

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

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

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

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

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

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

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

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

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



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

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

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

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

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349 care entity or donated or supplied at a reduced price  
350 to a charitable organization, to conform to changes  
351 made by the act; amending s. 499.01, F.S.; exempting  
352 certain blood establishments from the requirements to  
353 be permitted as a prescription drug manufacturer and  
354 register products; requiring that certain blood  
355 establishments obtain a restricted prescription drug  
356 distributor permit under specified conditions;  
357 limiting the prescription drugs that a blood  
358 establishment may distribute under a restricted  
359 prescription drug distributor permit; authorizing the  
360 Department of Health to adopt rules regarding the  
361 distribution of prescription drugs by blood  
362 establishments; amending s. 626.9541, F.S.;

363 authorizing insurers to offer rewards or incentives to  
364 health benefit plan members to encourage or reward  
365 participation in wellness or health improvement  
366 programs; authorizing insurers to require plan members  
367 not participating in programs to provide verification  
368 that their medical condition warrants  
369 nonparticipation; providing application; amending s.  
370 627.4147, F.S.; deleting a requirement that a medical  
371 malpractice insurance contract include a clause  
372 authorizing an insurer to admit liability and make a  
373 settlement offer if the offer is within policy limits  
374 without the insured's permission; amending s. 766.102,  
375 F.S.; providing that a physician who is an expert  
376 witness in a medical malpractice presuit action must  
377 meet certain requirements; amending s. 766.104, F.S.;

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

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

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436 Florida Healthy Kids Corporation operating fund;  
437 renumbering and transferring ss. 409.942, 409.944,  
438 409.945, 409.946, 409.953, and 409.9531, F.S., as ss.  
439 414.29, 163.464, 163.465, 163.466, 402.81, and 402.82,  
440 F.S., respectively; amending s. 443.111, F.S.;

441 conforming a cross-reference; directing the Agency for  
442 Health Care Administration to submit a reorganization  
443 plan to the Legislature; providing for the state's  
444 withdrawal from the Medicaid program under certain  
445 circumstances; providing for severability; providing  
446 an effective date.

447

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

449

450 Section 1. Paragraph (c) of subsection (2) of section  
451 163.387, Florida Statutes, is amended to read:

452 163.387 Redevelopment trust fund.—

453 (2)

454 (c) The following public bodies or taxing authorities are  
455 exempt from paragraph (a):

456 1. A special district that levies ad valorem taxes on  
457 taxable real property in more than one county.

458 2. A special district for which the sole available source  
459 of revenue the district has the authority to levy is ad valorem  
460 taxes at the time an ordinance is adopted under this section.

461 However, revenues or aid that may be dispensed or appropriated  
462 to a district as defined in s. 388.011 at the discretion of an  
463 entity other than such district shall not be deemed available.

464 3. A library district, except a library district in a



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465 jurisdiction where the community redevelopment agency had  
466 validated bonds as of April 30, 1984.

467 4. A neighborhood improvement district created under the  
468 Safe Neighborhoods Act.

469 5. A metropolitan transportation authority.

470 6. A water management district created under s. 373.069.

471 7. A hospital district that is a special district as  
472 defined in s. 189.403, a county hospital that has taxing  
473 authority under chapter 155, or a public health trust  
474 established pursuant to s. 154.07.

475 Section 2. Section 200.186, Florida Statutes, is created to  
476 read:

477 200.186 Hospital districts.—Notwithstanding any special act  
478 or other law governing the expenditure of ad valorem revenues,  
479 ad valorem revenues raised pursuant to a special act  
480 establishing a hospital district, by a county hospital pursuant  
481 to chapter 155, or a public health trust established pursuant to  
482 s. 154.07, and disbursed by the district, county hospital, or  
483 trust to municipalities or other organizations, may be used only  
484 to pay for health care services.

485 Section 3. Present subsections (7) and (8) of section  
486 393.0661, Florida Statutes, are redesignated as subsections (8)  
487 and (9), respectively, a new subsection (7) is added to that  
488 section, and present subsection (7) of that section is amended,  
489 to read:

490 393.0661 Home and community-based services delivery system;  
491 comprehensive redesign.—The Legislature finds that the home and  
492 community-based services delivery system for persons with  
493 developmental disabilities and the availability of appropriated

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494 funds are two of the critical elements in making services  
495 available. Therefore, it is the intent of the Legislature that  
496 the Agency for Persons with Disabilities shall develop and  
497 implement a comprehensive redesign of the system.

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

501 (8) ~~(7) Nothing in~~ This section or related in any  
502 administrative rule ~~does not shall be construed to~~ prevent or  
503 limit the Agency for Health Care Administration, in consultation  
504 with the Agency for Persons with Disabilities, from adjusting  
505 fees, reimbursement rates, lengths of stay, number of visits, or  
506 number of services, or from limiting enrollment, or making any  
507 other adjustment necessary to comply with the availability of  
508 moneys and any limitations or directions provided ~~for~~ in the  
509 General Appropriations Act or pursuant to s. 409.9022.

510 Section 4. The Division of Statutory Revision is requested  
511 to designate ss. 409.016-409.803, Florida Statutes, as part I of  
512 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC  
513 ASSISTANCE."

514 Section 5. Section 409.016, Florida Statutes, is amended to  
515 read:

516 409.016 Definitions.—As used in this part, the term  
517 chapter:

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

520 (2) "Secretary" means the Secretary of ~~the Department of~~  
521 Children and Family Services.

522 (3) "Social and economic services," ~~within the meaning of~~

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523 ~~this chapter,~~ means the providing of financial assistance as  
524 well as preventive and rehabilitative social services for  
525 children, adults, and families.

526 Section 6. Section 409.16713, Florida Statutes, is created  
527 to read:

528 409.16713 Medical assistance for children in out-of-home  
529 care and adopted children.-

530 (1) A child who is eligible under Title IV-E of the Social  
531 Security Act, as amended, for subsidized board payments, foster  
532 care, or adoption subsidies, and a child for whom the state has  
533 assumed temporary or permanent responsibility and who does not  
534 qualify for Title IV-E assistance but is in foster care, shelter  
535 or emergency shelter care, or subsidized adoption is eligible  
536 for medical assistance as provided in s. 409.903(4). This  
537 includes a young adult who is eligible to receive services under  
538 s. 409.1451(5) until the young adult reaches 21 years of age,  
539 and a person who was eligible, as a child, under Title IV-E for  
540 foster care or the state-provided foster care and who is a  
541 participant in the Road-to-Independence Program.

542 (2) If medical assistance under Title XIX of the Social  
543 Security Act, as amended, is not available due to the refusal of  
544 the federal Department of Health and Human Services to provide  
545 federal funds, a child or young adult described in subsection  
546 (1) is eligible for medical services under the Medicaid managed  
547 care program established in s. 409.963. Such medical assistance  
548 shall be obtained by the community-based care lead agencies  
549 established under s. 409.1671 and is subject to the availability  
550 of funds appropriated for such purpose in the General  
551 Appropriations Act.

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552 (3) It is the intent of the Legislature that the provision  
 553 of medical assistance meet the requirements of s. 471(a)(21) of  
 554 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),  
 555 related to eligibility for Title IV-E of the Social Security  
 556 Act, and that compliance with such provisions meet the  
 557 requirements of s. 402(a)(3) of the Social Security Act, as  
 558 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary  
 559 Assistance for Needy Families Block Grant Program.

560 Section 7. The Division of Statutory Revision is requested  
 561 to designate ss. 409.810-409.821, Florida Statutes, as part II  
 562 of chapter 409, Florida Statutes, entitled "KIDCARE."

563 Section 8. Section 624.91, Florida Statutes, is  
 564 transferred, renumbered as section 409.8115, Florida Statutes,  
 565 paragraph (b) of subsection (5) of that section is amended, and  
 566 subsection (8) is added to that section, to read:

567 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.-

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

569 (b) The Florida Healthy Kids Corporation shall:

570 1. Arrange for the collection of any family, local  
 571 contributions, or employer payment or premium, in an amount to  
 572 be determined by the board of directors, to provide for payment  
 573 of premiums for comprehensive insurance coverage and for the  
 574 actual or estimated administrative expenses.

575 2. Arrange for the collection of any voluntary  
 576 contributions ~~to provide~~ for payment of Florida Kidcare program  
 577 premiums for children who are not eligible for medical  
 578 assistance under Title XIX or Title XXI of the Social Security  
 579 Act.

580 3. Subject to ~~the provisions of~~ s. 409.8134, accept

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581 voluntary supplemental local match contributions that comply  
582 with ~~the requirements of~~ Title XXI of the Social Security Act  
583 for the purpose of providing additional ~~Florida~~ Kidcare coverage  
584 in contributing counties under Title XXI.

585 4. Establish the administrative and accounting procedures  
586 for the operation of the corporation.

587 5. Establish, with consultation from appropriate  
588 professional organizations, standards for preventive health  
589 services and providers and comprehensive insurance benefits  
590 appropriate to children if, ~~provided that~~ such standards for  
591 rural areas do ~~shall~~ not limit primary care providers to board-  
592 certified pediatricians.

593 6. Determine eligibility for children seeking to  
594 participate in the Title XXI-funded components of the ~~Florida~~  
595 Kidcare program consistent with the requirements specified in s.  
596 409.814, as well as the non-Title-XXI-eligible children as  
597 provided in subsection (3).

598 7. Establish procedures under which providers of local  
599 match to, applicants to, and participants in the program may  
600 have grievances reviewed by an impartial body and reported to  
601 the board of directors of the corporation.

602 8. Establish participation criteria and, if appropriate,  
603 contract with an authorized insurer, health maintenance  
604 organization, or third-party administrator to provide  
605 administrative services to the corporation.

606 9. Establish enrollment criteria that include penalties or  
607 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage  
608 upon voluntary cancellation for nonpayment of family premiums.

609 10. Contract with authorized insurers or providers ~~any~~

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610 ~~provider~~ of health care services, who meet ~~meeting~~ standards  
611 established by the corporation, for the provision of  
612 comprehensive insurance coverage to participants. Such standards  
613 must ~~shall~~ include criteria under which the corporation may  
614 contract with more than one provider of health care services in  
615 program sites. Health plans shall be selected through a  
616 competitive bid process. The Florida Healthy Kids Corporation  
617 shall purchase goods and services in the most cost-effective  
618 manner consistent with the delivery of quality medical care. The  
619 maximum administrative cost for a Florida Healthy Kids  
620 Corporation contract shall be 10 ~~15~~ percent. For health care  
621 contracts, the minimum medical loss ratio for a Florida Healthy  
622 Kids Corporation contract shall be 90 ~~85~~ percent. For dental  
623 contracts, the remaining compensation to be paid to the  
624 authorized insurer or provider must be at least 90 ~~under a~~  
625 ~~Florida Healthy Kids Corporation contract shall be no less than~~  
626 ~~an amount which is 85 percent of the premium, and,~~ to the extent  
627 any contract provision does not provide for this minimum  
628 compensation, this section prevails ~~shall prevail~~. The health  
629 plan selection criteria and scoring system, and the scoring  
630 results, shall be available upon request for inspection after  
631 the bids have been awarded.

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

634 12. Develop and implement a plan to publicize the Florida  
635 Kidcare program, the eligibility requirements of the program,  
636 and the procedures for enrollment in the program and to maintain  
637 public awareness of the corporation and the program. Such plan  
638 must include using the application form for the school lunch and

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639 breakfast programs as provided under s. 1006.06(7).

640 13. Secure staff necessary to properly administer the  
641 corporation. Staff costs shall be funded from state and local  
642 matching funds and such other private or public funds as become  
643 available. The board of directors shall determine the number of  
644 staff members necessary to administer the corporation.

645 14. In consultation with the partner agencies, provide an  
646 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the  
647 Governor, the Chief Financial Officer, the Commissioner of  
648 Education, the President of the Senate, the Speaker of the House  
649 of Representatives, and the Minority Leaders of the Senate and  
650 the House of Representatives.

651 15. Provide information on a quarterly basis to the  
652 Legislature and the Governor which compares the costs and  
653 utilization of the full-pay enrolled population and the Title  
654 XXI-subsidized enrolled population in the Florida Kidcare  
655 program. ~~The information,~~ At a minimum, the information must  
656 include:

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

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

663

664 By February 1, 2010, the Florida Healthy Kids Corporation shall  
665 provide a study to the Legislature and the Governor on premium  
666 impacts to the subsidized portion of the program from the  
667 inclusion of the full-pay program, which must ~~shall~~ include

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668 recommendations on how to eliminate or mitigate possible impacts  
669 to the subsidized premiums.

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

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

684 Section 9. Subsection (1) of section 409.813, Florida  
685 Statutes, is amended to read:

686 409.813 Health benefits coverage; program components;  
687 entitlement and nonentitlement.—

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

692 (a) Medicaid.~~†~~

693 (b) Medikids as created in s. 409.8132.~~†~~

694 (c) The Florida Healthy Kids Corporation as created in s.  
695 409.8115. ~~624.91;~~

696 (d) Employer-sponsored group health insurance plans



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697 approved under this part. ~~ss. 409.810-409.821;~~ and

698 (e) The Children's Medical Services network ~~established in~~  
699 ~~chapter 391.~~

700 Section 10. Subsection (4) of section 409.8132, Florida  
701 Statutes, is amended to read:

702 409.8132 Medikids program component.—

703 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The  
704 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,  
705 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,  
706 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, and 409.9205,  
707 409.987, 409.988, and 409.989 apply to the administration of the  
708 Medikids program component of the Florida Kidcare program,  
709 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified  
710 by ~~the provisions of~~ subsection (7).

711 Section 11. Subsection (1) of section 409.815, Florida  
712 Statutes, is amended to read:

713 409.815 Health benefits coverage; limitations.—

714 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare  
715 program, benefits available under Medicaid and Medikids include  
716 those goods and services provided under the medical assistance  
717 program authorized by Title XIX of the Social Security Act, and  
718 regulations thereunder, as administered in this state by the  
719 agency. This includes those mandatory Medicaid services  
720 authorized under s. 409.905 and optional Medicaid services  
721 authorized under s. 409.906, rendered on behalf of eligible  
722 individuals by qualified providers, in accordance with federal  
723 requirements ~~for Title XIX,~~ subject to any limitations or  
724 directions provided ~~for~~ in the General Appropriations Act, ~~or~~  
725 chapter 216, or s. 409.9022, and according to methodologies and

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726 limitations set forth in agency rules and policy manuals and  
727 handbooks incorporated by reference ~~thereto~~.

728 Section 12. Subsection (5) of section 409.818, Florida  
729 Statutes, is amended to read:

730 409.818 Administration.—In order to implement ss. 409.810-  
731 409.821, the following agencies shall have the following duties:

732 (5) The Florida Healthy Kids Corporation shall retain its  
733 functions as authorized in s. 409.8115 ~~624.91~~, including  
734 eligibility determination for participation in the Healthy Kids  
735 program.

736 Section 13. Paragraph (e) of subsection (2) of section  
737 154.503, Florida Statutes, is amended to read:

738 154.503 Primary Care for Children and Families Challenge  
739 Grant Program; creation; administration.—

740 (2) The department shall:

741 (e) Coordinate with the primary care program developed  
742 pursuant to s. 154.011, the Florida Healthy Kids Corporation  
743 program created in s. 409.8115 ~~624.91~~, the school health  
744 services program created in ss. 381.0056 and 381.0057, the  
745 Healthy Communities, Healthy People Program created in s.  
746 381.734, and the volunteer health care provider program  
747 established ~~developed~~ pursuant to s. 766.1115.

748 Section 14. Paragraph (c) of subsection (4) of section  
749 408.915, Florida Statutes, is amended to read:

750 408.915 Eligibility pilot project.—The Agency for Health  
751 Care Administration, in consultation with the steering committee  
752 established in s. 408.916, shall develop and implement a pilot  
753 project to integrate the determination of eligibility for health  
754 care services with information and referral services.

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755 (4) The pilot project shall include eligibility  
756 determinations for the following programs:

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

759 Section 15. Subsection (7) is added to section 1006.06,  
760 Florida Statutes, to read:

761 1006.06 School food service programs.—

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

764 (a) At a minimum:

765 1. Provide application information about the Kidcare  
766 program or an application for Kidcare to students at the  
767 beginning of each school year.

768 2. Modify the school district's application form for the  
769 lunch program under subsection (4) and the breakfast program  
770 under subsection (5) to incorporate a provision that permits the  
771 school district to share data from the application form with the  
772 state agencies and the Florida Healthy Kids Corporation and its  
773 agents that administer the Kidcare program unless the child's  
774 parent or guardian opts out of the provision.

775 (b) At the option of the school district, share income and  
776 other demographic data through an electronic interchange with  
777 the Florida Healthy Kids Corporation and other state agencies in  
778 order to determine eligibility for the Kidcare program on a  
779 regular and periodic basis.

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

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784           Section 16. The Division of Statutory Revision is requested  
785 to designate ss. 409.901 through 409.9205, Florida Statutes, as  
786 part III of chapter 409, Florida Statutes, entitled "MEDICAID."

787           Section 17. Section 409.901, Florida Statutes, is amended  
788 to read:

789           409.901 Definitions; ~~ss. 409.901-409.920.~~—As used in this  
790 part and part IV ss. 409.901-409.920, except as otherwise  
791 specifically provided, the term:

792           (1) "Affiliate" or "affiliated person" means any person who  
793 directly or indirectly manages, controls, or oversees the  
794 operation of a corporation or other business entity that is a  
795 Medicaid provider, regardless of whether such person is a  
796 partner, shareholder, owner, officer, director, agent, or  
797 employee of the entity.

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

801           (3) "Applicant" means an individual whose written  
802 application for medical assistance provided by Medicaid ~~under~~  
803 ~~ss. 409.903-409.906~~ has been submitted to the Department of  
804 Children and Family Services, or to the Social Security  
805 Administration if the application is for Supplemental Security  
806 Income, but has not received final action. The ~~This~~ term  
807 includes an individual, who need not be alive at the time of  
808 application, and whose application is submitted through a  
809 representative or a person acting for the individual.

810           (4) "Benefit" means any benefit, assistance, aid,  
811 obligation, promise, debt, liability, or the like, related to  
812 any covered injury, illness, or necessary medical care, goods,

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813 or services.

