of best
1971 practice guidelines for the prescribing and use of drugs in the
1972 Medicaid program, including translating best practice guidelines
1973 into practice; reviewing prescriber patterns and comparing them
1974 to indicators that are based on national standards and practice
1975 patterns of clinical peers in their community, statewide, and
1976 nationally; and determine deviations from best practice
1977 guidelines.
1978 (II) Implement processes for providing feedback to and
1979 educating prescribers using best practice educational materials
1980 and peer-to-peer consultation.
1981 (III) Assess Medicaid recipients who are outliers in their
1982 use of a single or multiple prescription drugs with regard to
1983 the numbers and types of drugs taken, drug dosages, combination
1984 drug therapies, and other indicators of improper use of
1985 prescription drugs.
1986 (IV) Alert prescribers to patients who fail to refill
1987 prescriptions in a timely fashion, are prescribed multiple drugs

1988 that may be redundant or contraindicated, or may have other
1989 potential medication problems.
1990 (V) Track spending trends for prescription drugs and
1991 deviation from best practice guidelines.
1992 (VI) Use educational and technological approaches to
1993 promote best practices, educate consumers, and train prescribers
1994 in the use of practice guidelines.
1995 (VII) Disseminate electronic and published materials.
1996 (VIII) Hold statewide and regional conferences.
1997 (IX) Implement disease management programs in cooperation
1998 with physicians and pharmacists, along with a model quality-
1999 based medication component for individuals having chronic
2000 medical conditions.
2001 12. The agency is authorized to contract for drug rebate
2002 administration, including, but not limited to, calculating
2003 rebate amounts, invoicing manufacturers, negotiating disputes
2004 with manufacturers, and maintaining a database of rebate
2005 collections.
2006 13. The agency may specify the preferred daily dosing form
2007 or strength for the purpose of promoting best practices with
2008 regard to the prescribing of certain drugs as specified in the
2009 General Appropriations Act and ensuring cost-effective
2010 prescribing practices.
2011 14. The agency may require prior authorization for
2012 Medicaid-covered prescribed drugs. The agency may, but is not
2013 required to, prior-authorize the use of a product:
2014 a. For an indication not approved in labeling;
2015 b. To comply with certain clinical guidelines; or

2016 c. If the product has the potential for overuse, misuse,
2017 or abuse.
2018
2019 The agency may require the prescribing professional to provide
2020 information about the rationale and supporting medical evidence
2021 for the use of a drug. The agency may post prior authorization
2022 criteria and protocol and updates to the list of drugs that are
2023 subject to prior authorization on an Internet website without
2024 amending its rule or engaging in additional rulemaking.
2025 15. The agency, in conjunction with the Pharmaceutical and
2026 Therapeutics Committee, may require age-related prior
2027 authorizations for certain prescribed drugs. The agency may
2028 preauthorize the use of a drug for a recipient who may not meet
2029 the age requirement or may exceed the length of therapy for use
2030 of this product as recommended by the manufacturer and approved
2031 by the Food and Drug Administration. Prior authorization may
2032 require the prescribing professional to provide information
2033 about the rationale and supporting medical evidence for the use
2034 of a drug.
2035 16. The agency shall implement a step-therapy prior
2036 authorization approval process for medications excluded from the
2037 preferred drug list. Medications listed on the preferred drug
2038 list must be used within the previous 12 months prior to the
2039 alternative medications that are not listed. The step-therapy
2040 prior authorization may require the prescriber to use the
2041 medications of a similar drug class or for a similar medical
2042 indication unless contraindicated in the Food and Drug
2043 Administration labeling. The trial period between the specified

2044 steps may vary according to the medical indication. The step-
2045 therapy approval process shall be developed in accordance with
2046 the committee as stated in s. 409.91195(7) and (8). A drug
2047 product may be approved without meeting the step-therapy prior
2048 authorization criteria if the prescribing physician provides the
2049 agency with additional written medical or clinical documentation
2050 that the product is medically necessary because:
2051 a. There is not a drug on the preferred drug list to treat
2052 the disease or medical condition which is an acceptable clinical
2053 alternative;
2054 b. The alternatives have been ineffective in the treatment
2055 of the beneficiary's disease; or
2056 c. Based on historic evidence and known characteristics of
2057 the patient and the drug, the drug is likely to be ineffective,
2058 or the number of doses have been ineffective.
2059
2060 The agency shall work with the physician to determine the best
2061 alternative for the patient. The agency may adopt rules waiving
2062 the requirements for written clinical documentation for specific
2063 drugs in limited clinical situations.
2064 17. The agency shall implement a return and reuse program
2065 for drugs dispensed by pharmacies to institutional recipients,
2066 which includes payment of a $5 restocking fee for the
2067 implementation and operation of the program. The return and
2068 reuse program shall be implemented electronically and in a
2069 manner that promotes efficiency. The program must permit a
2070 pharmacy to exclude drugs from the program if it is not
2071 practical or cost-effective for the drug to be included and must

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2072 provide for the return to inventory of drugs that cannot be
2073 credited or returned in a cost-effective manner. The agency
2074 shall determine if the program has reduced the amount of
2075 Medicaid prescription drugs which are destroyed on an annual
2076 basis and if there are additional ways to ensure more
2077 prescription drugs are not destroyed which could safely be
2078 reused. The agency's conclusion and recommendations shall be
2079 reported to the Legislature by December 1, 2005.
2080 (b) The agency shall implement this subsection to the
2081 extent that funds are appropriated to administer the Medicaid
2082 prescribed-drug spending-control program. The agency may
2083 contract all or any part of this program to private
2084 organizations.
2085 (c) The agency shall submit quarterly reports to the
2086 Governor, the President of the Senate, and the Speaker of the
2087 House of Representatives which must include, but need not be
2088 limited to, the progress made in implementing this subsection
2089 and its effect on Medicaid prescribed-drug expenditures.
2090 <u>(38)</u>~~(40)~~ Notwithstanding the provisions of chapter 287,
2091 the agency may, at its discretion, renew a contract or contracts
2092 for fiscal intermediary services one or more times for such
2093 periods as the agency may decide; however, all such renewals may
2094 not combine to exceed a total period longer than the term of the
2095 original contract.
2096 <u>(39)</u>~~(41)~~ The agency shall provide for the development of a
2097 demonstration project by establishment in Miami-Dade County of a
2098 long-term-care facility licensed pursuant to chapter 395 to
2099 improve access to health care for a predominantly minority,

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2100 medically underserved, and medically complex population and to
2101 evaluate alternatives to nursing home care and general acute
2102 care for such population. Such project is to be located in a
2103 health care condominium and colocated with licensed facilities
2104 providing a continuum of care. The establishment of this project
2105 is not subject to the provisions of s. 408.036 or s. 408.039.
2106 This subsection expires October 1, 2012.
2107 (42) The agency shall develop and implement a utilization
2108 management program for Medicaid-eligible recipients for the
2109 management of occupational, physical, respiratory, and speech
2110 therapies. The agency shall establish a utilization program that
2111 may require prior authorization in order to ensure medically
2112 necessary and cost-effective treatments. The program shall be
2113 operated in accordance with a federally approved waiver program
2114 or state plan amendment. The agency may seek a federal waiver or
2115 state plan amendment to implement this program. The agency may
2116 also competitively procure these services from an outside vendor
2117 on a regional or statewide basis.
2118 (40) (43) The agency may contract on a prepaid or fixed-sum
2119 basis with appropriately licensed prepaid dental health plans to
2120 provide dental services. This subsection expires October 1,
2121 2013.
2122 (41) (44) The Agency for Health Care Administration shall
2123 ensure that any Medicaid managed care plan as defined in s.
2124 409.9122(2)(f), whether paid on a capitated basis or a shared
2125 savings basis, is cost-effective. For purposes of this
2126 subsection, the term "cost-effective" means that a network's
2127 per-member, per-month costs to the state, including, but not

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2128 limited to, fee-for-service costs, administrative costs, and
2129 case-management fees, if any, must be no greater than the
2130 state's costs associated with contracts for Medicaid services
2131 established under subsection (3), which may be adjusted for
2132 health status. The agency shall conduct actuarially sound
2133 adjustments for health status in order to ensure such cost-
2134 effectiveness and shall publish the results on its Internet
2135 website and submit the results annually to the Governor, the
2136 President of the Senate, and the Speaker of the House of
2137 Representatives no later than December 31 of each year.
2138 Contracts established pursuant to this subsection which are not
2139 cost-effective may not be renewed. This subsection expires
2140 October 1, 2013.
2141 (42) ~~(45)~~ Subject to the availability of funds, the agency
2142 shall mandate a recipient's participation in a provider lock-in
2143 program, when appropriate, if a recipient is found by the agency
2144 to have used Medicaid goods or services at a frequency or amount
2145 not medically necessary, limiting the receipt of goods or
2146 services to medically necessary providers after the 21-day
2147 appeal process has ended, for a period of not less than 1 year.
2148 The lock-in programs shall include, but are not limited to,
2149 pharmacies, medical doctors, and infusion clinics. The
2150 limitation does not apply to emergency services and care
2151 provided to the recipient in a hospital emergency department.
2152 The agency shall seek any federal waivers necessary to implement
2153 this subsection. The agency shall adopt any rules necessary to
2154 comply with or administer this subsection. This subsection
2155 expires October 1, 2013.

