1 A bill to be entitled
2 An act relating to health care; transferring and
3 reassigning certain functions and responsibilities,
4 including records, personnel, property, and unexpended
5 balances of appropriations and other resources, from the
6 Department of Health to the Department of Business and
7 Professional Regulation by a type two transfer; providing
8 for the continued validity of pending judicial or
9 administrative actions to which the Department of Health
10 is a party; providing for the continued validity of lawful
11 orders issued by the Department of Health; transferring
12 rules created by the Department of Health to the
13 Department of Business and Professional Regulation;
14 providing for the continued validity of permits and
15 certifications issued by the Department of Health;
16 amending s. 400.179, F.S.; authorizing the Agency for
17 Health Care Administration to transfer funds to the Grants
18 and Donations Trust Fund for certain repayments; amending
19 s. 400.23, F.S.; providing minimum staffing requirements
20 for nursing homes for a specified period; amending s.
21 409.905, F.S.; prohibiting payment for certain hospital
22 inpatient per diem rate adjustment for 2 fiscal years;
23 amending s. 409.906, F.S.; prohibiting payment for
24 Medicaid chiropractic services, hospice care services, and
25 podiatric services for 2 fiscal years; authorizing payment
26 of a specified amount for Medicaid services provided by an
27 anesthesiologist assistant; amending s. 409.908, F.S.;
28 deleting a provision prohibiting Medicaid from making any

29 payment toward deductibles and coinsurance for services
30 not covered by Medicaid; providing limitations on Medicaid
31 payments for coinsurance; revising reimbursement rates for
32 providers of Medicaid prescribed drugs; requiring the
33 agency to revise reimbursement rates for hospitals,
34 nursing homes, county health departments, and community
35 intermediate care facilities for the developmentally
36 disabled for 2 fiscal years; requiring the agency to apply
37 the effect of the revised reimbursement rates to set
38 payment rates for managed care plans and nursing home
39 diversion programs; requiring the agency to establish
40 workgroups to evaluate alternative reimbursement and
41 payment methodologies for hospitals, nursing facilities,
42 and managed care plans; requiring a report; providing for
43 future repeal of the suspension of the use of cost data to
44 set certain rates; amending s. 409.911, F.S.; revising the
45 share data used to calculate disproportionate share
46 payments to hospitals; amending s. 409.9112, F.S.;
47 revising the time period during which the agency is
48 prohibited from distributing disproportionate share
49 payments to regional perinatal intensive care centers;
50 amending s. 409.9113, F.S.; requiring the agency to
51 distribute moneys provided in the General Appropriations
52 Act to statutorily defined teaching hospitals and family
53 practice teaching hospitals under the teaching hospital
54 disproportionate share program for the 2008-2009 fiscal
55 year; amending s. 409.9117, F.S.; prohibiting the agency
56 from distributing moneys under the primary care

57 disproportionate share program for the 2008-2009 fiscal
58 year; amending s. 409.912, F.S.; adding a county for
59 participation in the Medicaid behavioral health care
60 services specialty prepaid plan; revising reimbursement
61 rates to pharmacies for Medicaid prescribed drugs;
62 requiring the agency to notify the Legislature before
63 seeking an amendment to the state plan in order to
64 implement programs authorized by the Deficit Reduction Act
65 of 2005; creating s. 409.91206, F.S.; providing for
66 proposed alternatives for health and long-term care
67 reforms; amending s. 409.91211, F.S.; providing for
68 expansion of the Medicaid managed care pilot program to
69 Hardee, Highlands, Hillsborough, Manatee, Miami-Dade,
70 Monroe, Pasco, Pinellas, and Polk Counties; permitting
71 fee-for-service provider service networks to be reimbursed
72 on a risk-adjusted capitated basis for certain services;
73 requiring the agency to encourage cost-effective
74 administration by provider service networks; requiring
75 quarterly monitoring and annual evaluation of plan network
76 adequacy; requiring that Medicaid recipients receive
77 prescription drug coverage information for each plan;
78 requiring the agency to set standards for prompt claims
79 payment; revising assignment processes for certain
80 recipients; amending s. 409.9124, F.S.; removing the
81 limitation on the application of certain rates and rate
82 reductions used by the agency to reimburse managed care
83 plans; amending s. 409.913, F.S.; prohibiting mailing of
84 the explanation of benefits for certain Medicaid services;

85 repealing s. 381.0271, F.S., relating to the Florida
86 Patient Safety Corporation; repealing s. 381.0273, F.S.,
87 relating to public records exemption for patient safety
88 data; repealing s. 394.4595, F.S., relating to access to
89 patient records by the Florida statewide and local
90 advocacy councils; repealing s. 402.164, F.S., relating to
91 the Florida Statewide Advocacy Council and the Florida
92 local advocacy councils; repealing s. 402.165, F.S.,
93 relating to the Florida Statewide Advocacy Council;
94 repealing s. 402.166, F.S., relating to Florida local
95 advocacy councils; repealing s. 402.167, F.S., relating to
96 duties of state agencies that provide client services
97 relating to the Florida Statewide Advocacy Council and the
98 Florida local advocacy councils; repealing s. 409.9061,
99 F.S., relating to authority for a statewide laboratory
100 services contract; repealing s. 430.80, F.S., relating to
101 implementation of a teaching nursing home pilot project;
102 repealing s. 430.83, F.S., relating to the Sunshine for
103 Seniors Program; repealing ss. 464.0195, 464.0196, and
104 464.0197, F.S., relating to the Florida Center for
105 Nursing; repealing s. 464.0198, F.S., relating to the
106 Florida Center for Nursing Trust Fund; amending ss.
107 39.001, 39.0011, 39.202, 39.302, 215.22, 394.459,
108 394.4597, 394.4598, 394.4599, 394.4615, 400.0065, 400.118,
109 400.141, 415.1034, 415.104, 415.1055, 415.106, 415.107,
110 429.19, 429.28, 429.34, and 430.04, F.S.; conforming
111 provisions and correcting cross-references; providing an
112 effective date.

113
114 Be It Enacted by the Legislature of the State of Florida:
115
116 Section 1. (1) Effective April 1, 2009, all of the
117 statutory powers, duties and functions, records, personnel,
118 property, and unexpended balances of appropriations,
119 allocations, or other funds for the administration of part I of
120 chapter 499, Florida Statutes, relating to drugs, devices,
121 cosmetics, and household products shall be transferred by a type
122 two transfer, as defined in s. 20.06(2), Florida Statutes, from
123 the Department of Health to the Department of Business and
124 Professional Regulation.
125 (2) The transfer of regulatory authority under part I of
126 chapter 499, Florida Statutes, provided by this act shall not
127 affect the validity of any judicial or administrative action
128 pending as of 11:59 p.m. on the day before the effective date of
129 this act to which the Department of Health is at that time a
130 party, and the Department of Business and Professional
131 Regulation shall be substituted as a party in interest in any
132 such action.
133 (3) All lawful orders issued by the Department of Health
134 implementing or enforcing or otherwise in regard to any
135 provision of part I of chapter 499, Florida Statutes, issued
136 prior to the effective date of this act shall remain in effect
137 and be enforceable after the effective date of this act unless
138 thereafter modified in accordance with law.
139 (4) The rules of the Department of Health relating to the
140 implementation of part I of chapter 499, Florida Statutes, that

141 were in effect at 11:59 p.m. on the day prior to this act taking
142 effect shall become the rules of the Department of Business and
143 Professional Regulation and shall remain in effect until amended
144 or repealed in the manner provided by law.
145 (5) Notwithstanding the transfer of regulatory authority
146 under part I of chapter 499, Florida Statutes, provided by this
147 act, persons and entities holding in good standing any permit
148 under part I of chapter 499, Florida Statutes, as of 11:59 p.m.
149 on the day prior to the effective date of this act shall, as of
150 the effective date of this act, be deemed to hold in good
151 standing a permit in the same capacity as that for which the
152 permit was formerly issued.
153 (6) Notwithstanding the transfer of regulatory authority
154 under part I of chapter 499, Florida Statutes, provided by this
155 act, persons holding in good standing any certification under
156 part I of chapter 499, Florida Statutes, as of 11:59 p.m. on the
157 day prior to the effective date of this act shall, as of the
158 effective date of this act, be deemed to be certified in the
159 same capacity in which they were formerly certified.
160 Section 2. Paragraph (d) of subsection (2) of section
161 400.179, Florida Statutes, is amended to read:
162 400.179 Liability for Medicaid underpayments and
163 overpayments.--
164 (2) Because any transfer of a nursing facility may expose
165 the fact that Medicaid may have underpaid or overpaid the
166 transferor, and because in most instances, any such underpayment
167 or overpayment can only be determined following a formal field

168 audit, the liabilities for any such underpayments or
169 overpayments shall be as follows:
170 (d) Where the transfer involves a facility that has been
171 leased by the transferor:
172 1. The transferee shall, as a condition to being issued a
173 license by the agency, acquire, maintain, and provide proof to
174 the agency of a bond with a term of 30 months, renewable
175 annually, in an amount not less than the total of 3 months'
176 Medicaid payments to the facility computed on the basis of the
177 preceding 12-month average Medicaid payments to the facility.
178 2. A leasehold licensee may meet the requirements of
179 subparagraph 1. by payment of a nonrefundable fee, paid at
180 initial licensure, paid at the time of any subsequent change of
181 ownership, and paid annually thereafter, in the amount of 1
182 percent of the total of 3 months' Medicaid payments to the
183 facility computed on the basis of the preceding 12-month average
184 Medicaid payments to the facility. If a preceding 12-month
185 average is not available, projected Medicaid payments may be
186 used. The fee shall be deposited into the Health Care Trust Fund
187 and shall be accounted for separately as a Medicaid nursing home
188 overpayment account. These fees shall be used at the sole
189 discretion of the agency to repay nursing home Medicaid
190 overpayments. The agency is authorized to transfer funds to the
191 Grants and Donations Trust Fund for such repayments. Payment of
192 this fee shall not release the licensee from any liability for
193 any Medicaid overpayments, nor shall payment bar the agency from
194 seeking to recoup overpayments from the licensee and any other
195 liable party. As a condition of exercising this lease bond

196 alternative, licensees paying this fee must maintain an existing
197 lease bond through the end of the 30-month term period of that
198 bond. The agency is herein granted specific authority to
199 promulgate all rules pertaining to the administration and
200 management of this account, including withdrawals from the
201 account, subject to federal review and approval. This provision
202 shall take effect upon becoming law and shall apply to any
203 leasehold license application. The financial viability of the
204 Medicaid nursing home overpayment account shall be determined by
205 the agency through annual review of the account balance and the
206 amount of total outstanding, unpaid Medicaid overpayments owing
207 from leasehold licensees to the agency as determined by final
208 agency audits.
209 3. The leasehold licensee may meet the bond requirement
210 through other arrangements acceptable to the agency. The agency
211 is herein granted specific authority to promulgate rules
212 pertaining to lease bond arrangements.
213 4. All existing nursing facility licensees, operating the
214 facility as a leasehold, shall acquire, maintain, and provide
215 proof to the agency of the 30-month bond required in
216 subparagraph 1., above, on and after July 1, 1993, for each
217 license renewal.
218 5. It shall be the responsibility of all nursing facility
219 operators, operating the facility as a leasehold, to renew the
220 30-month bond and to provide proof of such renewal to the agency
221 annually.
222 6. Any failure of the nursing facility operator to
223 acquire, maintain, renew annually, or provide proof to the

224 agency shall be grounds for the agency to deny, revoke, and
225 suspend the facility license to operate such facility and to
226 take any further action, including, but not limited to,
227 enjoining the facility, asserting a moratorium pursuant to part
228 II of chapter 408, or applying for a receiver, deemed necessary
229 to ensure compliance with this section and to safeguard and
230 protect the health, safety, and welfare of the facility's
231 residents. A lease agreement required as a condition of bond
232 financing or refinancing under s. 154.213 by a health facilities
233 authority or required under s. 159.30 by a county or
234 municipality is not a leasehold for purposes of this paragraph
235 and is not subject to the bond requirement of this paragraph.
236 Section 3. Paragraph (a) of subsection (3) of section
237 400.23, Florida Statutes, is amended to read:
238 400.23 Rules; evaluation and deficiencies; licensure
239 status.--
240 (3)(a)1. The agency shall adopt rules providing minimum
241 staffing requirements for nursing homes. These requirements
242 shall include, for each nursing home facility:
243 a. A minimum certified nursing assistant staffing of 2.6
244 hours of direct care per resident per day beginning January 1,
245 2003, and increasing to 2.7 hours of direct care per resident
246 per day beginning January 1, 2007. Beginning January 1, 2002, no
247 facility shall staff below one certified nursing assistant per
248 20 residents, and a minimum licensed nursing staffing of 1.0
249 hour of direct care per resident per day but never below one
250 licensed nurse per 40 residents.

251 b. Beginning January 1, 2007, a minimum weekly average
252 certified nursing assistant staffing of 2.9 hours of direct care
253 per resident per day. For the purpose of this sub-subparagraph,
254 a week is defined as Sunday through Saturday.
255 c. Beginning July 1, 2008, and ending June 30, 2010, a
256 minimum daily combined average certified nursing assistant and
257 licensed nursing staffing of 3.7 hours of direct care per
258 resident per day, with a minimum certified nursing assistant
259 staffing of 2.6 hours of direct care per resident per day and a
260 minimum licensed nursing staffing of 1.0 hour of direct care per
261 resident per day. No facility shall staff below one certified
262 nursing assistant per 20 residents and one licensed nurse per 40
263 residents.
264 2. Nursing assistants employed under s. 400.211(2) may be
265 included in computing the staffing ratio for certified nursing
266 assistants only if their job responsibilities include only
267 nursing-assistant-related duties.
268 3. Each nursing home must document compliance with
269 staffing standards as required under this paragraph and post
270 daily the names of staff on duty for the benefit of facility
271 residents and the public.
272 4. The agency shall recognize the use of licensed nurses
273 for compliance with minimum staffing requirements for certified
274 nursing assistants, provided that the facility otherwise meets
275 the minimum staffing requirements for licensed nurses and that
276 the licensed nurses are performing the duties of a certified
277 nursing assistant. Unless otherwise approved by the agency,
278 licensed nurses counted toward the minimum staffing requirements

279 for certified nursing assistants must exclusively perform the
280 duties of a certified nursing assistant for the entire shift and
281 not also be counted toward the minimum staffing requirements for
282 licensed nurses. If the agency approved a facility's request to
283 use a licensed nurse to perform both licensed nursing and
284 certified nursing assistant duties, the facility must allocate
285 the amount of staff time specifically spent on certified nursing
286 assistant duties for the purpose of documenting compliance with
287 minimum staffing requirements for certified and licensed nursing
288 staff. In no event may the hours of a licensed nurse with dual
289 job responsibilities be counted twice.
290 Section 4. Paragraph (c) of subsection (5) of section
291 409.905, Florida Statutes, is amended to read:
292 409.905 Mandatory Medicaid services.--The agency may make
293 payments for the following services, which are required of the
294 state by Title XIX of the Social Security Act, furnished by
295 Medicaid providers to recipients who are determined to be
296 eligible on the dates on which the services were provided. Any
297 service under this section shall be provided only when medically
298 necessary and in accordance with state and federal law.
299 Mandatory services rendered by providers in mobile units to
300 Medicaid recipients may be restricted by the agency. Nothing in
301 this section shall be construed to prevent or limit the agency
302 from adjusting fees, reimbursement rates, lengths of stay,
303 number of visits, number of services, or any other adjustments
304 necessary to comply with the availability of moneys and any
305 limitations or directions provided for in the General
306 Appropriations Act or chapter 216.