814 (5) "Capitation" means a prospective per-member, per-month  
815 payment designed to represent, in the aggregate, an actuarially  
816 sound estimate of expenditures required for the management and  
817 provision of a specified set of medical services or long-term  
818 care services needed by members enrolled in a prepaid health  
819 plan.

820 (6)(5) "Change of ownership" has the same meaning as in s.  
821 408.803 and includes means:

822 ~~(a) An event in which the provider ownership changes to a~~  
823 ~~different individual entity as evidenced by a change in federal~~  
824 ~~employer identification number or taxpayer identification~~  
825 ~~number;~~

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

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

834  
835 ~~A change solely in the management company or board of directors~~  
836 ~~is not a change of ownership.~~

837 (7)(6) "Claim" means any communication, whether written or  
838 electronic (electronic impulse or magnetic), which is used by  
839 any person to apply for payment from the Medicaid program, or  
840 its fiscal agent, or a qualified plan under part IV of this  
841 chapter for each item or service purported by any person to have

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842 been provided ~~by a person~~ to a any Medicaid recipient.

843 (8)~~(7)~~ "Collateral" means:

844 (a) Any and all causes of action, suits, claims,  
845 counterclaims, and demands that accrue to a ~~the~~ recipient or to  
846 a ~~the~~ recipient's legal representative, related to any covered  
847 injury, illness, or necessary medical care, goods, or services  
848 that resulted in ~~necessitated that~~ Medicaid providing ~~provide~~  
849 medical assistance.

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

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

854 (9)~~(8)~~ "Convicted" or "conviction" means a finding of  
855 guilt, with or without an adjudication of guilt, in any federal  
856 or state trial court ~~of record relating to charges brought by~~  
857 ~~indictment or information~~, as a result of a jury verdict,  
858 nonjury trial, or entry of a plea of guilty or nolo contendere,  
859 regardless of whether an appeal from judgment is pending.

860 (10)~~(9)~~ "Covered injury or illness" means any sickness,  
861 injury, disease, disability, deformity, abnormality disease,  
862 necessary medical care, pregnancy, or death for which a third  
863 party is, may be, could be, should be, or has been liable, and  
864 for which Medicaid is, or may be, obligated to provide, or has  
865 provided, medical assistance.

866 (11)~~(10)~~ "Emergency medical condition" has the same meaning  
867 as in s. 395.002. ~~means:~~

868 ~~(a) A medical condition manifesting itself by acute~~  
869 ~~symptoms of sufficient severity, which may include severe pain~~  
870 ~~or other acute symptoms, such that the absence of immediate~~

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871 ~~medical attention could reasonably be expected to result in any~~  
872 ~~of the following:~~

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

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

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

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

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

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

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

884 ~~(12)(11) "Emergency services and care" has the same meaning~~  
885 ~~as in s. 395.002 means medical screening, examination, and~~  
886 ~~evaluation by a physician, or, to the extent permitted by~~  
887 ~~applicable laws, by other appropriate personnel under the~~  
888 ~~supervision of a physician, to determine whether an emergency~~  
889 ~~medical condition exists and, if it does, the care, treatment,~~  
890 ~~or surgery for a covered service by a physician which is~~  
891 ~~necessary to relieve or eliminate the emergency medical~~  
892 ~~condition, within the service capability of a hospital.~~

893 ~~(13)(12) "Legal representative" means a guardian,~~  
894 ~~conservator, survivor, or personal representative of a recipient~~  
895 ~~or applicant, or of the property or estate of a recipient or~~  
896 ~~applicant.~~

897 ~~(14)(13) "Managed care plan" means a health insurer~~  
898 ~~authorized under chapter 624, an exclusive provider organization~~  
899 ~~authorized under chapter 627, a health maintenance organization~~

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900 authorized under chapter 641, a provider service network  
901 authorized under s. 409.912(4)(d), or an accountable care  
902 organization authorized under federal law ~~health maintenance~~  
903 ~~organization authorized pursuant to chapter 641 or a prepaid~~  
904 ~~health plan authorized pursuant to s. 409.912.~~

905 (15) ~~(14)~~ "Medicaid" or Medicaid program means the medical  
906 assistance program authorized by Title XIX of the Social  
907 Security Act, 42 U.S.C. s. 1396 et seq., and regulations  
908 thereunder, as administered in this state by the agency.

909 ~~(15) "Medicaid agency" or "agency" means the single state~~  
910 ~~agency that administers or supervises the administration of the~~  
911 ~~state Medicaid plan under federal law.~~

912 ~~(16) "Medicaid program" means the program authorized under~~  
913 ~~Title XIX of the federal Social Security Act which provides for~~  
914 ~~payments for medical items or services, or both, on behalf of~~  
915 ~~any person who is determined by the Department of Children and~~  
916 ~~Family Services, or, for Supplemental Security Income, by the~~  
917 ~~Social Security Administration, to be eligible on the date of~~  
918 ~~service for Medicaid assistance.~~

919 (16) ~~(17)~~ "Medicaid provider" or "provider" means a person  
920 or entity that has a Medicaid provider agreement in effect with  
921 the agency and is in good standing with the agency. The term  
922 also includes a person or entity that provides medical services  
923 to a Medicaid recipient under the Medicaid managed care program  
924 in part IV of this chapter.

925 (17) ~~(18)~~ "Medicaid provider agreement" or "provider  
926 agreement" means a contract between the agency and a provider  
927 for the provision of services or goods, or both, to Medicaid  
928 recipients pursuant to Medicaid.



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929        (18)~~(19)~~ "Medicaid recipient" or "recipient" means an  
930 individual whom the Department of Children and Family Services,  
931 or, for Supplemental Security Income, ~~by~~ the Social Security  
932 Administration, determines is eligible, pursuant to federal and  
933 state law, to receive medical assistance and related services  
934 for which the agency may make payments under the Medicaid  
935 program. For the purposes of determining third-party liability,  
936 the term includes an individual formerly determined to be  
937 eligible for Medicaid, an individual who has received medical  
938 assistance under ~~the Medicaid program~~, or an individual on whose  
939 behalf Medicaid has become obligated.

940        (19)~~(20)~~ "Medicaid-related records" means records that  
941 relate to the provider's business or profession and to a  
942 Medicaid recipient. The term includes ~~Medicaid-related records~~  
943 ~~include~~ records related to non-Medicaid customers, clients, or  
944 patients but only to the extent that the documentation is shown  
945 by the agency to be necessary for determining ~~to determine~~ a  
946 provider's entitlement to payments under the Medicaid program.

947        (20)~~(21)~~ "Medical assistance" means any provision of,  
948 payment for, or liability for medical services or care by  
949 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.

950        (21)~~(22)~~ "Medical services" or "medical care" means medical  
951 or medically related institutional or noninstitutional care,  
952 goods, or services covered by the Medicaid program. The term  
953 includes any services authorized and funded in the General  
954 Appropriations Act.

955        (22)~~(23)~~ "MediPass" means a primary care case management  
956 program operated by the agency.

957        (23)~~(24)~~ "Minority physician network" means a network of

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958 primary care physicians with experience in managing Medicaid or  
959 Medicare recipients which ~~that~~ is predominantly owned by  
960 minorities, as defined in s. 288.703, and which may have a  
961 collaborative partnership with a public college or university  
962 and a tax-exempt charitable corporation.

963 ~~(24)(25)~~ "Payment," as it relates to third-party benefits,  
964 means performance of a duty, promise, or obligation, or  
965 discharge of a debt or liability, by the delivery, provision, or  
966 transfer of third-party benefits for medical services. To "pay"  
967 means to do any of the acts set forth in this subsection.

968 ~~(25)(26)~~ "Proceeds" means whatever is received upon the  
969 sale, exchange, collection, or other disposition of the  
970 collateral or proceeds thereon and includes insurance payable by  
971 reason of loss or damage to the collateral or proceeds. Money,  
972 checks, deposit accounts, and the like are "cash proceeds." All  
973 other proceeds are "noncash proceeds."

974 ~~(26)(27)~~ "Third party" means an individual, entity, or  
975 program, excluding Medicaid, that is, may be, could be, should  
976 be, or has been liable for all or part of the cost of medical  
977 services related to any medical assistance covered by Medicaid.  
978 A third party includes a third-party administrator or a pharmacy  
979 benefits manager.

980 ~~(27)(28)~~ "Third-party benefit" means any benefit that is or  
981 may be available at any time through contract, court award,  
982 judgment, settlement, agreement, or any arrangement between a  
983 third party and any person or entity, including, without  
984 limitation, a Medicaid recipient, a provider, another third  
985 party, an insurer, or the agency, for any Medicaid-covered  
986 injury, illness, goods, or services, including costs of medical

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987 services related thereto, for personal injury or for death of  
988 the recipient, but specifically excluding policies of life  
989 insurance on the recipient, unless available under terms of the  
990 policy to pay medical expenses prior to death. The term  
991 includes, without limitation, collateral, as defined in this  
992 section, health insurance, any benefit under a health  
993 maintenance organization, a preferred provider arrangement, a  
994 prepaid health clinic, liability insurance, uninsured motorist  
995 insurance or personal injury protection coverage, medical  
996 benefits under workers' compensation, and any obligation under  
997 law or equity to provide medical support.

998 Section 18. Section 409.902, Florida Statutes, is amended  
999 to read:

1000 409.902 Designated single state agency; eligibility  
1001 determinations; rules ~~payment requirements; program title;~~  
1002 ~~release of medical records.-~~

1003 (1) The agency ~~for Health Care Administration~~ is designated  
1004 as the single state agency authorized to administer the Medicaid  
1005 state plan and to make payments for medical assistance and  
1006 related services under Title XIX of the Social Security Act.  
1007 These payments shall be made, subject to any limitations or  
1008 directions provided for in the General Appropriations Act, only  
1009 for services included in the Medicaid program, ~~shall be made~~  
1010 only on behalf of eligible individuals, and ~~shall be made~~ only  
1011 to qualified providers in accordance with federal requirements  
1012 under ~~for~~ Title XIX of the Social Security Act and ~~the~~  
1013 ~~provisions of~~ state law.

1014 (a) The agency must notify the Legislature before seeking  
1015 an amendment to the state plan for purposes of implementing

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1016 provisions authorized by the Deficit Reduction Act of 2005.

1017 (b) The agency shall adopt any rules necessary to carry out  
1018 its statutory duties under this subsection and any other  
1019 statutory provisions related to its responsibility for the  
1020 Medicaid program and state compliance with federal Medicaid  
1021 requirements, including the Medicaid managed care program. This  
1022 ~~program of medical assistance is designated the "Medicaid~~  
1023 ~~program."~~

1024 (2) The Department of Children and Family Services is  
1025 responsible for determining Medicaid eligibility determinations,  
1026 including, but not limited to, policy, rules, and the agreement  
1027 with the Social Security Administration for Medicaid eligibility  
1028 ~~determinations~~ for Supplemental Security Income recipients, as  
1029 well as the actual determination of eligibility. As a condition  
1030 ~~of Medicaid eligibility, subject to federal approval, the agency~~  
1031 ~~for Health Care Administration and the Department of Children~~  
1032 ~~and Family Services shall ensure that each recipient of Medicaid~~  
1033 ~~consents to the release of her or his medical records to the~~  
1034 ~~agency for Health Care Administration and the Medicaid Fraud~~  
1035 ~~Control Unit of the Department of Legal Affairs.~~

1036 (a) Eligibility is restricted to United States citizens and  
1037 to lawfully admitted noncitizens who meet the criteria provided  
1038 in s. 414.095(3).

1039 1. Citizenship or immigration status must be verified. For  
1040 noncitizens, this includes verification of the validity of  
1041 documents with the United States Citizenship and Immigration  
1042 Services using the federal SAVE verification process.

1043 2. State funds may not be used to provide medical services  
1044 to individuals who do not meet the requirements of this

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1045 paragraph unless the services are necessary to treat an  
1046 emergency medical condition or are for pregnant women. Such  
1047 services are authorized only to the extent provided under  
1048 federal law and in accordance with federal regulations as  
1049 provided in 42 C.F.R. s. 440.255.

1050 (b) When adopting rules relating to eligibility for  
1051 institutional care services, hospice services, and home and  
1052 community-based waiver programs, and regardless of whether a  
1053 penalty will be applied due to the unlawful transfer of assets,  
1054 the payment of fair compensation by an applicant for a personal  
1055 care services contract entered into on or after October 1, 2011,  
1056 shall be evaluated using the following criteria:

1057 1. The contracted services do not duplicate services  
1058 available through other sources or providers, such as Medicaid,  
1059 Medicare, private insurance, or another legally obligated third  
1060 party;

1061 2. The contracted services directly benefit the individual  
1062 and are not services normally provided out of love and  
1063 consideration for the individual;

1064 3. The actual cost to deliver services is computed in a  
1065 manner that clearly reflects the actual number of hours to be  
1066 expended, and the contract clearly identifies each specific  
1067 service and the average number of hours of each service to be  
1068 delivered each month;

1069 4. The hourly rate for each contracted service is equal to  
1070 or less than the amount normally charged by a professional who  
1071 traditionally provides the same or similar services;

1072 5. The contracted services are provided on a prospective  
1073 basis only and not for services provided in the past; and

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1074 6. The contract provides fair compensation to the  
1075 individual in his or her lifetime as set forth in life  
1076 expectancy tables adopted in rule 65A-1.716, Florida  
1077 Administrative Code.

1078 (c) The department shall adopt any rules necessary to carry  
1079 out its statutory duties under this subsection for receiving and  
1080 processing Medicaid applications and determining Medicaid  
1081 eligibility, and any other statutory provisions related to  
1082 responsibility for the determination of Medicaid eligibility.

1083 Section 19. Section 409.9021, Florida Statutes, is amended  
1084 to read:

1085 409.9021 Conditions for Medicaid ~~Forfeiture of~~ eligibility  
1086 ~~agreement.~~—As a condition of Medicaid eligibility, subject to  
1087 federal regulation and approval:

1088 (1) A Medicaid applicant must consent ~~shall agree~~ in  
1089 writing to:

1090 (a) Have her or his medical records released to the agency  
1091 and the Medicaid Fraud Control Unit of the Department of Legal  
1092 Affairs.

1093 (b) Forfeit all entitlements to any goods or services  
1094 provided through the Medicaid program for the next 10 years if  
1095 he or she has been found to have committed Medicaid fraud,  
1096 ~~through judicial or administrative determination, two times in a~~  
1097 ~~period of 5 years.~~ This provision applies only to the Medicaid  
1098 recipient found to have committed or participated in Medicaid  
1099 ~~the~~ fraud and does not apply to any family member of the  
1100 recipient who was not involved in the fraud.

1101 (2) A Medicaid applicant must pay a \$10 monthly premium  
1102 that covers all Medicaid-eligible recipients in the applicant's

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1103 family. However, an individual who is eligible for the  
1104 Supplemental Security Income related Medicaid and is receiving  
1105 institutional care payments is exempt from this requirement. The  
1106 agency shall seek a federal waiver to authorize the imposition  
1107 and collection of this premium effective December 31, 2011. Upon  
1108 approval, the agency shall establish by rule procedures for  
1109 collecting premiums from recipients, advance notice of  
1110 cancellation, and waiting periods for reinstatement of coverage  
1111 upon voluntary cancellation for nonpayment of premiums.

1112 (3) A Medicaid applicant must participate, in good faith,  
1113 in:

1114 (a) A medically approved smoking cessation program if the  
1115 applicant smokes.

1116 (b) A medically directed weight loss program if the  
1117 applicant is or becomes morbidly obese.

1118 (c) A medically approved alcohol or substance abuse  
1119 recovery program if the applicant is or becomes diagnosed as a  
1120 substance abuser.

1121  
1122 The agency shall seek a federal waiver to authorize the  
1123 implementation of this subsection in order to assist the  
1124 recipient in mitigating lifestyle choices and avoiding behaviors  
1125 associated with the use of high-cost medical services.

1126 (4) A person who is eligible for Medicaid services and who  
1127 has access to health care coverage through an employer-sponsored  
1128 health plan may not receive Medicaid services reimbursed under  
1129 s. 409.908, s. 409.912, or s. 409.986, but may use Medicaid  
1130 financial assistance to pay the cost of premiums for the  
1131 employer-sponsored health plan for the eligible person and his

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1132 or her Medicaid-eligible family members.

1133 (5) A Medicaid recipient who has access to other insurance  
1134 or coverage created pursuant to state or federal law may opt out  
1135 of the Medicaid services provided under s. 409.908, s. 409.912,  
1136 or s. 409.986 and use Medicaid financial assistance to pay the  
1137 cost of premiums for the recipient and the recipient's Medicaid  
1138 eligible family members.

1139 (6) Subsections (4) and (5) shall be administered by the  
1140 agency in accordance with s. 409.964(1)(j). The maximum amount  
1141 available for the Medicaid financial assistance shall be  
1142 calculated based on the Medicaid capitated rate as if the  
1143 Medicaid recipient and the recipient's eligible family members  
1144 participated in a qualified plan for Medicaid managed care under  
1145 part IV of this chapter.

1146 Section 20. Section 409.9022, Florida Statutes, is created  
1147 to read:

1148 409.9022 Limitations on Medicaid expenditures.-

1149 (1) Except as specifically authorized in this section, a  
1150 state agency may not obligate or expend funds for the Medicaid  
1151 program in excess of the amount appropriated in the General  
1152 Appropriations Act.

1153 (2) If, at any time during the fiscal year, a state agency  
1154 determines that Medicaid expenditures may exceed the amount  
1155 appropriated during the fiscal year, the state agency shall  
1156 notify the Social Services Estimating Conference, which shall  
1157 meet to estimate Medicaid expenditures for the remainder of the  
1158 fiscal year. If, pursuant to this paragraph or for any other  
1159 purpose, the conference determines that Medicaid expenditures  
1160 will exceed appropriations for the fiscal year, the state agency



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1161 shall develop and submit a plan for revising Medicaid  
1162 expenditures in order to remain within the annual appropriation.  
1163 The plan must include cost-mitigating strategies to negate the  
1164 projected deficit for the remainder of the fiscal year and shall  
1165 be submitted in the form of a budget amendment to the  
1166 Legislative Budget Commission. The conference shall also  
1167 estimate the amount of savings which will result from such cost-  
1168 mitigating strategies proposed by the state agency as well as  
1169 any other strategies the conference may consider and recommend.