2156 (43) ~~(46)~~ The agency shall seek a federal waiver for
2157 permission to terminate the eligibility of a Medicaid recipient
2158 who has been found to have committed fraud, through judicial or
2159 administrative determination, two times in a period of 5 years.
2160 ~~(47) The agency shall conduct a study of available~~
2161 ~~electronic systems for the purpose of verifying the identity and~~
2162 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
2163 ~~to the Legislature a plan to implement an electronic~~
2164 ~~verification system for Medicaid recipients by January 31, 2005.~~
2165 (44) ~~(48)~~(a) A provider is not entitled to enrollment in
2166 the Medicaid provider network. The agency may implement a
2167 Medicaid fee-for-service provider network controls, including,
2168 but not limited to, competitive procurement and provider
2169 credentialing. If a credentialing process is used, the agency
2170 may limit its provider network based upon the following
2171 considerations: beneficiary access to care, provider
2172 availability, provider quality standards and quality assurance
2173 processes, cultural competency, demographic characteristics of
2174 beneficiaries, practice standards, service wait times, provider
2175 turnover, provider licensure and accreditation history, program
2176 integrity history, peer review, Medicaid policy and billing
2177 compliance records, clinical and medical record audit findings,
2178 and such other areas that are considered necessary by the agency
2179 to ensure the integrity of the program.
2180 (b) The agency shall limit its network of durable medical
2181 equipment and medical supply providers. For dates of service
2182 after January 1, 2009, the agency shall limit payment for
2183 durable medical equipment and supplies to providers that meet

2184 all the requirements of this paragraph.
2185 1. Providers must be accredited by a Centers for Medicare
2186 and Medicaid Services deemed accreditation organization for
2187 suppliers of durable medical equipment, prosthetics, orthotics,
2188 and supplies. The provider must maintain accreditation and is
2189 subject to unannounced reviews by the accrediting organization.
2190 2. Providers must provide the services or supplies
2191 directly to the Medicaid recipient or caregiver at the provider
2192 location or recipient's residence or send the supplies directly
2193 to the recipient's residence with receipt of mailed delivery.
2194 Subcontracting or consignment of the service or supply to a
2195 third party is prohibited.
2196 3. Notwithstanding subparagraph 2., a durable medical
2197 equipment provider may store nebulizers at a physician's office
2198 for the purpose of having the physician's staff issue the
2199 equipment if it meets all of the following conditions:
2200 a. The physician must document the medical necessity and
2201 need to prevent further deterioration of the patient's
2202 respiratory status by the timely delivery of the nebulizer in
2203 the physician's office.
2204 b. The durable medical equipment provider must have
2205 written documentation of the competency and training by a
2206 Florida-licensed registered respiratory therapist of any durable
2207 medical equipment staff who participate in the training of
2208 physician office staff for the use of nebulizers, including
2209 cleaning, warranty, and special needs of patients.
2210 c. The physician's office must have documented the
2211 training and competency of any staff member who initiates the

2212 delivery of nebulizers to patients. The durable medical
2213 equipment provider must maintain copies of all physician office
2214 training.
2215 d. The physician's office must maintain inventory records
2216 of stored nebulizers, including documentation of the durable
2217 medical equipment provider source.
2218 e. A physician contracted with a Medicaid durable medical
2219 equipment provider may not have a financial relationship with
2220 that provider or receive any financial gain from the delivery of
2221 nebulizers to patients.
2222 4. Providers must have a physical business location and a
2223 functional landline business phone. The location must be within
2224 the state or not more than 50 miles from the Florida state line.
2225 The agency may make exceptions for providers of durable medical
2226 equipment or supplies not otherwise available from other
2227 enrolled providers located within the state.
2228 5. Physical business locations must be clearly identified
2229 as a business that furnishes durable medical equipment or
2230 medical supplies by signage that can be read from 20 feet away.
2231 The location must be readily accessible to the public during
2232 normal, posted business hours and must operate no less than 5
2233 hours per day and no less than 5 days per week, with the
2234 exception of scheduled and posted holidays. The location may not
2235 be located within or at the same numbered street address as
2236 another enrolled Medicaid durable medical equipment or medical
2237 supply provider or as an enrolled Medicaid pharmacy that is also
2238 enrolled as a durable medical equipment provider. A licensed
2239 orthotist or prosthetist that provides only orthotic or

2240 prosthetic devices as a Medicaid durable medical equipment
2241 provider is exempt from the provisions in this paragraph.
2242 6. Providers must maintain a stock of durable medical
2243 equipment and medical supplies on site that is readily available
2244 to meet the needs of the durable medical equipment business
2245 location's customers.
2246 7. Providers must provide a surety bond of $50,000 for
2247 each provider location, up to a maximum of 5 bonds statewide or
2248 an aggregate bond of $250,000 statewide, as identified by
2249 Federal Employer Identification Number. Providers who post a
2250 statewide or an aggregate bond must identify all of their
2251 locations in any Medicaid durable medical equipment and medical
2252 supply provider enrollment application or bond renewal. Each
2253 provider location's surety bond must be renewed annually and the
2254 provider must submit proof of renewal even if the original bond
2255 is a continuous bond. A licensed orthotist or prosthetist that
2256 provides only orthotic or prosthetic devices as a Medicaid
2257 durable medical equipment provider is exempt from the provisions
2258 in this paragraph.
2259 8. Providers must obtain a level 2 background screening,
2260 as provided under s. 435.04, for each provider employee in
2261 direct contact with or providing direct services to recipients
2262 of durable medical equipment and medical supplies in their
2263 homes. This requirement includes, but is not limited to, repair
2264 and service technicians, fitters, and delivery staff. The
2265 provider shall pay for the cost of the background screening.
2266 9. The following providers are exempt from the
2267 requirements of subparagraphs 1. and 7.:

2268 a. Durable medical equipment providers owned and operated
2269 by a government entity.
2270 b. Durable medical equipment providers that are operating
2271 within a pharmacy that is currently enrolled as a Medicaid
2272 pharmacy provider.
2273 c. Active, Medicaid-enrolled orthopedic physician groups,
2274 primarily owned by physicians, which provide only orthotic and
2275 prosthetic devices.
2276 (45) ~~(49)~~ The agency shall contract with established
2277 minority physician networks that provide services to
2278 historically underserved minority patients. The networks must
2279 provide cost-effective Medicaid services, comply with the
2280 requirements to be a MediPass provider, and provide their
2281 primary care physicians with access to data and other management
2282 tools necessary to assist them in ensuring the appropriate use
2283 of services, including inpatient hospital services and
2284 pharmaceuticals.
2285 (a) The agency shall provide for the development and
2286 expansion of minority physician networks in each service area to
2287 provide services to Medicaid recipients who are eligible to
2288 participate under federal law and rules.
2289 (b) The agency shall reimburse each minority physician
2290 network as a fee-for-service provider, including the case
2291 management fee for primary care, if any, or as a capitated rate
2292 provider for Medicaid services. Any savings shall be shared with
2293 the minority physician networks pursuant to the contract.
2294 (c) For purposes of this subsection, the term "cost-
2295 effective" means that a network's per-member, per-month costs to

2296 the state, including, but not limited to, fee-for-service costs,
2297 administrative costs, and case-management fees, if any, must be
2298 no greater than the state's costs associated with contracts for
2299 Medicaid services established under subsection (3), which shall
2300 be actuarially adjusted for case mix, model, and service area.
2301 The agency shall conduct actuarially sound audits adjusted for
2302 case mix and model in order to ensure such cost-effectiveness
2303 and shall publish the audit results on its Internet website and
2304 submit the audit results annually to the Governor, the President
2305 of the Senate, and the Speaker of the House of Representatives
2306 no later than December 31. Contracts established pursuant to
2307 this subsection which are not cost-effective may not be renewed.
2308 (d) The agency may apply for any federal waivers needed to
2309 implement this subsection.
2310
2311 This subsection expires October 1, 2013.
2312 (46) ~~(50)~~ To the extent permitted by federal law and as
2313 allowed under s. 409.906, the agency shall provide reimbursement
2314 for emergency mental health care services for Medicaid
2315 recipients in crisis stabilization facilities licensed under s.
2316 394.875 as long as those services are less expensive than the
2317 same services provided in a hospital setting.
2318 (47) ~~(51)~~ The agency shall work with the Agency for Persons
2319 with Disabilities to develop a home and community-based waiver
2320 to serve children and adults who are diagnosed with familial
2321 dysautonomia or Riley-Day syndrome caused by a mutation of the
2322 IKBKAP gene on chromosome 9. The agency shall seek federal
2323 waiver approval and implement the approved waiver subject to the

2324 availability of funds and any limitations provided in the
2325 General Appropriations Act. The agency may adopt rules to
2326 implement this waiver program.
2327 (48) ~~(52)~~ The agency shall implement a program of all-
2328 inclusive care for children. The program of all-inclusive care
2329 for children shall be established to provide in-home hospice-
2330 like support services to children diagnosed with a life-
2331 threatening illness and enrolled in the Children's Medical
2332 Services network to reduce hospitalizations as appropriate. The
2333 agency, in consultation with the Department of Health, may
2334 implement the program of all-inclusive care for children after
2335 obtaining approval from the Centers for Medicare and Medicaid
2336 Services.
2337 (49) ~~(53)~~ Before seeking an amendment to the state plan for
2338 purposes of implementing programs authorized by the Deficit
2339 Reduction Act of 2005, the agency shall notify the Legislature.
2340 Section 11. Subsection (4) of section 409.91195, Florida
2341 Statutes, is amended to read:
2342 409.91195 Medicaid Pharmaceutical and Therapeutics
2343 Committee.—There is created a Medicaid Pharmaceutical and
2344 Therapeutics Committee within the agency for the purpose of
2345 developing a Medicaid preferred drug list.
2346 (4) Upon recommendation of the committee, the agency shall
2347 adopt a preferred drug list as described in s. 409.912(37) ~~(39)~~.
2348 To the extent feasible, the committee shall review all drug
2349 classes included on the preferred drug list every 12 months, and
2350 may recommend additions to and deletions from the preferred drug
2351 list, such that the preferred drug list provides for medically

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2352 appropriate drug therapies for Medicaid patients which achieve
2353 cost savings contained in the General Appropriations Act.
2354 Section 12. Subsection (1) of section 409.91196, Florida
2355 Statutes, is amended to read:
2356 409.91196 Supplemental rebate agreements; public records
2357 and public meetings exemption.—
2358 (1) The rebate amount, percent of rebate, manufacturer's
2359 pricing, and supplemental rebate, and other trade secrets as
2360 defined in s. 688.002 that the agency has identified for use in
2361 negotiations, held by the Agency for Health Care Administration
2362 under s. 409.912(37)~~(39)~~(a)7. are confidential and exempt from
2363 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
2364 Section 13. Section 409.91207, Florida Statutes, is
2365 amended to read:
2366 (Substantial rewording of section. See s. 409.91207,
2367 F.S., for present text.)
2368 409.91207 Medical homes.—
2369 (1) AUTHORITY.—The agency shall develop a method for
2370 designating qualified plans as a medical home network.
2371 (2) PURPOSE AND PRINCIPLES.—Medical home networks foster
2372 and support coordinated and effective primary care through case
2373 management, support to primary care providers, supplemental
2374 services, and dissemination of best practices. Medical home
2375 networks target patients with chronic illnesses and frequent
2376 service utilization in order to coordinate services, provide
2377 disease management and patient education, and improve quality of
2378 care. In addition to primary care, medical home networks are
2379 able to provide or arrange for pharmacy, outpatient diagnostic,

2380 and specialty physician services and coordinate with inpatient
2381 facilities and rehabilitative service providers.
2382 (3) DESIGNATION.—A qualified plan may request agency
2383 designation as a medical home network if the plan is accredited
2384 as a medical home network by the National Committee for Quality
2385 Assurance or:
2386 (a) The plan establishes a method for its enrollees to
2387 choose to participate as medical home patients and select a
2388 primary care provider that is certified as a medical home.
2389 (b) At least 85 percent of the primary care providers in a
2390 medical home network are certified by the qualified plan as
2391 having the following service capabilities:
2392 1. Supply all medically necessary primary and preventive
2393 services and provide all scheduled immunizations.
2394 2. Organize clinical data in electronic form using a
2395 patient-centered charting system.
2396 3. Maintain and update a patient's medication list and
2397 review all medications during each office visit.
2398 4. Maintain a system to track diagnostic tests and provide
2399 followup services regarding test results.
2400 5. Maintain a system to track referrals, including self-
2401 referrals by members.
2402 6. Supply care coordination and continuity of care through
2403 proactive contact with members and encourage family
2404 participation in care.
2405 7. Supply education and support using various materials
2406 and processes appropriate for individual patient needs.
2407 8. Communicate electronically.