307 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for
308 all covered services provided for the medical care and treatment
309 of a recipient who is admitted as an inpatient by a licensed
310 physician or dentist to a hospital licensed under part I of
311 chapter 395. However, the agency shall limit the payment for
312 inpatient hospital services for a Medicaid recipient 21 years of
313 age or older to 45 days or the number of days necessary to
314 comply with the General Appropriations Act.
315 (c) <u>For 2 fiscal years beginning July 1, 2008, and ending</u>
316 <u>June 30, 2010,</u> the Agency for Health Care Administration <u>may not</u>
317 ~~shall~~ adjust a hospital's current inpatient per diem rate to
318 reflect the cost of serving the Medicaid population at that
319 institution if:
320 1. The hospital experiences an increase in Medicaid
321 caseload by more than 25 percent in any year, primarily
322 resulting from the closure of a hospital in the same service
323 area occurring after July 1, 1995;
324 2. The hospital's Medicaid per diem rate is at least 25
325 percent below the Medicaid per patient cost for that year; or
326 3. The hospital is located in a county that has five or
327 fewer hospitals, began offering obstetrical services on or after
328 September 1999, and has submitted a request in writing to the
329 agency for a rate adjustment after July 1, 2000, but before
330 September 30, 2000, in which case such hospital's Medicaid
331 inpatient per diem rate shall be adjusted to cost, effective
332 July 1, 2002.
333
334 No later than October 1 of each year, the agency must provide

335 estimated costs for any adjustment in a hospital inpatient per
336 diem pursuant to this paragraph to the Executive Office of the
337 Governor, the House of Representatives General Appropriations
338 Committee, and the Senate Appropriations Committee. Before the
339 agency implements a change in a hospital's inpatient per diem
340 rate pursuant to this paragraph, the Legislature must have
341 specifically appropriated sufficient funds in the General
342 Appropriations Act to support the increase in cost as estimated
343 by the agency.
344 Section 5. Subsections (7), (14), and (19) of section
345 409.906, Florida Statutes, are amended, and subsection (26) is
346 added to that section, to read:
347 409.906 Optional Medicaid services.--Subject to specific
348 appropriations, the agency may make payments for services which
349 are optional to the state under Title XIX of the Social Security
350 Act and are furnished by Medicaid providers to recipients who
351 are determined to be eligible on the dates on which the services
352 were provided. Any optional service that is provided shall be
353 provided only when medically necessary and in accordance with
354 state and federal law. Optional services rendered by providers
355 in mobile units to Medicaid recipients may be restricted or
356 prohibited by the agency. Nothing in this section shall be
357 construed to prevent or limit the agency from adjusting fees,
358 reimbursement rates, lengths of stay, number of visits, or
359 number of services, or making any other adjustments necessary to
360 comply with the availability of moneys and any limitations or
361 directions provided for in the General Appropriations Act or
362 chapter 216. If necessary to safeguard the state's systems of

363 providing services to elderly and disabled persons and subject
364 to the notice and review provisions of s. 216.177, the Governor
365 may direct the Agency for Health Care Administration to amend
366 the Medicaid state plan to delete the optional Medicaid service
367 known as "Intermediate Care Facilities for the Developmentally
368 Disabled." Optional services may include:
369 (7) CHIROPRACTIC SERVICES.--For 2 fiscal years beginning
370 July 1, 2008, and ending June 30, 2010, the agency may not pay
371 for chiropractic services. ~~The agency may pay for manual~~
372 ~~manipulation of the spine and initial services, screening, and X~~
373 ~~rays provided to a recipient by a licensed chiropractic~~
374 ~~physician.~~
375 (14) HOSPICE CARE SERVICES.--For 2 fiscal years beginning
376 July 1, 2008, and ending June 30, 2010, the agency may not pay
377 for hospice care services. ~~The agency may pay for all reasonable~~
378 ~~and necessary services for the palliation or management of a~~
379 ~~recipient's terminal illness, if the services are provided by a~~
380 ~~hospice that is licensed under part IV of chapter 400 and meets~~
381 ~~Medicare certification requirements.~~
382 (19) PODIATRIC SERVICES.--For 2 fiscal years beginning
383 July 1, 2008, and ending June 30, 2010, the agency may not pay
384 for podiatric services. ~~The agency may pay for services,~~
385 ~~including diagnosis and medical, surgical, palliative, and~~
386 ~~mechanical treatment, related to ailments of the human foot and~~
387 ~~lower leg, if provided to a recipient by a podiatric physician~~
388 ~~licensed under state law.~~
389 (26) ANESTHESIOLOGIST ASSISTANT SERVICES.--The agency may
390 pay for all services provided to a recipient by an

391 anesthesiologist assistant licensed under s. 458.3475 or s.
392 459.023. Reimbursement for such services must be not less than
393 80 percent of the reimbursement that would be paid to a
394 physician who provided the same services.
395 Section 6. Subsections (13) and (14) of section 409.908,
396 Florida Statutes, as amended by chapter 2007-331, Laws of
397 Florida, are amended, and subsection (23) is added to that
398 section, to read:
399 409.908 Reimbursement of Medicaid providers.--Subject to
400 specific appropriations, the agency shall reimburse Medicaid
401 providers, in accordance with state and federal law, according
402 to methodologies set forth in the rules of the agency and in
403 policy manuals and handbooks incorporated by reference therein.
404 These methodologies may include fee schedules, reimbursement
405 methods based on cost reporting, negotiated fees, competitive
406 bidding pursuant to s. 287.057, and other mechanisms the agency
407 considers efficient and effective for purchasing services or
408 goods on behalf of recipients. If a provider is reimbursed based
409 on cost reporting and submits a cost report late and that cost
410 report would have been used to set a lower reimbursement rate
411 for a rate semester, then the provider's rate for that semester
412 shall be retroactively calculated using the new cost report, and
413 full payment at the recalculated rate shall be effected
414 retroactively. Medicare-granted extensions for filing cost
415 reports, if applicable, shall also apply to Medicaid cost
416 reports. Payment for Medicaid compensable services made on
417 behalf of Medicaid eligible persons is subject to the
418 availability of moneys and any limitations or directions

419 provided for in the General Appropriations Act or chapter 216.
420 Further, nothing in this section shall be construed to prevent
421 or limit the agency from adjusting fees, reimbursement rates,
422 lengths of stay, number of visits, or number of services, or
423 making any other adjustments necessary to comply with the
424 availability of moneys and any limitations or directions
425 provided for in the General Appropriations Act, provided the
426 adjustment is consistent with legislative intent.
427 (13) Medicare premiums for persons eligible for both
428 Medicare and Medicaid coverage shall be paid at the rates
429 established by Title XVIII of the Social Security Act. For
430 Medicare services rendered to Medicaid-eligible persons,
431 Medicaid shall pay Medicare deductibles and coinsurance as
432 follows:
433 ~~(a) Medicaid shall make no payment toward deductibles and~~
434 ~~coinsurance for any service that is not covered by Medicaid.~~
435 (a) ~~(b)~~ Medicaid's financial obligation for deductibles and
436 coinsurance payments shall be based on Medicare allowable fees,
437 not on a provider's billed charges.
438 (b) ~~(c)~~ Medicaid will pay no portion of Medicare
439 deductibles and coinsurance when payment that Medicare has made
440 for the service equals or exceeds what Medicaid would have paid
441 if it had been the sole payor. The combined payment of Medicare
442 and Medicaid shall not exceed the amount Medicaid would have
443 paid had it been the sole payor. The Legislature finds that
444 there has been confusion regarding the reimbursement for
445 services rendered to dually eligible Medicare beneficiaries.
446 Accordingly, the Legislature clarifies that it has always been

447 the intent of the Legislature before and after 1991 that, in
448 reimbursing in accordance with fees established by Title XVIII
449 for premiums, deductibles, and coinsurance for Medicare services
450 rendered by physicians to Medicaid eligible persons, physicians
451 be reimbursed at the lesser of the amount billed by the
452 physician or the Medicaid maximum allowable fee established by
453 the Agency for Health Care Administration, as is permitted by
454 federal law. It has never been the intent of the Legislature
455 with regard to such services rendered by physicians that
456 Medicaid be required to provide any payment for deductibles,
457 coinsurance, or copayments for Medicare cost sharing, or any
458 expenses incurred relating thereto, in excess of the payment
459 amount provided for under the State Medicaid plan for such
460 service. This payment methodology is applicable even in those
461 situations in which the payment for Medicare cost sharing for a
462 qualified Medicare beneficiary with respect to an item or
463 service is reduced or eliminated. This expression of the
464 Legislature is in clarification of existing law and shall apply
465 to payment for, and with respect to provider agreements with
466 respect to, items or services furnished on or after the
467 effective date of this act. This paragraph applies to payment by
468 Medicaid for items and services furnished before the effective
469 date of this act if such payment is the subject of a lawsuit
470 that is based on the provisions of this section, and that is
471 pending as of, or is initiated after, the effective date of this
472 act.
473 (c) ~~(d)~~ Notwithstanding paragraphs (a) and (b) ~~(a)-(c)~~:

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

474 1. Medicaid payments for Nursing Home Medicare part A
475 coinsurance shall be limited to the Medicaid nursing home per
476 diem rate less any amounts paid by Medicare, but only up to the
477 amount of Medicare coinsurance. The Medicaid per diem rate shall
478 be the rate in effect for the dates of service of the crossover
479 claims and may not be subsequently adjusted due to subsequent
480 per diem rate adjustments.
481 2. Medicaid shall pay all deductibles and coinsurance for
482 Medicare-eligible recipients receiving freestanding end stage
483 renal dialysis center services.
484 3. Medicaid payments for general hospital inpatient
485 services shall be limited to the Medicare deductible and
486 coinsurance per spell of illness. Medicaid payments for hospital
487 Medicare Part A coinsurance shall be limited to the Medicaid
488 hospital per diem rate less any amounts paid by Medicare, but
489 only up to the amount of Medicare coinsurance. Medicaid payments
490 for coinsurance shall be limited to the Medicaid per diem rate
491 in effect for the dates of service of the crossover claims and
492 may not be subsequently adjusted due to subsequent per diem
493 adjustments. ~~Medicaid shall make no payment toward coinsurance~~
494 ~~for Medicare general hospital inpatient services.~~
495 4. Medicaid shall pay all deductibles and coinsurance for
496 Medicare emergency transportation services provided by
497 ambulances licensed pursuant to chapter 401.
498 (14) A provider of prescribed drugs shall be reimbursed
499 the least of the amount billed by the provider, the provider's
500 usual and customary charge, or the Medicaid maximum allowable
501 fee established by the agency, plus a dispensing fee. The

502 Medicaid maximum allowable fee for ingredient cost will be based
503 on the lower of: average wholesale price (AWP) minus 16.4 ~~15.4~~
504 percent, wholesaler acquisition cost (WAC) plus 4.75 ~~5.75~~
505 percent, the federal upper limit (FUL), the state maximum
506 allowable cost (SMAC), or the usual and customary (UAC) charge
507 billed by the provider. Medicaid providers are required to
508 dispense generic drugs if available at lower cost and the agency
509 has not determined that the branded product is more cost-
510 effective, unless the prescriber has requested and received
511 approval to require the branded product. The agency is directed
512 to implement a variable dispensing fee for payments for
513 prescribed medicines while ensuring continued access for
514 Medicaid recipients. The variable dispensing fee may be based
515 upon, but not limited to, either or both the volume of
516 prescriptions dispensed by a specific pharmacy provider, the
517 volume of prescriptions dispensed to an individual recipient,
518 and dispensing of preferred-drug-list products. The agency may
519 increase the pharmacy dispensing fee authorized by statute and
520 in the annual General Appropriations Act by $0.50 for the
521 dispensing of a Medicaid preferred-drug-list product and reduce
522 the pharmacy dispensing fee by $0.50 for the dispensing of a
523 Medicaid product that is not included on the preferred drug
524 list. The agency may establish a supplemental pharmaceutical
525 dispensing fee to be paid to providers returning unused unit-
526 dose packaged medications to stock and crediting the Medicaid
527 program for the ingredient cost of those medications if the
528 ingredient costs to be credited exceed the value of the
529 supplemental dispensing fee. The agency is authorized to limit

530 reimbursement for prescribed medicine in order to comply with
531 any limitations or directions provided for in the General
532 Appropriations Act, which may include implementing a prospective
533 or concurrent utilization review program.
534 (23)(a) The agency shall establish rates at a level that
535 ensures no increase in statewide expenditures resulting from a
536 change in unit costs for 2 fiscal years effective July 1, 2008.
537 Reimbursement rates for the 2 fiscal years shall be as provided
538 in the General Appropriations Act.
539 (b) This subsection applies to the following provider
540 types:
541 1. Inpatient hospitals.
542 2. Outpatient hospitals.
543 3. Nursing homes.
544 4. County health departments.
545 5. Community intermediate care facilities for the
546 developmentally disabled.
547
548 The agency shall apply the effect of this subsection to the
549 reimbursement rates for managed care plans and nursing home
550 diversion programs.
551 (c) The agency shall create a workgroup on hospital
552 reimbursement, a workgroup on nursing facility reimbursement,
553 and a workgroup on managed care plan payment. The workgroups
554 shall evaluate alternative reimbursement and payment
555 methodologies for hospitals, nursing facilities, and managed
556 care plans, including prospective payment methodologies for
557 hospitals and nursing facilities. The nursing facility workgroup

558 shall also consider price-based methodologies for indirect care
559 and acuity adjustments for direct care. The agency shall submit
560 a report on the evaluated alternative reimbursement
561 methodologies to the relevant committees of the Senate and the
562 House of Representatives by November 1, 2009.
563 (d) This subsection expires June 30, 2010.
564 Section 7. Paragraph (a) of subsection (2) of section
565 409.911, Florida Statutes, is amended to read:
566 409.911 Disproportionate share program.--Subject to
567 specific allocations established within the General
568 Appropriations Act and any limitations established pursuant to
569 chapter 216, the agency shall distribute, pursuant to this
570 section, moneys to hospitals providing a disproportionate share
571 of Medicaid or charity care services by making quarterly
572 Medicaid payments as required. Notwithstanding the provisions of
573 s. 409.915, counties are exempt from contributing toward the
574 cost of this special reimbursement for hospitals serving a
575 disproportionate share of low-income patients.
576 (2) The Agency for Health Care Administration shall use
577 the following actual audited data to determine the Medicaid days
578 and charity care to be used in calculating the disproportionate
579 share payment:
580 (a) The average of the 2002, 2003, and 2004 ~~2000, 2001,~~
581 ~~and 2002~~ audited disproportionate share data to determine each
582 hospital's Medicaid days and charity care for the 2008-2009
583 ~~2006-2007~~ state fiscal year.
584 Section 8. Section 409.9112, Florida Statutes, is amended
585 to read:

586 409.9112 Disproportionate share program for regional
587 perinatal intensive care centers.--In addition to the payments
588 made under s. 409.911, the Agency for Health Care Administration
589 shall design and implement a system of making disproportionate
590 share payments to those hospitals that participate in the
591 regional perinatal intensive care center program established
592 pursuant to chapter 383. This system of payments shall conform
593 with federal requirements and shall distribute funds in each
594 fiscal year for which an appropriation is made by making
595 quarterly Medicaid payments. Notwithstanding the provisions of
596 s. 409.915, counties are exempt from contributing toward the
597 cost of this special reimbursement for hospitals serving a
598 disproportionate share of low-income patients. For the state
599 fiscal year 2008-2009 ~~2005-2006~~, the agency shall not distribute
600 moneys under the regional perinatal intensive care centers
601 disproportionate share program.
602 (1) The following formula shall be used by the agency to
603 calculate the total amount earned for hospitals that participate
604 in the regional perinatal intensive care center program:
605
606 TAE = HDSP/THDSP
607
608 Where:
609 TAE = total amount earned by a regional perinatal intensive
610 care center.
611 HDSP = the prior state fiscal year regional perinatal
612 intensive care center disproportionate share payment to the
613 individual hospital.

614 THDSP = the prior state fiscal year total regional
615 perinatal intensive care center disproportionate share payments
616 to all hospitals.
617 (2) The total additional payment for hospitals that
618 participate in the regional perinatal intensive care center
619 program shall be calculated by the agency as follows:
620
621 TAP = TAE x TA
622
623 Where:
624 TAP = total additional payment for a regional perinatal
625 intensive care center.
626 TAE = total amount earned by a regional perinatal intensive
627 care center.
628 TA = total appropriation for the regional perinatal
629 intensive care center disproportionate share program.
630 (3) In order to receive payments under this section, a
631 hospital must be participating in the regional perinatal
632 intensive care center program pursuant to chapter 383 and must
633 meet the following additional requirements:
634 (a) Agree to conform to all departmental and agency
635 requirements to ensure high quality in the provision of
636 services, including criteria adopted by departmental and agency
637 rule concerning staffing ratios, medical records, standards of
638 care, equipment, space, and such other standards and criteria as
639 the department and agency deem appropriate as specified by rule.
640 (b) Agree to provide information to the department and
641 agency, in a form and manner to be prescribed by rule of the

642 department and agency, concerning the care provided to all
643 patients in neonatal intensive care centers and high-risk
644 maternity care.
645 (c) Agree to accept all patients for neonatal intensive
646 care and high-risk maternity care, regardless of ability to pay,
647 on a functional space-available basis.
648 (d) Agree to develop arrangements with other maternity and
649 neonatal care providers in the hospital's region for the
650 appropriate receipt and transfer of patients in need of
651 specialized maternity and neonatal intensive care services.
652 (e) Agree to establish and provide a developmental
653 evaluation and services program for certain high-risk neonates,
654 as prescribed and defined by rule of the department.
655 (f) Agree to sponsor a program of continuing education in
656 perinatal care for health care professionals within the region
657 of the hospital, as specified by rule.
658 (g) Agree to provide backup and referral services to the
659 department's county health departments and other low-income
660 perinatal providers within the hospital's region, including the
661 development of written agreements between these organizations
662 and the hospital.
663 (h) Agree to arrange for transportation for high-risk
664 obstetrical patients and neonates in need of transfer from the
665 community to the hospital or from the hospital to another more
666 appropriate facility.
667 (4) Hospitals which fail to comply with any of the
668 conditions in subsection (3) or the applicable rules of the
669 department and agency shall not receive any payments under this