1170 (3) In preparing the budget amendment to revise Medicaid  
1171 expenditures in order to remain within appropriations, a state  
1172 agency shall include the following revisions to the Medicaid  
1173 state plan, in the priority order listed below:

1174 (a) Reduction in administrative costs.

1175 (b) Elimination of optional benefits.

1176 (c) Elimination of optional eligibility groups.

1177 (d) Reduction to institutional and provider reimbursement  
1178 rates.

1179 (e) Reduction in the amount, duration, and scope of  
1180 mandatory benefits.

1181  
1182 The state agency may not implement any of these cost-containment  
1183 measures until the amendment is approved by the Legislative  
1184 Budget Commission.

1185 (4) In order to remedy a projected expenditure in excess of  
1186 the amount appropriated in a specific appropriation within the  
1187 Medicaid budget, a state agency may, consistent with chapter  
1188 216:

1189 (a) Submit a budget amendment to transfer budget authority

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1190 between appropriation categories;

1191 (b) Submit a budget amendment to increase federal trust  
1192 authority or grants and donations trust authority if additional  
1193 federal or local funds are available; or

1194 (c) Submit any other budget amendment consistent with  
1195 chapter 216.

1196 (5) The agency shall amend the Medicaid state plan to  
1197 incorporate the provisions of this section.

1198 (6) Chapter 216 does not permit the transfer of funds from  
1199 any other program into the Medicaid program or the transfer of  
1200 funds out of the Medicaid program into any other program.

1201 Section 21. Section 409.903, Florida Statutes, is amended  
1202 to read:

1203 409.903 Mandatory payments for eligible persons.—The agency  
1204 shall make payments for medical assistance and related services  
1205 on behalf of the following categories of persons who the  
1206 Department of Children and Family Services, or the Social  
1207 Security Administration by contract with the department ~~of~~  
1208 ~~Children and Family Services~~, determines to be eligible for  
1209 Medicaid, subject to the income, assets, and categorical  
1210 eligibility tests set forth in federal and state law. Payment on  
1211 behalf of these recipients ~~Medicaid-eligible persons~~ is subject  
1212 to the availability of moneys and any limitations established by  
1213 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

1214 (1) Low-income families with children if ~~are eligible for~~  
1215 ~~Medicaid provided~~ they meet the following requirements:

1216 (a) The family includes a dependent child who is living  
1217 with a caretaker relative.

1218 (b) The family's income does not exceed the gross income

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1219 test limit.

1220 (c) The family's countable income and resources do not  
1221 exceed the applicable Aid to Families with Dependent Children  
1222 (AFDC) income and resource standards under the AFDC state plan  
1223 in effect on ~~in~~ July 1996, except as amended in the Medicaid  
1224 state plan to conform as closely as possible to the requirements  
1225 of the welfare transition program, to the extent permitted by  
1226 federal law.

1227 (2) A person who receives payments from, who is determined  
1228 eligible for, or who was eligible for but lost cash benefits  
1229 from the federal program known as the Supplemental Security  
1230 Income program (SSI). This ~~category~~ includes a low-income person  
1231 age 65 or over and a low-income person under age 65 considered  
1232 to be permanently and totally disabled.

1233 (3) A child under age 21 living in a low-income, two-parent  
1234 family, and a child under age 7 living with a nonrelative, ~~if~~  
1235 the income and assets of the family or child, as applicable, do  
1236 not exceed the resource limits under the Temporary Cash  
1237 Assistance Program.

1238 (4) A child who is eligible under Title IV-E of the Social  
1239 Security Act for subsidized board payments, foster care, or  
1240 adoption subsidies, and a child for whom the state has assumed  
1241 temporary or permanent responsibility and who does not qualify  
1242 for Title IV-E assistance but is in foster care, shelter or  
1243 emergency shelter care, or subsidized adoption. This ~~category~~  
1244 includes a young adult who is eligible to receive services under  
1245 s. 409.1451(5), until the young adult reaches 21 years of age, ~~if~~  
1246 without regard to any income, resource, or categorical  
1247 eligibility test that is otherwise required. This ~~category~~ also

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1248 includes a person who as a child was eligible under Title IV-E  
1249 of the Social Security Act for foster care or the state-provided  
1250 foster care and who is a participant in the Road-to-Independence  
1251 Program.

1252 (5) A pregnant woman for the duration of her pregnancy and  
1253 for the postpartum period as defined in federal law and rule, or  
1254 a child under age 1, if either is living in a family that has an  
1255 income which is at or below ~~150 percent of the most current~~  
1256 ~~federal poverty level, or, effective January 1, 1992, that has~~  
1257 ~~an income which is at or below~~ 185 percent of the most current  
1258 federal poverty level. Such a person is not subject to an assets  
1259 test. ~~Further,~~ A pregnant woman who applies for eligibility for  
1260 the Medicaid program through a qualified Medicaid provider must  
1261 be offered the opportunity, subject to federal rules, to be made  
1262 presumptively eligible for the Medicaid program.

1263 (6) A child ~~born after September 30, 1983,~~ living in a  
1264 family that has an income which is at or below 100 percent of  
1265 the current federal poverty level, who has attained the age of  
1266 6, but has not attained the age of 19. In determining the  
1267 eligibility of such a child, an assets test is not required. A  
1268 child who is eligible ~~for Medicaid~~ under this subsection must be  
1269 offered the opportunity, subject to federal rules, to be made  
1270 presumptively eligible. A child who has been deemed  
1271 presumptively eligible may ~~for Medicaid~~ shall not be enrolled in  
1272 a managed care plan until the child's full eligibility  
1273 ~~determination~~ for Medicaid has been determined ~~completed~~.

1274 (7) A child living in a family that has an income that  
1275 ~~which~~ is at or below 133 percent of the current federal poverty  
1276 level, who has attained the age of 1, but has not attained the

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1277 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an  
1278 assets test is not required. A child who is eligible ~~for~~  
1279 ~~Medicaid~~ under this subsection must be offered the opportunity,  
1280 subject to federal rules, to be made presumptively eligible. A  
1281 child who has been deemed presumptively eligible may ~~for~~  
1282 ~~Medicaid shall~~ not be enrolled in a managed care plan until the  
1283 child's full eligibility ~~determination~~ for Medicaid has been  
1284 determined ~~completed~~.

1285 (8) A person who is age 65 or over or is determined by the  
1286 agency to be disabled, whose income is at or below 100 percent  
1287 of the most current federal poverty level and whose assets do  
1288 not exceed limitations established by the agency. However, the  
1289 agency may only pay for premiums, coinsurance, and deductibles,  
1290 as required by federal law, unless additional coverage is  
1291 provided for any or all members of this group under ~~by~~ s.  
1292 409.904(1).

1293 Section 22. Section 409.904, Florida Statutes, is amended  
1294 to read:

1295 409.904 Optional payments for eligible persons.—The agency  
1296 may make payments for medical assistance and related services on  
1297 behalf of the following categories of persons who are determined  
1298 to be eligible for Medicaid, subject to the income, assets, and  
1299 categorical eligibility tests set forth in federal and state  
1300 law. Payment on behalf of these ~~Medicaid-eligible~~ persons is  
1301 subject to the availability of moneys and any limitations  
1302 established by the General Appropriations Act, ~~or~~ chapter 216,  
1303 or s. 409.9022.

1304 (1) ~~Effective January 1, 2006, and~~ Subject to federal  
1305 waiver approval, a person who is age 65 or older or is

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1306 determined to be disabled, whose income is at or below 88  
1307 percent of the federal poverty level, whose assets do not exceed  
1308 established limitations, and who is not eligible for Medicare  
1309 or, if eligible for Medicare, is also eligible for and receiving  
1310 Medicaid-covered institutional care services, hospice services,  
1311 or home and community-based services. The agency shall seek  
1312 federal authorization through a waiver to provide this coverage.  
1313 This subsection expires June 30, 2011.

1314 (2) The following persons who are eligible for the Medicaid  
1315 nonpoverty medical subsidy, which includes the same services as  
1316 those provided to other Medicaid recipients, with the exception  
1317 of services in skilled nursing facilities and intermediate care  
1318 facilities for the developmentally disabled:

1319 (a) A family, a pregnant woman, a child under age 21, a  
1320 person age 65 or over, or a blind or disabled person, who would  
1321 be eligible under any group listed in s. 409.903(1), (2), or  
1322 (3), except that the income or assets of such family or person  
1323 exceed established limitations. For a family or person in one of  
1324 these coverage groups, medical expenses are deductible from  
1325 income in accordance with federal requirements in order to make  
1326 a determination of eligibility. ~~A family or person eligible~~  
1327 ~~under the coverage known as the "medically needy," is eligible~~  
1328 ~~to receive the same services as other Medicaid recipients, with~~  
1329 ~~the exception of services in skilled nursing facilities and~~  
1330 ~~intermediate care facilities for the developmentally disabled.~~  
1331 This paragraph expires June 30, 2011.

1332 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a  
1333 child younger than 21 years of age who would be eligible under  
1334 any group listed in s. 409.903, except that the income or assets

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1335 of such group exceed established limitations. For a person in  
1336 one of these coverage groups, medical expenses are deductible  
1337 from income in accordance with federal requirements in order to  
1338 make a determination of eligibility. ~~A person eligible under the~~  
1339 ~~coverage known as the "medically needy" is eligible to receive~~  
1340 ~~the same services as other Medicaid recipients, with the~~  
1341 ~~exception of services in skilled nursing facilities and~~  
1342 ~~intermediate care facilities for the developmentally disabled.~~

1343 (c) A family, a person age 65 or older, or a blind or  
1344 disabled person, who would be eligible under any group listed in  
1345 s. 409.903(1), (2), or (3), except that the income or assets of  
1346 such family or person exceed established limitations. For a  
1347 family or person in one of these coverage groups, medical  
1348 expenses are deductible from income in accordance with federal  
1349 requirements in order to make a determination of eligibility. A  
1350 family, a person age 65 or older, or a blind or disabled person,  
1351 covered under the Medicaid nonpoverty medical subsidy, is  
1352 eligible to receive physician services only.

1353 (3) A person who is in need of the services of a licensed  
1354 nursing facility, a licensed intermediate care facility for the  
1355 developmentally disabled, or a state mental hospital, whose  
1356 income does not exceed 300 percent of the SSI income standard,  
1357 and who meets the assets standards established under federal and  
1358 state law. In determining the person's responsibility for the  
1359 cost of care, the following amounts must be deducted from the  
1360 person's income:

1361 (a) The monthly personal allowance for residents as set  
1362 based on appropriations.

1363 (b) The reasonable costs of medically necessary services

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1364 and supplies that are not reimbursable by the Medicaid program.

1365 (c) The cost of premiums, copayments, coinsurance, and  
1366 deductibles for supplemental health insurance.

1367 (4) A low-income person who meets all other requirements  
1368 for Medicaid eligibility except citizenship and who is in need  
1369 of emergency medical services. The eligibility of such a  
1370 recipient is limited to the period of the emergency, in  
1371 accordance with federal regulations.

1372 (5) Subject to specific federal authorization, a woman  
1373 living in a family that has an income that is at or below 185  
1374 percent of the most current federal poverty level. Coverage is  
1375 limited to ~~is eligible for~~ family planning services as specified  
1376 in s. 409.905(3) for a period of up to 24 months following a  
1377 loss of Medicaid benefits.

1378 (6) A child who has not attained the age of 19 who has been  
1379 determined eligible for the Medicaid program is deemed to be  
1380 eligible for a total of 6 months, regardless of changes in  
1381 circumstances other than attainment of the maximum age.

1382 ~~Effective January 1, 1999,~~ A child who has not attained the age  
1383 of 5 and who has been determined eligible for the Medicaid  
1384 program is deemed to be eligible for a total of 12 months  
1385 regardless of changes in circumstances other than attainment of  
1386 the maximum age.

1387 (7) A child under 1 year of age who lives in a family that  
1388 has an income above 185 percent of the most recently published  
1389 federal poverty level, but which is at or below 200 percent of  
1390 such poverty level. In determining the eligibility ~~of such~~  
1391 ~~child,~~ an assets test is not required. A child who is eligible  
1392 ~~for Medicaid~~ under this subsection must be offered the



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1393 opportunity, subject to federal rules, to be made presumptively  
1394 eligible.

1395 (8) An eligible person ~~A Medicaid-eligible individual~~ for  
1396 the individual's health insurance premiums, if the agency  
1397 determines that such payments are cost-effective.

1398 (9) Eligible women with incomes at or below 200 percent of  
1399 the federal poverty level and under age 65, for cancer treatment  
1400 pursuant to the federal Breast and Cervical Cancer Prevention  
1401 and Treatment Act of 2000, screened through the Mary Brogan  
1402 Breast and Cervical Cancer Early Detection Program established  
1403 under s. 381.93.

1404 Section 23. Section 409.905, Florida Statutes, is amended  
1405 to read:

1406 409.905 Mandatory Medicaid services.—The agency shall ~~may~~  
1407 make payments for the following services, which are required ~~of~~  
1408 ~~the state~~ by Title XIX of the Social Security Act, furnished by  
1409 Medicaid providers to recipients who are ~~determined to be~~  
1410 eligible on the dates on which the services were provided. Any  
1411 service under this section shall be provided only when medically  
1412 necessary and in accordance with state and federal law.

1413 Mandatory services rendered by providers in mobile units to  
1414 Medicaid recipients may be restricted by the agency. This  
1415 section does not ~~Nothing in this section shall be construed to~~  
1416 prevent or limit the agency from adjusting fees, reimbursement  
1417 rates, lengths of stay, number of visits, number of services, or  
1418 any other adjustments necessary to comply with the availability  
1419 of moneys and any limitations or directions provided ~~for~~ in the  
1420 General Appropriations Act, or ~~or~~ chapter 216, or s. 409.9022.

1421 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The

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1422 agency shall pay for services provided to a recipient by a  
1423 licensed advanced registered nurse practitioner who has a valid  
1424 collaboration agreement with a licensed physician on file with  
1425 the Department of Health or who provides anesthesia services in  
1426 accordance with established protocol required by state law and  
1427 approved by the medical staff of the facility in which the  
1428 ~~anesthetic~~ service is performed. Reimbursement for such services  
1429 must be provided in an amount that equals at least ~~not less than~~  
1430 80 percent of the reimbursement to a physician who provides the  
1431 same services, unless otherwise provided ~~for~~ in the General  
1432 Appropriations Act.

1433 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT  
1434 SERVICES.—The agency shall pay for early and periodic screening  
1435 and diagnosis of a recipient under age 21 to ascertain physical  
1436 and mental problems and conditions and ~~provide treatment to~~  
1437 ~~correct or ameliorate these problems and conditions. These~~  
1438 ~~services include~~ all services determined by the agency to be  
1439 medically necessary for the treatment, correction, or  
1440 amelioration of these problems and conditions, including  
1441 personal care, private duty nursing, durable medical equipment,  
1442 physical therapy, occupational therapy, speech therapy,  
1443 respiratory therapy, and immunizations.

1444 (3) FAMILY PLANNING SERVICES.—The agency shall pay for  
1445 services necessary to enable a recipient voluntarily to plan  
1446 family size or to space children. These services include  
1447 information; education; counseling regarding the availability,  
1448 benefits, and risks of each method of pregnancy prevention;  
1449 drugs and supplies; and necessary medical care and followup.  
1450 Each recipient participating in ~~the~~ family planning ~~portion of~~

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1451 ~~the Medicaid program~~ must be provided the choice of freedom to  
1452 ~~choose~~ any alternative method of family planning, as required by  
1453 federal law.

1454 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for  
1455 nursing and home health aide services, supplies, appliances, and  
1456 durable medical equipment, necessary to assist a recipient  
1457 living at home. An entity that provides such services must  
1458 ~~pursuant to this subsection shall~~ be licensed under part III of  
1459 chapter 400. These services, equipment, and supplies, or  
1460 reimbursement therefor, may be limited as provided in the  
1461 General Appropriations Act and do not include services,  
1462 equipment, or supplies provided to a person residing in a  
1463 hospital or nursing facility.

1464 (a) ~~In providing home health care services,~~ The agency  
1465 shall may require prior authorization of home health services  
1466 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing  
1467 rates. ~~The agency shall require prior authorization for visits~~  
1468 ~~for home health services that are not associated with a skilled~~  
1469 ~~nursing visit when the home health agency billing rates exceed~~  
1470 ~~the state average by 50 percent or more.~~ The home health agency  
1471 must submit the recipient's plan of care and documentation that  
1472 supports the recipient's diagnosis to the agency when requesting  
1473 prior authorization.

1474 (b) The agency shall implement a comprehensive utilization  
1475 management program ~~that requires prior authorization~~ of all  
1476 private duty nursing services, an individualized treatment plan  
1477 that includes information about medication and treatment orders,  
1478 treatment goals, methods of care to be used, and plans for care  
1479 coordination by nurses and other health professionals. The

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1480 utilization management program must ~~shall~~ also include a process  
1481 for periodically reviewing the ongoing use of private duty  
1482 nursing services. The assessment of need shall be based on a  
1483 child's condition;; family support and care supplements;; a  
1484 family's ability to provide care;;~~and~~ a family's and child's  
1485 schedule regarding work, school, sleep, and care for other  
1486 family dependents; and a determination of the medical necessity  
1487 for private duty nursing instead of other more cost-effective  
1488 in-home services. When implemented, the private duty nursing  
1489 utilization management program shall replace the current  
1490 authorization program used by the agency ~~for Health Care~~  
1491 ~~Administration~~ and the Children's Medical Services program of  
1492 the Department of Health. The agency may competitively bid ~~on~~ a  
1493 contract to select a qualified organization to provide  
1494 utilization management of private duty nursing services. The  
1495 agency may ~~is authorized to~~ seek federal waivers to implement  
1496 this initiative.

1497 (c) The agency may not pay for home health services unless  
1498 the services are medically necessary and:

1499 1. The services are ordered by a physician.

1500 2. The written prescription for the services is signed and  
1501 dated by the recipient's physician before the development of a  
1502 plan of care and before any request requiring prior  
1503 authorization.