2408 9. Supply voice-to-voice telephone coverage to medical
2409 home patients 24 hours per day, 7 days per week, to enable
2410 medical home patients to speak to a licensed health care
2411 professional who triages and forwards calls, as appropriate.
2412 10. Maintain an office schedule of at least 30 scheduled
2413 hours per week.
2414 11. Use scheduling processes to promote continuity with
2415 clinicians, including providing care for walk-in, routine, and
2416 urgent care visits.
2417 12. Implement and document behavioral health and substance
2418 abuse screening procedures and make referrals as needed.
2419 13. Use data to identify and track patients' health and
2420 service use patterns.
2421 14. Coordinate care and followup for patients receiving
2422 services in inpatient and outpatient facilities.
2423 15. Implement processes to promote access to care and
2424 member communication.
2425 16. Maintain electronic medical records.
2426 17. Develop a health care team that provides ongoing
2427 support, oversight, and guidance for all medical care received
2428 by the patient and documents contact with specialists and other
2429 health care providers caring for the patient.
2430 18. Supply postvisit followup care for patients.
2431 19. Implement specific evidence-based clinical practice
2432 guidelines for preventive and chronic care.
2433 20. Implement a medication reconciliation procedure to
2434 avoid interactions or duplications.
2435 21. Use personalized screening, brief intervention, and

2436 referral to treatment procedures for appropriate patients
2437 requiring specialty treatment.
2438 22. Offer at least 4 hours per week of after-hours care to
2439 patients.
2440 23. Use health assessment tools to identify patient needs
2441 and risks.
2442 (c) The qualified plan offers support services to its
2443 primary care providers, including:
2444 1. Case management, outreach, care coordination, and other
2445 targeted support services for medical home patients.
2446 2. Ongoing assessment of spending and service utilization
2447 by all medical home network patients.
2448 3. Periodic evaluation of patient outcomes.
2449 4. Coordination with inpatient facilities, behavioral
2450 health, and rehabilitative service providers.
2451 5. Establishing specific methods to manage pharmacy and
2452 behavioral health services.
2453 6. Paying primary care providers at rates equal to or
2454 greater than 80 percent of the Medicare rate.
2455 (4) AGENCY DUTIES.—The agency shall:
2456 (a) Maintain a record of qualified plans designated as
2457 medical home networks.
2458 (b) Develop a standard form to be used by the qualified
2459 plans to certify to the agency that they meet the necessary
2460 service and primary care provider support capabilities to be
2461 designated a medical home.
2462 Section 14. Section 409.91211, Florida Statutes, is
2463 amended to read:

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2464 (Substantial rewording of section. See s. 409.91211,
2465 F.S., for present text.)
2466 409.91211.—Medicaid managed care pilot program.—
2467 (1) AUTHORITY.—The agency is authorized to implement a
2468 managed care pilot program based on the Section 1115 waiver
2469 approved by the Centers for Medicare and Medicaid Services on
2470 October 19, 2005, including continued operation of the program
2471 in Baker, Broward, Clay, Duval, and Nassau Counties. The managed
2472 care pilot program shall be consistent with the provisions of
2473 this section, subject to federal approval.
2474 (2) EXTENSION.—No later than July 1, 2010, the agency
2475 shall begin the process of requesting an extension of the
2476 Section 1115 waiver. The agency shall report at least monthly to
2477 the Legislature on progress in negotiating for the extension of
2478 the waiver. Changes to the terms and conditions relating to the
2479 low-income pool must be approved by the Legislative Budget
2480 Commission.
2481 (3) EXPANSION.—The agency shall expand the managed care
2482 pilot program to Miami-Dade County in a manner that enrolls all
2483 eligible recipients in a qualified plan no later than June 30,
2484 2011.
2485 (4) QUALIFIED PLANS.—Managed care plans qualified to
2486 participate in the Medicaid managed care pilot program include
2487 health insurers authorized under chapter 624, exclusive provider
2488 organizations authorized under chapter 627, health maintenance
2489 organizations authorized under chapter 641, the Children's
2490 Medical Services Network under chapter 391, and provider service
2491 networks authorized pursuant to s. 409.912(4)(d).

2492 (5) PLAN REQUIREMENTS.—The agency shall apply the
2493 following requirements to all qualified plans:
2494 (a) Prepaid rates shall be risk adjusted pursuant to
2495 subsection (17).
2496 (b) All Medicaid recipients shall be offered the
2497 opportunity to use their Medicaid premium to pay for the
2498 recipient's share of cost pursuant to s. 409.9122(13).
2499 (6) INTERGOVERNMENTAL TRANSFERS.—In order to preserve
2500 intergovernmental transfers of funds from Miami-Dade County, the
2501 agency shall develop methodologies, including, but not limited
2502 to, a supplemental capitation rate, risk pool, or incentive
2503 payments, which may be paid to prepaid plans or plans owned and
2504 operated by providers that contract with safety net providers,
2505 trauma hospitals, children's hospitals, and statutory teaching
2506 hospitals. In order to preserve certified public expenditures
2507 from Miami-Dade County, the agency shall seek federal approval
2508 to implement a methodology that allows supplemental payments to
2509 be made directly to physicians employed by or under contract
2510 with a medical school in Florida in recognition of the costs
2511 associated with graduate medical education or their teaching
2512 mission. Alternatively, the agency may develop additional
2513 methodologies including, but not limited to, methodologies
2514 mentioned above, as well as capitated rates that exclude
2515 payments made to these physicians so that they may be paid
2516 directly. Once methodologies and payment mechanisms are
2517 approved, the agency shall submit the plan for preserving
2518 intergovernmental transfers and certified public expenditures to
2519 the Legislative Budget Commission. After the assignment and

2520 enrollment of all mandatory eligible persons in Miami-Dade
2521 County into managed care plans, an amendment shall be submitted
2522 to the Legislative Budget Commission requesting authority for
2523 the transfer of sufficient funds from appropriate line items
2524 within the Grants and Donations Trust Fund and the Medical Care
2525 Trust Fund within the Agency for Health Care Administration in
2526 the General Appropriations Act to the line item for Prepaid
2527 Health Plans within the General Appropriations Act. The agency
2528 shall submit a report to the Legislature regarding how the
2529 developed and approved methodologies and payment mechanisms may
2530 be applied to other counties in the state pursuant to managed
2531 care payments under s. 409.968.
2532 (7) ENROLLMENT.—All Medicaid recipients in the counties in
2533 which the managed care pilot program has been implemented shall
2534 be enrolled in a qualified plan. Each recipient shall have a
2535 choice of plans and may select any plan unless that plan is
2536 restricted by contract to a specific population that does not
2537 include the recipient. Medicaid recipients shall have 30 days in
2538 which to make a choice of plans. All recipients shall be offered
2539 choice counseling services in accordance with this section.
2540 (8) CHOICE COUNSELING.—The agency shall provide choice
2541 counseling and may contract for the provision of choice
2542 counseling services. Choice counseling shall be provided in the
2543 native or preferred language of the recipient, consistent with
2544 federal requirements. The agency shall maintain a record of the
2545 recipients who receive such services, identifying the scope and
2546 method of the services provided. The agency shall make available

2547 clear and easily understandable choice information to Medicaid
2548 recipients that includes:
2549 (a) An explanation that each recipient has the right to
2550 choose a qualified plan at the time of enrollment in Medicaid
2551 and again at regular intervals set by the agency and that, if a
2552 recipient does not choose a qualified plan, the agency will
2553 assign the recipient to a qualified plan according to the
2554 criteria specified in this section.
2555 (b) A list and description of the benefits provided in
2556 each plan.
2557 (c) Information about earning credits in the plan's
2558 enhanced benefit program.
2559 (d) An explanation of benefit limits.
2560 (e) Information about cost-sharing requirements of each
2561 plan.
2562 (f) A current list of providers participating in the
2563 network, including location and contact information.
2564 (g) Plan performance data.
2565 (9) AUTOMATIC ENROLLMENT.—The agency shall automatically
2566 enroll Medicaid recipients who do not voluntarily choose a
2567 managed care plan. Enrollment shall be distributed among all
2568 qualified plans. When automatically enrolling recipients, the
2569 agency shall take into account the following criteria:
2570 (a) The plan has sufficient network capacity to meet the
2571 needs of the recipients.
2572 (b) The recipient has previously received services from
2573 one of the plan's primary care providers.

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2574 (c) Primary care providers in one plan are more
2575 geographically accessible to the recipient's residence.
2576
2577 The agency may not engage in practices that are designed to
2578 favor one qualified plan over another.
2579 (10) DISENROLLMENT.—After a recipient has selected and
2580 enrolled in a qualified plan, the recipient shall have 90 days
2581 to voluntarily disenroll and select another qualified plan.
2582 After 90 days, further changes may be made only for good cause.
2583 "Good cause" includes, but is not limited to, poor quality of
2584 care, lack of access to necessary specialty services, an
2585 unreasonable delay or denial of service, or fraudulent
2586 enrollment. The agency must make a determination as to whether
2587 cause exists. However, the agency may require a recipient to use
2588 the qualified plan's grievance process prior to the agency's
2589 determination of cause, except in cases in which immediate risk
2590 of permanent damage to the recipient's health is alleged. The
2591 agency must make a determination and take final action on a
2592 recipient's request so that disenrollment occurs no later than
2593 the first day of the second month after the month the request
2594 was made. If the agency fails to act within the specified
2595 timeframe, the recipient's request to disenroll is deemed to be
2596 approved as of the date agency action was required. Recipients
2597 who disagree with the agency's finding that cause does not exist
2598 for disenrollment shall be advised of their right to pursue a
2599 Medicaid fair hearing to dispute the agency's finding.
2600 (11) ENROLLMENT PERIOD.—Medicaid recipients enrolled in a
2601 qualified plan after the 90-day period shall remain in the plan