670 section until full compliance is achieved. A hospital which is
671 not in compliance in two or more consecutive quarters shall not
672 receive its share of the funds. Any forfeited funds shall be
673 distributed by the remaining participating regional perinatal
674 intensive care center program hospitals.
675 Section 9. Section 409.9113, Florida Statutes, is amended
676 to read:
677 409.9113 Disproportionate share program for teaching
678 hospitals.--In addition to the payments made under ss. 409.911
679 and 409.9112, the Agency for Health Care Administration shall
680 make disproportionate share payments to statutorily defined
681 teaching hospitals for their increased costs associated with
682 medical education programs and for tertiary health care services
683 provided to the indigent. This system of payments shall conform
684 with federal requirements and shall distribute funds in each
685 fiscal year for which an appropriation is made by making
686 quarterly Medicaid payments. Notwithstanding s. 409.915,
687 counties are exempt from contributing toward the cost of this
688 special reimbursement for hospitals serving a disproportionate
689 share of low-income patients. For the state fiscal year 2008-
690 2009 ~~2006-2007~~, the agency shall distribute the moneys provided
691 in the General Appropriations Act to statutorily defined
692 teaching hospitals and family practice teaching hospitals under
693 the teaching hospital disproportionate share program. The funds
694 provided for statutorily defined teaching hospitals shall be
695 distributed in the same proportion as the state fiscal year
696 2003-2004 teaching hospital disproportionate share funds were
697 distributed or as otherwise provided in the General

698 Appropriations Act. The funds provided for family practice
699 teaching hospitals shall be distributed equally among family
700 practice teaching hospitals.
701 (1) On or before September 15 of each year, the Agency for
702 Health Care Administration shall calculate an allocation
703 fraction to be used for distributing funds to state statutory
704 teaching hospitals. Subsequent to the end of each quarter of the
705 state fiscal year, the agency shall distribute to each statutory
706 teaching hospital, as defined in s. 408.07, an amount determined
707 by multiplying one-fourth of the funds appropriated for this
708 purpose by the Legislature times such hospital's allocation
709 fraction. The allocation fraction for each such hospital shall
710 be determined by the sum of three primary factors, divided by
711 three. The primary factors are:
712 (a) The number of nationally accredited graduate medical
713 education programs offered by the hospital, including programs
714 accredited by the Accreditation Council for Graduate Medical
715 Education and the combined Internal Medicine and Pediatrics
716 programs acceptable to both the American Board of Internal
717 Medicine and the American Board of Pediatrics at the beginning
718 of the state fiscal year preceding the date on which the
719 allocation fraction is calculated. The numerical value of this
720 factor is the fraction that the hospital represents of the total
721 number of programs, where the total is computed for all state
722 statutory teaching hospitals.
723 (b) The number of full-time equivalent trainees in the
724 hospital, which comprises two components:

725 1. The number of trainees enrolled in nationally
726 accredited graduate medical education programs, as defined in
727 paragraph (a). Full-time equivalents are computed using the
728 fraction of the year during which each trainee is primarily
729 assigned to the given institution, over the state fiscal year
730 preceding the date on which the allocation fraction is
731 calculated. The numerical value of this factor is the fraction
732 that the hospital represents of the total number of full-time
733 equivalent trainees enrolled in accredited graduate programs,
734 where the total is computed for all state statutory teaching
735 hospitals.
736 2. The number of medical students enrolled in accredited
737 colleges of medicine and engaged in clinical activities,
738 including required clinical clerkships and clinical electives.
739 Full-time equivalents are computed using the fraction of the
740 year during which each trainee is primarily assigned to the
741 given institution, over the course of the state fiscal year
742 preceding the date on which the allocation fraction is
743 calculated. The numerical value of this factor is the fraction
744 that the given hospital represents of the total number of full-
745 time equivalent students enrolled in accredited colleges of
746 medicine, where the total is computed for all state statutory
747 teaching hospitals.
748
749 The primary factor for full-time equivalent trainees is computed
750 as the sum of these two components, divided by two.
751 (c) A service index that comprises three components:

752 1. The Agency for Health Care Administration Service
753 Index, computed by applying the standard Service Inventory
754 Scores established by the Agency for Health Care Administration
755 to services offered by the given hospital, as reported on
756 Worksheet A-2 for the last fiscal year reported to the agency
757 before the date on which the allocation fraction is calculated.
758 The numerical value of this factor is the fraction that the
759 given hospital represents of the total Agency for Health Care
760 Administration Service Index values, where the total is computed
761 for all state statutory teaching hospitals.
762 2. A volume-weighted service index, computed by applying
763 the standard Service Inventory Scores established by the Agency
764 for Health Care Administration to the volume of each service,
765 expressed in terms of the standard units of measure reported on
766 Worksheet A-2 for the last fiscal year reported to the agency
767 before the date on which the allocation factor is calculated.
768 The numerical value of this factor is the fraction that the
769 given hospital represents of the total volume-weighted service
770 index values, where the total is computed for all state
771 statutory teaching hospitals.
772 3. Total Medicaid payments to each hospital for direct
773 inpatient and outpatient services during the fiscal year
774 preceding the date on which the allocation factor is calculated.
775 This includes payments made to each hospital for such services
776 by Medicaid prepaid health plans, whether the plan was
777 administered by the hospital or not. The numerical value of this
778 factor is the fraction that each hospital represents of the

779 total of such Medicaid payments, where the total is computed for
780 all state statutory teaching hospitals.
781
782 The primary factor for the service index is computed as the sum
783 of these three components, divided by three.
784 (2) By October 1 of each year, the agency shall use the
785 following formula to calculate the maximum additional
786 disproportionate share payment for statutorily defined teaching
787 hospitals:
788
789 TAP = THAF x A
790
791 Where:
792 TAP = total additional payment.
793 THAF = teaching hospital allocation factor.
794 A = amount appropriated for a teaching hospital
795 disproportionate share program.
796 Section 10. Section 409.9117, Florida Statutes, is amended
797 to read:
798 409.9117 Primary care disproportionate share program.--For
799 the state fiscal year <u>2008-2009</u> ~~2006-2007~~, the agency shall not
800 distribute moneys under the primary care disproportionate share
801 program.
802 (1) If federal funds are available for disproportionate
803 share programs in addition to those otherwise provided by law,
804 there shall be created a primary care disproportionate share
805 program.

806 (2) The following formula shall be used by the agency to
807 calculate the total amount earned for hospitals that participate
808 in the primary care disproportionate share program:
809
810 TAE = HDSP/THDSP
811
812 Where:
813 TAE = total amount earned by a hospital participating in
814 the primary care disproportionate share program.
815 HDSP = the prior state fiscal year primary care
816 disproportionate share payment to the individual hospital.
817 THDSP = the prior state fiscal year total primary care
818 disproportionate share payments to all hospitals.
819 (3) The total additional payment for hospitals that
820 participate in the primary care disproportionate share program
821 shall be calculated by the agency as follows:
822
823 TAP = TAE x TA
824
825 Where:
826 TAP = total additional payment for a primary care hospital.
827 TAE = total amount earned by a primary care hospital.
828 TA = total appropriation for the primary care
829 disproportionate share program.
830 (4) In the establishment and funding of this program, the
831 agency shall use the following criteria in addition to those
832 specified in s. 409.911, payments may not be made to a hospital
833 unless the hospital agrees to:

834 (a) Cooperate with a Medicaid prepaid health plan, if one
835 exists in the community.
836 (b) Ensure the availability of primary and specialty care
837 physicians to Medicaid recipients who are not enrolled in a
838 prepaid capitated arrangement and who are in need of access to
839 such physicians.
840 (c) Coordinate and provide primary care services free of
841 charge, except copayments, to all persons with incomes up to 100
842 percent of the federal poverty level who are not otherwise
843 covered by Medicaid or another program administered by a
844 governmental entity, and to provide such services based on a
845 sliding fee scale to all persons with incomes up to 200 percent
846 of the federal poverty level who are not otherwise covered by
847 Medicaid or another program administered by a governmental
848 entity, except that eligibility may be limited to persons who
849 reside within a more limited area, as agreed to by the agency
850 and the hospital.
851 (d) Contract with any federally qualified health center,
852 if one exists within the agreed geopolitical boundaries,
853 concerning the provision of primary care services, in order to
854 guarantee delivery of services in a nonduplicative fashion, and
855 to provide for referral arrangements, privileges, and
856 admissions, as appropriate. The hospital shall agree to provide
857 at an onsite or offsite facility primary care services within 24
858 hours to which all Medicaid recipients and persons eligible
859 under this paragraph who do not require emergency room services
860 are referred during normal daylight hours.

861 (e) Cooperate with the agency, the county, and other
862 entities to ensure the provision of certain public health
863 services, case management, referral and acceptance of patients,
864 and sharing of epidemiological data, as the agency and the
865 hospital find mutually necessary and desirable to promote and
866 protect the public health within the agreed geopolitical
867 boundaries.
868 (f) In cooperation with the county in which the hospital
869 resides, develop a low-cost, outpatient, prepaid health care
870 program to persons who are not eligible for the Medicaid
871 program, and who reside within the area.
872 (g) Provide inpatient services to residents within the
873 area who are not eligible for Medicaid or Medicare, and who do
874 not have private health insurance, regardless of ability to pay,
875 on the basis of available space, except that nothing shall
876 prevent the hospital from establishing bill collection programs
877 based on ability to pay.
878 (h) Work with the Florida Healthy Kids Corporation, the
879 Florida Health Care Purchasing Cooperative, and business health
880 coalitions, as appropriate, to develop a feasibility study and
881 plan to provide a low-cost comprehensive health insurance plan
882 to persons who reside within the area and who do not have access
883 to such a plan.
884 (i) Work with public health officials and other experts to
885 provide community health education and prevention activities
886 designed to promote healthy lifestyles and appropriate use of
887 health services.

888 (j) Work with the local health council to develop a plan
889 for promoting access to affordable health care services for all
890 persons who reside within the area, including, but not limited
891 to, public health services, primary care services, inpatient
892 services, and affordable health insurance generally.
893
894 Any hospital that fails to comply with any of the provisions of
895 this subsection, or any other contractual condition, may not
896 receive payments under this section until full compliance is
897 achieved.
898 Section 11. Paragraph (b) of subsection (4) and paragraph
899 (a) of subsection (39) of section 409.912, Florida Statutes, are
900 amended, and subsection (53) is added to that section, to read:
901 409.912 Cost-effective purchasing of health care.--The
902 agency shall purchase goods and services for Medicaid recipients
903 in the most cost-effective manner consistent with the delivery
904 of quality medical care. To ensure that medical services are
905 effectively utilized, the agency may, in any case, require a
906 confirmation or second physician's opinion of the correct
907 diagnosis for purposes of authorizing future services under the
908 Medicaid program. This section does not restrict access to
909 emergency services or poststabilization care services as defined
910 in 42 C.F.R. part 438.114. Such confirmation or second opinion
911 shall be rendered in a manner approved by the agency. The agency
912 shall maximize the use of prepaid per capita and prepaid
913 aggregate fixed-sum basis services when appropriate and other
914 alternative service delivery and reimbursement methodologies,
915 including competitive bidding pursuant to s. 287.057, designed

916 to facilitate the cost-effective purchase of a case-managed
917 continuum of care. The agency shall also require providers to
918 minimize the exposure of recipients to the need for acute
919 inpatient, custodial, and other institutional care and the
920 inappropriate or unnecessary use of high-cost services. The
921 agency shall contract with a vendor to monitor and evaluate the
922 clinical practice patterns of providers in order to identify
923 trends that are outside the normal practice patterns of a
924 provider's professional peers or the national guidelines of a
925 provider's professional association. The vendor must be able to
926 provide information and counseling to a provider whose practice
927 patterns are outside the norms, in consultation with the agency,
928 to improve patient care and reduce inappropriate utilization.
929 The agency may mandate prior authorization, drug therapy
930 management, or disease management participation for certain
931 populations of Medicaid beneficiaries, certain drug classes, or
932 particular drugs to prevent fraud, abuse, overuse, and possible
933 dangerous drug interactions. The Pharmaceutical and Therapeutics
934 Committee shall make recommendations to the agency on drugs for
935 which prior authorization is required. The agency shall inform
936 the Pharmaceutical and Therapeutics Committee of its decisions
937 regarding drugs subject to prior authorization. The agency is
938 authorized to limit the entities it contracts with or enrolls as
939 Medicaid providers by developing a provider network through
940 provider credentialing. The agency may competitively bid single-
941 source-provider contracts if procurement of goods or services
942 results in demonstrated cost savings to the state without
943 limiting access to care. The agency may limit its network based

944 on the assessment of beneficiary access to care, provider
945 availability, provider quality standards, time and distance
946 standards for access to care, the cultural competence of the
947 provider network, demographic characteristics of Medicaid
948 beneficiaries, practice and provider-to-beneficiary standards,
949 appointment wait times, beneficiary use of services, provider
950 turnover, provider profiling, provider licensure history,
951 previous program integrity investigations and findings, peer
952 review, provider Medicaid policy and billing compliance records,
953 clinical and medical record audits, and other factors. Providers
954 shall not be entitled to enrollment in the Medicaid provider
955 network. The agency shall determine instances in which allowing
956 Medicaid beneficiaries to purchase durable medical equipment and
957 other goods is less expensive to the Medicaid program than long-
958 term rental of the equipment or goods. The agency may establish
959 rules to facilitate purchases in lieu of long-term rentals in
960 order to protect against fraud and abuse in the Medicaid program
961 as defined in s. 409.913. The agency may seek federal waivers
962 necessary to administer these policies.
963 (4) The agency may contract with:
964 (b) An entity that is providing comprehensive behavioral
965 health care services to certain Medicaid recipients through a
966 capitated, prepaid arrangement pursuant to the federal waiver
967 provided for by s. 409.905(5). Such an entity must be licensed
968 under chapter 624, chapter 636, or chapter 641 and must possess
969 the clinical systems and operational competence to manage risk
970 and provide comprehensive behavioral health care to Medicaid
971 recipients. As used in this paragraph, the term "comprehensive

972 behavioral health care services" means covered mental health and
973 substance abuse treatment services that are available to
974 Medicaid recipients. The secretary of the Department of Children
975 and Family Services shall approve provisions of procurements
976 related to children in the department's care or custody prior to
977 enrolling such children in a prepaid behavioral health plan. Any
978 contract awarded under this paragraph must be competitively
979 procured. In developing the behavioral health care prepaid plan
980 procurement document, the agency shall ensure that the
981 procurement document requires the contractor to develop and
982 implement a plan to ensure compliance with s. 394.4574 related
983 to services provided to residents of licensed assisted living
984 facilities that hold a limited mental health license. Except as
985 provided in subparagraph 8., and except in counties where the
986 Medicaid managed care pilot program is authorized pursuant to s.
987 409.91211, the agency shall seek federal approval to contract
988 with a single entity meeting these requirements to provide
989 comprehensive behavioral health care services to all Medicaid
990 recipients not enrolled in a Medicaid managed care plan
991 authorized under s. 409.91211 or a Medicaid health maintenance
992 organization in an AHCA area. In an AHCA area where the Medicaid
993 managed care pilot program is authorized pursuant to s.
994 409.91211 in one or more counties, the agency may procure a
995 contract with a single entity to serve the remaining counties as
996 an AHCA area or the remaining counties may be included with an
997 adjacent AHCA area and shall be subject to this paragraph. Each
998 entity must offer sufficient choice of providers in its network
999 to ensure recipient access to care and the opportunity to select

1000 a provider with whom they are satisfied. The network shall
1001 include all public mental health hospitals. To ensure unimpaired
1002 access to behavioral health care services by Medicaid
1003 recipients, all contracts issued pursuant to this paragraph
1004 shall require 80 percent of the capitation paid to the managed
1005 care plan, including health maintenance organizations, to be
1006 expended for the provision of behavioral health care services.
1007 In the event the managed care plan expends less than 80 percent
1008 of the capitation paid pursuant to this paragraph for the
1009 provision of behavioral health care services, the difference
1010 shall be returned to the agency. The agency shall provide the
1011 managed care plan with a certification letter indicating the
1012 amount of capitation paid during each calendar year for the
1013 provision of behavioral health care services pursuant to this
1014 section. The agency may reimburse for substance abuse treatment
1015 services on a fee-for-service basis until the agency finds that
1016 adequate funds are available for capitated, prepaid
1017 arrangements.
1018 1. By January 1, 2001, the agency shall modify the
1019 contracts with the entities providing comprehensive inpatient
1020 and outpatient mental health care services to Medicaid
1021 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
1022 Counties, to include substance abuse treatment services.
1023 2. By July 1, 2003, the agency and the Department of
1024 Children and Family Services shall execute a written agreement
1025 that requires collaboration and joint development of all policy,
1026 budgets, procurement documents, contracts, and monitoring plans

1027 that have an impact on the state and Medicaid community mental
1028 health and targeted case management programs.
1029 3. Except as provided in subparagraph 8., by July 1, 2006,
1030 the agency and the Department of Children and Family Services
1031 shall contract with managed care entities in each AHCA area
1032 except area 6 or arrange to provide comprehensive inpatient and
1033 outpatient mental health and substance abuse services through
1034 capitated prepaid arrangements to all Medicaid recipients who
1035 are eligible to participate in such plans under federal law and
1036 regulation. In AHCA areas where eligible individuals number less
1037 than 150,000, the agency shall contract with a single managed
1038 care plan to provide comprehensive behavioral health services to
1039 all recipients who are not enrolled in a Medicaid health
1040 maintenance organization or a Medicaid capitated managed care
1041 plan authorized under s. 409.91211. The agency may contract with
1042 more than one comprehensive behavioral health provider to
1043 provide care to recipients who are not enrolled in a Medicaid
1044 capitated managed care plan authorized under s. 409.91211 or a
1045 Medicaid health maintenance organization in AHCA areas where the
1046 eligible population exceeds 150,000. In an AHCA area where the
1047 Medicaid managed care pilot program is authorized pursuant to s.
1048 409.91211 in one or more counties, the agency may procure a
1049 contract with a single entity to serve the remaining counties as
1050 an AHCA area or the remaining counties may be included with an
1051 adjacent AHCA area and shall be subject to this paragraph.
1052 Contracts for comprehensive behavioral health providers awarded
1053 pursuant to this section shall be competitively procured. Both
1054 for-profit and not-for-profit corporations shall be eligible to

1055 compete. Managed care plans contracting with the agency under
1056 subsection (3) shall provide and receive payment for the same
1057 comprehensive behavioral health benefits as provided in AHCA
1058 rules, including handbooks incorporated by reference. In AHCA
1059 area 11, the agency shall contract with at least two
1060 comprehensive behavioral health care providers to provide
1061 behavioral health care to recipients in that area who are
1062 enrolled in, or assigned to, the MediPass program. One of the
1063 behavioral health care contracts shall be with the existing
1064 provider service network pilot project, as described in
1065 paragraph (d), for the purpose of demonstrating the cost-
1066 effectiveness of the provision of quality mental health services
1067 through a public hospital-operated managed care model. Payment
1068 shall be at an agreed-upon capitated rate to ensure cost
1069 savings. Of the recipients in area 11 who are assigned to
1070 MediPass under the provisions of s. 409.9122(2)(k), a minimum of
1071 50,000 of those MediPass-enrolled recipients shall be assigned
1072 to the existing provider service network in area 11 for their
1073 behavioral care.
1074 4. By October 1, 2003, the agency and the department shall
1075 submit a plan to the Governor, the President of the Senate, and
1076 the Speaker of the House of Representatives which provides for
1077 the full implementation of capitated prepaid behavioral health
1078 care in all areas of the state.
1079 a. Implementation shall begin in 2003 in those AHCA areas
1080 of the state where the agency is able to establish sufficient
1081 capitation rates.