1504 3. The physician ordering the services is not employed,  
1505 under contract with, or otherwise affiliated with the home  
1506 health agency rendering the services. However, this subparagraph  
1507 does not apply to a home health agency affiliated with a  
1508 retirement community, of which the parent corporation or a

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1509 related legal entity owns a rural health clinic certified under  
1510 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed  
1511 under part II of chapter 400, or an apartment or single-family  
1512 home for independent living. For purposes of this subparagraph,  
1513 the agency may, on a case-by-case basis, provide an exception  
1514 for medically fragile children who are younger than 21 years of  
1515 age.

1516 4. The physician ordering the services has examined the  
1517 recipient within the 30 days preceding the initial request for  
1518 the services and biannually thereafter.

1519 5. The written prescription for the services includes the  
1520 recipient's acute or chronic medical condition or diagnosis, the  
1521 home health service required, and, for skilled nursing services,  
1522 the frequency and duration of the services.

1523 6. The national provider identifier, Medicaid  
1524 identification number, or medical practitioner license number of  
1525 the physician ordering the services is listed on the written  
1526 prescription for the services, the claim for home health  
1527 reimbursement, and the prior authorization request.

1528 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for  
1529 all covered services provided for the medical care and treatment  
1530 of a recipient who is admitted as an inpatient by a licensed  
1531 physician or dentist to a hospital licensed under part I of  
1532 chapter 395. However, the agency shall limit the payment for  
1533 inpatient hospital services for a Medicaid recipient 21 years of  
1534 age or older to 45 days or the number of days necessary to  
1535 comply with the General Appropriations Act.

1536 (a) The agency may ~~is authorized to~~ implement reimbursement  
1537 and utilization management reforms in order to comply with any

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

1563 (b) A licensed hospital maintained primarily for the care  
1564 and treatment of patients having mental disorders or mental  
1565 diseases may ~~is~~ not eligible to participate in the hospital  
1566 inpatient portion of the Medicaid program except as provided in

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1567 federal law. However, the Department of Children and Family  
1568 Services shall apply for a waiver, ~~within 9 months after June 5,~~  
1569 ~~1991,~~ designed to provide hospitalization services for mental  
1570 health reasons to children and adults in the most cost-effective  
1571 and lowest cost setting possible. Such waiver shall include a  
1572 request for the opportunity to pay for care in hospitals known  
1573 under federal law as "institutions for mental disease" or  
1574 "IMD's." The waiver proposal shall propose no additional  
1575 aggregate cost to the state or Federal Government, and shall be  
1576 conducted in Hillsborough County, Highlands County, Hardee  
1577 County, Manatee County, and Polk County. The waiver proposal may  
1578 incorporate competitive bidding for hospital services,  
1579 comprehensive brokering, prepaid capitated arrangements, or  
1580 other mechanisms deemed by the department to show promise in  
1581 reducing the cost of acute care and increasing the effectiveness  
1582 of preventive care. When developing the waiver proposal, the  
1583 department shall take into account price, quality,  
1584 accessibility, linkages of the hospital to community services  
1585 and family support programs, plans of the hospital to ensure the  
1586 earliest discharge possible, and the comprehensiveness of the  
1587 mental health and other health care services offered by  
1588 participating providers.

1589 (c) The agency shall adjust a hospital's current inpatient  
1590 per diem rate to reflect the cost of serving the Medicaid  
1591 population at that institution if:

1592 1. The hospital experiences an increase in Medicaid  
1593 caseload by more than 25 percent in any year, primarily  
1594 resulting from the closure of a hospital in the same service  
1595 area occurring after July 1, 1995;

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1596 2. The hospital's Medicaid per diem rate is at least 25  
1597 percent below the Medicaid per patient cost for that year; or

1598 3. The hospital is located in a county that has six or  
1599 fewer general acute care hospitals, began offering obstetrical  
1600 services on or after September 1999, and has submitted a request  
1601 in writing to the agency for a rate adjustment after July 1,  
1602 2000, but before September 30, 2000, in which case such  
1603 hospital's Medicaid inpatient per diem rate shall be adjusted to  
1604 cost, effective July 1, 2002. By October 1 of each year, the  
1605 agency must provide estimated costs for any adjustment in a  
1606 hospital inpatient per diem rate to the Executive Office of the  
1607 Governor, the House of Representatives General Appropriations  
1608 Committee, and the Senate Appropriations Committee. Before the  
1609 agency implements a change in a hospital's inpatient per diem  
1610 rate pursuant to this paragraph, the Legislature must have  
1611 specifically appropriated sufficient funds in the General  
1612 Appropriations Act to support the increase in cost as estimated  
1613 by the agency.

1614 (d) The agency shall implement a hospitalist program in  
1615 nonteaching hospitals, select counties, or statewide. The  
1616 program shall require hospitalists to manage Medicaid  
1617 recipients' hospital admissions and lengths of stay. Individuals  
1618 who are dually eligible for Medicare and Medicaid are exempted  
1619 from this requirement. Medicaid participating physicians and  
1620 other practitioners with hospital admitting privileges shall  
1621 coordinate and review admissions of Medicaid recipients with the  
1622 hospitalist. The agency may competitively bid a contract for  
1623 selection of a single qualified organization to provide  
1624 hospitalist services. The agency may procure hospitalist



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1625 services by individual county or may combine counties in a  
1626 single procurement. The qualified organization shall contract  
1627 with or employ board-eligible physicians in Miami-Dade, Palm  
1628 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency  
1629 may ~~is authorized to~~ seek federal waivers to implement this  
1630 program.

1631 (e) The agency shall implement a comprehensive utilization  
1632 management program for hospital neonatal intensive care stays in  
1633 certain high-volume participating hospitals, select counties, or  
1634 statewide, and shall replace existing hospital inpatient  
1635 utilization management programs for neonatal intensive care  
1636 admissions. The program shall be designed to manage the lengths  
1637 of stay for children being treated in neonatal intensive care  
1638 units and must seek the earliest medically appropriate discharge  
1639 to the child's home or other less costly treatment setting. The  
1640 agency may competitively bid a contract for selection of a  
1641 qualified organization to provide neonatal intensive care  
1642 utilization management services. The agency may ~~is authorized to~~  
1643 seek any federal waivers to implement this initiative.

1644 (f) The agency may develop and implement a program to  
1645 reduce the number of hospital readmissions among the non-  
1646 Medicare population eligible in areas 9, 10, and 11.

1647 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for  
1648 preventive, diagnostic, therapeutic, or palliative care and  
1649 other services provided to a recipient in the outpatient portion  
1650 of a hospital licensed under part I of chapter 395, and provided  
1651 under the direction of a licensed physician or licensed dentist,  
1652 except that payment for such care and services is limited to  
1653 \$1,500 per state fiscal year per recipient, unless an exception

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1654 has been made by the agency, and with the exception of a  
1655 Medicaid recipient under age 21, in which case the only  
1656 limitation is medical necessity.

1657 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay  
1658 for medically necessary diagnostic laboratory procedures ordered  
1659 by a licensed physician or other licensed health care  
1660 practitioner ~~of the healing arts~~ which are provided for a  
1661 recipient in a laboratory that meets the requirements for  
1662 Medicare participation and is licensed under chapter 483, if  
1663 required.

1664 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-  
1665 hour-a-day nursing and rehabilitative services for a recipient  
1666 in a nursing facility licensed under part II of chapter 400 or  
1667 in a rural hospital, as defined in s. 395.602, or in a Medicare  
1668 certified skilled nursing facility operated by a general  
1669 hospital, as defined in ~~by~~ s. 395.002(10), which ~~that~~ is  
1670 licensed under part I of chapter 395, and in accordance with  
1671 ~~provisions set forth in~~ s. 409.908(2)(a), which services are  
1672 ordered by and provided under the direction of a licensed  
1673 physician. However, if a nursing facility has been destroyed or  
1674 otherwise made uninhabitable by natural disaster or other  
1675 emergency and another nursing facility is not available, the  
1676 agency must pay for similar services temporarily in a hospital  
1677 licensed under part I of chapter 395 provided federal funding is  
1678 approved and available. The agency shall pay only for bed-hold  
1679 days if the facility has an occupancy rate of 95 percent or  
1680 greater. The agency is authorized to seek any federal waivers to  
1681 implement this policy.

1682 (9) PHYSICIAN SERVICES.—The agency shall pay for covered

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1683 services and procedures rendered to a Medicaid recipient by, or  
1684 under the personal supervision of, a person licensed under state  
1685 law to practice medicine or osteopathic medicine. These services  
1686 may be furnished in the physician's office, the ~~Medicaid~~  
1687 recipient's home, a hospital, a nursing facility, or elsewhere,  
1688 but must ~~shall~~ be medically necessary for the treatment of a  
1689 covered ~~an~~ injury or, ~~illness, or disease~~ within the scope of  
1690 the practice of medicine or osteopathic medicine as defined by  
1691 state law. The agency may ~~shall~~ not pay for services that are  
1692 clinically unproven, experimental, or for purely cosmetic  
1693 purposes.

1694 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for  
1695 professional and technical portable radiological services  
1696 ordered by a licensed physician or other licensed health care  
1697 practitioner ~~of the healing arts~~ which are provided by a  
1698 licensed professional in a setting other than a hospital,  
1699 clinic, or office of a physician or practitioner ~~of the healing~~  
1700 ~~arts~~, on behalf of a recipient.

1701 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for  
1702 outpatient primary ~~health~~ care services for a recipient provided  
1703 by a clinic certified by and participating in the Medicare  
1704 program which is located in a federally designated, rural,  
1705 medically underserved area and has on its staff one or more  
1706 licensed primary care nurse practitioners or physician  
1707 assistants, and a licensed staff supervising physician or a  
1708 consulting supervising physician.

1709 (12) TRANSPORTATION SERVICES.—The agency shall ensure that  
1710 appropriate transportation services are available for a Medicaid  
1711 recipient in need of transport to a qualified Medicaid provider

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1712 for medically necessary ~~and Medicaid-compensable~~ services, if  
1713 the recipient's ~~provided a client's~~ ability to choose a specific  
1714 transportation provider is ~~shall be~~ limited to those options  
1715 resulting from policies established by the agency to meet the  
1716 fiscal limitations of the General Appropriations Act. The agency  
1717 may pay for necessary transportation and other related travel  
1718 expenses ~~as necessary~~ only if these services are not otherwise  
1719 available.

1720 Section 24. Section 409.906, Florida Statutes, is amended  
1721 to read:

1722 409.906 Optional Medicaid services.—Subject to specific  
1723 appropriations, the agency may make payments for services which  
1724 are optional to the state under Title XIX of the Social Security  
1725 Act and are furnished by Medicaid providers to recipients who  
1726 are determined to be eligible on the dates on which the services  
1727 were provided. Any optional service that is provided shall be  
1728 provided only when medically necessary and in accordance with  
1729 state and federal law. Optional services rendered by providers  
1730 in mobile units to Medicaid recipients may be restricted or  
1731 prohibited by the agency. ~~Nothing in~~ This section does not shall  
1732 ~~be construed to~~ prevent or limit the agency from adjusting fees,  
1733 reimbursement rates, lengths of stay, number of visits, or  
1734 number of services, or making any other adjustments necessary to  
1735 comply with the availability of moneys and any limitations or  
1736 directions provided for in the General Appropriations Act, ~~or~~  
1737 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~  
1738 ~~state's systems of providing services to elderly and disabled~~  
1739 ~~persons and subject to the notice and review provisions of s.~~  
1740 ~~216.177, the Governor may direct the Agency for Health Care~~

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1741 ~~Administration to amend the Medicaid state plan to delete the~~  
1742 ~~optional Medicaid service known as "Intermediate Care Facilities~~  
1743 ~~for the Developmentally Disabled."~~ Optional services may  
1744 include:

1745 (1) ADULT DENTAL SERVICES.—For a recipient who is 21 years  
1746 of age or older:

1747 (a) The agency may pay for medically necessary, emergency  
1748 dental procedures to alleviate pain or infection. Emergency  
1749 dental care is ~~shall be~~ limited to emergency oral examinations,  
1750 necessary radiographs, extractions, and incision and drainage of  
1751 abscess, ~~for a recipient who is 21 years of age or older.~~

1752 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or  
1753 partial dentures, the procedures required to seat full or  
1754 partial dentures, and the repair and reline of full or partial  
1755 dentures, provided by or under the direction of a licensed  
1756 dentist, ~~for a recipient who is 21 years of age or older.~~

1757 (c) ~~However,~~ Medicaid will not provide reimbursement for  
1758 dental services provided in a mobile dental unit, except for a  
1759 mobile dental unit:

1760 1. Owned by, operated by, or having a contractual agreement  
1761 with the Department of Health and complying with Medicaid's  
1762 county health department clinic services program specifications  
1763 as a county health department clinic services provider.

1764 2. Owned by, operated by, or having a contractual  
1765 arrangement with a federally qualified health center and  
1766 complying with Medicaid's federally qualified health center  
1767 specifications as a federally qualified health center provider.

1768 3. Rendering dental services to Medicaid recipients, 21  
1769 years of age and older, at nursing facilities.

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1770 4. Owned by, operated by, or having a contractual agreement  
1771 with a state-approved dental educational institution.

1772 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for  
1773 an annual routine physical examination, conducted by or under  
1774 the direction of a licensed physician, for a recipient age 21 or  
1775 older, without regard to medical necessity, in order to detect  
1776 and prevent disease, disability, or other health condition or  
1777 its progression.

1778 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay  
1779 for services provided to a recipient in an ambulatory surgical  
1780 center licensed under part I of chapter 395, by or under the  
1781 direction of a licensed physician or dentist.

1782 (4) BIRTH CENTER SERVICES.—The agency may pay for  
1783 examinations and delivery, recovery, ~~and~~ newborn assessment, and  
1784 related services, provided in a licensed birth center staffed  
1785 with licensed physicians, certified nurse midwives, and midwives  
1786 licensed in accordance with chapter 467, to a recipient expected  
1787 to experience a low-risk pregnancy and delivery.

1788 (5) CASE MANAGEMENT SERVICES.—The agency may pay for  
1789 primary care case management services rendered to a recipient  
1790 pursuant to a federally approved waiver, ~~and~~ targeted case  
1791 management services for specific groups of targeted recipients,  
1792 for which funding has been provided and which are rendered  
1793 pursuant to federal guidelines. The agency may ~~is authorized to~~  
1794 limit reimbursement for targeted case management services in  
1795 order to comply with any limitations or directions provided for  
1796 in the General Appropriations Act.

1797 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for  
1798 diagnostic, preventive, or corrective procedures, including

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1799 orthodontia in severe cases, provided to a recipient under age  
1800 21, by or under the supervision of a licensed dentist. Services  
1801 ~~provided under this program~~ include treatment of the teeth and  
1802 associated structures of the oral cavity, as well as treatment  
1803 of disease, injury, or impairment that may affect the oral or  
1804 general health of the individual. However, Medicaid may ~~will~~ not  
1805 provide reimbursement for dental services provided in a mobile  
1806 dental unit, except for a mobile dental unit:

1807 (a) Owned by, operated by, or having a contractual  
1808 agreement with the Department of Health and complying with  
1809 Medicaid's county health department clinic services program  
1810 specifications as a county health department clinic services  
1811 provider.

1812 (b) Owned by, operated by, or having a contractual  
1813 arrangement with a federally qualified health center and  
1814 complying with Medicaid's federally qualified health center  
1815 specifications as a federally qualified health center provider.

1816 (c) Rendering dental services to Medicaid recipients, 21  
1817 years of age and older, at nursing facilities.

1818 (d) Owned by, operated by, or having a contractual  
1819 agreement with a state-approved dental educational institution.

1820 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual  
1821 manipulation of the spine and initial services, screening, and X  
1822 rays provided to a recipient by a licensed chiropractic  
1823 physician.

1824 (8) COMMUNITY MENTAL HEALTH SERVICES.—

1825 ~~(a)~~ The agency may pay for rehabilitative services provided  
1826 to a recipient by a mental health or substance abuse provider  
1827 under contract with the agency or the Department of Children and

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1828 Family Services to provide such services. ~~These~~ Services that  
1829 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or  
1830 recommended by a psychiatrist, and ~~these~~ services that ~~which~~ are  
1831 medical in nature must ~~shall~~ be rendered or recommended by a  
1832 physician or psychiatrist.

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



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1857 or directions provided for in the General Appropriations Act.

1858 (b) The agency may ~~is authorized to~~ implement reimbursement  
1859 and use management reforms in order to comply with any  
1860 limitations or directions in the General Appropriations Act,  
1861 which may include, but are not limited to: prior authorization  
1862 of treatment and service plans; prior authorization of services;  
1863 enhanced use review programs for highly used services; and  
1864 limits on services for recipients ~~those~~ determined to be abusing  
1865 their benefit coverages.

1866 (9) DIALYSIS FACILITY SERVICES.—Subject to specific  
1867 appropriations being provided for this purpose, the agency may  
1868 pay a dialysis facility that is approved as a dialysis facility  
1869 in accordance with Title XVIII of the Social Security Act, for  
1870 dialysis services that are provided to a Medicaid recipient  
1871 under the direction of a physician licensed to practice medicine  
1872 or osteopathic medicine in this state, including dialysis  
1873 services provided in the recipient's home by a hospital-based or  
1874 freestanding dialysis facility.

1875 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize  
1876 and pay for certain durable medical equipment and supplies  
1877 provided to a Medicaid recipient as medically necessary.

1878 (11) HEALTHY START SERVICES.—The agency may pay for a  
1879 continuum of risk-appropriate medical and psychosocial services  
1880 for the Healthy Start program in accordance with a federal  
1881 waiver. The agency may not implement the federal waiver unless  
1882 the waiver permits the state to limit enrollment or the amount,  
1883 duration, and scope of services to ensure that expenditures will  
1884 not exceed funds appropriated by the Legislature or available  
1885 from local sources. If ~~the Health Care Financing Administration~~

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1886 ~~does not approve~~ a federal waiver for Healthy Start services is  
1887 not approved, the agency, in consultation with the Department of  
1888 Health and the Florida Association of Healthy Start Coalitions,  
1889 ~~may is authorized to~~ establish a Medicaid certified-match  
1890 program for Healthy Start services. Participation in the Healthy  
1891 Start certified-match program is ~~shall be~~ voluntary, and  
1892 reimbursement is ~~shall be~~ limited to the federal Medicaid share  
1893 provided to Medicaid-enrolled Healthy Start coalitions for  
1894 services provided to Medicaid recipients. The agency may not  
1895 ~~shall~~ take ~~no~~ action to implement a certified-match program  
1896 without ensuring that the amendment and review requirements of  
1897 ss. 216.177 and 216.181 have been met.