2602 for 12 months. After 12 months, the recipient may select another
2603 plan. However, nothing shall prevent a Medicaid recipient from
2604 changing primary care providers within the qualified plan during
2605 the 12-month period.
2606 (12) GRIEVANCES.—Each qualified plan shall establish an
2607 internal process for reviewing and responding to grievances from
2608 enrollees. The contract shall specify timeframes for submission,
2609 plan response, and resolution. Grievances not resolved by a
2610 plan's internal process shall be submitted to the Subscriber
2611 Assistance Panel pursuant to s. 408.7056. Each plan shall submit
2612 quarterly reports on the number, description, and outcome of
2613 grievances filed by enrollees. The agency shall establish a
2614 similar process for provider service networks.
2615 (13) BENEFITS.—Qualified plans operating in the Medicaid
2616 managed care pilot program shall cover the services specified in
2617 ss. 409.905 and 409.906, emergency services provided under s.
2618 409.9128, and such other services as the plan may offer. Plans
2619 may customize benefit packages for nonpregnant adults, vary
2620 cost-sharing provisions, and provide coverage for additional
2621 services. The agency shall evaluate the proposed benefit
2622 packages to ensure services are sufficient to meet the needs of
2623 the plans' enrollees and to verify actuarial equivalence.
2624 (14) PENALTIES.—Qualified plans that reduce enrollment
2625 levels or leave a county where the managed care pilot program
2626 has been implemented shall reimburse the agency for the cost of
2627 enrollment changes, including the cost of additional choice
2628 counseling services. When more than one qualified plan leaves a

2629 county at the same time, costs shall be shared by the plans
2630 proportionate to their enrollments.
2631 (15) ACCESS TO DATA.—The agency shall make encounter data
2632 available to those plans accepting enrollees who are assigned to
2633 them from other plans leaving a county where the managed care
2634 pilot program has been implemented.
2635 (16) ENHANCED BENEFITS.—Each plan operating in the managed
2636 care pilot program shall establish an incentive program that
2637 rewards specific healthy behaviors with credits in a flexible
2638 spending account pursuant to s. 409.9122(14).
2639 (17) PAYMENTS TO MANAGED CARE PLANS.—
2640 (a) The agency shall continue the budget-neutral
2641 adjustment of capitation rates for all prepaid plans in existing
2642 managed care pilot program counties.
2643 (b) Beginning September 1, 2010, the agency shall begin a
2644 budget-neutral adjustment of capitation rates for all prepaid
2645 plans in Miami-Dade County. The adjustment to capitation rates
2646 shall be based on aggregate risk scores for each prepaid plan's
2647 enrollees. During the first 2 years of the adjustment, the
2648 agency shall ensure that no plan has an aggregate risk score
2649 that varies by more than 10 percent from the aggregate weighted
2650 average for all plans. The risk adjusted capitation rates shall
2651 be phased in as follows:
2652 1. In the first fiscal year, 75 percent of the capitation
2653 rate shall be based on the current methodology and 25 percent
2654 shall be based on the risk-adjusted rate methodology.

2655 2. In the second fiscal year, 50 percent of the capitation
2656 rate shall be based on the current methodology and 50 percent
2657 shall be based on the risk-adjusted methodology.
2658 3. In the third fiscal year, the risk-adjusted capitation
2659 methodology shall be fully implemented.
2660 (c) During this period, the agency shall establish a
2661 technical advisory panel to obtain input from the prepaid plans
2662 affected by the transition to risk adjusted rates.
2663 (18) LOW-INCOME POOL.—Funds from a low-income pool shall
2664 be distributed in accordance with the terms and conditions of
2665 the 1115 waiver and in a manner authorized by the General
2666 Appropriations Act. The distribution of funds is intended for
2667 the following purposes:
2668 (a) Assure a broad and fair distribution of available
2669 funds based on the access provided by Medicaid participating
2670 hospitals, regardless of their ownership status, through their
2671 delivery of inpatient or outpatient care for Medicaid
2672 beneficiaries and uninsured and underinsured individuals;
2673 (b) Assure accessible emergency inpatient and outpatient
2674 care for Medicaid beneficiaries and uninsured and underinsured
2675 individuals;
2676 (c) Enhance primary, preventive, and other ambulatory care
2677 coverages for uninsured individuals;
2678 (d) Promote teaching and specialty hospital programs;
2679 (e) Promote the stability and viability of statutorily
2680 defined rural hospitals and hospitals that serve as sole
2681 community hospitals;

2682 (f) Recognize the extent of hospital uncompensated care
2683 costs;
2684 (g) Maintain and enhance essential community hospital
2685 care;
2686 (h) Maintain incentives for local governmental entities to
2687 contribute to the cost of uncompensated care;
2688 (i) Promote measures to avoid preventable
2689 hospitalizations;
2690 (j) Account for hospital efficiency; and
2691 (k) Contribute to a community's overall health system.
2692 (19) ENCOUNTER DATA.—The agency shall maintain and operate
2693 the Medicaid Encounter Data System pursuant to s. 409.9122(15).
2694 (20) EVALUATION.—The agency shall contract with the
2695 University of Florida to complete a comprehensive evaluation of
2696 the managed care pilot program. The evaluation shall include an
2697 assessment of patient satisfaction, changes in benefits and
2698 coverage, implementation and impact of enhanced benefits, access
2699 to care and service utilization by enrolled recipients, and
2700 costs per enrollee.
2701 Section 15. Section 409.9122, Florida Statutes, is amended
2702 to read:
2703 409.9122 Mandatory Medicaid managed care enrollment;
2704 programs and procedures.—
2705 (1) It is the intent of the Legislature that the MediPass
2706 program be cost-effective, provide quality health care, and
2707 improve access to health services, and that the program be
2708 statewide. This subsection expires October 1, 2013.
2709 (2)(a) The agency shall enroll in a managed care plan or

2710 MediPass all Medicaid recipients, except those Medicaid
2711 recipients who are: in an institution; enrolled in the Medicaid
2712 medically needy program; or eligible for both Medicaid and
2713 Medicare. Upon enrollment, individuals will be able to change
2714 their managed care option during the 90-day opt out period
2715 required by federal Medicaid regulations. The agency is
2716 authorized to seek the necessary Medicaid state plan amendment
2717 to implement this policy. However, to the extent permitted by
2718 federal law, the agency may enroll in a managed care plan or
2719 MediPass a Medicaid recipient who is exempt from mandatory
2720 managed care enrollment, provided that:
2721 1. The recipient's decision to enroll in a managed care
2722 plan or MediPass is voluntary;
2723 2. If the recipient chooses to enroll in a managed care
2724 plan, the agency has determined that the managed care plan
2725 provides specific programs and services which address the
2726 special health needs of the recipient; and
2727 3. The agency receives any necessary waivers from the
2728 federal Centers for Medicare and Medicaid Services.
2729
2730 ~~The agency shall develop rules to establish policies by which~~
2731 ~~exceptions to the mandatory managed care enrollment requirement~~
2732 ~~may be made on a case-by-case basis. The rules shall include the~~
2733 ~~specific criteria to be applied when making a determination as~~
2734 ~~to whether to exempt a recipient from mandatory enrollment in a~~
2735 ~~managed care plan or MediPass.~~ School districts participating in
2736 the certified school match program pursuant to ss. 409.908(21)
2737 and 1011.70 shall be reimbursed by Medicaid, subject to the

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2738 limitations of s. 1011.70(1), for a Medicaid-eligible child
2739 participating in the services as authorized in s. 1011.70, as
2740 provided for in s. 409.9071, regardless of whether the child is
2741 enrolled in MediPass or a managed care plan. Managed care plans
2742 shall make a good faith effort to execute agreements with school
2743 districts regarding the coordinated provision of services
2744 authorized under s. 1011.70. County health departments
2745 delivering school-based services pursuant to ss. 381.0056 and
2746 381.0057 shall be reimbursed by Medicaid for the federal share
2747 for a Medicaid-eligible child who receives Medicaid-covered
2748 services in a school setting, regardless of whether the child is
2749 enrolled in MediPass or a managed care plan. Managed care plans
2750 shall make a good faith effort to execute agreements with county
2751 health departments regarding the coordinated provision of
2752 services to a Medicaid-eligible child. To ensure continuity of
2753 care for Medicaid patients, the agency, the Department of
2754 Health, and the Department of Education shall develop procedures
2755 for ensuring that a student's managed care plan or MediPass
2756 provider receives information relating to services provided in
2757 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
2758 (b) A Medicaid recipient shall not be enrolled in or
2759 assigned to a managed care plan or MediPass unless the managed
2760 care plan or MediPass has complied with the quality-of-care
2761 standards specified in paragraphs (3)(a) and (b), respectively.
2762 (c) Medicaid recipients shall have a choice of managed
2763 care plans or MediPass. The Agency for Health Care
2764 Administration, the Department of Health, the Department of
2765 Children and Family Services, and the Department of Elderly

2766 Affairs shall cooperate to ensure that each Medicaid recipient
2767 receives clear and easily understandable information that meets
2768 the following requirements:
2769 1. Explains the concept of managed care, including
2770 MediPass.
2771 2. Provides information on the comparative performance of
2772 managed care plans and MediPass in the areas of quality,
2773 credentialing, preventive health programs, network size and
2774 availability, and patient satisfaction.
2775 3. Explains where additional information on each managed
2776 care plan and MediPass in the recipient's area can be obtained.
2777 4. Explains that recipients have the right to choose their
2778 managed care coverage at the time they first enroll in Medicaid
2779 and again at regular intervals set by the agency. However, if a
2780 recipient does not choose a managed care plan or MediPass, the
2781 agency will assign the recipient to a managed care plan or
2782 MediPass according to the criteria specified in this section.
2783 5. Explains the recipient's right to complain, file a
2784 grievance, or change managed care plans or MediPass providers if
2785 the recipient is not satisfied with the managed care plan or
2786 MediPass.
2787 (d) The agency shall develop a mechanism for providing
2788 information to Medicaid recipients for the purpose of making a
2789 managed care plan or MediPass selection. Examples of such
2790 mechanisms may include, but not be limited to, interactive
2791 information systems, mailings, and mass marketing materials.
2792 Managed care plans and MediPass providers are prohibited from
2793 providing inducements to Medicaid recipients to select their

2794 plans or from prejudicing Medicaid recipients against other
2795 managed care plans or MediPass providers.
2796 (e) Medicaid recipients who are already enrolled in a
2797 managed care plan or MediPass shall be offered the opportunity
2798 to change managed care plans or MediPass providers on a
2799 staggered basis, as defined by the agency. All Medicaid
2800 recipients shall have 30 days in which to make a choice of
2801 managed care plans or MediPass providers. Those Medicaid
2802 recipients who do not make a choice shall be assigned in
2803 accordance with paragraph (f). To facilitate continuity of care,
2804 for a Medicaid recipient who is also a recipient of Supplemental
2805 Security Income (SSI), prior to assigning the SSI recipient to a
2806 managed care plan or MediPass, the agency shall determine
2807 whether the SSI recipient has an ongoing relationship with a
2808 MediPass provider or managed care plan, and if so, the agency
2809 shall assign the SSI recipient to that MediPass provider or
2810 managed care plan. Those SSI recipients who do not have such a
2811 provider relationship shall be assigned to a managed care plan
2812 or MediPass provider in accordance with paragraph (f).
2813 (f) If a Medicaid recipient does not choose a managed care
2814 plan or MediPass provider, the agency shall assign the Medicaid
2815 recipient to a managed care plan or MediPass provider. Medicaid
2816 recipients eligible for managed care plan enrollment who are
2817 subject to mandatory assignment but who fail to make a choice
2818 shall be assigned to managed care plans until an enrollment of
2819 35 percent in MediPass and 65 percent in managed care plans, of
2820 all those eligible to choose managed care, is achieved. Once
2821 this enrollment is achieved, the assignments shall be divided in