1082 b. If the agency determines that the proposed capitation
1083 rate in any area is insufficient to provide appropriate
1084 services, the agency may adjust the capitation rate to ensure
1085 that care will be available. The agency and the department may
1086 use existing general revenue to address any additional required
1087 match but may not over-obligate existing funds on an annualized
1088 basis.
1089 c. Subject to any limitations provided for in the General
1090 Appropriations Act, the agency, in compliance with appropriate
1091 federal authorization, shall develop policies and procedures
1092 that allow for certification of local and state funds.
1093 5. Children residing in a statewide inpatient psychiatric
1094 program, or in a Department of Juvenile Justice or a Department
1095 of Children and Family Services residential program approved as
1096 a Medicaid behavioral health overlay services provider shall not
1097 be included in a behavioral health care prepaid health plan or
1098 any other Medicaid managed care plan pursuant to this paragraph.
1099 6. In converting to a prepaid system of delivery, the
1100 agency shall in its procurement document require an entity
1101 providing only comprehensive behavioral health care services to
1102 prevent the displacement of indigent care patients by enrollees
1103 in the Medicaid prepaid health plan providing behavioral health
1104 care services from facilities receiving state funding to provide
1105 indigent behavioral health care, to facilities licensed under
1106 chapter 395 which do not receive state funding for indigent
1107 behavioral health care, or reimburse the unsubsidized facility
1108 for the cost of behavioral health care provided to the displaced
1109 indigent care patient.

1110 7. Traditional community mental health providers under
1111 contract with the Department of Children and Family Services
1112 pursuant to part IV of chapter 394, child welfare providers
1113 under contract with the Department of Children and Family
1114 Services in areas 1 and 6, and inpatient mental health providers
1115 licensed pursuant to chapter 395 must be offered an opportunity
1116 to accept or decline a contract to participate in any provider
1117 network for prepaid behavioral health services.
1118 8. All Medicaid-eligible children, except children in area
1119 1 and children in Highlands, Hardee, Polk, or Manatee Counties
1120 of area 6 For fiscal year 2004-2005, all Medicaid eligible
1121 children, except children in areas 1 and 6, whose cases are open
1122 for child welfare services in the HomeSafeNet system, shall be
1123 enrolled in MediPass or in Medicaid fee-for-service and all
1124 their behavioral health care services including inpatient,
1125 outpatient psychiatric, community mental health, and case
1126 management shall be reimbursed on a fee for service basis.
1127 Beginning July 1, 2005, such children, who are open for child
1128 welfare services in the HomeSafeNet system, shall receive their
1129 behavioral health care services through a specialty prepaid plan
1130 operated by community-based lead agencies either through a
1131 single agency or formal agreements among several agencies. The
1132 specialty prepaid plan must result in savings to the state
1133 comparable to savings achieved in other Medicaid managed care
1134 and prepaid programs. Such plan must provide mechanisms to
1135 maximize state and local revenues. The specialty prepaid plan
1136 shall be developed by the agency and the Department of Children
1137 and Family Services. The agency is authorized to seek any

1138 federal waivers to implement this initiative. Medicaid-eligible
1139 children whose cases are open for child welfare services in the
1140 HomeSafeNet system and who reside in AHCA area 10 are exempt
1141 from the specialty prepaid plan upon the development of a
1142 service delivery mechanism for children who reside in area 10 as
1143 specified in s. 409.91211(3)(dd).

1144 (39)(a) The agency shall implement a Medicaid prescribed-
1145 drug spending-control program that includes the following
1146 components:

1147 1. A Medicaid preferred drug list, which shall be a
1148 listing of cost-effective therapeutic options recommended by the
1149 Medicaid Pharmacy and Therapeutics Committee established
1150 pursuant to s. 409.91195 and adopted by the agency for each
1151 therapeutic class on the preferred drug list. At the discretion
1152 of the committee, and when feasible, the preferred drug list
1153 should include at least two products in a therapeutic class. The
1154 agency may post the preferred drug list and updates to the
1155 preferred drug list on an Internet website without following the
1156 rulemaking procedures of chapter 120. Antiretroviral agents are
1157 excluded from the preferred drug list. The agency shall also
1158 limit the amount of a prescribed drug dispensed to no more than
1159 a 34-day supply unless the drug products' smallest marketed
1160 package is greater than a 34-day supply, or the drug is
1161 determined by the agency to be a maintenance drug in which case
1162 a 100-day maximum supply may be authorized. The agency is
1163 authorized to seek any federal waivers necessary to implement
1164 these cost-control programs and to continue participation in the
1165 federal Medicaid rebate program, or alternatively to negotiate

1166 state-only manufacturer rebates. The agency may adopt rules to
1167 implement this subparagraph. The agency shall continue to
1168 provide unlimited contraceptive drugs and items. The agency must
1169 establish procedures to ensure that:
1170 a. There will be a response to a request for prior
1171 consultation by telephone or other telecommunication device
1172 within 24 hours after receipt of a request for prior
1173 consultation; and
1174 b. A 72-hour supply of the drug prescribed will be
1175 provided in an emergency or when the agency does not provide a
1176 response within 24 hours as required by sub-subparagraph a.
1177 2. Reimbursement to pharmacies for Medicaid prescribed
1178 drugs shall be set at the lesser of: the average wholesale price
1179 (AWP) minus <u>16.4</u> ~~15.4~~ percent, the wholesaler acquisition cost
1180 (WAC) plus <u>4.75</u> ~~5.75~~ percent, the federal upper limit (FUL), the
1181 state maximum allowable cost (SMAC), or the usual and customary
1182 (UAC) charge billed by the provider.
1183 3. The agency shall develop and implement a process for
1184 managing the drug therapies of Medicaid recipients who are using
1185 significant numbers of prescribed drugs each month. The
1186 management process may include, but is not limited to,
1187 comprehensive, physician-directed medical-record reviews, claims
1188 analyses, and case evaluations to determine the medical
1189 necessity and appropriateness of a patient's treatment plan and
1190 drug therapies. The agency may contract with a private
1191 organization to provide drug-program-management services. The
1192 Medicaid drug benefit management program shall include
1193 initiatives to manage drug therapies for HIV/AIDS patients,

1194 patients using 20 or more unique prescriptions in a 180-day
1195 period, and the top 1,000 patients in annual spending. The
1196 agency shall enroll any Medicaid recipient in the drug benefit
1197 management program if he or she meets the specifications of this
1198 provision and is not enrolled in a Medicaid health maintenance
1199 organization.
1200 4. The agency may limit the size of its pharmacy network
1201 based on need, competitive bidding, price negotiations,
1202 credentialing, or similar criteria. The agency shall give
1203 special consideration to rural areas in determining the size and
1204 location of pharmacies included in the Medicaid pharmacy
1205 network. A pharmacy credentialing process may include criteria
1206 such as a pharmacy's full-service status, location, size,
1207 patient educational programs, patient consultation, disease
1208 management services, and other characteristics. The agency may
1209 impose a moratorium on Medicaid pharmacy enrollment when it is
1210 determined that it has a sufficient number of Medicaid-
1211 participating providers. The agency must allow dispensing
1212 practitioners to participate as a part of the Medicaid pharmacy
1213 network regardless of the practitioner's proximity to any other
1214 entity that is dispensing prescription drugs under the Medicaid
1215 program. A dispensing practitioner must meet all credentialing
1216 requirements applicable to his or her practice, as determined by
1217 the agency.
1218 5. The agency shall develop and implement a program that
1219 requires Medicaid practitioners who prescribe drugs to use a
1220 counterfeit-proof prescription pad for Medicaid prescriptions.
1221 The agency shall require the use of standardized counterfeit-

1222 proof prescription pads by Medicaid-participating prescribers or
1223 prescribers who write prescriptions for Medicaid recipients. The
1224 agency may implement the program in targeted geographic areas or
1225 statewide.
1226 6. The agency may enter into arrangements that require
1227 manufacturers of generic drugs prescribed to Medicaid recipients
1228 to provide rebates of at least 15.1 percent of the average
1229 manufacturer price for the manufacturer's generic products.
1230 These arrangements shall require that if a generic-drug
1231 manufacturer pays federal rebates for Medicaid-reimbursed drugs
1232 at a level below 15.1 percent, the manufacturer must provide a
1233 supplemental rebate to the state in an amount necessary to
1234 achieve a 15.1-percent rebate level.
1235 7. The agency may establish a preferred drug list as
1236 described in this subsection, and, pursuant to the establishment
1237 of such preferred drug list, it is authorized to negotiate
1238 supplemental rebates from manufacturers that are in addition to
1239 those required by Title XIX of the Social Security Act and at no
1240 less than 14 percent of the average manufacturer price as
1241 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
1242 the federal or supplemental rebate, or both, equals or exceeds
1243 29 percent. There is no upper limit on the supplemental rebates
1244 the agency may negotiate. The agency may determine that specific
1245 products, brand-name or generic, are competitive at lower rebate
1246 percentages. Agreement to pay the minimum supplemental rebate
1247 percentage will guarantee a manufacturer that the Medicaid
1248 Pharmaceutical and Therapeutics Committee will consider a
1249 product for inclusion on the preferred drug list. However, a

1250 pharmaceutical manufacturer is not guaranteed placement on the
1251 preferred drug list by simply paying the minimum supplemental
1252 rebate. Agency decisions will be made on the clinical efficacy
1253 of a drug and recommendations of the Medicaid Pharmaceutical and
1254 Therapeutics Committee, as well as the price of competing
1255 products minus federal and state rebates. The agency is
1256 authorized to contract with an outside agency or contractor to
1257 conduct negotiations for supplemental rebates. For the purposes
1258 of this section, the term "supplemental rebates" means cash
1259 rebates. Effective July 1, 2004, value-added programs as a
1260 substitution for supplemental rebates are prohibited. The agency
1261 is authorized to seek any federal waivers to implement this
1262 initiative.
1263 8. The Agency for Health Care Administration shall expand
1264 home delivery of pharmacy products. To assist Medicaid patients
1265 in securing their prescriptions and reduce program costs, the
1266 agency shall expand its current mail-order-pharmacy diabetes-
1267 supply program to include all generic and brand-name drugs used
1268 by Medicaid patients with diabetes. Medicaid recipients in the
1269 current program may obtain nondiabetes drugs on a voluntary
1270 basis. This initiative is limited to the geographic area covered
1271 by the current contract. The agency may seek and implement any
1272 federal waivers necessary to implement this subparagraph.
1273 9. The agency shall limit to one dose per month any drug
1274 prescribed to treat erectile dysfunction.
1275 10.a. The agency may implement a Medicaid behavioral drug
1276 management system. The agency may contract with a vendor that
1277 has experience in operating behavioral drug management systems

1278 to implement this program. The agency is authorized to seek
1279 federal waivers to implement this program.
1280 b. The agency, in conjunction with the Department of
1281 Children and Family Services, may implement the Medicaid
1282 behavioral drug management system that is designed to improve
1283 the quality of care and behavioral health prescribing practices
1284 based on best practice guidelines, improve patient adherence to
1285 medication plans, reduce clinical risk, and lower prescribed
1286 drug costs and the rate of inappropriate spending on Medicaid
1287 behavioral drugs. The program may include the following
1288 elements:
1289 (I) Provide for the development and adoption of best
1290 practice guidelines for behavioral health-related drugs such as
1291 antipsychotics, antidepressants, and medications for treating
1292 bipolar disorders and other behavioral conditions; translate
1293 them into practice; review behavioral health prescribers and
1294 compare their prescribing patterns to a number of indicators
1295 that are based on national standards; and determine deviations
1296 from best practice guidelines.
1297 (II) Implement processes for providing feedback to and
1298 educating prescribers using best practice educational materials
1299 and peer-to-peer consultation.
1300 (III) Assess Medicaid beneficiaries who are outliers in
1301 their use of behavioral health drugs with regard to the numbers
1302 and types of drugs taken, drug dosages, combination drug
1303 therapies, and other indicators of improper use of behavioral
1304 health drugs.

1305 (IV) Alert prescribers to patients who fail to refill
1306 prescriptions in a timely fashion, are prescribed multiple same-
1307 class behavioral health drugs, and may have other potential
1308 medication problems.
1309 (V) Track spending trends for behavioral health drugs and
1310 deviation from best practice guidelines.
1311 (VI) Use educational and technological approaches to
1312 promote best practices, educate consumers, and train prescribers
1313 in the use of practice guidelines.
1314 (VII) Disseminate electronic and published materials.
1315 (VIII) Hold statewide and regional conferences.
1316 (IX) Implement a disease management program with a model
1317 quality-based medication component for severely mentally ill
1318 individuals and emotionally disturbed children who are high
1319 users of care.
1320 11.a. The agency shall implement a Medicaid prescription
1321 drug management system. The agency may contract with a vendor
1322 that has experience in operating prescription drug management
1323 systems in order to implement this system. Any management system
1324 that is implemented in accordance with this subparagraph must
1325 rely on cooperation between physicians and pharmacists to
1326 determine appropriate practice patterns and clinical guidelines
1327 to improve the prescribing, dispensing, and use of drugs in the
1328 Medicaid program. The agency may seek federal waivers to
1329 implement this program.
1330 b. The drug management system must be designed to improve
1331 the quality of care and prescribing practices based on best
1332 practice guidelines, improve patient adherence to medication

1333 plans, reduce clinical risk, and lower prescribed drug costs and
1334 the rate of inappropriate spending on Medicaid prescription
1335 drugs. The program must:
1336 (I) Provide for the development and adoption of best
1337 practice guidelines for the prescribing and use of drugs in the
1338 Medicaid program, including translating best practice guidelines
1339 into practice; reviewing prescriber patterns and comparing them
1340 to indicators that are based on national standards and practice
1341 patterns of clinical peers in their community, statewide, and
1342 nationally; and determine deviations from best practice
1343 guidelines.
1344 (II) Implement processes for providing feedback to and
1345 educating prescribers using best practice educational materials
1346 and peer-to-peer consultation.
1347 (III) Assess Medicaid recipients who are outliers in their
1348 use of a single or multiple prescription drugs with regard to
1349 the numbers and types of drugs taken, drug dosages, combination
1350 drug therapies, and other indicators of improper use of
1351 prescription drugs.
1352 (IV) Alert prescribers to patients who fail to refill
1353 prescriptions in a timely fashion, are prescribed multiple drugs
1354 that may be redundant or contraindicated, or may have other
1355 potential medication problems.
1356 (V) Track spending trends for prescription drugs and
1357 deviation from best practice guidelines.
1358 (VI) Use educational and technological approaches to
1359 promote best practices, educate consumers, and train prescribers
1360 in the use of practice guidelines.