1898 (12) HEARING SERVICES.—The agency may pay for hearing and  
1899 related services, including hearing evaluations, hearing aid  
1900 devices, dispensing of the hearing aid, and related repairs, ~~if~~  
1901 provided to a recipient by a licensed hearing aid specialist,  
1902 otolaryngologist, otologist, audiologist, or physician.

1903 (13) HOME AND COMMUNITY-BASED SERVICES.—

1904 (a) The agency may pay for home-based or community-based  
1905 services that are rendered to a recipient in accordance with a  
1906 federally approved waiver program. The agency may limit or  
1907 eliminate coverage for certain services, preauthorize high-cost  
1908 or highly utilized services, or make any other adjustments  
1909 necessary to comply with any limitations or directions provided  
1910 ~~for~~ in the General Appropriations Act.

1911 (b) The agency may consolidate types of services offered in  
1912 the Aged and Disabled Waiver, the Channeling Waiver, the Project  
1913 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury  
1914 Waiver programs in order to group similar services under a

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1915 single service, or continue a service upon evidence of the need  
1916 for including a particular service type in a particular waiver.  
1917 The agency may ~~is authorized to~~ seek a Medicaid state plan  
1918 amendment or federal waiver approval to implement this policy.

1919 (c) The agency may implement a utilization management  
1920 program designed to prior-authorize home and community-based  
1921 service plans which ~~and~~ includes, but is not limited to,  
1922 assessing proposed quantity and duration of services and  
1923 monitoring ongoing service use by participants in the program.  
1924 The agency may ~~is authorized to~~ competitively procure a  
1925 qualified organization to provide utilization management of home  
1926 and community-based services. The agency may ~~is authorized to~~  
1927 seek any federal waivers to implement this initiative.

1928 (d) The agency shall assess a fee against the parents of a  
1929 child who is being served by a waiver under this subsection if  
1930 the adjusted household income is greater than 100 percent of the  
1931 federal poverty level. The amount of the fee shall be calculated  
1932 using a sliding scale based on the size of the family, the  
1933 amount of the parent's adjusted gross income, and the federal  
1934 poverty guidelines. The agency shall seek a federal waiver to  
1935 implement this provision.

1936 (14) HOSPICE CARE SERVICES.—The agency may pay for all  
1937 reasonable and necessary services for the palliation or  
1938 management of a recipient's terminal illness, if the services  
1939 are provided by a hospice that is licensed under part IV of  
1940 chapter 400 and meets Medicare certification requirements.

1941 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY  
1942 DISABLED SERVICES.—The agency may pay for health-related care  
1943 and services provided on a 24-hour-a-day basis by a facility

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1944 licensed and certified as a Medicaid Intermediate Care Facility  
1945 for the Developmentally Disabled, for a recipient who needs such  
1946 care because of a developmental disability. Payment may ~~shall~~  
1947 not include bed-hold days except in facilities with occupancy  
1948 rates of 95 percent or greater. The agency may ~~is authorized to~~  
1949 seek any federal waiver approvals to implement this policy. If  
1950 necessary to safeguard the state's systems of providing services  
1951 to elderly and disabled persons and subject to notice and review  
1952 under s. 216.177, the Governor may direct the agency to amend  
1953 the Medicaid state plan to delete these services.

1954 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-  
1955 hour-a-day intermediate care nursing and rehabilitation services  
1956 rendered to a recipient in a nursing facility licensed under  
1957 part II of chapter 400~~7~~ if the services are ordered by and  
1958 provided under the direction of a physician.

1959 (17) OPTOMETRIC SERVICES.—The agency may pay for services  
1960 provided to a recipient, including examination, diagnosis,  
1961 treatment, and management, related to ocular pathology~~7~~ if the  
1962 services are provided by a licensed optometrist or physician.

1963 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for  
1964 all services provided to a recipient by a physician assistant  
1965 licensed under s. 458.347 or s. 459.022. Reimbursement for such  
1966 services must be at least ~~not less than~~ 80 percent of the  
1967 reimbursement that would be paid to a physician who provided the  
1968 same services.

1969 (19) PODIATRIC SERVICES.—The agency may pay for services,  
1970 including diagnosis and medical, surgical, palliative, and  
1971 mechanical treatment, related to ailments of the human foot and  
1972 lower leg, if provided to a recipient by a podiatric physician

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1973 licensed under state law.

1974 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for  
1975 medications that are prescribed for a recipient by a physician  
1976 or other licensed health care practitioner ~~of the healing arts~~  
1977 authorized to prescribe medications and that are dispensed to  
1978 the recipient by a licensed pharmacist or physician in  
1979 accordance with applicable state and federal law. However, the  
1980 agency may not pay for any psychotropic medication prescribed  
1981 for a child younger than the age for which the federal Food and  
1982 Drug Administration has approved its use.

1983 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency  
1984 may pay for all services provided to a recipient by a registered  
1985 nurse first assistant as described in s. 464.027. Reimbursement  
1986 for such services must be at least ~~may not be less than~~ 80  
1987 percent of the reimbursement that would be paid to a physician  
1988 providing the same services.

1989 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-  
1990 inclusive psychiatric inpatient hospital care provided to a  
1991 recipient age 65 or older in a state mental hospital.

1992 (23) VISUAL SERVICES.—The agency may pay for visual  
1993 examinations, eyeglasses, and eyeglass repairs for a recipient  
1994 if they are prescribed by a licensed physician specializing in  
1995 diseases of the eye or by a licensed optometrist. Eyeglass  
1996 frames for adult recipients are ~~shall be~~ limited to one pair per  
1997 recipient every 2 years, except a second pair may be provided  
1998 ~~during that period~~ after prior authorization. Eyeglass lenses  
1999 for adult recipients are ~~shall be~~ limited to one pair per year  
2000 except a second pair may be provided ~~during that period~~ after  
2001 prior authorization.

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2002 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~  
2003 ~~Health Care Administration~~, in consultation with the Department  
2004 of Children and Family Services, may establish a targeted case-  
2005 management project in those counties identified by the  
2006 department ~~of Children and Family Services~~ and for all counties  
2007 with a community-based child welfare project, as authorized  
2008 under s. 409.1671, which have been specifically approved by the  
2009 department. The covered group that is ~~of individuals who are~~  
2010 eligible for ~~to receive~~ targeted case management include  
2011 children who are eligible for Medicaid; who are between the ages  
2012 of birth through 21; and who are under protective supervision or  
2013 postplacement supervision, under foster-care supervision, or in  
2014 shelter care or foster care. The number of eligible children  
2015 ~~individuals who are eligible to receive targeted case management~~  
2016 is limited to the number for whom the department ~~of Children and~~  
2017 ~~Family Services~~ has matching funds to cover the costs. The  
2018 general revenue funds required to match the funds for services  
2019 provided by the community-based child welfare projects are  
2020 limited to funds available for services described under s.  
2021 409.1671. The department ~~of Children and Family Services~~ may  
2022 transfer the general revenue matching funds as billed by the  
2023 agency ~~for Health Care Administration~~.

2024 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for  
2025 assistive-care services provided to recipients with functional  
2026 or cognitive impairments residing in assisted living facilities,  
2027 adult family-care homes, or residential treatment facilities.  
2028 These services may include health support, assistance with the  
2029 activities of daily living and the instrumental acts of daily  
2030 living, assistance with medication administration, and

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2031 arrangements for health care.

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

2054 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may  
2055 pay for all services provided to a recipient by an  
2056 anesthesiologist assistant licensed under s. 458.3475 or s.  
2057 459.023. Reimbursement for such services must be at least ~~not~~  
2058 ~~less than~~ 80 percent of the reimbursement that would be paid to  
2059 a physician who provided the same services.

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2060 Section 25. Section 409.9062, Florida Statutes, is amended  
2061 to read:

2062 409.9062 Lung transplant services for Medicaid recipients.—  
2063 Subject to the availability of funds and ~~subject to~~ any  
2064 limitations or directions provided ~~for~~ in the General  
2065 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~  
2066 ~~for Health Care Administration~~ Medicaid program shall pay for  
2067 medically necessary lung transplant services for Medicaid  
2068 recipients. These payments must be used to reimburse approved  
2069 lung transplant facilities a global fee for providing lung  
2070 transplant services to Medicaid recipients.

2071 Section 26. Paragraph (h) of subsection (3) of section  
2072 409.907, Florida Statutes, is amended to read:

2073 409.907 Medicaid provider agreements.—The agency may make  
2074 payments for medical assistance and related services rendered to  
2075 Medicaid recipients only to an individual or entity who has a  
2076 provider agreement in effect with the agency, who is performing  
2077 services or supplying goods in accordance with federal, state,  
2078 and local law, and who agrees that no person shall, on the  
2079 grounds of handicap, race, color, or national origin, or for any  
2080 other reason, be subjected to discrimination under any program  
2081 or activity for which the provider receives payment from the  
2082 agency.

2083 (3) The provider agreement developed by the agency, in  
2084 addition to the requirements specified in subsections (1) and  
2085 (2), shall require the provider to:

2086 (h) Be liable for and indemnify, defend, and hold the  
2087 agency harmless from all claims, suits, judgments, or damages,  
2088 including court costs and attorney's fees, arising out of the



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2089 negligence or omissions of the provider in the course of  
2090 providing services to a recipient or a person believed to be a  
2091 recipient, subject to s. 766.1183 or s. 766.1184.

2092 Section 27. Section 409.908, Florida Statutes, is amended  
2093 to read:

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

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2118 number of services, or making any other adjustments necessary to  
2119 comply with the availability of moneys and any limitations or  
2120 directions provided ~~for~~ in the General Appropriations Act if  
2121 ~~provided~~ the adjustment is consistent with legislative intent.

2122 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed  
2123 under part I of chapter 395 must be made prospectively or on the  
2124 basis of negotiation.

2125 (a) Inpatient care.—

2126 1. Reimbursement for inpatient care is limited as provided  
2127 ~~for~~ in s. 409.905(5), except for:

2128 a.1. ~~The raising of rate reimbursement caps, excluding~~  
2129 rural hospitals.

2130 b.2. ~~Recognition of the costs of graduate medical~~  
2131 education.

2132 c.3. ~~Other methodologies recognized in the General~~  
2133 Appropriations Act.

2134 2. If ~~During the years~~ funds are transferred from the  
2135 Department of Health, any reimbursement supported by such funds  
2136 is ~~shall be~~ subject to certification by the Department of Health  
2137 that the hospital has complied with s. 381.0403. The agency may  
2138 ~~is authorized to~~ receive funds from state entities, including,  
2139 but not limited to, the Department of Health, local governments,  
2140 and other local political subdivisions, for the purpose of  
2141 making special exception payments, including federal matching  
2142 funds, through the Medicaid inpatient reimbursement  
2143 methodologies. Funds received from state entities or local  
2144 governments for this purpose shall be separately accounted for  
2145 and may ~~shall~~ not be commingled with other state or local funds  
2146 in any manner. The agency may certify all local governmental

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2147 funds used as state match under Title XIX of the Social Security  
2148 Act, to the extent that the identified local health care  
2149 provider that is otherwise entitled to and is contracted to  
2150 receive such local funds is the benefactor under the state's  
2151 Medicaid program as determined under the General Appropriations  
2152 Act and pursuant to an agreement between the agency ~~for Health~~  
2153 ~~Care Administration~~ and the local governmental entity. The local  
2154 governmental entity shall use a certification form prescribed by  
2155 the agency. At a minimum, the certification form must ~~shall~~  
2156 identify the amount being certified and describe the  
2157 relationship between the certifying local governmental entity  
2158 and the local health care provider. The agency shall prepare an  
2159 annual statement of impact which documents the specific  
2160 activities undertaken during the previous fiscal year pursuant  
2161 to this paragraph, to be submitted to the Legislature annually  
2162 by no later than January 1, ~~annually~~.

2163 (b) Outpatient care.—

2164 1. Reimbursement for hospital outpatient care is limited to  
2165 \$1,500 per state fiscal year per recipient, except for:

2166 a.1. ~~Such~~ Care provided to a Medicaid recipient under age  
2167 21, in which case the only limitation is medical necessity.

2168 b.2. Renal dialysis services.

2169 c.3. Other exceptions made by the agency.

2170 2. The agency may ~~is authorized to~~ receive funds from state  
2171 entities, including, but not limited to, the Department of  
2172 Health, the Board of Governors of the State University System,  
2173 local governments, and other local political subdivisions, for  
2174 the purpose of making payments, including federal matching  
2175 funds, through the Medicaid outpatient reimbursement

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2176 methodologies. Funds received ~~from state entities and local~~  
2177 ~~governments~~ for this purpose shall be separately accounted for  
2178 and may ~~shall~~ not be commingled with other state or local funds  
2179 ~~in any manner.~~

2180 3. The agency may limit inflationary increases for  
2181 outpatient hospital services as directed by the General  
2182 Appropriations Act.

2183 (c) Disproportionate share.—Hospitals that provide services  
2184 to a disproportionate share of low-income Medicaid recipients,  
2185 ~~or~~ that participate in the regional perinatal intensive care  
2186 center program under chapter 383, or that participate in the  
2187 statutory teaching hospital disproportionate share program may  
2188 receive additional reimbursement. The total amount of payment  
2189 for disproportionate share hospitals shall be fixed by the  
2190 General Appropriations Act. The computation of these payments  
2191 must comply ~~be made in compliance~~ with all federal regulations  
2192 and the methodologies described in ss. 409.911, 409.9112, and  
2193 409.9113.

2194 ~~(d) The agency is authorized to limit inflationary~~  
2195 ~~increases for outpatient hospital services as directed by the~~  
2196 ~~General Appropriations Act.~~

2197 (2) NURSING HOME CARE.—

2198 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II  
2199 of chapter 400 and state-owned-and-operated intermediate care  
2200 facilities for the developmentally disabled licensed under part  
2201 VIII of chapter 400 must be made prospectively.

2202 (a)2. Unless otherwise limited or directed in the General  
2203 Appropriations Act, reimbursement to hospitals licensed under  
2204 part I of chapter 395 for ~~the provision of~~ swing-bed nursing

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

2231 (b) Subject to any limitations or directions provided ~~for~~  
2232 in the General Appropriations Act, the agency shall establish  
2233 and implement a Florida Title XIX Long-Term Care Reimbursement

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2234 Plan (Medicaid) for nursing home care in order to provide care  
2235 and services that conform to ~~in conformance with the~~ applicable  
2236 state and federal laws, rules, regulations, and quality and  
2237 safety standards and to ensure that individuals eligible for  
2238 medical assistance have reasonable geographic access to such  
2239 care.

2240 1. The agency shall amend the long-term care reimbursement  
2241 plan and cost reporting system to create direct care and  
2242 indirect care subcomponents of the patient care component of the  
2243 per diem rate. These two subcomponents together must ~~shall~~ equal  
2244 the patient care component of the per diem rate. Separate cost-  
2245 based ceilings shall be calculated for each patient care  
2246 subcomponent. The direct care subcomponent of the per diem rate  
2247 is ~~shall be~~ limited by the cost-based class ceiling, and the  
2248 indirect care subcomponent may be limited by the lower of the  
2249 cost-based class ceiling, the target rate class ceiling, or the  
2250 individual provider target.

2251 2. The direct care subcomponent includes ~~shall include~~  
2252 salaries and benefits of direct care staff providing nursing  
2253 services, including registered nurses, licensed practical  
2254 nurses, and certified nursing assistants who deliver care  
2255 directly to residents in the nursing home facility. This  
2256 excludes nursing administration, minimum data set, and care plan  
2257 coordinators, staff development, and the staffing coordinator.  
2258 The direct care subcomponent also includes medically necessary  
2259 dental care, vision care, hearing care, and podiatric care.

2260 3. All other patient care costs are ~~shall be~~ included in  
2261 the indirect care cost subcomponent of the patient care per diem  
2262 rate. ~~There shall be no~~ Costs may not be directly or indirectly

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2263 allocated to the direct care subcomponent from a home office or  
2264 management company.

2265 4. On July 1 of each year, the agency shall report to the  
2266 Legislature direct and indirect care costs, including average  
2267 direct and indirect care costs per resident per facility and  
2268 direct care and indirect care salaries and benefits per category  
2269 of staff member per facility.

2270 5. In order to offset the cost of general and professional  
2271 liability insurance, the agency shall amend the plan to allow  
2272 for interim rate adjustments to reflect increases in the cost of  
2273 general or professional liability insurance for nursing homes.  
2274 This provision shall be implemented to the extent existing  
2275 appropriations are available.

2276  
2277 It is the intent of the Legislature that the reimbursement plan  
2278 achieve the goal of providing access to health care for nursing  
2279 home residents who require large amounts of care while  
2280 encouraging diversion services as an alternative to nursing home  
2281 care for residents who can be served within the community. The  
2282 agency shall base the establishment of any maximum rate of  
2283 payment, whether overall or component, on the available moneys  
2284 ~~as~~ provided ~~for~~ in the General Appropriations Act. The agency  
2285 may base the maximum rate of payment on the results of  
2286 scientifically valid analysis and conclusions derived from  
2287 objective statistical data pertinent to the particular maximum  
2288 rate of payment.

2289 (c) The agency shall request and implement Medicaid waivers  
2290 approved by the federal Centers for Medicare and Medicaid  
2291 Services to advance and treat a portion of the Medicaid nursing

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2292 home per diem as capital for creating and operating a risk-  
2293 retention group for self-insurance purposes, consistent with  
2294 federal and state laws and rules.