2822 order to maintain an enrollment in MediPass and managed care
2823 plans which is in a 35 percent and 65 percent proportion,
2824 respectively. Thereafter, assignment of Medicaid recipients who
2825 fail to make a choice shall be based proportionally on the
2826 preferences of recipients who have made a choice in the previous
2827 period. Such proportions shall be revised at least quarterly to
2828 reflect an update of the preferences of Medicaid recipients. The
2829 agency shall disproportionately assign Medicaid-eligible
2830 recipients who are required to but have failed to make a choice
2831 of managed care plan or MediPass, ~~including children, and who~~
2832 ~~would be assigned to the MediPass program to children's networks~~
2833 ~~as described in s. 409.912(4)(g),~~ Children's Medical Services
2834 Network as defined in s. 391.021, exclusive provider
2835 organizations, provider service networks, minority physician
2836 networks, and pediatric emergency department diversion programs
2837 authorized by this chapter or the General Appropriations Act, in
2838 such manner as the agency deems appropriate, until the agency
2839 has determined that the networks and programs have sufficient
2840 numbers to be operated economically. For purposes of this
2841 paragraph, when referring to assignment, the term "managed care
2842 plans" includes health maintenance organizations, exclusive
2843 provider organizations, provider service networks, minority
2844 physician networks, Children's Medical Services Network, and
2845 pediatric emergency department diversion programs authorized by
2846 this chapter or the General Appropriations Act. When making
2847 assignments, the agency shall take into account the following
2848 criteria:
2849 1. A managed care plan has sufficient network capacity to

2850 meet the need of members.
2851 2. The managed care plan or MediPass has previously
2852 enrolled the recipient as a member, or one of the managed care
2853 plan's primary care providers or MediPass providers has
2854 previously provided health care to the recipient.
2855 3. The agency has knowledge that the member has previously
2856 expressed a preference for a particular managed care plan or
2857 MediPass provider as indicated by Medicaid fee-for-service
2858 claims data, but has failed to make a choice.
2859 4. The managed care plan's or MediPass primary care
2860 providers are geographically accessible to the recipient's
2861 residence.
2862 (g) When more than one managed care plan or MediPass
2863 provider meets the criteria specified in paragraph (f), the
2864 agency shall make recipient assignments consecutively by family
2865 unit.
2866 (h) The agency may not engage in practices that are
2867 designed to favor one managed care plan over another or that are
2868 designed to influence Medicaid recipients to enroll in MediPass
2869 rather than in a managed care plan or to enroll in a managed
2870 care plan rather than in MediPass. This subsection does not
2871 prohibit the agency from reporting on the performance of
2872 MediPass or any managed care plan, as measured by performance
2873 criteria developed by the agency.
2874 (i) After a recipient has made his or her selection or has
2875 been enrolled in a managed care plan or MediPass, the recipient
2876 shall have 90 days to exercise the opportunity to voluntarily
2877 disenroll and select another managed care plan or MediPass.

2878 After 90 days, no further changes may be made except for good
2879 cause. Good cause includes, but is not limited to, poor quality
2880 of care, lack of access to necessary specialty services, an
2881 unreasonable delay or denial of service, or fraudulent
2882 enrollment. The agency shall develop criteria for good cause
2883 disenrollment for chronically ill and disabled populations who
2884 are assigned to managed care plans if more appropriate care is
2885 available through the MediPass program. The agency must make a
2886 determination as to whether cause exists. However, the agency
2887 may require a recipient to use the managed care plan's or
2888 MediPass grievance process prior to the agency's determination
2889 of cause, except in cases in which immediate risk of permanent
2890 damage to the recipient's health is alleged. The grievance
2891 process, when utilized, must be completed in time to permit the
2892 recipient to disenroll by the first day of the second month
2893 after the month the disenrollment request was made. If the
2894 managed care plan or MediPass, as a result of the grievance
2895 process, approves an enrollee's request to disenroll, the agency
2896 is not required to make a determination in the case. The agency
2897 must make a determination and take final action on a recipient's
2898 request so that disenrollment occurs no later than the first day
2899 of the second month after the month the request was made. If the
2900 agency fails to act within the specified timeframe, the
2901 recipient's request to disenroll is deemed to be approved as of
2902 the date agency action was required. Recipients who disagree
2903 with the agency's finding that cause does not exist for
2904 disenrollment shall be advised of their right to pursue a
2905 Medicaid fair hearing to dispute the agency's finding.

2906 (j) The agency shall apply for a federal waiver from the
2907 Centers for Medicare and Medicaid Services to lock eligible
2908 Medicaid recipients into a managed care plan or MediPass for 12
2909 months after an open enrollment period. After 12 months'
2910 enrollment, a recipient may select another managed care plan or
2911 MediPass provider. However, nothing shall prevent a Medicaid
2912 recipient from changing primary care providers within the
2913 managed care plan or MediPass program during the 12-month
2914 period.
2915 (k) When a Medicaid recipient does not choose a managed
2916 care plan or MediPass provider, the agency shall assign the
2917 Medicaid recipient to a managed care plan, except in those
2918 counties in which there are fewer than two managed care plans
2919 accepting Medicaid enrollees, in which case assignment shall be
2920 to a managed care plan or a MediPass provider. Medicaid
2921 recipients in counties with fewer than two managed care plans
2922 accepting Medicaid enrollees who are subject to mandatory
2923 assignment but who fail to make a choice shall be assigned to
2924 managed care plans until an enrollment of 35 percent in MediPass
2925 and 65 percent in managed care plans, of all those eligible to
2926 choose managed care, is achieved. Once that enrollment is
2927 achieved, the assignments shall be divided in order to maintain
2928 an enrollment in MediPass and managed care plans which is in a
2929 35 percent and 65 percent proportion, respectively. For purposes
2930 of this paragraph, when referring to assignment, the term
2931 "managed care plans" includes exclusive provider organizations,
2932 provider service networks, Children's Medical Services Network,
2933 minority physician networks, and pediatric emergency department

2934 diversion programs authorized by this chapter or the General
2935 Appropriations Act. When making assignments, the agency shall
2936 take into account the following criteria:
2937 1. A managed care plan has sufficient network capacity to
2938 meet the need of members.
2939 2. The managed care plan or MediPass has previously
2940 enrolled the recipient as a member, or one of the managed care
2941 plan's primary care providers or MediPass providers has
2942 previously provided health care to the recipient.
2943 3. The agency has knowledge that the member has previously
2944 expressed a preference for a particular managed care plan or
2945 MediPass provider as indicated by Medicaid fee-for-service
2946 claims data, but has failed to make a choice.
2947 4. The managed care plan's or MediPass primary care
2948 providers are geographically accessible to the recipient's
2949 residence.
2950 5. The agency has authority to make mandatory assignments
2951 based on quality of service and performance of managed care
2952 plans.
2953 (l) Notwithstanding the provisions of chapter 287, the
2954 agency may, at its discretion, renew cost-effective contracts
2955 for choice counseling services once or more for such periods as
2956 the agency may decide. However, all such renewals may not
2957 combine to exceed a total period longer than the term of the
2958 original contract.
2959
2960 This subsection expires October 1, 2013.
2961 (3)(a) The agency shall establish quality-of-care

2962 standards for managed care plans. These standards shall be based
2963 upon, but are not limited to:
2964 1. Compliance with the accreditation requirements as
2965 provided in s. 641.512.
2966 2. Compliance with Early and Periodic Screening,
2967 Diagnosis, and Treatment screening requirements.
2968 3. The percentage of voluntary disenrollments.
2969 4. Immunization rates.
2970 5. Standards of the National Committee for Quality
2971 Assurance and other approved accrediting bodies.
2972 6. Recommendations of other authoritative bodies.
2973 7. Specific requirements of the Medicaid program, or
2974 standards designed to specifically assist the unique needs of
2975 Medicaid recipients.
2976 8. Compliance with the health quality improvement system
2977 as established by the agency, which incorporates standards and
2978 guidelines developed by the Medicaid Bureau of the Health Care
2979 Financing Administration as part of the quality assurance reform
2980 initiative.
2981 (b) For the MediPass program, the agency shall establish
2982 standards which are based upon, but are not limited to:
2983 1. Quality-of-care standards which are comparable to those
2984 required of managed care plans.
2985 2. Credentialing standards for MediPass providers.
2986 3. Compliance with Early and Periodic Screening,
2987 Diagnosis, and Treatment screening requirements.
2988 4. Immunization rates.
2989 5. Specific requirements of the Medicaid program, or

2990 standards designed to specifically assist the unique needs of
2991 Medicaid recipients.
2992
2993 This subsection expires October 1, 2013.
2994 (4)(a) Each female recipient may select as her primary
2995 care provider an obstetrician/gynecologist who has agreed to
2996 participate as a MediPass primary care case manager.
2997 (b) The agency shall establish a complaints and grievance
2998 process to assist Medicaid recipients enrolled in the MediPass
2999 program to resolve complaints and grievances. The agency shall
3000 investigate reports of quality-of-care grievances which remain
3001 unresolved to the satisfaction of the enrollee.
3002
3003 This subsection expires October 1, 2013.
3004 (5)(a) The agency shall work cooperatively with the Social
3005 Security Administration to identify beneficiaries who are
3006 jointly eligible for Medicare and Medicaid and shall develop
3007 cooperative programs to encourage these beneficiaries to enroll
3008 in a Medicare participating health maintenance organization or
3009 prepaid health plans.
3010 (b) The agency shall work cooperatively with the
3011 Department of Elderly Affairs to assess the potential cost-
3012 effectiveness of providing MediPass to beneficiaries who are
3013 jointly eligible for Medicare and Medicaid on a voluntary choice
3014 basis. If the agency determines that enrollment of these
3015 beneficiaries in MediPass has the potential for being cost-
3016 effective for the state, the agency shall offer MediPass to
3017 these beneficiaries on a voluntary choice basis in the counties