1361 (VII) Disseminate electronic and published materials.
1362 (VIII) Hold statewide and regional conferences.
1363 (IX) Implement disease management programs in cooperation
1364 with physicians and pharmacists, along with a model quality-
1365 based medication component for individuals having chronic
1366 medical conditions.
1367 12. The agency is authorized to contract for drug rebate
1368 administration, including, but not limited to, calculating
1369 rebate amounts, invoicing manufacturers, negotiating disputes
1370 with manufacturers, and maintaining a database of rebate
1371 collections.
1372 13. The agency may specify the preferred daily dosing form
1373 or strength for the purpose of promoting best practices with
1374 regard to the prescribing of certain drugs as specified in the
1375 General Appropriations Act and ensuring cost-effective
1376 prescribing practices.
1377 14. The agency may require prior authorization for
1378 Medicaid-covered prescribed drugs. The agency may, but is not
1379 required to, prior-authorize the use of a product:
1380 a. For an indication not approved in labeling;
1381 b. To comply with certain clinical guidelines; or
1382 c. If the product has the potential for overuse, misuse,
1383 or abuse.
1384
1385 The agency may require the prescribing professional to provide
1386 information about the rationale and supporting medical evidence
1387 for the use of a drug. The agency may post prior authorization
1388 criteria and protocol and updates to the list of drugs that are

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

1389 subject to prior authorization on an Internet website without
1390 amending its rule or engaging in additional rulemaking.
1391 15. The agency, in conjunction with the Pharmaceutical and
1392 Therapeutics Committee, may require age-related prior
1393 authorizations for certain prescribed drugs. The agency may
1394 preauthorize the use of a drug for a recipient who may not meet
1395 the age requirement or may exceed the length of therapy for use
1396 of this product as recommended by the manufacturer and approved
1397 by the Food and Drug Administration. Prior authorization may
1398 require the prescribing professional to provide information
1399 about the rationale and supporting medical evidence for the use
1400 of a drug.
1401 16. The agency shall implement a step-therapy prior
1402 authorization approval process for medications excluded from the
1403 preferred drug list. Medications listed on the preferred drug
1404 list must be used within the previous 12 months prior to the
1405 alternative medications that are not listed. The step-therapy
1406 prior authorization may require the prescriber to use the
1407 medications of a similar drug class or for a similar medical
1408 indication unless contraindicated in the Food and Drug
1409 Administration labeling. The trial period between the specified
1410 steps may vary according to the medical indication. The step-
1411 therapy approval process shall be developed in accordance with
1412 the committee as stated in s. 409.91195(7) and (8). A drug
1413 product may be approved without meeting the step-therapy prior
1414 authorization criteria if the prescribing physician provides the
1415 agency with additional written medical or clinical documentation
1416 that the product is medically necessary because:

1417 a. There is not a drug on the preferred drug list to treat
1418 the disease or medical condition which is an acceptable clinical
1419 alternative;
1420 b. The alternatives have been ineffective in the treatment
1421 of the beneficiary's disease; or
1422 c. Based on historic evidence and known characteristics of
1423 the patient and the drug, the drug is likely to be ineffective,
1424 or the number of doses have been ineffective.
1425
1426 The agency shall work with the physician to determine the best
1427 alternative for the patient. The agency may adopt rules waiving
1428 the requirements for written clinical documentation for specific
1429 drugs in limited clinical situations.
1430 17. The agency shall implement a return and reuse program
1431 for drugs dispensed by pharmacies to institutional recipients,
1432 which includes payment of a $5 restocking fee for the
1433 implementation and operation of the program. The return and
1434 reuse program shall be implemented electronically and in a
1435 manner that promotes efficiency. The program must permit a
1436 pharmacy to exclude drugs from the program if it is not
1437 practical or cost-effective for the drug to be included and must
1438 provide for the return to inventory of drugs that cannot be
1439 credited or returned in a cost-effective manner. The agency
1440 shall determine if the program has reduced the amount of
1441 Medicaid prescription drugs which are destroyed on an annual
1442 basis and if there are additional ways to ensure more
1443 prescription drugs are not destroyed which could safely be

1444 reused. The agency's conclusion and recommendations shall be
1445 reported to the Legislature by December 1, 2005.
1446 (53) Before seeking an amendment to the state plan for
1447 purposes of implementing programs authorized by the Deficit
1448 Reduction Act of 2005, the agency shall notify the Legislature.
1449 Section 12. Section 409.91206, Florida Statutes, is
1450 created to read:
1451 409.91206 Alternatives for health and long-term care
1452 reforms.--The Governor, the President of the Senate, and the
1453 Speaker of the House of Representatives may convene workgroups
1454 to propose alternatives for cost-effective health and long-term
1455 care reforms, including, but not limited to, reforms for
1456 Medicaid.
1457 Section 13. Section 409.91211, Florida Statutes, as
1458 amended by chapter 2007-331, Laws of Florida, is amended to
1459 read:
1460 409.91211 Medicaid managed care pilot program.--
1461 (1)(a) The agency is authorized to seek and implement
1462 experimental, pilot, or demonstration project waivers, pursuant
1463 to s. 1115 of the Social Security Act, to create a statewide
1464 initiative to provide for a more efficient and effective service
1465 delivery system that enhances quality of care and client
1466 outcomes in the Florida Medicaid program pursuant to this
1467 section. ~~Phase one of the demonstration shall be implemented in~~
1468 ~~two geographic areas.~~ One demonstration site shall include only
1469 Broward County. A second demonstration site shall initially
1470 include Duval County and shall be expanded to include Baker,
1471 Clay, and Nassau Counties within 1 year after the Duval County

1472 program becomes operational. A third demonstration site shall
1473 include Hardee, Highlands, Hillsborough, Manatee, Miami-Dade,
1474 Monroe, Pasco, Pinellas, and Polk Counties. The agency shall
1475 begin enrolling recipients in the third demonstration site by
1476 September 1, 2010. The agency shall implement expansion of the
1477 program to include the remaining counties of the state and
1478 remaining eligibility groups in accordance with the process
1479 specified in the federally approved special terms and conditions
1480 numbered 11-W-00206/4, as approved by the federal Centers for
1481 Medicare and Medicaid Services on October 19, 2005, with a goal
1482 of full statewide implementation by June 30, 2011.
1483 (b) This waiver authority is contingent upon federal
1484 approval to preserve the upper-payment-limit funding mechanism
1485 for hospitals, including a guarantee of a reasonable growth
1486 factor, a methodology to allow the use of a portion of these
1487 funds to serve as a risk pool for demonstration sites,
1488 provisions to preserve the state's ability to use
1489 intergovernmental transfers, and provisions to protect the
1490 disproportionate share program authorized pursuant to this
1491 chapter. Upon completion of the evaluation conducted under s. 3,
1492 ch. 2005-133, Laws of Florida, the agency may request statewide
1493 expansion of the demonstration projects. Statewide phase-in to
1494 additional counties shall be contingent upon review and approval
1495 by the Legislature. Under the upper-payment-limit program, or
1496 the low-income pool as implemented by the Agency for Health Care
1497 Administration pursuant to federal waiver, the state matching
1498 funds required for the program shall be provided by local
1499 governmental entities through intergovernmental transfers in

1500 accordance with published federal statutes and regulations. The
1501 Agency for Health Care Administration shall distribute upper-
1502 payment-limit, disproportionate share hospital, and low-income
1503 pool funds according to published federal statutes, regulations,
1504 and waivers and the low-income pool methodology approved by the
1505 federal Centers for Medicare and Medicaid Services.
1506 (c) It is the intent of the Legislature that the low-
1507 income pool plan required by the terms and conditions of the
1508 Medicaid reform waiver and submitted to the federal Centers for
1509 Medicare and Medicaid Services propose the distribution of the
1510 above-mentioned program funds based on the following objectives:
1511 1. Assure a broad and fair distribution of available funds
1512 based on the access provided by Medicaid participating
1513 hospitals, regardless of their ownership status, through their
1514 delivery of inpatient or outpatient care for Medicaid
1515 beneficiaries and uninsured and underinsured individuals;
1516 2. Assure accessible emergency inpatient and outpatient
1517 care for Medicaid beneficiaries and uninsured and underinsured
1518 individuals;
1519 3. Enhance primary, preventive, and other ambulatory care
1520 coverages for uninsured individuals;
1521 4. Promote teaching and specialty hospital programs;
1522 5. Promote the stability and viability of statutorily
1523 defined rural hospitals and hospitals that serve as sole
1524 community hospitals;
1525 6. Recognize the extent of hospital uncompensated care
1526 costs;
1527 7. Maintain and enhance essential community hospital care;

1528 8. Maintain incentives for local governmental entities to
1529 contribute to the cost of uncompensated care;
1530 9. Promote measures to avoid preventable hospitalizations;
1531 10. Account for hospital efficiency; and
1532 11. Contribute to a community's overall health system.
1533 (2) The Legislature intends for the capitated managed care
1534 pilot program to:
1535 (a) Provide recipients in Medicaid fee-for-service or the
1536 MediPass program a comprehensive and coordinated capitated
1537 managed care system for all health care services specified in
1538 ss. 409.905 and 409.906.
1539 (b) Stabilize Medicaid expenditures under the pilot
1540 program compared to Medicaid expenditures in the pilot area for
1541 the 3 years before implementation of the pilot program, while
1542 ensuring:
1543 1. Consumer education and choice.
1544 2. Access to medically necessary services.
1545 3. Coordination of preventative, acute, and long-term
1546 care.
1547 4. Reductions in unnecessary service utilization.
1548 (c) Provide an opportunity to evaluate the feasibility of
1549 statewide implementation of capitated managed care networks as a
1550 replacement for the current Medicaid fee-for-service and
1551 MediPass systems.
1552 (3) The agency shall have the following powers, duties,
1553 and responsibilities with respect to the pilot program:
1554 (a) To implement a system to deliver all mandatory
1555 services specified in s. 409.905 and optional services specified

1556 in s. 409.906, as approved by the Centers for Medicare and
1557 Medicaid Services and the Legislature in the waiver pursuant to
1558 this section. Services to recipients under plan benefits shall
1559 include emergency services provided under s. 409.9128.
1560 (b) To implement a pilot program, including Medicaid
1561 eligibility categories specified in ss. 409.903 and 409.904, as
1562 authorized in an approved federal waiver.
1563 (c) To implement the managed care pilot program that
1564 maximizes all available state and federal funds, including those
1565 obtained through intergovernmental transfers, the low-income
1566 pool, supplemental Medicaid payments, and the disproportionate
1567 share program. Within the parameters allowed by federal statute
1568 and rule, the agency may seek options for making direct payments
1569 to hospitals and physicians employed by or under contract with
1570 the state's medical schools for the costs associated with
1571 graduate medical education under Medicaid reform.
1572 (d) To implement actuarially sound, risk-adjusted
1573 capitation rates for Medicaid recipients in the pilot program
1574 which cover comprehensive care, enhanced services, and
1575 catastrophic care.
1576 (e) To implement policies and guidelines for phasing in
1577 financial risk for approved provider service networks over a 3-
1578 year period. These policies and guidelines must include an
1579 option for a provider service network to be paid fee-for-service
1580 rates. For any provider service network established in a managed
1581 care pilot area, the option to be paid fee-for-service rates
1582 shall include a savings-settlement mechanism that is consistent
1583 with s. 409.912(44). <u>Provider service networks opting to be paid</u>

1584 fee-for-service rates shall have the option to be reimbursed for
1585 prescribed drugs and transportation services on a risk-adjusted
1586 captitated basis. This model shall be converted to a risk-
1587 adjusted capitated rate no later than the beginning of the
1588 fourth year of operation, and may be converted earlier at the
1589 option of the provider service network. Federally qualified
1590 health centers may be offered an opportunity to accept or
1591 decline a contract to participate in any provider network for
1592 prepaid primary care services. The agency shall encourage the
1593 development of innovative methods by provider service networks
1594 to perform administrative functions in a cost-effective manner,
1595 including coordination and consolidation of such functions
1596 between provider service networks and across demonstration
1597 sites.
1598 (f) To implement stop-loss requirements and the transfer
1599 of excess cost to catastrophic coverage that accommodates the
1600 risks associated with the development of the pilot program.
1601 (g) To recommend a process to be used by the Social
1602 Services Estimating Conference to determine and validate the
1603 rate of growth of the per-member costs of providing Medicaid
1604 services under the managed care pilot program.
1605 (h) To implement program standards and credentialing
1606 requirements for capitated managed care networks to participate
1607 in the pilot program, including those related to fiscal
1608 solvency, quality of care, and adequacy of access to health care
1609 providers. The agency shall monitor quarterly and evaluate
1610 annually each plan based on the program standards and
1611 credentialing requirements for adequacy of access to health care

1612 providers to ensure consistent compliance. It is the intent of
1613 the Legislature that, to the extent possible, any pilot program
1614 authorized by the state under this section include any federally
1615 qualified health center, federally qualified rural health
1616 clinic, county health department, the Children's Medical
1617 Services Network within the Department of Health, or other
1618 federally, state, or locally funded entity that serves the
1619 geographic areas within the boundaries of the pilot program that
1620 requests to participate. This paragraph does not relieve an
1621 entity that qualifies as a capitated managed care network under
1622 this section from any other licensure or regulatory requirements
1623 contained in state or federal law which would otherwise apply to
1624 the entity. The standards and credentialing requirements shall
1625 be based upon, but are not limited to:
1626 1. Compliance with the accreditation requirements as
1627 provided in s. 641.512.
1628 2. Compliance with early and periodic screening,
1629 diagnosis, and treatment screening requirements under federal
1630 law.
1631 3. The percentage of voluntary disenrollments.
1632 4. Immunization rates.
1633 5. Standards of the National Committee for Quality
1634 Assurance and other approved accrediting bodies.
1635 6. Recommendations of other authoritative bodies.
1636 7. Specific requirements of the Medicaid program, or
1637 standards designed to specifically meet the unique needs of
1638 Medicaid recipients.

1639 8. Compliance with the health quality improvement system
1640 as established by the agency, which incorporates standards and
1641 guidelines developed by the Centers for Medicare and Medicaid
1642 Services as part of the quality assurance reform initiative.
1643 9. The network's infrastructure capacity to manage
1644 financial transactions, recordkeeping, data collection, and
1645 other administrative functions.
1646 10. The network's ability to submit any financial,
1647 programmatic, or patient-encounter data or other information
1648 required by the agency to determine the actual services provided
1649 and the cost of administering the plan.
1650 (i) To implement a mechanism for providing information to
1651 Medicaid recipients for the purpose of selecting a capitated
1652 managed care plan. For each plan available to a recipient, the
1653 agency, at a minimum, shall ensure that the recipient is
1654 provided with:
1655 1. A list and description of the benefits provided.
1656 2. Information about cost sharing.
1657 3. Plan performance data, if available.
1658 4. An explanation of benefit limitations.
1659 5. Contact information, including identification of
1660 providers participating in the network, geographic locations,
1661 and transportation limitations.
1662 6. Specific information about covered prescription drugs
1663 for each plan.
1664 7.~~6.~~ Any other information the agency determines would
1665 facilitate a recipient's understanding of the plan or insurance
1666 that would best meet his or her needs.

1667 (j) To implement a system to ensure that there is a record
1668 of recipient acknowledgment that choice counseling has been
1669 provided.
1670 (k) To implement a choice counseling system to ensure that
1671 the choice counseling process and related material are designed
1672 to provide counseling through face-to-face interaction, by
1673 telephone, and in writing and through other forms of relevant
1674 media. Materials shall be written at the fourth-grade reading
1675 level and available in a language other than English when 5
1676 percent of the county speaks a language other than English.
1677 Choice counseling shall also use language lines and other
1678 services for impaired recipients, such as TTD/TTY.
1679 (l) To implement a system that prohibits capitated managed
1680 care plans, their representatives, and providers employed by or
1681 contracted with the capitated managed care plans from recruiting
1682 persons eligible for or enrolled in Medicaid, from providing
1683 inducements to Medicaid recipients to select a particular
1684 capitated managed care plan, and from prejudicing Medicaid
1685 recipients against other capitated managed care plans. The
1686 system shall require the entity performing choice counseling to
1687 determine if the recipient has made a choice of a plan or has
1688 opted out because of duress, threats, payment to the recipient,
1689 or incentives promised to the recipient by a third party. If the
1690 choice counseling entity determines that the decision to choose
1691 a plan was unlawfully influenced or a plan violated any of the
1692 provisions of s. 409.912(21), the choice counseling entity shall
1693 immediately report the violation to the agency's program
1694 integrity section for investigation. Verification of choice

1695 counseling by the recipient shall include a stipulation that the
1696 recipient acknowledges the provisions of this subsection.
1697 (m) To implement a choice counseling system that promotes
1698 health literacy and provides information aimed to reduce
1699 minority health disparities through outreach activities for
1700 Medicaid recipients.
1701 (n) To contract with entities to perform choice
1702 counseling. The agency may establish standards and performance
1703 contracts, including standards requiring the contractor to hire
1704 choice counselors who are representative of the state's diverse
1705 population and to train choice counselors in working with
1706 culturally diverse populations.
1707 (o) To implement eligibility assignment processes to
1708 facilitate client choice while ensuring pilot programs of
1709 adequate enrollment levels. These processes shall ensure that
1710 pilot sites have sufficient levels of enrollment to conduct a
1711 valid test of the managed care pilot program within a 2-year
1712 timeframe.
1713 (p) To implement standards for plan compliance, including,
1714 but not limited to, standards for quality assurance and
1715 performance improvement, standards for peer or professional
1716 reviews, grievance policies, and policies for maintaining
1717 program integrity. The agency shall set reasonable standards for
1718 prompt payment of provider claims. The agency shall develop a
1719 data-reporting system, seek input from managed care plans in
1720 order to establish requirements for patient-encounter reporting,
1721 and ensure that the data reported is accurate and complete.