2295 (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any  
2296 limitations or directions provided ~~for~~ in the General  
2297 Appropriations Act, the following Medicaid services and goods  
2298 may be reimbursed on a fee-for-service basis. For each allowable  
2299 service or goods furnished in accordance with Medicaid rules,  
2300 policy manuals, handbooks, and state and federal law, the  
2301 payment shall be the amount billed by the provider, the  
2302 provider's usual and customary charge, or the maximum allowable  
2303 fee established by the agency, whichever amount is less, with  
2304 the exception of those services or goods for which the agency  
2305 makes payment using a methodology based on capitation rates,  
2306 average costs, or negotiated fees.

- 2307 (a) Advanced registered nurse practitioner services.  
2308 (b) Birth center services.  
2309 (c) Chiropractic services.  
2310 (d) Community mental health services.  
2311 (e) Dental services, including oral and maxillofacial  
2312 surgery.  
2313 (f) Durable medical equipment.  
2314 (g) Hearing services.  
2315 (h) Occupational therapy for Medicaid recipients under age  
2316 21.  
2317 (i) Optometric services.  
2318 (j) Orthodontic services.  
2319 (k) Personal care for Medicaid recipients under age 21.  
2320 (l) Physical therapy for Medicaid recipients under age 21.



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

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2350 using an all-inclusive rate stipulated in a fee schedule  
2351 established by the agency. A provider of the visual, dental, and  
2352 hearing components of such services shall be reimbursed the  
2353 lesser of the amount billed by the provider or the Medicaid  
2354 maximum allowable fee established by the agency.

2355 (7) FAMILY PLANNING SERVICES.—A provider of family planning  
2356 services shall be reimbursed the lesser of the amount billed by  
2357 the provider or an all-inclusive amount per type of visit for  
2358 physicians and advanced registered nurse practitioners, as  
2359 established by the agency in a fee schedule.

2360 (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-  
2361 based or community-based services rendered pursuant to a  
2362 federally approved waiver shall be reimbursed based on an  
2363 established or negotiated rate for each service. These rates  
2364 shall be established according to an analysis of the expenditure  
2365 history and prospective budget developed by each contract  
2366 provider participating in the waiver program, or under any other  
2367 methodology adopted by the agency and approved by the Federal  
2368 Government in accordance with the waiver. Privately owned and  
2369 operated community-based residential facilities that ~~which~~ meet  
2370 agency requirements and ~~which~~ formerly received Medicaid  
2371 reimbursement for the optional intermediate care facility for  
2372 the mentally retarded service may participate in the  
2373 developmental services waiver as part of a home-and-community-  
2374 based continuum of care for Medicaid recipients who receive  
2375 waiver services.

2376 (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider  
2377 of home health care services or of medical supplies and  
2378 appliances shall be reimbursed on the basis of competitive

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2379 bidding or for the lesser of the amount billed by the provider  
2380 or the agency's established maximum allowable amount, except  
2381 that, ~~in the case of the rental of durable medical equipment,~~  
2382 the total rental payments for durable medical equipment may not  
2383 exceed the purchase price of the equipment over its expected  
2384 useful life or the agency's established maximum allowable  
2385 amount, whichever amount is less.

2386 (10) HOSPICE.—A hospice shall be reimbursed through a  
2387 prospective system for each Medicaid hospice patient at Medicaid  
2388 rates using the methodology established for hospice  
2389 reimbursement pursuant to Title XVIII of the federal Social  
2390 Security Act.

2391 (11) LABORATORY SERVICES.—A provider of independent  
2392 laboratory services shall be reimbursed on the basis of  
2393 competitive bidding or for the least of the amount billed by the  
2394 provider, the provider's usual and customary charge, or the  
2395 Medicaid maximum allowable fee established by the agency.

2396 (12) PHYSICIAN SERVICES.—

2397 (a) A physician shall be reimbursed the lesser of the  
2398 amount billed by the provider or the Medicaid maximum allowable  
2399 fee established by the agency.

2400 (b) The agency shall adopt a fee schedule, subject to any  
2401 limitations or directions provided ~~for~~ in the General  
2402 Appropriations Act, based on a resource-based relative value  
2403 scale for pricing Medicaid physician services. Under the ~~this~~  
2404 fee schedule, physicians shall be paid a dollar amount for each  
2405 service based on the average resources required to provide the  
2406 service, including, but not limited to, estimates of average  
2407 physician time and effort, practice expense, and the costs of

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2408 professional liability insurance. The fee schedule must ~~shall~~  
2409 provide increased reimbursement for preventive and primary care  
2410 services and lowered reimbursement for specialty services by  
2411 using at least two conversion factors, one for cognitive  
2412 services and another for procedural services. The fee schedule  
2413 may ~~shall~~ not increase total Medicaid physician expenditures  
2414 unless moneys are available. The agency ~~for Health Care~~  
2415 ~~Administration~~ shall seek the advice of a 16-member advisory  
2416 panel in formulating and adopting the fee schedule. The panel  
2417 shall consist of Medicaid physicians licensed under chapters 458  
2418 and 459 and ~~shall~~ be composed of 50 percent primary care  
2419 physicians and 50 percent specialty care physicians.

2420 (c) Notwithstanding paragraph (b), reimbursement fees to  
2421 physicians for providing total obstetrical services to Medicaid  
2422 recipients, which include prenatal, delivery, and postpartum  
2423 care, must ~~shall~~ be at least \$1,500 per delivery for a pregnant  
2424 woman with low medical risk and at least \$2,000 per delivery for  
2425 a pregnant woman with high medical risk. However, reimbursement  
2426 to physicians working in regional perinatal intensive care  
2427 centers designated pursuant to chapter 383, for services to  
2428 ~~certain~~ pregnant Medicaid recipients with a high medical risk,  
2429 may be made according to obstetrical care and neonatal care  
2430 groupings and rates established by the agency. Nurse midwives  
2431 licensed under part I of chapter 464 or midwives licensed under  
2432 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent  
2433 of the low medical risk fee. The agency shall by rule determine,  
2434 for the purpose of this paragraph, what constitutes a high or  
2435 low medical risk pregnant woman and may ~~shall~~ not pay more based  
2436 solely on the fact that a caesarean section was performed,

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2437 rather than a vaginal delivery. The agency shall by rule  
2438 determine a prorated payment for obstetrical services ~~in cases~~  
2439 where only part of the total prenatal, delivery, or postpartum  
2440 care was performed. The Department of Health shall adopt rules  
2441 for appropriate insurance coverage for midwives licensed under  
2442 chapter 467. Before issuing and renewing ~~Prior to the issuance~~  
2443 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~  
2444 ~~of~~ an inactive license for midwives licensed under chapter 467,  
2445 such licensees must ~~shall~~ submit proof of coverage with each  
2446 application.

2447 (d) Effective January 1, 2013, Medicaid fee-for-service  
2448 payments to primary care physicians for primary care services  
2449 must be at least 100 percent of the Medicare payment rate for  
2450 such services.

2451 (13) DUALY ELIGIBLE RECIPIENTS.—Medicare premiums for  
2452 persons eligible for both Medicare and Medicaid coverage shall  
2453 be paid at the rates established by Title XVIII of the Social  
2454 Security Act. For Medicare services rendered to Medicaid-  
2455 eligible persons, Medicaid shall pay Medicare deductibles and  
2456 coinsurance as follows:

2457 (a) Medicaid's financial obligation for deductibles and  
2458 coinsurance payments shall be based on Medicare allowable fees,  
2459 not on a provider's billed charges.

2460 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare  
2461 deductibles and coinsurance if ~~when~~ payment that Medicare has  
2462 made for the service equals or exceeds what Medicaid would have  
2463 paid if it had been the sole payor. The combined payment of  
2464 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid  
2465 would have paid had it been the sole payor. The Legislature

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

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2495 (c) Notwithstanding paragraphs (a) and (b):

2496 1. Medicaid payments for Nursing Home Medicare part A  
2497 coinsurance are limited to the Medicaid nursing home per diem  
2498 rate less any amounts paid by Medicare, but only up to the  
2499 amount of Medicare coinsurance. The Medicaid per diem rate is  
2500 ~~shall be~~ the rate in effect for the dates of service of the  
2501 crossover claims and may not be subsequently adjusted due to  
2502 subsequent per diem rate adjustments.

2503 2. Medicaid shall pay all deductibles and coinsurance for  
2504 Medicare-eligible recipients receiving freestanding end stage  
2505 renal dialysis center services.

2506 3. Medicaid payments for general and specialty hospital  
2507 inpatient services are limited to the Medicare deductible and  
2508 coinsurance per spell of illness. Medicaid payments for hospital  
2509 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid  
2510 hospital per diem rate less any amounts paid by Medicare, but  
2511 only up to the amount of Medicare coinsurance. Medicaid payments  
2512 for coinsurance are ~~shall be~~ limited to the Medicaid per diem  
2513 rate in effect for the dates of service of the crossover claims  
2514 and may not be subsequently adjusted due to subsequent per diem  
2515 adjustments.

2516 4. Medicaid shall pay all deductibles and coinsurance for  
2517 Medicare emergency transportation services provided by  
2518 ambulances licensed pursuant to chapter 401.

2519 5. Medicaid shall pay all deductibles and coinsurance for  
2520 portable X-ray Medicare Part B services provided in a nursing  
2521 home.

2522 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall  
2523 be reimbursed the least of the amount billed by the provider,

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2524 the provider's usual and customary charge, or the Medicaid  
2525 maximum allowable fee established by the agency, plus a  
2526 dispensing fee. The Medicaid maximum allowable fee for  
2527 ingredient cost must ~~will~~ be based on the lower of ~~the~~ average  
2528 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition  
2529 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the  
2530 state maximum allowable cost (SMAC), or the usual and customary  
2531 (UAC) charge billed by the provider.

2532 (a) Medicaid providers must ~~are required to~~ dispense  
2533 generic drugs if available at lower cost and the agency has not  
2534 determined that the branded product is more cost-effective,  
2535 unless the prescriber has requested and received approval to  
2536 require the branded product.

2537 (b) The agency shall ~~is directed to~~ implement a variable  
2538 dispensing fee for ~~payments for~~ prescribed medicines while  
2539 ensuring continued access for Medicaid recipients. The variable  
2540 dispensing fee may be based upon, but not limited to, either or  
2541 both the volume of prescriptions dispensed by a specific  
2542 pharmacy provider, the volume of prescriptions dispensed to an  
2543 individual recipient, and dispensing of preferred-drug-list  
2544 products.

2545 (c) The agency may increase the pharmacy dispensing fee  
2546 authorized by statute and in the ~~annual~~ General Appropriations  
2547 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-  
2548 list product and reduce the pharmacy dispensing fee by \$0.50 for  
2549 the dispensing of a Medicaid product that is not included on the  
2550 preferred drug list.

2551 (d) The agency may establish a supplemental pharmaceutical  
2552 dispensing fee to be paid to providers returning unused unit-



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2553 dose packaged medications to stock and crediting the Medicaid  
2554 program for the ingredient cost of those medications if the  
2555 ingredient costs to be credited exceed the value of the  
2556 supplemental dispensing fee.

2557 (e) The agency ~~may is authorized to~~ limit reimbursement for  
2558 prescribed medicine in order to comply with any limitations or  
2559 directions provided ~~for~~ in the General Appropriations Act, which  
2560 may include implementing a prospective or concurrent utilization  
2561 review program.

2562 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary  
2563 care case management services rendered pursuant to a federally  
2564 approved waiver shall be reimbursed by payment of a fixed,  
2565 prepaid monthly sum for each Medicaid recipient enrolled with  
2566 the provider.

2567 (16) RURAL HEALTH CLINICS.—A provider of rural health  
2568 clinic services and federally qualified health center services  
2569 shall be reimbursed a rate per visit based on total reasonable  
2570 costs of the clinic, as determined by the agency in accordance  
2571 with federal regulations.

2572 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case  
2573 management services shall be reimbursed pursuant to an  
2574 established fee, except where the Federal Government requires a  
2575 public provider be reimbursed on the basis of average actual  
2576 costs.

2577 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the  
2578 General Appropriations Act, a provider of transportation  
2579 services shall be reimbursed the lesser of the amount billed by  
2580 the provider or the Medicaid maximum allowable fee established  
2581 by the agency, except if ~~when~~ the agency has entered into a

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2582 direct contract with the provider, or with a community  
2583 transportation coordinator, for the provision of an all-  
2584 inclusive service, or if ~~when~~ services are provided pursuant to  
2585 an agreement negotiated between the agency and the provider. ~~The~~  
2586 ~~agency, as provided for in s. 427.0135, shall purchase~~  
2587 ~~transportation services through the community coordinated~~  
2588 ~~transportation system, if available, unless the agency, after~~  
2589 ~~consultation with the commission, determines that it cannot~~  
2590 ~~reach mutually acceptable contract terms with the commission.~~  
2591 ~~The agency may then contract for the same transportation~~  
2592 ~~services provided in a more cost-effective manner and of~~  
2593 ~~comparable or higher quality and standards. Nothing in~~

2594 (a) This subsection does not ~~shall be construed to~~ limit or  
2595 preclude the agency from contracting for services using a  
2596 prepaid capitation rate or from establishing maximum fee  
2597 schedules, individualized reimbursement policies by provider  
2598 type, negotiated fees, prior authorization, competitive bidding,  
2599 increased use of mass transit, or any other mechanism that the  
2600 agency considers efficient and effective for the purchase of  
2601 services on behalf of Medicaid clients, including implementing a  
2602 transportation eligibility process.

2603 (b) The agency may ~~shall not be required to~~ contract with  
2604 any community transportation coordinator or transportation  
2605 operator that has been determined by the agency, the Department  
2606 of Legal Affairs Medicaid Fraud Control Unit, or any other state  
2607 or federal agency to have engaged in any abusive or fraudulent  
2608 billing activities.

2609 (c) The agency shall ~~is authorized to~~ competitively procure  
2610 transportation services or make other changes necessary to

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2611 secure approval of federal waivers needed to permit federal  
2612 financing of Medicaid transportation services at the service  
2613 matching rate rather than the administrative matching rate.  
2614 ~~Notwithstanding chapter 427, the agency is authorized to~~  
2615 ~~continue contracting for Medicaid nonemergency transportation~~  
2616 ~~services in agency service area 11 with managed care plans that~~  
2617 ~~were under contract for those services before July 1, 2004.~~

2618 (d) Transportation to access covered services provided by a  
2619 qualified plan pursuant to part IV of this chapter shall be  
2620 contracted for by the plan. A qualified plan is not required to  
2621 purchase such services through a coordinated transportation  
2622 system established pursuant to part I of chapter 427.

2623 (19) COUNTY HEALTH DEPARTMENTS.—County health department  
2624 services shall be reimbursed a rate per visit based on total  
2625 reasonable costs of the clinic, as determined by the agency in  
2626 accordance with federal regulations under the authority of 42  
2627 C.F.R. s. 431.615.

2628 (20) DIALYSIS.—A renal dialysis facility that provides  
2629 dialysis services under s. 409.906(9) must be reimbursed the  
2630 lesser of the amount billed by the provider, the provider's  
2631 usual and customary charge, or the maximum allowable fee  
2632 established by the agency, whichever ~~amount~~ is less.

2633 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse  
2634 school districts that ~~which~~ certify the state match pursuant to  
2635 ss. 409.9071 and 1011.70 for the federal portion of the school  
2636 district's allowable costs to deliver the services, based on the  
2637 reimbursement schedule. The school district shall determine the  
2638 costs for delivering services as authorized in ss. 409.9071 and  
2639 1011.70 for which the state match will be certified.

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2640 Reimbursement of school-based providers is contingent on such  
2641 providers being enrolled as Medicaid providers and meeting the  
2642 qualifications contained in 42 C.F.R. s. 440.110, unless  
2643 otherwise waived by the federal Centers for Medicare and  
2644 Medicaid Services Health Care Financing Administration. Speech  
2645 therapy providers who are certified through the Department of  
2646 Education pursuant to rule 6A-4.0176, Florida Administrative  
2647 Code, are eligible for reimbursement for services that are  
2648 provided on school premises. Any employee of the school district  
2649 who has been fingerprinted and has received a criminal  
2650 background check in accordance with Department of Education  
2651 rules and guidelines is ~~shall be~~ exempt from any agency  
2652 requirements relating to criminal background checks.

2653 ~~(22) The agency shall request and implement Medicaid~~  
2654 ~~waivers from the federal Health Care Financing Administration to~~  
2655 ~~advance and treat a portion of the Medicaid nursing home per~~  
2656 ~~diem as capital for creating and operating a risk-retention~~  
2657 ~~group for self-insurance purposes, consistent with federal and~~  
2658 ~~state laws and rules.~~

2659 (22)-(23) (a) LIMITATION ON REIMBURSEMENT RATES.—The agency  
2660 shall establish rates at a level that ensures no increase in  
2661 statewide expenditures resulting from a change in unit costs for  
2662 2 fiscal years effective July 1, 2009. Reimbursement rates for  
2663 the 2 fiscal years shall be as provided in the General  
2664 Appropriations Act.

2665 (a)-(b) This subsection applies to the following provider  
2666 types:

- 2667 1. Inpatient hospitals.
- 2668 2. Outpatient hospitals.

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2669 3. Nursing homes.

2670 4. County health departments.

2671 5. Community intermediate care facilities for the  
2672 developmentally disabled.

2673 6. Prepaid health plans.

2674 (b) The agency shall apply ~~the effect of~~ this subsection to  
2675 the reimbursement rates for nursing home diversion programs.

2676 ~~(c) The agency shall create a workgroup on hospital~~  
2677 ~~reimbursement, a workgroup on nursing facility reimbursement,~~  
2678 ~~and a workgroup on managed care plan payment. The workgroups~~  
2679 ~~shall evaluate alternative reimbursement and payment~~  
2680 ~~methodologies for hospitals, nursing facilities, and managed~~  
2681 ~~care plans, including prospective payment methodologies for~~  
2682 ~~hospitals and nursing facilities. The nursing facility workgroup~~  
2683 ~~shall also consider price-based methodologies for indirect care~~  
2684 ~~and acuity adjustments for direct care. The agency shall submit~~  
2685 ~~a report on the evaluated alternative reimbursement~~  
2686 ~~methodologies to the relevant committees of the Senate and the~~  
2687 ~~House of Representatives by November 1, 2009.~~

2688 (c) ~~(d)~~ This subsection expires June 30, 2011.