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3018 where MediPass operates.
3019
3020 This subsection expires October 1, 2013.
3021 (6) MediPass enrolled recipients may receive up to 10
3022 visits of reimbursable services by participating Medicaid
3023 physicians licensed under chapter 460 and up to four visits of
3024 reimbursable services by participating Medicaid physicians
3025 licensed under chapter 461. Any further visits must be by prior
3026 authorization by the MediPass primary care provider. However,
3027 nothing in this subsection may be construed to increase the
3028 total number of visits or the total amount of dollars per year
3029 per person under current Medicaid rules, unless otherwise
3030 provided for in the General Appropriations Act. This subsection
3031 expires October 1, 2013.
3032 (7) The agency shall investigate the feasibility of
3033 developing managed care plan and MediPass options for the
3034 following groups of Medicaid recipients:
3035 (a) Pregnant women and infants.
3036 (b) Elderly and disabled recipients, especially those who
3037 are at risk of nursing home placement.
3038 (c) Persons with developmental disabilities.
3039 (d) Qualified Medicare beneficiaries.
3040 (e) Adults who have chronic, high-cost medical conditions.
3041 (f) Adults and children who have mental health problems.
3042 (g) Other recipients for whom managed care plans and
3043 MediPass offer the opportunity of more cost-effective care and
3044 greater access to qualified providers.
3045 (8)(a) The agency shall encourage the development of

3046 ~~public and private partnerships to foster the growth of health~~
3047 ~~maintenance organizations and prepaid health plans that will~~
3048 ~~provide high-quality health care to Medicaid recipients.~~
3049 ~~(b) Subject to the availability of moneys and any~~
3050 ~~limitations established by the General Appropriations Act or~~
3051 ~~chapter 216, the agency is authorized to enter into contracts~~
3052 ~~with traditional providers of health care to low-income persons~~
3053 ~~to assist such providers with the technical aspects of~~
3054 ~~cooperatively developing Medicaid prepaid health plans.~~
3055 ~~1. The agency may contract with disproportionate share~~
3056 ~~hospitals, county health departments, federally initiated or~~
3057 ~~federally funded community health centers, and counties that~~
3058 ~~operate either a hospital or a community clinic.~~
3059 ~~2. A contract may not be for more than $100,000 per year,~~
3060 ~~and no contract may be extended with any particular provider for~~
3061 ~~more than 2 years. The contract is intended only as seed or~~
3062 ~~development funding and requires a commitment from the~~
3063 ~~interested party.~~
3064 ~~3. A contract must require participation by at least one~~
3065 ~~community health clinic and one disproportionate share hospital.~~
3066 (7)~~(9)~~(a) The agency shall develop and implement a
3067 comprehensive plan to ensure that recipients are adequately
3068 informed of their choices and rights under all Medicaid managed
3069 care programs and that Medicaid managed care programs meet
3070 acceptable standards of quality in patient care, patient
3071 satisfaction, and financial solvency.
3072 (b) The agency shall provide adequate means for informing
3073 patients of their choice and rights under a managed care plan at

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3074 the time of eligibility determination.

3075 (c) The agency shall require managed care plans and
3076 MediPass providers to demonstrate and document plans and
3077 activities, as defined by rule, including outreach and followup,
3078 undertaken to ensure that Medicaid recipients receive the health
3079 care service to which they are entitled.

3080

3081 This subsection expires October 1, 2013.

3082 (8) ~~(10)~~ The agency shall consult with Medicaid consumers
3083 and their representatives on an ongoing basis regarding
3084 measurements of patient satisfaction, procedures for resolving
3085 patient grievances, standards for ensuring quality of care,
3086 mechanisms for providing patient access to services, and
3087 policies affecting patient care. This subsection expires October
3088 1, 2013.

3089 (9) ~~(11)~~ The agency may extend eligibility for Medicaid
3090 recipients enrolled in licensed and accredited health
3091 maintenance organizations for the duration of the enrollment
3092 period or for 6 months, whichever is earlier, provided the
3093 agency certifies that such an offer will not increase state
3094 expenditures. This subsection expires October 1, 2013.

3095 (10) ~~(12)~~ A managed care plan that has a Medicaid contract
3096 shall at least annually review each primary care physician's
3097 active patient load and shall ensure that additional Medicaid
3098 recipients are not assigned to physicians who have a total
3099 active patient load of more than 3,000 patients. As used in this
3100 subsection, the term "active patient" means a patient who is
3101 seen by the same primary care physician, or by a physician

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3102 assistant or advanced registered nurse practitioner under the
3103 supervision of the primary care physician, at least three times
3104 within a calendar year. Each primary care physician shall
3105 annually certify to the managed care plan whether or not his or
3106 her patient load exceeds the limits established under this
3107 subsection and the managed care plan shall accept such
3108 certification on face value as compliance with this subsection.
3109 The agency shall accept the managed care plan's representations
3110 that it is in compliance with this subsection based on the
3111 certification of its primary care physicians, unless the agency
3112 has an objective indication that access to primary care is being
3113 compromised, such as receiving complaints or grievances relating
3114 to access to care. If the agency determines that an objective
3115 indication exists that access to primary care is being
3116 compromised, it may verify the patient load certifications
3117 submitted by the managed care plan's primary care physicians and
3118 that the managed care plan is not assigning Medicaid recipients
3119 to primary care physicians who have an active patient load of
3120 more than 3,000 patients. This subsection expires October 1,
3121 2013.
3122 ~~(13) Effective July 1, 2003, the agency shall adjust the~~
3123 ~~enrollee assignment process of Medicaid managed prepaid health~~
3124 ~~plans for those Medicaid managed prepaid plans operating in~~
3125 ~~Miami-Dade County which have executed a contract with the agency~~
3126 ~~for a minimum of 8 consecutive years in order for the Medicaid~~
3127 ~~managed prepaid plan to maintain a minimum enrollment level of~~
3128 ~~15,000 members per month. When assigning enrollees pursuant to~~
3129 ~~this subsection, the agency shall give priority to providers~~

3130 ~~that initially qualified under this subsection until such~~
3131 ~~providers reach and maintain an enrollment level of 15,000~~
3132 ~~members per month. A prepaid health plan that has a statewide~~
3133 ~~Medicaid enrollment of 25,000 or more members is not eligible~~
3134 ~~for enrollee assignments under this subsection.~~
3135 (11) ~~(14)~~ The agency shall include in its calculation of
3136 the hospital inpatient component of a Medicaid health
3137 maintenance organization's capitation rate any special payments,
3138 including, but not limited to, upper payment limit or
3139 disproportionate share hospital payments, made to qualifying
3140 hospitals through the fee-for-service program. The agency may
3141 seek federal waiver approval or state plan amendment as needed
3142 to implement this adjustment.
3143 (12)(a) Beginning September 1, 2010, the agency shall
3144 begin a budget-neutral adjustment of capitation rates for all
3145 Medicaid prepaid plans in the state. The adjustment to
3146 capitation rates shall be based on aggregate risk scores for
3147 each prepaid plan's enrollees. During the first 2 years of the
3148 adjustment, the agency shall ensure that no plan has an
3149 aggregate risk score that varies more than 10 percent from the
3150 aggregate weighted average for all plans. The risk adjusted
3151 capitation rates shall be phased in as follows:
3152 1. In the first fiscal year, 75 percent of the capitation
3153 rate shall be based on the current methodology and 25 percent
3154 shall be based on the risk-adjusted rate methodology.
3155 2. In the second fiscal year, 50 percent of the capitation
3156 rate shall be based on the current methodology and 50 percent
3157 shall be based on the risk-adjusted methodology.

3158 3. In the third fiscal year, the risk-adjusted capitation
3159 methodology shall be fully implemented.
3160 (b) During this period, the agency shall establish a
3161 technical advisory panel to obtain input from the prepaid plans
3162 affected by the transition to risk adjusted rates.
3163 (13) The agency shall develop a process to enable any
3164 recipient with access to employer sponsored insurance to opt out
3165 of all qualified plans in the Medicaid program and to use
3166 Medicaid financial assistance to pay for the recipient's share
3167 of cost in any such plan. Contingent on federal approval, the
3168 agency shall also enable recipients with access to other
3169 insurance or related products providing access to health care
3170 services created pursuant to state law, including any plan or
3171 product available pursuant to Cover Florida, the Florida Health
3172 Choices Program, or any health exchange, to opt out. The amount
3173 of financial assistance provided for each recipient shall not
3174 exceed the amount of the Medicaid premium that would have been
3175 paid to a plan for that recipient.
3176 (14) Each qualified plan shall establish an incentive
3177 program that rewards specific healthy behaviors with credits in
3178 a flexible spending account pursuant to s. 409.9122(14).
3179 (a) At the discretion of the recipient, credits shall be
3180 used to purchase otherwise uncovered health and related services
3181 during the entire period of and for a maximum of 3 years after
3182 the recipient's Medicaid eligibility, whether or not the
3183 recipient remains continuously enrolled in the plan in which the
3184 credits were earned.

3185 (b) Enhanced benefits offered by a qualified plan shall be
3186 structured to provide greater incentives for those diseases
3187 linked with lifestyle and conditions or behaviors associated
3188 with avoidable utilization of high-cost services.
3189 (c) To fund these credits, each plan must maintain a
3190 reserve account in an amount up to 2 percent of the plan's
3191 Medicaid premium revenue or benchmark premium revenue in the
3192 case of provider service networks based on an actuarial
3193 assessment of the value of the enhanced benefit program.
3194 (15) The agency shall maintain and operate the Medicaid
3195 Encounter Data System to collect, process, store, and report on
3196 covered services provided to all Florida Medicaid recipients
3197 enrolled in prepaid managed care plans. Prepaid managed care
3198 plans shall submit encounter data electronically in a format
3199 that complies with the Health Insurance Portability and
3200 Accountability Act provisions for electronic claims and in
3201 accordance with deadlines established by the agency. Prepaid
3202 managed care plans must certify that the data reported is
3203 accurate and complete. The agency is responsible for validating
3204 the data submitted by the plans.
3205 (16) The agency may establish a per-member per-month
3206 payment for Medicare Advantage Special Needs members that are
3207 also eligible for Medicaid as a mechanism for meeting the
3208 state's cost sharing obligation. The agency may also develop a
3209 per-member per-month payment for Medicaid only covered services
3210 for which the state is responsible. The agency shall develop a
3211 mechanism to ensure that such per-member per-month payment
3212 enhances the value to the state and enrolled members by limiting

3213 cost sharing, enhancing the scope of Medicare supplemental
3214 benefits that are equal to or greater than Medicaid coverage for
3215 select services, and improving care coordination.
3216 (17) The agency shall establish, and managed care plans
3217 shall use, a uniform method of accounting for and reporting
3218 medical and nonmedical costs. The agency shall make such
3219 information available to the public.
3220 (18) Effective October 1, 2013, school districts
3221 participating in the certified school match program pursuant to
3222 ss. 409.908(21) and 1011.70 shall be reimbursed by Medicaid,
3223 subject to the limitations of s. 1011.70(1), for a Medicaid-
3224 eligible child participating in the services as authorized in s.
3225 1011.70, as provided for in s. 409.9071. Managed care plans
3226 shall make a good faith effort to execute agreements with school
3227 districts regarding the coordinated provision of services
3228 authorized under s. 1011.70 and county health departments
3229 delivering school-based services pursuant to ss. 381.0056 and
3230 381.0057. To ensure continuity of care for Medicaid patients,
3231 the agency, the Department of Health, and the Department of
3232 Education shall develop procedures for ensuring that a student's
3233 managed care plan receives information relating to services
3234 provided in accordance with ss. 381.0056, 381.0057, 409.9071,
3235 and 1011.70.
3236 (19) The agency may, on a case-by-case basis, exempt a
3237 recipient from mandatory enrollment in a managed care plan when
3238 the recipient has a unique, time-limited disease or condition-
3239 related circumstance and managed care enrollment will interfere
3240 with ongoing care because the recipient's provider does not