1722 1. In performing the duties required under this section,
1723 the agency shall work with managed care plans to establish a
1724 uniform system to measure and monitor outcomes for a recipient
1725 of Medicaid services.
1726 2. The system shall use financial, clinical, and other
1727 criteria based on pharmacy, medical services, and other data
1728 that is related to the provision of Medicaid services,
1729 including, but not limited to:
1730 a. The Health Plan Employer Data and Information Set
1731 (HEDIS) or measures that are similar to HEDIS.
1732 b. Member satisfaction.
1733 c. Provider satisfaction.
1734 d. Report cards on plan performance and best practices.
1735 e. Compliance with the requirements for prompt payment of
1736 claims under ss. 627.613, 641.3155, and 641.513.
1737 f. Utilization and quality data for the purpose of
1738 ensuring access to medically necessary services, including
1739 underutilization or inappropriate denial of services.
1740 3. The agency shall require the managed care plans that
1741 have contracted with the agency to establish a quality assurance
1742 system that incorporates the provisions of s. 409.912(27) and
1743 any standards, rules, and guidelines developed by the agency.
1744 4. The agency shall establish an encounter database in
1745 order to compile data on health services rendered by health care
1746 practitioners who provide services to patients enrolled in
1747 managed care plans in the demonstration sites. The encounter
1748 database shall:

1749 a. Collect the following for each type of patient
1750 encounter with a health care practitioner or facility,
1751 including:
1752 (I) The demographic characteristics of the patient.
1753 (II) The principal, secondary, and tertiary diagnosis.
1754 (III) The procedure performed.
1755 (IV) The date and location where the procedure was
1756 performed.
1757 (V) The payment for the procedure, if any.
1758 (VI) If applicable, the health care practitioner's
1759 universal identification number.
1760 (VII) If the health care practitioner rendering the
1761 service is a dependent practitioner, the modifiers appropriate
1762 to indicate that the service was delivered by the dependent
1763 practitioner.
1764 b. Collect appropriate information relating to
1765 prescription drugs for each type of patient encounter.
1766 c. Collect appropriate information related to health care
1767 costs and utilization from managed care plans participating in
1768 the demonstration sites.
1769 5. To the extent practicable, when collecting the data the
1770 agency shall use a standardized claim form or electronic
1771 transfer system that is used by health care practitioners,
1772 facilities, and payors.
1773 6. Health care practitioners and facilities in the
1774 demonstration sites shall electronically submit, and managed
1775 care plans participating in the demonstration sites shall
1776 electronically receive, information concerning claims payments

1777 and any other information reasonably related to the encounter
1778 database using a standard format as required by the agency.
1779 7. The agency shall establish reasonable deadlines for
1780 phasing in the electronic transmittal of full encounter data.
1781 8. The system must ensure that the data reported is
1782 accurate and complete.
1783 (q) To implement a grievance resolution process for
1784 Medicaid recipients enrolled in a capitated managed care network
1785 under the pilot program modeled after the subscriber assistance
1786 panel, as created in s. 408.7056. This process shall include a
1787 mechanism for an expedited review of no greater than 24 hours
1788 after notification of a grievance if the life of a Medicaid
1789 recipient is in imminent and emergent jeopardy.
1790 (r) To implement a grievance resolution process for health
1791 care providers employed by or contracted with a capitated
1792 managed care network under the pilot program in order to settle
1793 disputes among the provider and the managed care network or the
1794 provider and the agency.
1795 (s) To implement criteria in an approved federal waiver to
1796 designate health care providers as eligible to participate in
1797 the pilot program. These criteria must include at a minimum
1798 those criteria specified in s. 409.907.
1799 (t) To use health care provider agreements for
1800 participation in the pilot program.
1801 (u) To require that all health care providers under
1802 contract with the pilot program be duly licensed in the state,
1803 if such licensure is available, and meet other criteria as may

1804 be established by the agency. These criteria shall include at a
1805 minimum those criteria specified in s. 409.907.
1806 (v) To ensure that managed care organizations work
1807 collaboratively with other state or local governmental programs
1808 or institutions for the coordination of health care to eligible
1809 individuals receiving services from such programs or
1810 institutions.
1811 (w) To implement procedures to minimize the risk of
1812 Medicaid fraud and abuse in all plans operating in the Medicaid
1813 managed care pilot program authorized in this section.
1814 1. The agency shall ensure that applicable provisions of
1815 this chapter and chapters 414, 626, 641, and 932 which relate to
1816 Medicaid fraud and abuse are applied and enforced at the
1817 demonstration project sites.
1818 2. Providers must have the certification, license, and
1819 credentials that are required by law and waiver requirements.
1820 3. The agency shall ensure that the plan is in compliance
1821 with s. 409.912(21) and (22).
1822 4. The agency shall require that each plan establish
1823 functions and activities governing program integrity in order to
1824 reduce the incidence of fraud and abuse. Plans must report
1825 instances of fraud and abuse pursuant to chapter 641.
1826 5. The plan shall have written administrative and
1827 management arrangements or procedures, including a mandatory
1828 compliance plan, which are designed to guard against fraud and
1829 abuse. The plan shall designate a compliance officer who has
1830 sufficient experience in health care.

1831 6.a. The agency shall require all managed care plan
1832 contractors in the pilot program to report all instances of
1833 suspected fraud and abuse. A failure to report instances of
1834 suspected fraud and abuse is a violation of law and subject to
1835 the penalties provided by law.
1836 b. An instance of fraud and abuse in the managed care
1837 plan, including, but not limited to, defrauding the state health
1838 care benefit program by misrepresentation of fact in reports,
1839 claims, certifications, enrollment claims, demographic
1840 statistics, or patient-encounter data; misrepresentation of the
1841 qualifications of persons rendering health care and ancillary
1842 services; bribery and false statements relating to the delivery
1843 of health care; unfair and deceptive marketing practices; and
1844 false claims actions in the provision of managed care, is a
1845 violation of law and subject to the penalties provided by law.
1846 c. The agency shall require that all contractors make all
1847 files and relevant billing and claims data accessible to state
1848 regulators and investigators and that all such data is linked
1849 into a unified system to ensure consistent reviews and
1850 investigations.
1851 (x) To develop and provide actuarial and benefit design
1852 analyses that indicate the effect on capitation rates and
1853 benefits offered in the pilot program over a prospective 5-year
1854 period based on the following assumptions:
1855 1. Growth in capitation rates which is limited to the
1856 estimated growth rate in general revenue.

1857 2. Growth in capitation rates which is limited to the
1858 average growth rate over the last 3 years in per-recipient
1859 Medicaid expenditures.
1860 3. Growth in capitation rates which is limited to the
1861 growth rate of aggregate Medicaid expenditures between the 2003-
1862 2004 fiscal year and the 2004-2005 fiscal year.
1863 (y) To develop a mechanism to require capitated managed
1864 care plans to reimburse qualified emergency service providers,
1865 including, but not limited to, ambulance services, in accordance
1866 with ss. 409.908 and 409.9128. The pilot program must include a
1867 provision for continuing fee-for-service payments for emergency
1868 services, including, but not limited to, individuals who access
1869 ambulance services or emergency departments and who are
1870 subsequently determined to be eligible for Medicaid services.
1871 (z) To ensure that school districts participating in the
1872 certified school match program pursuant to ss. 409.908(21) and
1873 1011.70 shall be reimbursed by Medicaid, subject to the
1874 limitations of s. 1011.70(1), for a Medicaid-eligible child
1875 participating in the services as authorized in s. 1011.70, as
1876 provided for in s. 409.9071, regardless of whether the child is
1877 enrolled in a capitated managed care network. Capitated managed
1878 care networks must make a good faith effort to execute
1879 agreements with school districts regarding the coordinated
1880 provision of services authorized under s. 1011.70. County health
1881 departments and federally qualified health centers delivering
1882 school-based services pursuant to ss. 381.0056 and 381.0057 must
1883 be reimbursed by Medicaid for the federal share for a Medicaid-
1884 eligible child who receives Medicaid-covered services in a

1885 school setting, regardless of whether the child is enrolled in a
1886 capitated managed care network. Capitated managed care networks
1887 must make a good faith effort to execute agreements with county
1888 health departments and federally qualified health centers
1889 regarding the coordinated provision of services to a Medicaid-
1890 eligible child. To ensure continuity of care for Medicaid
1891 patients, the agency, the Department of Health, and the
1892 Department of Education shall develop procedures for ensuring
1893 that a student's capitated managed care network provider
1894 receives information relating to services provided in accordance
1895 with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
1896 (aa) To implement a mechanism whereby Medicaid recipients
1897 who are already enrolled in a managed care plan or the MediPass
1898 program in the pilot areas shall be offered the opportunity to
1899 change to capitated managed care plans on a staggered basis, as
1900 defined by the agency. All Medicaid recipients shall have 30
1901 days in which to make a choice of capitated managed care plans.
1902 Those Medicaid recipients who do not make a choice shall be
1903 assigned to a capitated managed care plan in accordance with
1904 paragraph (4)(a) and shall be exempt from s. 409.9122. To
1905 facilitate continuity of care for a Medicaid recipient who is
1906 also a recipient of Supplemental Security Income (SSI), prior to
1907 assigning the SSI recipient to a capitated managed care plan,
1908 the agency shall determine whether the SSI recipient has an
1909 ongoing relationship with a provider or capitated managed care
1910 plan, and, if so, the agency shall assign the SSI recipient to
1911 that provider or capitated managed care plan where feasible.
1912 Those SSI recipients who do not have such a provider

1913 relationship shall be assigned to a capitated managed care plan
1914 provider in accordance with paragraph (4)(a) and shall be exempt
1915 from s. 409.9122.
1916 (bb) To develop and recommend a service delivery
1917 alternative for children having chronic medical conditions which
1918 establishes a medical home project to provide primary care
1919 services to this population. The project shall provide
1920 community-based primary care services that are integrated with
1921 other subspecialties to meet the medical, developmental, and
1922 emotional needs for children and their families. This project
1923 shall include an evaluation component to determine impacts on
1924 hospitalizations, length of stays, emergency room visits, costs,
1925 and access to care, including specialty care and patient and
1926 family satisfaction.
1927 (cc) To develop and recommend service delivery mechanisms
1928 within capitated managed care plans to provide Medicaid services
1929 as specified in ss. 409.905 and 409.906 to persons with
1930 developmental disabilities sufficient to meet the medical,
1931 developmental, and emotional needs of these persons.
1932 (dd) To implement service delivery mechanisms within
1933 capitated managed care plans to provide Medicaid services as
1934 specified in ss. 409.905 and 409.906 to Medicaid-eligible
1935 children whose cases are open for child welfare services in the
1936 HomeSafeNet system. These services must be coordinated with
1937 community-based care providers as specified in s. 409.1671,
1938 where available, and be sufficient to meet the medical,
1939 developmental, behavioral, and emotional needs of these
1940 children. These service delivery mechanisms must be implemented

1941 no later than July 1, 2008, in AHCA area 10 in order for the
1942 children in AHCA area 10 to remain exempt from the statewide
1943 plan under s. 409.912(4)(b)8.
1944 (4)(a) A Medicaid recipient in the pilot area who is not
1945 currently enrolled in a capitated managed care plan upon
1946 implementation is not eligible for services as specified in ss.
1947 409.905 and 409.906~~,~~ for the amount of time that the recipient
1948 does not enroll in a capitated managed care network. If a
1949 Medicaid recipient has not enrolled in a capitated managed care
1950 plan within 30 days after eligibility, the agency shall assign
1951 the Medicaid recipient to a provider service network. The agency
1952 shall assign such recipients to provider service networks for
1953 the first 5 years of implementation of each demonstration site
1954 or until the number of recipients enrolled in provider service
1955 networks in that demonstration site reaches 10 percent of the
1956 total number of participating Medicaid recipients in that
1957 demonstration site, whichever is first. After that time, if a
1958 Medicaid recipient has not enrolled in a capitated managed care
1959 plan within 30 days after eligibility, the agency shall assign
1960 the Medicaid recipient to a capitated managed care plan based on
1961 the assessed needs of the recipient as determined by the agency,
1962 and the recipient shall be exempt from s. 409.9122. When making
1963 such assignments, the agency shall take into account the
1964 following criteria:
1965 1. A capitated managed care network has sufficient network
1966 capacity to meet the needs of members.
1967 2. The capitated managed care network has previously
1968 enrolled the recipient as a member, or one of the capitated

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

1969 managed care network's primary care providers has previously
1970 provided health care to the recipient.
1971 3. The agency has knowledge that the member has previously
1972 expressed a preference for a particular capitated managed care
1973 network as indicated by Medicaid fee-for-service claims data,
1974 but has failed to make a choice.
1975 4. The capitated managed care network's primary care
1976 providers are geographically accessible to the recipient's
1977 residence.
1978 (b) When more than one capitated managed care network
1979 provider meets the criteria specified in paragraph (3)(h), the
1980 agency shall make recipient assignments consecutively by family
1981 unit.
1982 (c) If a recipient is currently enrolled with a Medicaid
1983 managed care organization that also operates an approved reform
1984 plan within a demonstration area and the recipient fails to
1985 choose a plan during the reform enrollment process or during
1986 redetermination of eligibility, the recipient shall be
1987 automatically assigned by the agency to a provider service
1988 network. The agency shall assign such recipients to provider
1989 service networks for the first 5 years of implementation of each
1990 demonstration site or until the number of recipients enrolled in
1991 provider service networks in that demonstration site reaches 10
1992 percent of the total number of participating Medicaid recipients
1993 in that demonstration site, whichever is first. After that time
1994 into the most appropriate reform plan operated by the
1995 recipient's current Medicaid managed care plan. If the
1996 recipient's current managed care plan does not operate a reform

1997 ~~plan in the demonstration area which adequately meets the needs~~
1998 ~~of the Medicaid recipient~~, the agency shall use the automatic
1999 assignment process as prescribed in the special terms and
2000 conditions numbered 11-W-00206/4. All enrollment and choice
2001 counseling materials provided by the agency must contain an
2002 explanation of the provisions of this paragraph for current
2003 managed care recipients.
2004 (d) The agency may not engage in practices that are
2005 designed to favor one capitated managed care plan over another
2006 or that are designed to influence Medicaid recipients to enroll
2007 in a particular capitated managed care network in order to
2008 strengthen its particular fiscal viability.
2009 (e) After a recipient has made a selection or has been
2010 enrolled in a capitated managed care network, the recipient
2011 shall have 90 days in which to voluntarily disenroll and select
2012 another capitated managed care network. After 90 days, no
2013 further changes may be made except for cause. Cause shall
2014 include, but not be limited to, poor quality of care, lack of
2015 access to necessary specialty services, an unreasonable delay or
2016 denial of service, inordinate or inappropriate changes of
2017 primary care providers, service access impairments due to
2018 significant changes in the geographic location of services, or
2019 fraudulent enrollment. The agency may require a recipient to use
2020 the capitated managed care network's grievance process as
2021 specified in paragraph (3)(q) prior to the agency's
2022 determination of cause, except in cases in which immediate risk
2023 of permanent damage to the recipient's health is alleged. The
2024 grievance process, when used, must be completed in time to

2025 permit the recipient to disenroll no later than the first day of
2026 the second month after the month the disenrollment request was
2027 made. If the capitated managed care network, as a result of the
2028 grievance process, approves an enrollee's request to disenroll,
2029 the agency is not required to make a determination in the case.
2030 The agency must make a determination and take final action on a
2031 recipient's request so that disenrollment occurs no later than
2032 the first day of the second month after the month the request
2033 was made. If the agency fails to act within the specified
2034 timeframe, the recipient's request to disenroll is deemed to be
2035 approved as of the date agency action was required. Recipients
2036 who disagree with the agency's finding that cause does not exist
2037 for disenrollment shall be advised of their right to pursue a
2038 Medicaid fair hearing to dispute the agency's finding.
2039 (f) The agency shall apply for federal waivers from the
2040 Centers for Medicare and Medicaid Services to lock eligible
2041 Medicaid recipients into a capitated managed care network for 12
2042 months after an open enrollment period. After 12 months of
2043 enrollment, a recipient may select another capitated managed
2044 care network. However, nothing shall prevent a Medicaid
2045 recipient from changing primary care providers within the
2046 capitated managed care network during the 12-month period.
2047 (g) The agency shall apply for federal waivers from the
2048 Centers for Medicare and Medicaid Services to allow recipients
2049 to purchase health care coverage through an employer-sponsored
2050 health insurance plan instead of through a Medicaid-certified
2051 plan. This provision shall be known as the opt-out option.