2689 (23) PAYMENT METHODOLOGIES.—If a provider is reimbursed  
2690 based on cost reporting and submits a cost report late and that  
2691 cost report would have been used to set a lower reimbursement  
2692 rate for a rate semester, the provider's rate for that semester  
2693 shall be retroactively calculated using the new cost report, and  
2694 full payment at the recalculated rate shall be applied  
2695 retroactively. Medicare-granted extensions for filing cost  
2696 reports, if applicable, also apply to Medicaid cost reports.

2697 (24) RETURN OF PAYMENTS.—If a provider fails to notify the

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2698 agency within 5 business days after suspension or disenrollment  
2699 from Medicare, sanctions may be imposed pursuant to this  
2700 chapter, and the provider may be required to return funds paid  
2701 to the provider during the period of time that the provider was  
2702 suspended or disenrolled ~~as a Medicare provider.~~

2703 Section 28. Subsection (1) of section 409.9081, Florida  
2704 Statutes, is amended to read:

2705 409.9081 Copayments.—

2706 (1) ~~The agency shall require,~~ Subject to federal  
2707 regulations and limitations, each Medicaid recipient must ~~to~~ pay  
2708 at the time of service a nominal copayment for the following  
2709 Medicaid services:

2710 (a) Hospital outpatient services: up to \$3 for each  
2711 hospital outpatient visit.

2712 (b) Physician services: up to \$2 copayment for each visit  
2713 with a primary care physician and up to \$3 copayment for each  
2714 visit with a specialty care physician licensed under chapter  
2715 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463.~~

2716 (c) Hospital emergency department visits for nonemergency  
2717 care: 5 percent of up to the first \$300 of the Medicaid payment  
2718 for emergency room services, not to exceed \$15. The agency shall  
2719 seek a federal waiver of the requirement that cost-sharing  
2720 amounts for nonemergency services and care furnished in a  
2721 hospital emergency department be nominal. Upon waiver approval,  
2722 a Medicaid recipient who requests such services and care, must  
2723 pay a \$100 copayment to the hospital for the nonemergency  
2724 services and care provided in the hospital emergency department.

2725 (d) Prescription drugs: a coinsurance equal to 2.5 percent  
2726 of the Medicaid cost of the prescription drug at the time of

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2727 purchase. The maximum coinsurance is ~~shall be~~ \$7.50 per  
2728 prescription drug purchased.

2729 Section 29. Paragraphs (b) and (d) of subsection (4) and  
2730 subsections (8), (34), (44), (47), and (53) of section 409.912,  
2731 Florida Statutes, are amended, and subsections (48) through (52)  
2732 of that section are renumbered as subsections (47) through (51)  
2733 respectively, to read:

2734 409.912 Cost-effective purchasing of health care.—The  
2735 agency shall purchase goods and services for Medicaid recipients  
2736 in the most cost-effective manner consistent with the delivery  
2737 of quality medical care. To ensure that medical services are  
2738 effectively utilized, the agency may, in any case, require a  
2739 confirmation or second physician's opinion of the correct  
2740 diagnosis for purposes of authorizing future services under the  
2741 Medicaid program. This section does not restrict access to  
2742 emergency services or poststabilization care services as defined  
2743 in 42 C.F.R. part 438.114. Such confirmation or second opinion  
2744 shall be rendered in a manner approved by the agency. The agency  
2745 shall maximize the use of prepaid per capita and prepaid  
2746 aggregate fixed-sum basis services when appropriate and other  
2747 alternative service delivery and reimbursement methodologies,  
2748 including competitive bidding pursuant to s. 287.057, designed  
2749 to facilitate the cost-effective purchase of a case-managed  
2750 continuum of care. The agency shall also require providers to  
2751 minimize the exposure of recipients to the need for acute  
2752 inpatient, custodial, and other institutional care and the  
2753 inappropriate or unnecessary use of high-cost services. The  
2754 agency shall contract with a vendor to monitor and evaluate the  
2755 clinical practice patterns of providers in order to identify

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



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2785 review, provider Medicaid policy and billing compliance records,  
2786 clinical and medical record audits, and other factors. Providers  
2787 shall not be entitled to enrollment in the Medicaid provider  
2788 network. The agency shall determine instances in which allowing  
2789 Medicaid beneficiaries to purchase durable medical equipment and  
2790 other goods is less expensive to the Medicaid program than long-  
2791 term rental of the equipment or goods. The agency may establish  
2792 rules to facilitate purchases in lieu of long-term rentals in  
2793 order to protect against fraud and abuse in the Medicaid program  
2794 as defined in s. 409.913. The agency may seek federal waivers  
2795 necessary to administer these policies.

2796 (4) The agency may contract with:

2797 (b) An entity that is providing comprehensive behavioral  
2798 health care services to ~~certain~~ Medicaid recipients through a  
2799 capitated, prepaid arrangement pursuant to the federal waiver  
2800 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.  
2801 Such entity must be licensed under chapter 624, chapter 636, or  
2802 chapter 641, or authorized under paragraph (c) or paragraph (d),  
2803 and must possess the clinical systems and operational competence  
2804 to manage risk and provide comprehensive behavioral health care  
2805 to Medicaid recipients. As used in this paragraph, the term  
2806 "comprehensive behavioral health care services" means covered  
2807 mental health and substance abuse treatment services that are  
2808 available to Medicaid recipients. The Secretary ~~of the~~  
2809 ~~Department~~ of Children and Family Services must ~~shall~~ approve  
2810 ~~provisions of~~ procurements related to children in the  
2811 department's care or custody before enrolling such children in a  
2812 prepaid behavioral health plan. Any contract awarded under this  
2813 paragraph must be competitively procured. ~~In developing~~ The

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

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2843 networks, ~~to~~ be expended for the provision of behavioral health  
2844 care services. If the managed care plan expends less than 90 ~~80~~  
2845 percent ~~of the capitation paid~~ for the provision of behavioral  
2846 health care services, the difference shall be returned to the  
2847 agency. The agency shall provide the plan with a certification  
2848 letter indicating the amount of capitation paid during each  
2849 calendar year for behavioral health care services pursuant to  
2850 this section. The agency may reimburse ~~for~~ substance abuse  
2851 treatment services on a fee-for-service basis until the agency  
2852 finds that adequate funds are available for capitated, prepaid  
2853 arrangements.

2854 1. ~~By January 1, 2001,~~ The agency shall modify the  
2855 contracts with the entities providing comprehensive inpatient  
2856 and outpatient mental health care services to Medicaid  
2857 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk  
2858 Counties, to include substance abuse treatment services.

2859 2. ~~By July 1, 2003, the agency and the Department of~~  
2860 ~~Children and Family Services shall execute a written agreement~~  
2861 ~~that requires collaboration and joint development of all policy,~~  
2862 ~~budgets, procurement documents, contracts, and monitoring plans~~  
2863 ~~that have an impact on the state and Medicaid community mental~~  
2864 ~~health and targeted case management programs.~~

2865 2.3. Except as provided in subparagraph 5. 8., ~~by July 1,~~  
2866 ~~2006,~~ the agency and the Department of Children and Family  
2867 Services shall contract with managed care entities in each AHCA  
2868 area ~~except area 6~~ or arrange to provide comprehensive inpatient  
2869 and outpatient mental health and substance abuse services  
2870 through capitated prepaid arrangements to all Medicaid  
2871 recipients who are eligible to participate in such plans under

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

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2901 are enrolled in, or assigned to, the MediPass program. One of  
2902 the ~~behavioral health care~~ contracts must be with the existing  
2903 provider service network pilot project, as described in  
2904 paragraph (d), for the purpose of demonstrating the cost-  
2905 effectiveness of the provision of quality mental health services  
2906 through a public hospital-operated managed care model. Payment  
2907 shall be at an agreed-upon capitated rate to ensure cost  
2908 savings. Of the recipients in area 11 who are assigned to  
2909 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those  
2910 MediPass-enrolled recipients shall be assigned to the existing  
2911 provider service network in area 11 for their behavioral care.

2912 ~~4. By October 1, 2003, the agency and the department shall~~  
2913 ~~submit a plan to the Governor, the President of the Senate, and~~  
2914 ~~the Speaker of the House of Representatives which provides for~~  
2915 ~~the full implementation of capitated prepaid behavioral health~~  
2916 ~~care in all areas of the state.~~

2917 ~~a. Implementation shall begin in 2003 in those AHCA areas~~  
2918 ~~of the state where the agency is able to establish sufficient~~  
2919 ~~capitation rates.~~

2920 ~~b. If the agency determines that the proposed capitation~~  
2921 ~~rate in any area is insufficient to provide appropriate~~  
2922 ~~services, the agency may adjust the capitation rate to ensure~~  
2923 ~~that care will be available. The agency and the department may~~  
2924 ~~use existing general revenue to address any additional required~~  
2925 ~~match but may not over-obligate existing funds on an annualized~~  
2926 ~~basis.~~

2927 ~~e. Subject to any limitations provided in the General~~  
2928 ~~Appropriations Act, the agency, in compliance with appropriate~~  
2929 ~~federal authorization, shall develop policies and procedures~~

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2930 ~~that allow for certification of local and state funds.~~

2931 ~~3.5.~~ Children residing in a statewide inpatient psychiatric  
2932 program, or in a Department of Juvenile Justice or a Department  
2933 of Children and Family Services residential program approved as  
2934 a Medicaid behavioral health overlay services provider may not  
2935 be included in a behavioral health care prepaid health plan or  
2936 any other Medicaid managed care plan pursuant to this paragraph.

2937 ~~6.~~ ~~In converting to a prepaid system of delivery, the~~  
2938 ~~agency shall in its procurement document require an entity~~  
2939 ~~providing only comprehensive behavioral health care services to~~  
2940 ~~prevent the displacement of indigent care patients by enrollees~~  
2941 ~~in the Medicaid prepaid health plan providing behavioral health~~  
2942 ~~care services from facilities receiving state funding to provide~~  
2943 ~~indigent behavioral health care, to facilities licensed under~~  
2944 ~~chapter 395 which do not receive state funding for indigent~~  
2945 ~~behavioral health care, or reimburse the unsubsidized facility~~  
2946 ~~for the cost of behavioral health care provided to the displaced~~  
2947 ~~indigent care patient.~~

2948 ~~4.7.~~ Traditional community mental health providers under  
2949 contract with the Department of Children and Family Services  
2950 pursuant to part IV of chapter 394, ~~child welfare providers~~  
2951 ~~under contract with the Department of Children and Family~~  
2952 ~~Services in areas 1 and 6,~~ and inpatient mental health providers  
2953 licensed pursuant to chapter 395 must be offered an opportunity  
2954 to accept or decline a contract to participate in any provider  
2955 network for prepaid behavioral health services.

2956 ~~5.8.~~ All Medicaid-eligible children, except children in  
2957 area 1 and children in ~~Highlands County, Hardee County, Polk~~  
2958 ~~County, or Manatee County~~ in ~~of~~ area 6, whose cases ~~that~~ are

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

2983 (d) A provider service network, which may be reimbursed on  
2984 a fee-for-service or prepaid basis.

2985 1. A provider service network that ~~which~~ is reimbursed by  
2986 the agency on a prepaid basis is ~~shall be~~ exempt from parts I  
2987 and III of chapter 641, but must comply with the solvency

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2988 requirements in s. 641.2261(2) and meet appropriate financial  
2989 reserve, quality assurance, and patient rights requirements ~~as~~  
2990 established by the agency.

2991 2. ~~Medicaid recipients assigned to a provider service~~  
2992 ~~network shall be chosen equally from those who would otherwise~~  
2993 ~~have been assigned to prepaid plans and MediPass.~~ The agency may  
2994 ~~is authorized to~~ seek federal Medicaid waivers as necessary to  
2995 implement ~~the provisions of~~ this section. ~~Any contract~~  
2996 ~~previously awarded to a provider service network operated by a~~  
2997 ~~hospital pursuant to this subsection shall remain in effect for~~  
2998 ~~a period of 3 years following the current contract expiration~~  
2999 ~~date, regardless of any contractual provisions to the contrary.~~

3000 3. A provider service network is a network established or  
3001 organized and operated by a health care provider, or group of  
3002 affiliated health care providers, including minority physician  
3003 networks and emergency room diversion programs that meet the  
3004 requirements of s. 409.986 ~~409.91211~~, which provides a  
3005 substantial proportion of the health care items and services  
3006 under a contract directly through the provider or affiliated  
3007 group of providers and may make arrangements with physicians or  
3008 other health care professionals, health care institutions, or  
3009 any combination of such individuals or institutions to assume  
3010 all or part of the financial risk on a prospective basis for the  
3011 provision of basic health services by the physicians, by other  
3012 health professionals, or through the institutions. The health  
3013 care providers must have a controlling interest in the governing  
3014 body of the provider service network organization.

3015 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum  
3016 basis with an exclusive provider organization to provide health



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3017 care services to Medicaid recipients if provided that the  
3018 exclusive provider organization meets applicable managed care  
3019 plan requirements in this section, ss. 409.987, 409.988  
3020 ~~409.9122, 409.9123,~~ 409.9128, and 627.6472, and other applicable  
3021 provisions of law.

3022 ~~(b) For a period of no longer than 24 months after the~~  
3023 ~~effective date of this paragraph, when a member of an exclusive~~  
3024 ~~provider organization that is contracted by the agency to~~  
3025 ~~provide health care services to Medicaid recipients in rural~~  
3026 ~~areas without a health maintenance organization obtains services~~  
3027 ~~from a provider that participates in the Medicaid program in~~  
3028 ~~this state, the provider shall be paid in accordance with the~~  
3029 ~~appropriate fee schedule for services provided to eligible~~  
3030 ~~Medicaid recipients. The agency may seek waiver authority to~~  
3031 ~~implement this paragraph.~~

3032 (34) The agency and entities that contract with the agency  
3033 to provide health care services to Medicaid recipients under  
3034 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~  
3035 must comply with the provisions of s. 641.513 in providing  
3036 emergency services and care to Medicaid recipients and MediPass  
3037 recipients. Where feasible, safe, and cost-effective, the agency  
3038 shall encourage hospitals, emergency medical services providers,  
3039 and other public and private health care providers to work  
3040 together in their local communities to enter into agreements or  
3041 arrangements to ensure access to alternatives to emergency  
3042 services and care for those Medicaid recipients who need  
3043 nonemergent care. The agency shall coordinate with hospitals,  
3044 emergency medical services providers, private health plans,  
3045 capitated managed care networks as established in s. 409.986

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3046 ~~409.91211~~, and other public and private health care providers to  
3047 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),  
3048 627.6405, and 641.31097 to develop and implement emergency  
3049 department diversion programs for Medicaid recipients.

3050 (44) The agency ~~for Health Care Administration~~ shall ensure  
3051 that any Medicaid managed care plan as defined in s.  
3052 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis  
3053 or a shared savings basis, is cost-effective. For purposes of  
3054 this subsection, the term "cost-effective" means that a  
3055 network's per-member, per-month costs to the state, including,  
3056 but not limited to, fee-for-service costs, administrative costs,  
3057 and case-management fees, if any, must be no greater than the  
3058 state's costs associated with contracts for Medicaid services  
3059 established under subsection (3), which may be adjusted for  
3060 health status. The agency shall conduct actuarially sound  
3061 adjustments for health status in order to ensure such cost-  
3062 effectiveness and shall annually publish the results on its  
3063 Internet website. Contracts established pursuant to this  
3064 subsection which are not cost-effective may not be renewed.

3065 ~~(47) The agency shall conduct a study of available~~  
3066 ~~electronic systems for the purpose of verifying the identity and~~  
3067 ~~eligibility of a Medicaid recipient. The agency shall recommend~~  
3068 ~~to the Legislature a plan to implement an electronic~~  
3069 ~~verification system for Medicaid recipients by January 31, 2005.~~

3070 ~~(53) Before seeking an amendment to the state plan for~~  
3071 ~~purposes of implementing programs authorized by the Deficit~~  
3072 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~

3073 Section 30. Paragraph (a) of subsection (1) of section  
3074 409.915, Florida Statutes, is amended to read:

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3075 409.915 County contributions to Medicaid.—Although the  
3076 state is responsible for the full portion of the state share of  
3077 the matching funds required for the Medicaid program, in order  
3078 to acquire a certain portion of these funds, the state shall  
3079 charge the counties for certain items of care and service as  
3080 provided in this section.

3081 (1) Each county shall participate in the following items of  
3082 care and service:

3083 (a) For both health maintenance members and fee-for-service  
3084 beneficiaries, payments for inpatient hospitalization in excess  
3085 of 10 days, but not in excess of 45 days, with the exception of  
3086 pregnant women and children whose income is greater than ~~in~~  
3087 ~~excess of~~ the federal poverty level and who do not receive a  
3088 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~  
3089 ~~medically needy Program~~, and for adult lung transplant services.

3090 Section 31. Section 409.9301, Florida Statutes, is  
3091 transferred, renumbered as section 409.9067, Florida Statutes,  
3092 and subsections (1) and (2) of that section are amended, to  
3093 read:

3094 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—

3095 (1) PROGRAM ESTABLISHED.—A program is established in the  
3096 agency ~~for Health Care Administration~~ to provide pharmaceutical  
3097 expense assistance to individuals diagnosed with cancer or  
3098 individuals who have obtained ~~received~~ organ transplants who  
3099 received a Medicaid nonpoverty medical subsidy before ~~were~~  
3100 ~~medically needy recipients prior to~~ January 1, 2006.

3101 (2) ELIGIBILITY.—Eligibility for the program is limited to  
3102 an individual who:

3103 (a) Is a resident of this state;

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3104 (b) Was a Medicaid recipient who received a nonpoverty  
3105 medical subsidy before ~~under the Florida Medicaid medically~~  
3106 ~~needy program prior to~~ January 1, 2006;

3107 (c) Is eligible for Medicare;

3108 (d) Is a cancer patient or an organ transplant recipient;  
3109 and

3110 (e) Requests to be enrolled in the program.

3111 Section 32. Subsection (1) of section 409.9126, Florida  
3112 Statutes, is amended to read:

3113 409.9126 Children with special health care needs.—

3114 (1) Except as provided in subsection (4), children eligible  
3115 for Children's Medical Services who receive Medicaid benefits,  
3116 and other Medicaid-eligible children with special health care  
3117 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987  
3118 ~~409.9122~~ and shall be served through the Children's Medical  
3119 Services network established in chapter 391.