3241 participate in the managed care plans available in the
3242 recipient's area.
3243 Section 16. Subsection (18) of section 430.04, Florida
3244 Statutes, is amended to read:
3245 430.04 Duties and responsibilities of the Department of
3246 Elderly Affairs.—The Department of Elderly Affairs shall:
3247 (18) Administer all Medicaid waivers and programs relating
3248 to elders and their appropriations. The waivers include, but are
3249 not limited to:
3250 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~
3251 ~~established in s. 430.502(7), (8), and (9).~~
3252 (a)~~(b)~~ The Assisted Living for the Frail Elderly Waiver.
3253 (b)~~(c)~~ The Aged and Disabled Adult Waiver.
3254 (c)~~(d)~~ The Adult Day Health Care Waiver.
3255 (d)~~(e)~~ The Consumer-Directed Care Plus Program as defined
3256 in s. 409.221.
3257 (e)~~(f)~~ The Program of All-inclusive Care for the Elderly.
3258 (f)~~(g)~~ The Long-Term Care Community-Based Diversion Pilot
3259 Project as described in s. 430.705.
3260 (g)~~(h)~~ The Channeling Services Waiver for Frail Elders.
3261
3262 The department shall develop a transition plan for recipients
3263 receiving services in long-term care Medicaid waivers for elders
3264 or disabled adults on the date qualified plans become available
3265 in each recipient's region pursuant to s. 409.981(2) to enroll
3266 those recipients in qualified plans. This subsection expires
3267 October 1, 2012.

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3268 Section 17. Section 430.2053, Florida Statutes, is amended
3269 to read:
3270 430.2053 Aging resource centers.—
3271 (1) The department, in consultation with the Agency for
3272 Health Care Administration and the Department of Children and
3273 Family Services, shall develop pilot projects for aging resource
3274 centers. ~~By October 31, 2004, the department, in consultation~~
3275 ~~with the agency and the Department of Children and Family~~
3276 ~~Services, shall develop an implementation plan for aging~~
3277 ~~resource centers and submit the plan to the Governor, the~~
3278 ~~President of the Senate, and the Speaker of the House of~~
3279 ~~Representatives. The plan must include qualifications for~~
3280 ~~designation as a center, the functions to be performed by each~~
3281 ~~center, and a process for determining that a current area agency~~
3282 ~~on aging is ready to assume the functions of an aging resource~~
3283 ~~center.~~
3284 ~~(2) Each area agency on aging shall develop, in~~
3285 ~~consultation with the existing community care for the elderly~~
3286 ~~lead agencies within their planning and service areas, a~~
3287 ~~proposal that describes the process the area agency on aging~~
3288 ~~intends to undertake to transition to an aging resource center~~
3289 ~~prior to July 1, 2005, and that describes the area agency's~~
3290 ~~compliance with the requirements of this section. The proposals~~
3291 ~~must be submitted to the department prior to December 31, 2004.~~
3292 ~~The department shall evaluate all proposals for readiness and,~~
3293 ~~prior to March 1, 2005, shall select three area agencies on~~
3294 ~~aging which meet the requirements of this section to begin the~~
3295 ~~transition to aging resource centers. Those area agencies on~~

3296 ~~aging which are not selected to begin the transition to aging~~
3297 ~~resource centers shall, in consultation with the department and~~
3298 ~~the existing community care for the elderly lead agencies within~~
3299 ~~their planning and service areas, amend their proposals as~~
3300 ~~necessary and resubmit them to the department prior to July 1,~~
3301 ~~2005. The department may transition additional area agencies to~~
3302 ~~aging resource centers as it determines that area agencies are~~
3303 ~~in compliance with the requirements of this section.~~
3304 ~~(3) The Auditor General and the Office of Program Policy~~
3305 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
3306 ~~review and assess the department's process for determining an~~
3307 ~~area agency's readiness to transition to an aging resource~~
3308 ~~center.~~
3309 ~~(a) The review must, at a minimum, address the~~
3310 ~~appropriateness of the department's criteria for selection of an~~
3311 ~~area agency to transition to an aging resource center, the~~
3312 ~~instruments applied, the degree to which the department~~
3313 ~~accurately determined each area agency's compliance with the~~
3314 ~~readiness criteria, the quality of the technical assistance~~
3315 ~~provided by the department to an area agency in correcting any~~
3316 ~~weaknesses identified in the readiness assessment, and the~~
3317 ~~degree to which each area agency overcame any identified~~
3318 ~~weaknesses.~~
3319 ~~(b) Reports of these reviews must be submitted to the~~
3320 ~~appropriate substantive and appropriations committees in the~~
3321 ~~Senate and the House of Representatives on March 1 and September~~
3322 ~~1 of each year until full transition to aging resource centers~~
3323 ~~has been accomplished statewide, except that the first report~~

3324 ~~must be submitted by February 1, 2005, and must address all~~
3325 ~~readiness activities undertaken through December 31, 2004. The~~
3326 ~~perspectives of all participants in this review process must be~~
3327 ~~included in each report.~~
3328 (2)~~(4)~~ The purposes of an aging resource center shall be:
3329 (a) To provide Florida's elders and their families with a
3330 locally focused, coordinated approach to integrating information
3331 and referral for all available services for elders with the
3332 eligibility determination entities for state and federally
3333 funded long-term-care services.
3334 (b) To provide for easier access to long-term-care
3335 services by Florida's elders and their families by creating
3336 multiple access points to the long-term-care network that flow
3337 through one established entity with wide community recognition.
3338 (3)~~(5)~~ The duties of an aging resource center are to:
3339 (a) Develop referral agreements with local community
3340 service organizations, such as senior centers, existing elder
3341 service providers, volunteer associations, and other similar
3342 organizations, to better assist clients who do not need or do
3343 not wish to enroll in programs funded by the department or the
3344 agency. The referral agreements must also include a protocol,
3345 developed and approved by the department, which provides
3346 specific actions that an aging resource center and local
3347 community service organizations must take when an elder or an
3348 elder's representative seeking information on long-term-care
3349 services contacts a local community service organization prior
3350 to contacting the aging resource center. The protocol shall be
3351 designed to ensure that elders and their families are able to

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3352 access information and services in the most efficient and least
3353 cumbersome manner possible.
3354 (b) Provide an initial screening of all clients who
3355 request long-term-care services to determine whether the person
3356 would be most appropriately served through any combination of
3357 federally funded programs, state-funded programs, locally funded
3358 or community volunteer programs, or private funding for
3359 services.
3360 (c) Determine eligibility for the programs and services
3361 listed in subsection (9) ~~(11)~~ for persons residing within the
3362 geographic area served by the aging resource center and
3363 determine a priority ranking for services which is based upon
3364 the potential recipient's frailty level and likelihood of
3365 institutional placement without such services.
3366 (d) Manage the availability of financial resources for the
3367 programs and services listed in subsection (9) ~~(11)~~ for persons
3368 residing within the geographic area served by the aging resource
3369 center.
3370 (e) When financial resources become available, refer a
3371 client to the most appropriate entity to begin receiving
3372 services. The aging resource center shall make referrals to lead
3373 agencies for service provision that ensure that individuals who
3374 are vulnerable adults in need of services pursuant to s.
3375 415.104(3)(b), or who are victims of abuse, neglect, or
3376 exploitation in need of immediate services to prevent further
3377 harm and are referred by the adult protective services program,
3378 are given primary consideration for receiving community-care-
3379 for-the-elderly services in compliance with the requirements of

3380 s. 430.205(5)(a) and that other referrals for services are in
3381 compliance with s. 430.205(5)(b).
3382 (f) Convene a work group to advise in the planning,
3383 implementation, and evaluation of the aging resource center. The
3384 work group shall be comprised of representatives of local
3385 service providers, Alzheimer's Association chapters, housing
3386 authorities, social service organizations, advocacy groups,
3387 representatives of clients receiving services through the aging
3388 resource center, and any other persons or groups as determined
3389 by the department. The aging resource center, in consultation
3390 with the work group, must develop annual program improvement
3391 plans that shall be submitted to the department for
3392 consideration. The department shall review each annual
3393 improvement plan and make recommendations on how to implement
3394 the components of the plan.
3395 (g) Enhance the existing area agency on aging in each
3396 planning and service area by integrating, either physically or
3397 virtually, the staff and services of the area agency on aging
3398 with the staff of the department's local CARES Medicaid ~~nursing~~
3399 ~~home~~ preadmission screening unit and a sufficient number of
3400 staff from the Department of Children and Family Services'
3401 Economic Self-Sufficiency Unit necessary to determine the
3402 financial eligibility for all persons age 60 and older residing
3403 within the area served by the aging resource center that are
3404 seeking Medicaid services, Supplemental Security Income, and
3405 food stamps.
3406 (h) Assist clients who request long-term care services in
3407 being evaluated for eligibility for enrollment in the Medicaid

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3408 long-term care managed care program as qualified plans become
3409 available in each of the regions pursuant to s. 409.981(2).
3410 (i) Provide choice counseling for the Medicaid long-term
3411 care managed care program by integrating, either physically or
3412 virtually, choice counseling staff and services as qualified
3413 plans become available in each of the regions pursuant to s.
3414 409.981(2). Pursuant to s. 409.984(1), the agency may contract
3415 directly with the aging resource center to provide choice
3416 counseling services or may contract with another vendor if the
3417 aging resource center does not choose to provide such services.
3418 (j) Assist Medicaid recipients enrolled in the Medicaid
3419 long-term care managed care program with informally resolving
3420 grievances with a managed care network and assist Medicaid
3421 recipients in accessing the managed care network's formal
3422 grievance process as qualified plans become available in each of
3423 the regions pursuant to s. 409.981(2).
3424 (4) ~~(6)~~ The department shall select the entities to become
3425 aging resource centers based on each entity's readiness and
3426 ability to perform the duties listed in subsection (3) ~~(5)~~ and
3427 the entity's:
3428 (a) Expertise in the needs of each target population the
3429 center proposes to serve and a thorough knowledge of the
3430 providers that serve these populations.
3431 (b) Strong connections to service providers, volunteer
3432 agencies, and community institutions.
3433 (c) Expertise in information and referral activities.
3434 (d) Knowledge of long-term-care resources, including
3435 resources designed to provide services in the least restrictive

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3436 setting.