2052 1. A recipient who chooses the Medicaid opt-out option
2053 shall have an opportunity for a specified period of time, as
2054 authorized under a waiver granted by the Centers for Medicare
2055 and Medicaid Services, to select and enroll in a Medicaid-
2056 certified plan. If the recipient remains in the employer-
2057 sponsored plan after the specified period, the recipient shall
2058 remain in the opt-out program for at least 1 year or until the
2059 recipient no longer has access to employer-sponsored coverage,
2060 until the employer's open enrollment period for a person who
2061 opts out in order to participate in employer-sponsored coverage,
2062 or until the person is no longer eligible for Medicaid,
2063 whichever time period is shorter.
2064 2. Notwithstanding any other provision of this section,
2065 coverage, cost sharing, and any other component of employer-
2066 sponsored health insurance shall be governed by applicable state
2067 and federal laws.
2068 (5) This section does not authorize the agency to
2069 implement any provision of s. 1115 of the Social Security Act
2070 experimental, pilot, or demonstration project waiver to reform
2071 the state Medicaid program in any part of the state other than
2072 the two geographic areas specified in this section unless
2073 approved by the Legislature.
2074 (6) The agency shall develop and submit for approval
2075 applications for waivers of applicable federal laws and
2076 regulations as necessary to implement the managed care pilot
2077 project as defined in this section. The agency shall post all
2078 waiver applications under this section on its Internet website
2079 30 days before submitting the applications to the United States

2080 Centers for Medicare and Medicaid Services. All waiver
2081 applications shall be provided for review and comment to the
2082 appropriate committees of the Senate and House of
2083 Representatives for at least 10 working days prior to
2084 submission. All waivers submitted to and approved by the United
2085 States Centers for Medicare and Medicaid Services under this
2086 section must be approved by the Legislature. Federally approved
2087 waivers must be submitted to the President of the Senate and the
2088 Speaker of the House of Representatives for referral to the
2089 appropriate legislative committees. The appropriate committees
2090 shall recommend whether to approve the implementation of any
2091 waivers to the Legislature as a whole. The agency shall submit a
2092 plan containing a recommended timeline for implementation of any
2093 waivers and budgetary projections of the effect of the pilot
2094 program under this section on the total Medicaid budget for the
2095 2006-2007 through 2009-2010 state fiscal years. This
2096 implementation plan shall be submitted to the President of the
2097 Senate and the Speaker of the House of Representatives at the
2098 same time any waivers are submitted for consideration by the
2099 Legislature. The agency may implement the waiver and special
2100 terms and conditions numbered 11-W-00206/4, as approved by the
2101 federal Centers for Medicare and Medicaid Services. If the
2102 agency seeks approval by the Federal Government of any
2103 modifications to these special terms and conditions, the agency
2104 must provide written notification of its intent to modify these
2105 terms and conditions to the President of the Senate and the
2106 Speaker of the House of Representatives at least 15 days before
2107 submitting the modifications to the Federal Government for

2108 consideration. The notification must identify all modifications
2109 being pursued and the reason the modifications are needed. Upon
2110 receiving federal approval of any modifications to the special
2111 terms and conditions, the agency shall provide a report to the
2112 Legislature describing the federally approved modifications to
2113 the special terms and conditions within 7 days after approval by
2114 the Federal Government.
2115 (7)(a) The Secretary of Health Care Administration shall
2116 convene a technical advisory panel to advise the agency in the
2117 areas of risk-adjusted-rate setting, benefit design, and choice
2118 counseling. The panel shall include representatives from the
2119 Florida Association of Health Plans, representatives from
2120 provider-sponsored networks, a Medicaid consumer representative,
2121 and a representative from the Office of Insurance Regulation.
2122 (b) The technical advisory panel shall advise the agency
2123 concerning:
2124 1. The risk-adjusted rate methodology to be used by the
2125 agency, including recommendations on mechanisms to recognize the
2126 risk of all Medicaid enrollees and for the transition to a risk-
2127 adjustment system, including recommendations for phasing in risk
2128 adjustment and the use of risk corridors.
2129 2. Implementation of an encounter data system to be used
2130 for risk-adjusted rates.
2131 3. Administrative and implementation issues regarding the
2132 use of risk-adjusted rates, including, but not limited to, cost,
2133 simplicity, client privacy, data accuracy, and data exchange.
2134 4. Issues of benefit design, including the actuarial
2135 equivalence and sufficiency standards to be used.

2136 5. The implementation plan for the proposed choice-
2137 counseling system, including the information and materials to be
2138 provided to recipients, the methodologies by which recipients
2139 will be counseled regarding choice, criteria to be used to
2140 assess plan quality, the methodology to be used to assign
2141 recipients into plans if they fail to choose a managed care
2142 plan, and the standards to be used for responsiveness to
2143 recipient inquiries.
2144 (c) The technical advisory panel shall continue in
2145 existence and advise the agency on matters outlined in this
2146 subsection.
2147 (8) The agency must ensure, in the first two state fiscal
2148 years in which a risk-adjusted methodology is a component of
2149 rate setting, that no managed care plan providing comprehensive
2150 benefits to TANF and SSI recipients has an aggregate risk score
2151 that varies by more than 10 percent from the aggregate weighted
2152 mean of all managed care plans providing comprehensive benefits
2153 to TANF and SSI recipients in a reform area. The agency's
2154 payment to a managed care plan shall be based on such revised
2155 aggregate risk score.
2156 (9) After any calculations of aggregate risk scores or
2157 revised aggregate risk scores in subsection (8), the capitation
2158 rates for plans participating under this section shall be phased
2159 in as follows:
2160 (a) In the first year, the capitation rates shall be
2161 weighted so that 75 percent of each capitation rate is based on
2162 the current methodology and 25 percent is based on a new risk-
2163 adjusted capitation rate methodology.

2164 (b) In the second year, the capitation rates shall be
2165 weighted so that 50 percent of each capitation rate is based on
2166 the current methodology and 50 percent is based on a new risk-
2167 adjusted rate methodology.
2168 (c) In the following fiscal year, the risk-adjusted
2169 capitation methodology may be fully implemented.
2170 (10) Subsections (8) and (9) do not apply to managed care
2171 plans offering benefits exclusively to high-risk, specialty
2172 populations. The agency may set risk-adjusted rates immediately
2173 for such plans.
2174 (11) Before the implementation of risk-adjusted rates, the
2175 rates shall be certified by an actuary and approved by the
2176 federal Centers for Medicare and Medicaid Services.
2177 (12) For purposes of this section, the term "capitated
2178 managed care plan" includes health insurers authorized under
2179 chapter 624, exclusive provider organizations authorized under
2180 chapter 627, health maintenance organizations authorized under
2181 chapter 641, the Children's Medical Services Network under
2182 chapter 391, and provider service networks that elect to be paid
2183 fee-for-service for up to 3 years as authorized under this
2184 section.
2185 (13) Upon review and approval of the applications for
2186 waivers of applicable federal laws and regulations to implement
2187 the managed care pilot program by the Legislature, the agency
2188 may initiate adoption of rules pursuant to ss. 120.536(1) and
2189 120.54 to implement and administer the managed care pilot
2190 program as provided in this section.

2191 (14) It is the intent of the Legislature that if any
2192 conflict exists between the provisions contained in this section
2193 and other provisions of this chapter which relate to the
2194 implementation of the Medicaid managed care pilot program, the
2195 provisions contained in this section shall control. The agency
2196 shall provide a written report to the Legislature by April 1,
2197 2006, identifying any provisions of this chapter which conflict
2198 with the implementation of the Medicaid managed care pilot
2199 program created in this section. After April 1, 2006, the agency
2200 shall provide a written report to the Legislature immediately
2201 upon identifying any provisions of this chapter which conflict
2202 with the implementation of the Medicaid managed care pilot
2203 program created in this section.
2204 Section 14. Subsection (2) of section 409.9124, Florida
2205 Statutes, is amended to read:
2206 409.9124 Managed care reimbursement.--The agency shall
2207 develop and adopt by rule a methodology for reimbursing managed
2208 care plans.
2209 (2) Each year prior to establishing new managed care
2210 rates, the agency shall review all prior year adjustments for
2211 changes in trend, and shall reduce or eliminate those
2212 adjustments which are not reasonable and which reflect policies
2213 or programs which are not in effect. In addition, the agency
2214 shall apply only those policy reductions applicable to the
2215 fiscal year for which the rates are being set, which can be
2216 accurately estimated and verified by an independent actuary, and
2217 which have been implemented prior to or will be implemented
2218 during the fiscal year. ~~The agency shall pay rates at per-~~

2219 ~~member, per-month averages that do not exceed the amounts~~
2220 ~~allowed for in the General Appropriations Act applicable to the~~
2221 ~~fiscal year for which the rates will be in effect.~~
2222 Section 15. Subsection (36) of section 409.913, Florida
2223 Statutes, is amended to read:
2224 409.913 Oversight of the integrity of the Medicaid
2225 program.--The agency shall operate a program to oversee the
2226 activities of Florida Medicaid recipients, and providers and
2227 their representatives, to ensure that fraudulent and abusive
2228 behavior and neglect of recipients occur to the minimum extent
2229 possible, and to recover overpayments and impose sanctions as
2230 appropriate. Beginning January 1, 2003, and each year
2231 thereafter, the agency and the Medicaid Fraud Control Unit of
2232 the Department of Legal Affairs shall submit a joint report to
2233 the Legislature documenting the effectiveness of the state's
2234 efforts to control Medicaid fraud and abuse and to recover
2235 Medicaid overpayments during the previous fiscal year. The
2236 report must describe the number of cases opened and investigated
2237 each year; the sources of the cases opened; the disposition of
2238 the cases closed each year; the amount of overpayments alleged
2239 in preliminary and final audit letters; the number and amount of
2240 fines or penalties imposed; any reductions in overpayment
2241 amounts negotiated in settlement agreements or by other means;
2242 the amount of final agency determinations of overpayments; the
2243 amount deducted from federal claiming as a result of
2244 overpayments; the amount of overpayments recovered each year;
2245 the amount of cost of investigation recovered each year; the
2246 average length of time to collect from the time the case was

2247 opened until the overpayment is paid in full; the amount
2248 determined as uncollectible and the portion of the uncollectible
2249 amount subsequently reclaimed from the Federal Government; the
2250 number of providers, by type, that are terminated from
2251 participation in the Medicaid program as a result of fraud and
2252 abuse; and all costs associated with discovering and prosecuting
2253 cases of Medicaid overpayments and making recoveries in such
2254 cases. The report must also document actions taken to prevent
2255 overpayments and the number of providers prevented from
2256 enrolling in or reenrolling in the Medicaid program as a result
2257 of documented Medicaid fraud and abuse and must recommend
2258 changes necessary to prevent or recover overpayments.
2259 (36) The agency shall provide to each Medicaid recipient
2260 or his or her representative an explanation of benefits in the
2261 form of a letter that is mailed to the most recent address of
2262 the recipient on the record with the Department of Children and
2263 Family Services. The explanation of benefits must include the
2264 patient's name, the name of the health care provider and the
2265 address of the location where the service was provided, a
2266 description of all services billed to Medicaid in terminology
2267 that should be understood by a reasonable person, and
2268 information on how to report inappropriate or incorrect billing
2269 to the agency or other law enforcement entities for review or
2270 investigation. The explanation of benefits may not be mailed for
2271 Medicaid independent laboratory services as described in s.
2272 409.905(7) or for Medicaid certified match services as described
2273 in ss. 409.9071 and 1011.70.

2274 Section 16. Paragraph (a) of subsection (8) of section
2275 39.001, Florida Statutes, is amended to read:
2276 39.001 Purposes and intent; personnel standards and
2277 screening.--
2278 (8) PLAN FOR COMPREHENSIVE APPROACH.--
2279 (a) The office shall develop a state plan for the
2280 promotion of adoption, support of adoptive families, and
2281 prevention of abuse, abandonment, and neglect of children and
2282 shall submit the state plan to the Speaker of the House of
2283 Representatives, the President of the Senate, and the Governor
2284 no later than December 31, 2008. The Department of Children and
2285 Family Services, the Department of Corrections, the Department
2286 of Education, the Department of Health, the Department of
2287 Juvenile Justice, the Department of Law Enforcement, the Agency
2288 for Persons with Disabilities, and the Agency for Workforce
2289 Innovation shall participate and fully cooperate in the
2290 development of the state plan at both the state and local
2291 levels. Furthermore, appropriate local agencies and
2292 organizations shall be provided an opportunity to participate in
2293 the development of the state plan at the local level.
2294 Appropriate local groups and organizations shall include, but
2295 not be limited to, community mental health centers; guardian ad
2296 litem programs for children under the circuit court; the school
2297 boards of the local school districts; ~~the Florida local advocacy~~
2298 ~~councils;~~ community-based care lead agencies; private or public
2299 organizations or programs with recognized expertise in working
2300 with child abuse prevention programs for children and families;
2301 private or public organizations or programs with recognized

2302 expertise in working with children who are sexually abused,
2303 physically abused, emotionally abused, abandoned, or neglected
2304 and with expertise in working with the families of such
2305 children; private or public programs or organizations with
2306 expertise in maternal and infant health care; multidisciplinary
2307 child protection teams; child day care centers; law enforcement
2308 agencies; and the circuit courts, when guardian ad litem
2309 programs are not available in the local area. The state plan to
2310 be provided to the Legislature and the Governor shall include,
2311 as a minimum, the information required of the various groups in
2312 paragraph (b).
2313 Section 17. Subsection (2) of section 39.0011, Florida
2314 Statutes, is amended to read:
2315 39.0011 Direct-support organization.--
2316 (2) The number of members on the board of directors of the
2317 direct-support organization shall be determined by the Chief
2318 Child Advocate. Membership on the board of directors of the
2319 direct-support organization shall include, but not be limited
2320 to, a guardian ad litem; ~~a member of a local advocacy council;~~ a
2321 representative from a community-based care lead agency; a
2322 representative from a private or public organization or program
2323 with recognized expertise in working with child abuse prevention
2324 programs for children and families; a representative of a
2325 private or public organization or program with recognized
2326 expertise in working with children who are sexually abused,
2327 physically abused, emotionally abused, abandoned, or neglected
2328 and with expertise in working with the families of such
2329 children; an individual working at a state adoption agency; and

2330 the parent of a child adopted from within the child welfare
2331 system.
2332 Section 18. Paragraph (k) of subsection (2) of section
2333 39.202, Florida Statutes, is amended to read:
2334 39.202 Confidentiality of reports and records in cases of
2335 child abuse or neglect.--
2336 (2) Except as provided in subsection (4), access to such
2337 records, excluding the name of the reporter which shall be
2338 released only as provided in subsection (5), shall be granted
2339 only to the following persons, officials, and agencies:
2340 (k) ~~Any appropriate official of a Florida advocacy council~~
2341 ~~investigating a report of known or suspected child abuse,~~
2342 ~~abandonment, or neglect;~~ The Auditor General or the Office of
2343 Program Policy Analysis and Government Accountability for the
2344 purpose of conducting audits or examinations pursuant to law~~;~~ or
2345 the guardian ad litem for the child.
2346 Section 19. Subsections (5), (6), and (7) of section
2347 39.302, Florida Statutes, are renumbered as subsections (4),
2348 (5), and (6), respectively, and present subsection (4) is
2349 amended to read:
2350 39.302 Protective investigations of institutional child
2351 abuse, abandonment, or neglect.--
2352 ~~(4) The department shall notify the Florida local advocacy~~
2353 ~~council in the appropriate district of the department as to~~
2354 ~~every report of institutional child abuse, abandonment, or~~
2355 ~~neglect in the district in which a client of the department is~~
2356 ~~alleged or shown to have been abused, abandoned, or neglected,~~

2357 ~~which notification shall be made within 48 hours after the~~
2358 ~~department commences its investigation.~~
2359 Section 20. Paragraph (v) of subsection (1) of section
2360 215.22, Florida Statutes, is redesignated as paragraph (u), and
2361 present paragraph (u) of that subsection is amended to read:
2362 215.22 Certain income and certain trust funds exempt.--
2363 (1) The following income of a revenue nature or the
2364 following trust funds shall be exempt from the appropriation
2365 required by s. 215.20(1):
2366 ~~(u) The Florida Center for Nursing Trust Fund.~~
2367 Section 21. Paragraph (c) of subsection (5) and subsection
2368 (12) of section 394.459, Florida Statutes, are amended to read:
2369 394.459 Rights of patients.--
2370 (5) COMMUNICATION, ABUSE REPORTING, AND VISITS.--
2371 (c) Each facility must permit immediate access to any
2372 patient, subject to the patient's right to deny or withdraw
2373 consent at any time, by the patient's family members, guardian,
2374 guardian advocate, representative, ~~Florida statewide or local~~
2375 ~~advocacy council,~~ or attorney, unless such access would be
2376 detrimental to the patient. If a patient's right to communicate
2377 or to receive visitors is restricted by the facility, written
2378 notice of such restriction and the reasons for the restriction
2379 shall be served on the patient, the patient's attorney, and the
2380 patient's guardian, guardian advocate, or representative; and
2381 such restriction shall be recorded on the patient's clinical
2382 record with the reasons therefor. The restriction of a patient's
2383 right to communicate or to receive visitors shall be reviewed at
2384 least every 7 days. The right to communicate or receive visitors

2385 shall not be restricted as a means of punishment. Nothing in
2386 this paragraph shall be construed to limit the provisions of
2387 paragraph (d).
2388 (12) POSTING OF NOTICE OF RIGHTS OF PATIENTS.--Each
2389 facility shall post a notice listing and describing, in the
2390 language and terminology that the persons to whom the notice is
2391 addressed can understand, the rights provided in this section.
2392 This notice shall include a statement that provisions of the
2393 federal Americans with Disabilities Act apply and the name and
2394 telephone number of a person to contact for further information.
2395 This notice shall be posted in a place readily accessible to
2396 patients and in a format easily seen by patients. This notice
2397 shall include the telephone number ~~numbers~~ of the ~~Florida local~~
2398 ~~advocacy council and~~ Advocacy Center for Persons with
2399 Disabilities, Inc.
2400 Section 22. Paragraph (d) of subsection (2) of section
2401 394.4597, Florida Statutes, is amended to read:
2402 394.4597 Persons to be notified; patient's
2403 representative.--
2404 (2) INVOLUNTARY PATIENTS.--
2405 (d) When the receiving or treatment facility selects a
2406 representative, first preference shall be given to a health care
2407 surrogate, if one has been previously selected by the patient.
2408 If the patient has not previously selected a health care
2409 surrogate, the selection, except for good cause documented in
2410 the patient's clinical record, shall be made from the following
2411 list in the order of listing:
2412 1. The patient's spouse.

2413 2. An adult child of the patient.
2414 3. A parent of the patient.
2415 4. The adult next of kin of the patient.
2416 5. An adult friend of the patient.
2417 ~~6. The appropriate Florida local advocacy council as~~
2418 ~~provided in s. 402.166.~~
2419 Section 23. Subsection (1) of section 394.4598, Florida
2420 Statutes, is amended to read:
2421 394.4598 Guardian advocate.--
2422 (1) The administrator may petition the court for the
2423 appointment of a guardian advocate based upon the opinion of a
2424 psychiatrist that the patient is incompetent to consent to
2425 treatment. If the court finds that a patient is incompetent to
2426 consent to treatment and has not been adjudicated incapacitated
2427 and a guardian with the authority to consent to mental health
2428 treatment appointed, it shall appoint a guardian advocate. The
2429 patient has the right to have an attorney represent him or her
2430 at the hearing. If the person is indigent, the court shall
2431 appoint the office of the public defender to represent him or
2432 her at the hearing. The patient has the right to testify, cross-
2433 examine witnesses, and present witnesses. The proceeding shall
2434 be recorded either electronically or stenographically, and
2435 testimony shall be provided under oath. One of the professionals
2436 authorized to give an opinion in support of a petition for
2437 involuntary placement, as described in s. 394.4655 or s.
2438 394.467, must testify. A guardian advocate must meet the
2439 qualifications of a guardian contained in part IV of chapter
2440 744, except that a professional referred to in this part, an

2441 employee of the facility providing direct services to the
2442 patient under this part, a departmental employee, or a facility
2443 administrator~~, or member of the Florida local advocacy council~~
2444 shall not be appointed. A person who is appointed as a guardian
2445 advocate must agree to the appointment.
2446 Section 24. Paragraph (b) of subsection (2) of section
2447 394.4599, Florida Statutes, is amended to read:
2448 394.4599 Notice.--
2449 (2) INVOLUNTARY PATIENTS.--
2450 (b) A receiving facility shall give prompt notice of the
2451 whereabouts of a patient who is being involuntarily held for
2452 examination, by telephone or in person within 24 hours after the
2453 patient's arrival at the facility, unless the patient requests
2454 that no notification be made. Contact attempts shall be
2455 documented in the patient's clinical record and shall begin as
2456 soon as reasonably possible after the patient's arrival. ~~Notice~~
2457 ~~that a patient is being admitted as an involuntary patient shall~~
2458 ~~be given to the Florida local advocacy council no later than the~~
2459 ~~next working day after the patient is admitted.~~
2460 Section 25. Subsection (5) of section 394.4615, Florida
2461 Statutes, is amended to read:
2462 394.4615 Clinical records; confidentiality.--
2463 (5) Information from clinical records may be used by the
2464 Agency for Health Care Administration and~~,~~ the department~~, and~~
2465 ~~the Florida advocacy councils~~ for the purpose of monitoring
2466 facility activity and complaints concerning facilities.
2467 Section 26. Paragraphs (h) and (i) of subsection (2) of
2468 section 400.0065, Florida Statutes, are redesignated as

2469 paragraphs (g) and (h), respectively, and present paragraph (g)
2470 of that subsection is amended to read:
2471 400.0065 State Long-Term Care Ombudsman; duties and
2472 responsibilities.--
2473 (2) The State Long-Term Care Ombudsman shall have the duty
2474 and authority to:
2475 ~~(g) Enter into a cooperative agreement with the Statewide~~
2476 ~~Advocacy Council for the purpose of coordinating and avoiding~~
2477 ~~duplication of advocacy services provided to residents.~~
2478 Section 27. Paragraph (a) of subsection (2) of section
2479 400.118, Florida Statutes, is amended to read:
2480 400.118 Quality assurance; early warning system;
2481 monitoring; rapid response teams.--
2482 (2)(a) The agency shall establish within each district
2483 office one or more quality-of-care monitors, based on the number
2484 of nursing facilities in the district, to monitor all nursing
2485 facilities in the district on a regular, unannounced, aperiodic
2486 basis, including nights, evenings, weekends, and holidays.
2487 Quality-of-care monitors shall visit each nursing facility at
2488 least quarterly. Priority for additional monitoring visits shall
2489 be given to nursing facilities with a history of resident care
2490 deficiencies. Quality-of-care monitors shall be registered
2491 nurses who are trained and experienced in nursing facility
2492 regulation, standards of practice in long-term care, and
2493 evaluation of patient care. Individuals in these positions shall
2494 not be deployed by the agency as a part of the district survey
2495 team in the conduct of routine, scheduled surveys, but shall
2496 function solely and independently as quality-of-care monitors.

2497 Quality-of-care monitors shall assess the overall quality of
2498 life in the nursing facility and shall assess specific
2499 conditions in the facility directly related to resident care,
2500 including the operations of internal quality improvement and
2501 risk management programs and adverse incident reports. The
2502 quality-of-care monitor shall include in an assessment visit
2503 observation of the care and services rendered to residents and
2504 formal and informal interviews with residents, family members,
2505 facility staff, resident guests, volunteers, other regulatory
2506 staff, and representatives of a long-term care ombudsman council
2507 ~~or Florida advocacy council~~.
2508 Section 28. Subsections (13) and (20) of section 400.141,
2509 Florida Statutes, are amended to read:
2510 400.141 Administration and management of nursing home
2511 facilities.--Every licensed facility shall comply with all
2512 applicable standards and rules of the agency and shall:
2513 (13) Publicly display a poster provided by the agency
2514 containing the names, addresses, and telephone numbers for the
2515 state's abuse hotline, the State Long-Term Care Ombudsman, the
2516 Agency for Health Care Administration consumer hotline, the
2517 Advocacy Center for Persons with Disabilities, ~~the Florida~~
2518 ~~Statewide Advocacy Council,~~ and the Medicaid Fraud Control Unit,
2519 with a clear description of the assistance to be expected from
2520 each.
2521 (20) Maintain general and professional liability insurance
2522 coverage that is in force at all times. ~~In lieu of general and~~
2523 ~~professional liability insurance coverage, a state-designated~~
2524 ~~teaching nursing home and its affiliated assisted living~~

2525 ~~facilities created under s. 430.80 may demonstrate proof of~~
2526 ~~financial responsibility as provided in s. 430.80(3)(h).~~
2527
2528 Facilities that have been awarded a Gold Seal under the program
2529 established in s. 400.235 may develop a plan to provide
2530 certified nursing assistant training as prescribed by federal
2531 regulations and state rules and may apply to the agency for
2532 approval of their program.
2533 Section 29. Paragraph (a) of subsection (1) of section
2534 415.1034, Florida Statutes, is amended to read:
2535 415.1034 Mandatory reporting of abuse, neglect, or
2536 exploitation of vulnerable adults; mandatory reports of death.--
2537 (1) MANDATORY REPORTING.--
2538 (a) Any person, including, but not limited to, any:
2539 1. Physician, osteopathic physician, medical examiner,
2540 chiropractic physician, nurse, paramedic, emergency medical
2541 technician, or hospital personnel engaged in the admission,
2542 examination, care, or treatment of vulnerable adults;
2543 2. Health professional or mental health professional other
2544 than one listed in subparagraph 1.;
2545 3. Practitioner who relies solely on spiritual means for
2546 healing;
2547 4. Nursing home staff; assisted living facility staff;
2548 adult day care center staff; adult family-care home staff;
2549 social worker; or other professional adult care, residential, or
2550 institutional staff;
2551 5. State, county, or municipal criminal justice employee
2552 or law enforcement officer;

2553 6. An employee of the Department of Business and
2554 Professional Regulation conducting inspections of public lodging
2555 establishments under s. 509.032;
2556 7. ~~Florida advocacy council member or~~ Long-term care
2557 ombudsman council member; or
2558 8. Bank, savings and loan, or credit union officer,
2559 trustee, or employee,
2560
2561 who knows, or has reasonable cause to suspect, that a vulnerable
2562 adult has been or is being abused, neglected, or exploited shall
2563 immediately report such knowledge or suspicion to the central
2564 abuse hotline.
2565 Section 30. Subsection (1) of section 415.104, Florida
2566 Statutes, is amended to read:
2567 415.104 Protective investigations of cases of abuse,
2568 neglect, or exploitation of vulnerable adults; transmittal of
2569 records to state attorney.--
2570 (1) The department shall, upon receipt of a report
2571 alleging abuse, neglect, or exploitation of a vulnerable adult,
2572 begin within 24 hours a protective investigation of the facts
2573 alleged therein. If a caregiver refuses to allow the department
2574 to begin a protective investigation or interferes with the
2575 conduct of such an investigation, the appropriate law
2576 enforcement agency shall be contacted for assistance. If, during
2577 the course of the investigation, the department has reason to
2578 believe that the abuse, neglect, or exploitation is perpetrated
2579 by a second party, the appropriate law enforcement agency and
2580 state attorney shall be orally notified. The department and the

2581 law enforcement agency shall cooperate to allow the criminal
2582 investigation to proceed concurrently with, and not be hindered
2583 by, the protective investigation. The department shall make a
2584 preliminary written report to the law enforcement agencies
2585 within 5 working days after the oral report. The department
2586 shall, within 24 hours after receipt of the report, notify the
2587 ~~appropriate Florida local advocacy council, or~~ long-term care
2588 ombudsman council, when appropriate, that an alleged abuse,
2589 neglect, or exploitation perpetrated by a second party has
2590 occurred. Notice to the ~~Florida local advocacy council or~~ long-
2591 term care ombudsman council may be accomplished orally or in
2592 writing and shall include the name and location of the
2593 vulnerable adult alleged to have been abused, neglected, or
2594 exploited and the nature of the report.
2595 Section 31. Subsection (8) of section 415.1055, Florida
2596 Statutes, is amended to read:
2597 415.1055 Notification to administrative entities.--
2598 (8) At the conclusion of a protective investigation at a
2599 facility, the department shall notify ~~either~~ the ~~Florida local~~
2600 ~~advocacy council or~~ long-term care ombudsman council of the
2601 results of the investigation. This notification must be in
2602 writing.
2603 Section 32. Subsection (2) of section 415.106, Florida
2604 Statutes, is amended to read:
2605 415.106 Cooperation by the department and criminal justice
2606 and other agencies.--
2607 (2) To ensure coordination, communication, and cooperation
2608 with the investigation of abuse, neglect, or exploitation of

2609 vulnerable adults, the department shall develop and maintain
2610 interprogram agreements or operational procedures among
2611 appropriate departmental programs and the State Long-Term Care
2612 Ombudsman Council~~, the Florida Statewide Advocacy Council,~~ and
2613 other agencies that provide services to vulnerable adults. These
2614 agreements or procedures must cover such subjects as the
2615 appropriate roles and responsibilities of the department in
2616 identifying and responding to reports of abuse, neglect, or
2617 exploitation of vulnerable adults; the provision of services;
2618 and related coordinated activities.
2619 Section 33. Paragraph (g) of subsection (3) of section
2620 415.107, Florida Statutes, is amended to read:
2621 415.107 Confidentiality of reports and records.--
2622 (3) Access to all records, excluding the name of the
2623 reporter which shall be released only as provided in subsection
2624 (6), shall be granted only to the following persons, officials,
2625 and agencies:
2626 (g) Any appropriate official of the ~~Florida advocacy~~
2627 ~~council or~~ long-term care ombudsman council investigating a
2628 report of known or suspected abuse, neglect, or exploitation of
2629 a vulnerable adult.
2630 Section 34. Subsection (9) of section 429.19, Florida
2631 Statutes, is amended to read:
2632 429.19 Violations; imposition of administrative fines;
2633 grounds.--
2634 (9) The agency shall develop and disseminate an annual
2635 list of all facilities sanctioned or fined $5,000 or more for
2636 violations of state standards, the number and class of

2637 violations involved, the penalties imposed, and the current
2638 status of cases. The list shall be disseminated, at no charge,
2639 to the Department of Elderly Affairs, the Department of Health,
2640 the Department of Children and Family Services, the Agency for
2641 Persons with Disabilities, the area agencies on aging, ~~the~~
2642 ~~Florida Statewide Advocacy Council,~~ and the state and local
2643 ombudsman councils. The Department of Children and Family
2644 Services shall disseminate the list to service providers under
2645 contract to the department who are responsible for referring
2646 persons to a facility for residency. The agency may charge a fee
2647 commensurate with the cost of printing and postage to other
2648 interested parties requesting a copy of this list.
2649 Section 35. Subsection (2) of section 429.28, Florida
2650 Statutes, is amended to read:
2651 429.28 Resident bill of rights.--
2652 (2) The administrator of a facility shall ensure that a
2653 written notice of the rights, obligations, and prohibitions set
2654 forth in this part is posted in a prominent place in each
2655 facility and read or explained to residents who cannot read.
2656 This notice shall include the name, address, and telephone
2657 numbers of the local ombudsman council and central abuse hotline
2658 and, when applicable, <u>and</u> the Advocacy Center for Persons with
2659 Disabilities, Inc., ~~and the Florida local advocacy council,~~
2660 where complaints may be lodged. The facility must ensure a
2661 resident's access to a telephone to call the local ombudsman
2662 council, central abuse hotline, <u>and the</u> Advocacy Center for
2663 Persons with Disabilities, Inc.~~, and the Florida local advocacy~~
2664 ~~council.~~

2665 Section 36. Section 429.34, Florida Statutes, is amended
2666 to read:
2667 429.34 Right of entry and inspection.--In addition to the
2668 requirements of s. 408.811, any duly designated officer or
2669 employee of the department, the Department of Children and
2670 Family Services, the Medicaid Fraud Control Unit of the Office
2671 of the Attorney General, the state or local fire marshal, or a
2672 member of the state or local long-term care ombudsman council
2673 shall have the right to enter unannounced upon and into the
2674 premises of any facility licensed pursuant to this part in order
2675 to determine the state of compliance with the provisions of this
2676 part, part II of chapter 408, and applicable rules. Data
2677 collected by the state or local long-term care ombudsman
2678 councils ~~or the state or local advocacy councils~~ may be used by
2679 the agency in investigations involving violations of regulatory
2680 standards.
2681 Section 37. Subsection (3) of section 430.04, Florida
2682 Statutes, is amended to read:
2683 430.04 Duties and responsibilities of the Department of
2684 Elderly Affairs.--The Department of Elderly Affairs shall:
2685 (3) Prepare and submit to the Governor, each Cabinet
2686 member, the President of the Senate, the Speaker of the House of
2687 Representatives, the minority leaders of the House and Senate,
2688 and chairpersons of appropriate House and Senate committees a
2689 master plan for policies and programs in the state related to
2690 aging. The plan must identify and assess the needs of the
2691 elderly population in the areas of housing, employment,
2692 education and training, medical care, long-term care, preventive

2693 care, protective services, social services, mental health,
2694 transportation, and long-term care insurance, and other areas
2695 considered appropriate by the department. The plan must assess
2696 the needs of particular subgroups of the population and evaluate
2697 the capacity of existing programs, both public and private and
2698 in state and local agencies, to respond effectively to
2699 identified needs. If the plan recommends the transfer of any
2700 program or service from the Department of Children and Family
2701 Services to another state department, the plan must also include
2702 recommendations that provide for an independent third-party
2703 mechanism~~, as currently exists in the Florida advocacy councils~~
2704 ~~established in ss. 402.165 and 402.166,~~ for protecting the
2705 constitutional and human rights of recipients of departmental
2706 services. The plan must include policy goals and program
2707 strategies designed to respond efficiently to current and
2708 projected needs. The plan must also include policy goals and
2709 program strategies to promote intergenerational relationships
2710 and activities. Public hearings and other appropriate processes
2711 shall be utilized by the department to solicit input for the
2712 development and updating of the master plan from parties
2713 including, but not limited to, the following:
2714 (a) Elderly citizens and their families and caregivers.
2715 (b) Local-level public and private service providers,
2716 advocacy organizations, and other organizations relating to the
2717 elderly.
2718 (c) Local governments.
2719 (d) All state agencies that provide services to the
2720 elderly.

2721 (e) University centers on aging.
2722 (f) Area agency on aging and community care for the
2723 elderly lead agencies.
2724 Section 38. Sections 381.0271, 381.0273, 394.4595,
2725 402.164, 402.165, 402.166, 402.167, 409.9061, 430.80, 430.83,
2726 464.0195, 464.0196, 464.0197, and 464.0198, Florida Statutes,
2727 are repealed.
2728 Section 39. This act shall take effect July 1, 2008.