3437 (e) Financial solvency and stability.

3438 (f) Ability to collect, monitor, and analyze data in a
3439 timely and accurate manner, along with systems that meet the
3440 department's standards.

3441 (g) Commitment to adequate staffing by qualified personnel
3442 to effectively perform all functions.

3443 (h) Ability to meet all performance standards established
3444 by the department.

3445 <u>(5)</u>~~(7)~~ The aging resource center shall have a governing
3446 body which shall be the same entity described in s. 20.41(7),
3447 and an executive director who may be the same person as
3448 described in s. 20.41(7). The governing body shall annually
3449 evaluate the performance of the executive director.

3450 <u>(6)</u>~~(8)~~ The aging resource center may not be a provider of
3451 direct services other than <u>choice counseling as qualified plans</u>
3452 <u>become available in each of the regions pursuant to s.</u>
3453 <u>409.981(2),</u> information and referral services<u>,</u> and screening.

3454 <u>(7)</u>~~(9)~~ The aging resource center must agree to allow the
3455 department to review any financial information the department
3456 determines is necessary for monitoring or reporting purposes,
3457 including financial relationships.

3458 <u>(8)</u>~~(10)~~ The duties and responsibilities of the community
3459 care for the elderly lead agencies within each area served by an
3460 aging resource center shall be to:

3461 (a) Develop strong community partnerships to maximize the
3462 use of community resources for the purpose of assisting elders
3463 to remain in their community settings for as long as it is

3464 safely possible.
3465 (b) Conduct comprehensive assessments of clients that have
3466 been determined eligible and develop a care plan consistent with
3467 established protocols that ensures that the unique needs of each
3468 client are met.
3469 <u>(9)</u> ~~(11)~~ The services to be administered through the aging
3470 resource center shall include those funded by the following
3471 programs:
3472 (a) Community care for the elderly.
3473 (b) Home care for the elderly.
3474 (c) Contracted services.
3475 (d) Alzheimer's disease initiative.
3476 (e) Aged and disabled adult Medicaid waiver. <u>This</u>
3477 <u>paragraph expires October 1, 2012.</u>
3478 (f) Assisted living for the frail elderly Medicaid waiver.
3479 <u>This paragraph expires October 1, 2012.</u>
3480 (g) Older Americans Act.
3481 <u>(10)</u> ~~(12)~~ The department shall, prior to designation of an
3482 aging resource center, develop by rule operational and quality
3483 assurance standards and outcome measures to ensure that clients
3484 receiving services through all long-term-care programs
3485 administered through an aging resource center are receiving the
3486 appropriate care they require and that contractors and
3487 subcontractors are adhering to the terms of their contracts and
3488 are acting in the best interests of the clients they are
3489 serving, consistent with the intent of the Legislature to reduce
3490 the use of and cost of nursing home care. The department shall
3491 by rule provide operating procedures for aging resource centers,

3492 which shall include:
3493 (a) Minimum standards for financial operation, including
3494 audit procedures.
3495 (b) Procedures for monitoring and sanctioning of service
3496 providers.
3497 (c) Minimum standards for technology utilized by the aging
3498 resource center.
3499 (d) Minimum staff requirements which shall ensure that the
3500 aging resource center employs sufficient quality and quantity of
3501 staff to adequately meet the needs of the elders residing within
3502 the area served by the aging resource center.
3503 (e) Minimum accessibility standards, including hours of
3504 operation.
3505 (f) Minimum oversight standards for the governing body of
3506 the aging resource center to ensure its continuous involvement
3507 in, and accountability for, all matters related to the
3508 development, implementation, staffing, administration, and
3509 operations of the aging resource center.
3510 (g) Minimum education and experience requirements for
3511 executive directors and other executive staff positions of aging
3512 resource centers.
3513 (h) Minimum requirements regarding any executive staff
3514 positions that the aging resource center must employ and minimum
3515 requirements that a candidate must meet in order to be eligible
3516 for appointment to such positions.
3517 (11) ~~(13)~~ In an area in which the department has designated
3518 an area agency on aging as an aging resource center, the
3519 department and the agency shall not make payments for the

3520 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
3521 Community Diversion Project for such persons who were not
3522 screened and enrolled through the aging resource center. The
3523 department shall cease making payments for recipients in
3524 qualified plans as qualified plans become available in each of
3525 the regions pursuant to s. 409.981(2).
3526 (12) ~~(14)~~ Each aging resource center shall enter into a
3527 memorandum of understanding with the department for
3528 collaboration with the CARES unit staff. The memorandum of
3529 understanding shall outline the staff person responsible for
3530 each function and shall provide the staffing levels necessary to
3531 carry out the functions of the aging resource center.
3532 (13) ~~(15)~~ Each aging resource center shall enter into a
3533 memorandum of understanding with the Department of Children and
3534 Family Services for collaboration with the Economic Self-
3535 Sufficiency Unit staff. The memorandum of understanding shall
3536 outline which staff persons are responsible for which functions
3537 and shall provide the staffing levels necessary to carry out the
3538 functions of the aging resource center.
3539 (14) As qualified plans become available in each of the
3540 regions pursuant to s. 409.981(2), if an aging resource center
3541 does not contract with the agency to provide Medicaid long-term
3542 care managed care choice counseling pursuant to s. 409.984(1),
3543 the aging resource center shall enter into a memorandum of
3544 understanding with the agency to coordinate staffing and
3545 collaborate with the choice counseling vendor. The memorandum of
3546 understanding shall identify the staff responsible for each
3547 function and shall provide the staffing levels necessary to

3548 carry out the functions of the aging resource center.
3549 (15) ~~(16)~~ If any of the state activities described in this
3550 section are outsourced, either in part or in whole, the contract
3551 executing the outsourcing shall mandate that the contractor or
3552 its subcontractors shall, either physically or virtually,
3553 execute the provisions of the memorandum of understanding
3554 instead of the state entity whose function the contractor or
3555 subcontractor now performs.
3556 (16) ~~(17)~~ In order to be eligible to begin transitioning to
3557 an aging resource center, an area agency on aging board must
3558 ensure that the area agency on aging which it oversees meets all
3559 of the minimum requirements set by law and in rule.
3560 ~~(18) The department shall monitor the three initial~~
3561 ~~projects for aging resource centers and report on the progress~~
3562 ~~of those projects to the Governor, the President of the Senate,~~
3563 ~~and the Speaker of the House of Representatives by June 30,~~
3564 ~~2005. The report must include an evaluation of the~~
3565 ~~implementation process.~~
3566 (17) ~~(19)~~(a) Once an aging resource center is operational,
3567 the department, in consultation with the agency, may develop
3568 capitation rates for any of the programs administered through
3569 the aging resource center. Capitation rates for programs shall
3570 be based on the historical cost experience of the state in
3571 providing those same services to the population age 60 or older
3572 residing within each area served by an aging resource center.
3573 Each capitated rate may vary by geographic area as determined by
3574 the department.
3575 (b) The department and the agency may determine for each

3576 area served by an aging resource center whether it is
3577 appropriate, consistent with federal and state laws and
3578 regulations, to develop and pay separate capitated rates for
3579 each program administered through the aging resource center or
3580 to develop and pay capitated rates for service packages which
3581 include more than one program or service administered through
3582 the aging resource center.
3583 (c) Once capitation rates have been developed and
3584 certified as actuarially sound, the department and the agency
3585 may pay service providers the capitated rates for services when
3586 appropriate.
3587 (d) The department, in consultation with the agency, shall
3588 annually reevaluate and recertify the capitation rates,
3589 adjusting forward to account for inflation, programmatic
3590 changes.
3591 ~~(20) The department, in consultation with the agency,~~
3592 ~~shall submit to the Governor, the President of the Senate, and~~
3593 ~~the Speaker of the House of Representatives, by December 1,~~
3594 ~~2006, a report addressing the feasibility of administering the~~
3595 ~~following services through aging resource centers beginning July~~
3596 ~~1, 2007:~~
3597 ~~(a) Medicaid nursing home services.~~
3598 ~~(b) Medicaid transportation services.~~
3599 ~~(c) Medicaid hospice care services.~~
3600 ~~(d) Medicaid intermediate care services.~~
3601 ~~(e) Medicaid prescribed drug services.~~
3602 ~~(f) Medicaid assistive care services.~~
3603 ~~(g) Any other long-term-care program or Medicaid service.~~

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3604 (18) ~~(21)~~ This section shall not be construed to allow an
3605 aging resource center to restrict, manage, or impede the local
3606 fundraising activities of service providers.
3607 Section 18. Subsection (4) of section 641.386, Florida
3608 Statutes, is amended to read:
3609 641.386 Agent licensing and appointment required;
3610 exceptions.—
3611 (4) All agents and health maintenance organizations shall
3612 comply with and be subject to the applicable provisions of ss.
3613 641.309 and 409.912(20) ~~(21)~~, and all companies and entities
3614 appointing agents shall comply with s. 626.451, when marketing
3615 for any health maintenance organization licensed pursuant to
3616 this part, including those organizations under contract with the
3617 Agency for Health Care Administration to provide health care
3618 services to Medicaid recipients or any private entity providing
3619 health care services to Medicaid recipients pursuant to a
3620 prepaid health plan contract with the Agency for Health Care
3621 Administration.
3622 Section 19. Effective October 1, 2012, sections 430.701,
3623 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,
3624 430.708, and 430.709 Florida Statutes, are repealed.
3625 Section 20. Sections 409.9301, 409.942, 409.944, 409.945,
3626 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered
3627 as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
3628 402.87, Florida Statutes, respectively.
3629 Section 21. Paragraph (a) of subsection (1) of section
3630 443.111, Florida Statutes, is amended to read:
3631 443.111 Payment of benefits.—

3632 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
3633 in accordance with rules adopted by the Agency for Workforce
3634 Innovation, subject to the following requirements:
3635 (a) Benefits are payable by mail or electronically.
3636 Notwithstanding s. 402.82(4) ~~409.942(4)~~, The agency may develop
3637 a system for the payment of benefits by electronic funds
3638 transfer, including, but not limited to, debit cards, electronic
3639 payment cards, or any other means of electronic payment that the
3640 agency deems to be commercially viable or cost-effective.
3641 Commodities or services related to the development of such a
3642 system shall be procured by competitive solicitation, unless
3643 they are purchased from a state term contract pursuant to s.
3644 287.056. The agency shall adopt rules necessary to administer
3645 the system.
3646 Section 22. Except as otherwise expressly provided in this
3647 act, this act shall take effect July 1, 2010, if HB 7223 or
3648 similar legislation is adopted in the same legislative session
3649 or an extension thereof and becomes law.