3120 Section 33. The Division of Statutory Revision is requested  
3121 to create part IV of chapter 409, Florida Statutes, consisting  
3122 of sections 409.961-409.978, Florida Statutes, entitled  
3123 "MEDICAID MANAGED CARE."

3124 Section 34. Section 409.961, Florida Statutes, is created  
3125 to read:

3126 409.961 Construction; applicability.—It is the intent of  
3127 the Legislature that if any conflict exists between ss. 409.961-  
3128 409.978 and other parts or sections of this chapter, the  
3129 provisions in ss. 409.961-409.978 control. Sections 409.961-  
3130 409.978 apply only to the Medicaid managed care program, as  
3131 provided in this part.

3132 Section 35. Section 409.962, Florida Statutes, is created

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3133 to read:

3134 409.962 Definitions.—As used in this part, and including  
3135 the terms defined in s. 409.901, the term:

3136 (1) "Direct care management" means care management  
3137 activities that involve direct interaction between providers and  
3138 patients.

3139 (2) "Home and community-based services" means a specific  
3140 set of services designed to assist recipients qualifying under  
3141 s. 409.974 in avoiding institutionalization.

3142 (3) "Medicaid managed care program" means the integrated,  
3143 statewide Medicaid program created in this part, which includes  
3144 the provision of managed care medical assistance services  
3145 described in ss. 409.971 and 409.972 and managed long-term care  
3146 services described in ss. 409.973-409.978.

3147 (4) "Provider service network" means an entity of which a  
3148 controlling interest is owned by, or a controlling interest in  
3149 the governing body of the entity is composed of, a health care  
3150 provider, a group of affiliated providers, or a public agency or  
3151 entity that delivers health services. For purposes of this  
3152 chapter, health care providers include Florida-licensed health  
3153 care professionals, Florida-licensed health care facilities,  
3154 federally qualified health centers, and home health care  
3155 agencies.

3156 (5) "Qualified plan" means a managed care plan that is  
3157 determined eligible to participate in the Medicaid managed care  
3158 program pursuant to s. 409.965.

3159 (6) "Specialty plan" means a qualified plan that serves  
3160 Medicaid recipients who meet specified criteria based on age,  
3161 medical condition, or diagnosis.

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3162 Section 36. Section 409.963, Florida Statutes, is created  
3163 to read:

3164 409.963 Medicaid managed care program.—The Medicaid managed  
3165 care program is established as a statewide, integrated managed  
3166 care program for all covered medical assistance services and  
3167 long-term care services as provided under this part. Pursuant to  
3168 s. 409.902, the program shall be administered by the agency, and  
3169 eligibility for the program shall be determined by the  
3170 Department of Children and Family Services.

3171 (1) The agency shall submit amendments to the Medicaid  
3172 state plan or to existing waivers, or submit new waiver requests  
3173 under section 1115 or other applicable sections of the Social  
3174 Security Act, by August 1, 2011, as needed to implement the  
3175 managed care program. At a minimum, the waiver requests must  
3176 include a waiver that allows home and community-based services  
3177 to be preferred over nursing home services for persons who can  
3178 be safely managed in the home and community, and a waiver that  
3179 requires dually eligible recipients to participate in the  
3180 Medicaid managed care program. The waiver requests must also  
3181 include provisions authorizing the state to limit enrollment in  
3182 managed long-term care, establish waiting lists, and limit the  
3183 amount, duration, and scope of home and community-based services  
3184 to ensure that expenditures for persons eligible for managed  
3185 long-term care services do not exceed funds provided in the  
3186 General Appropriations Act.

3187 (a) The agency shall initiate any necessary procurements  
3188 required to implement the managed care program as soon as  
3189 practicable, but no later than July 1, 2011, in anticipation of  
3190 prompt approval of the waivers needed for the managed care

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3191 program by the United States Department of Health and Human  
3192 Services.

3193 (b) In submitting waivers, the agency shall work with the  
3194 federal Centers for Medicare and Medicaid Services to accomplish  
3195 approval of all waivers by December 1, 2011, in order to begin  
3196 implementation of the managed care program by December 31, 2011.

3197 (c) Before seeking a waiver, the agency shall provide  
3198 public notice and the opportunity for public comment and include  
3199 public feedback in the waiver application.

3200 (2) The agency shall begin implementation of the Medicaid  
3201 managed care program on December 31, 2011. If waiver approval is  
3202 obtained, the program shall be implemented in accordance with  
3203 the terms and conditions of the waiver. If necessary waivers  
3204 have not been timely received, the agency shall notify the  
3205 Centers for Medicare and Medicaid Services of the state's  
3206 implementation of the managed care program and request the  
3207 federal agency to continue providing federal funds equivalent to  
3208 the funding level provided under the Federal Medical Assistance  
3209 Percentage in order to implement the managed care program.

3210 (a) If the Centers for Medicare and Medicaid Services  
3211 refuses to continue providing federal funds, the managed care  
3212 program shall be implemented as a state-only funded program to  
3213 the extent state funds are available.

3214 (b) If implemented as a state-only funded program, priority  
3215 shall be given to providing:

3216 1. Nursing home services to persons eligible for nursing  
3217 home care.

3218 2. Medical services to persons served by the Agency for  
3219 Persons with Disabilities.

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



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

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3278 paragraph, access to health care coverage through an employer-  
3279 sponsored health plan means that the Medicaid financial  
3280 assistance available to the person is sufficient to pay the  
3281 premium for the employer-sponsored health plan for the eligible  
3282 person and his or her Medicaid eligible family members.

3283 1. The agency shall develop a process that allows a  
3284 recipient who has access to employer-sponsored health coverage  
3285 to use Medicaid financial assistance to pay the cost of the  
3286 premium for the recipient and the recipient's Medicaid-eligible  
3287 family members for such coverage. The amount of financial  
3288 assistance may not exceed the Medicaid capitated rate that would  
3289 have been paid to a qualified plan for that recipient and the  
3290 recipient's family members.

3291 2. Contingent upon federal approval, the agency shall also  
3292 allow recipients who have access to other insurance or coverage  
3293 created pursuant to state or federal law to opt out of Medicaid  
3294 managed care and apply the Medicaid capitated rate that would  
3295 have been paid to a qualified plan for that recipient and the  
3296 recipient's family to pay for the other insurance product.

3297 (2) The following Medicaid recipients are exempt from  
3298 mandatory enrollment in the managed care program but may  
3299 volunteer to participate in the program:

3300 (a) Recipients residing in residential commitment  
3301 facilities operated through the Department of Juvenile Justice,  
3302 group care facilities operated by the Department of Children and  
3303 Family Services, or treatment facilities funded through the  
3304 substance abuse and mental health program of the Department of  
3305 Children and Family Services.

3306 (b) Persons eligible for refugee assistance.

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3307       (3) Medicaid recipients who are exempt from mandatory  
3308 participation under this section and who do not choose to enroll  
3309 in the Medicaid managed care program shall be served though the  
3310 Medicaid fee-for-service program as provided under part III of  
3311 this chapter.

3312       Section 38. Section 409.965, Florida Statutes, is created  
3313 to read:

3314       409.965 Qualified plans; regions; selection criteria.-  
3315 Services in the Medicaid managed care program shall be provided  
3316 by qualified plans.

3317       (1) The agency shall select qualified plans to participate  
3318 in the Medicaid managed care program using an invitation to  
3319 negotiate issued pursuant to s. 287.057.

3320       (a) The agency shall notice separate invitations to  
3321 negotiate for the managed medical assistance component and the  
3322 managed long-term care component of the managed care program.

3323       (b) At least 30 days before noticing the invitation to  
3324 negotiate and annually thereafter, the agency shall compile and  
3325 publish a databook consisting of a comprehensive set of  
3326 utilization and spending data for the 3 most recent contract  
3327 years, consistent with the rate-setting periods for all Medicaid  
3328 recipients by region and county. Pursuant to s. 409.970, the  
3329 source of the data must include both historic fee-for-service  
3330 claims and validated data from the Medicaid Encounter Data  
3331 System. The report shall be made available electronically and  
3332 must delineate utilization by age, gender, eligibility group,  
3333 geographic area, and acuity level.

3334       (2) Separate and simultaneous procurements shall be  
3335 conducted in each of the following regions:

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

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3365 (q) Region 17, which consists of Brevard and Seminole  
3366 counties.

3367 (r) Region 18, which consists of Indian River, Martin,  
3368 Okeechobee, and St. Lucie counties.

3369 (s) Region 19, which consists of Charlotte, Collier,  
3370 Glades, Hendry, and Lee counties.

3371 (3) The invitation to negotiate must specify the criteria  
3372 and the relative weight of the criteria to be used for  
3373 determining the acceptability of a reply and guiding the  
3374 selection of qualified plans with which the agency shall  
3375 contract. In addition to other criteria developed by the agency,  
3376 the agency shall give preference to the following factors in  
3377 selecting qualified plans:

3378 (a) Accreditation by the National Committee for Quality  
3379 Assurance or another nationally recognized accrediting body.

3380 (b) Experience serving similar populations, including the  
3381 organization's record in achieving specific quality standards  
3382 for similar populations.

3383 (c) Availability and accessibility of primary care and  
3384 specialty physicians in the provider network.

3385 (d) Establishment of partnerships with community providers  
3386 that provide community-based services.

3387 (e) The organization's commitment to quality improvement  
3388 and documentation of achievements in specific quality-  
3389 improvement projects, including active involvement by the  
3390 organization's leadership.

3391 (f) Provision of additional benefits, particularly dental  
3392 care for all recipients, disease management, and other programs  
3393 offering additional benefits.

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3394 (g) Establishment of incentive programs that reward  
3395 specific behaviors with health-related benefits not otherwise  
3396 covered by the organizations' benefit plan. Such behaviors may  
3397 include participation in smoking-cessation programs, weight-loss  
3398 programs, or other activities designed to mitigate lifestyle  
3399 choices and avoid behaviors associated with the use of high-cost  
3400 medical services.

3401 (h) Organizations without a history of voluntary or  
3402 involuntary withdrawal from any state Medicaid program or  
3403 program area.

3404 (i) Evidence that an organization has written agreements or  
3405 signed contracts or has made substantial progress in  
3406 establishing relationships with providers before the  
3407 organization submits a reply. The agency shall evaluate such  
3408 evidence based on the following factors:

3409 1. Contracts with primary care and specialty physicians in  
3410 sufficient numbers to meet the specific performance standards  
3411 established pursuant to s. 409.966(2) (b).

3412 2. Specific arrangements that provide evidence that the  
3413 compensation offered by the plan is sufficient to retain primary  
3414 care and specialty physicians in sufficient numbers to comply  
3415 with the performance standards established pursuant to s.  
3416 409.966(2) throughout the 5-year contract term. The agency shall  
3417 give preference to plans that provide evidence that primary care  
3418 physicians within the plan's provider network will be  
3419 compensated for primary care services with payments equivalent  
3420 to or greater than payments for such services under the Medicare  
3421 program, whether compensation is made on a fee-for-service basis  
3422 or by sub-capitation.

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3423 3. Contracts with community pharmacies located in rural  
3424 areas; contracts with community pharmacies serving specialty  
3425 disease populations, including, but not limited to, HIV/AIDS  
3426 patients, hemophiliacs, patients suffering from end-stage renal  
3427 disease, diabetes, or cancer; community pharmacies located  
3428 within distinct cultural communities that reflect the unique  
3429 cultural dynamics of such communities, including, but not  
3430 limited to, languages spoken, ethnicities served, unique disease  
3431 states serviced, and geographic location within the  
3432 neighborhoods of culturally distinct populations; and community  
3433 pharmacies providing value-added services to patients, such as  
3434 free delivery, immunizations, disease management, diabetes  
3435 education, and medication utilization review.

3436 4. Contracts with cancer disease management programs that  
3437 have a proven record of clinical efficiencies and cost savings.

3438 5. Contracts with diabetes disease management programs that  
3439 have a proven record of clinical efficiencies and cost savings.

3440 (j) The capitated rates provided in the reply to the  
3441 invitation to negotiate.

3442 (k) Establishment of a claims payment process to ensure  
3443 that claims that are not contested or denied will be paid within  
3444 20 days after receipt.

3445 (l) Utilizing a tiered approach, organizations that are  
3446 based in Florida and have operational functions performed in  
3447 Florida, either performed in-house or through contractual  
3448 arrangements, by Florida-employed staff. The highest number of  
3449 points shall be awarded to any plan with all or substantially  
3450 all of its operational functions performed in the state. The  
3451 second highest number of points shall be awarded to any plan

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3452 with a majority of its operational functions performed in the  
3453 state. The agency may establish a third tier; however, no  
3454 preference points shall be awarded to plans that perform only  
3455 community outreach, medical director functions, and state  
3456 administrative functions in the state. For purposes of this  
3457 paragraph, operational functions include claims processing,  
3458 member services, provider relations, utilization and prior  
3459 authorization, case management, disease and quality functions,  
3460 and finance and administration. For purposes of this paragraph,  
3461 "based in Florida" means that the entity's principal office is  
3462 in Florida and the plan is not a subsidiary, directly or  
3463 indirectly through one or more subsidiaries of, or a joint  
3464 venture with, any other entity whose principal office is not  
3465 located in the state.

3466 (m) For long-term care plans, additional criteria as  
3467 specified in s. 409.976(3).

3468 (4) Acceptable replies to the invitation to negotiate for  
3469 each region shall be ranked, and the agency shall select the  
3470 number of qualified plans with which to contract in each region.

3471 (a) The agency may not select more than one plan per 20,000  
3472 Medicaid recipients residing in the region who are subject to  
3473 mandatory managed care enrollment, except that, in addition to  
3474 the Children's Medical Services Network, a region may not have  
3475 fewer than three or more than 10 qualified plans for the managed  
3476 medical assistance or the managed long-term care components of  
3477 the program.

3478 (b) If the funding available in the General Appropriations  
3479 Act is not adequate to meet the proposed statewide requirement  
3480 under the Medicaid managed care program, the agency shall enter



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3481 into negotiations with qualified plans that responded to the  
3482 invitation to negotiate. The negotiation process may alter the  
3483 rank of a qualified plan. If negotiations are conducted, the  
3484 agency shall select qualified plans that are responsive and  
3485 provide the best value to the state.

3486 (5) The agency may issue a new invitation to negotiate in  
3487 any region:

3488 (a) At any time if:

3489 1. Data becomes available to the agency indicating that the  
3490 population of recipients residing in the region who are subject  
3491 to mandatory managed care enrollment cannot be served by the  
3492 plans under contract with the agency in that region or has  
3493 increased by more than 20,000 since the most recent invitation  
3494 to negotiate was issued in that region; and

3495 2. The agency has not contracted with the maximum number of  
3496 plans authorized for that region.

3497 (b) At any time during the first 2 years after the initial  
3498 contract period and upon the request of a qualified plan under  
3499 contract in one or more regions if:

3500 1. Data becomes available to the agency indicating that the  
3501 population of Medicaid recipients residing in the region who are  
3502 subject to mandatory managed care enrollment has increased by  
3503 more than 20,000 since the initial invitation to negotiate was  
3504 issued for the contract period; and

3505 2. The agency has not contracted with the maximum number of  
3506 plans authorized for that region.

3507  
3508 The term of a contract executed under this subsection shall be  
3509 for the remainder of the 5-year contract cycle.

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3510       (6) The Children's Medical Services Network authorized  
3511 under chapter 391 is a qualified plan for purposes of the  
3512 managed care medical assistance component of the Medicaid  
3513 managed care program. Participation by the network shall be  
3514 pursuant to a single statewide contract with the agency which is  
3515 not subject to the procurement requirements of this section. The  
3516 network must meet all other plan requirements for the managed  
3517 care medical assistance component of the program.

3518       (7) In order to allow a provider service network in rural  
3519 areas sufficient time to develop an adequate provider network to  
3520 participate in the Medicaid managed care program on a capitated  
3521 basis, the network may submit an application or invitation to  
3522 negotiate after July 1, 2011, as required by the agency, for a  
3523 region where there was no Medicaid-contracted health maintenance  
3524 organization or provider service network on July 1, 2011. For  
3525 the first 12 months that the network operates in the region, the  
3526 agency shall assign existing Medicaid provider agreements to the  
3527 provider service network for purposes of administering managed  
3528 care services and building an adequate provider network to meet  
3529 the access standards established by the agency.

3530       Section 39. Section 409.966, Florida Statutes, is created  
3531 to read:

3532       409.966 Plan contracts.—

3533       (1) The agency shall execute a 5-year contract with each  
3534 qualified plan selected through the procurement process  
3535 described in s. 409.965. A contract between the agency and the  
3536 qualified plan may be amended annually, or as needed, to reflect  
3537 capitated rate adjustments due to funding availability pursuant  
3538 to the General Appropriations Act and ss. 409.9022, 409.972, and

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3539 409.975(2).

3540 (a) A plan contract may not be renewed; however, the agency  
3541 may extend the term of a contract, keeping intact all  
3542 operational provisions in the contract, including capitation  
3543 rates, to cover any delays in transitioning to a new plan.

3544 (b) If a plan applies for a rate increase that is not the  
3545 result of a solicitation from the agency and the application for  
3546 rate increase is not timely withdrawn, the plan will be deemed  
3547 to have submitted a notice of intent to leave the region before  
3548 the end of the contract term.

3549 (2) The agency shall establish such contract requirements  
3550 as are necessary for the operation of the Medicaid managed care  
3551 program. In addition to any other provisions the agency may deem  
3552 necessary, the contract must require:

3553 (a) Access.—The agency shall establish specific standards  
3554 for the number, type, and regional distribution of providers in  
3555 plan networks in order to ensure access to care. Each qualified  
3556 plan shall:

3557 1. Maintain a network of providers in sufficient numbers to  
3558 meet the access standards for specified services for all  
3559 recipients enrolled in the plan.

3560 2. Establish and maintain an accurate and complete  
3561 electronic database of contracted providers, including  
3562 information about licensure or registration, locations and hours  
3563 of operation, specialty credentials and other certifications,  
3564 specific performance indicators, and such other information as  
3565 the agency deems necessary. The provider database must be  
3566 available online to both the agency and the public and allow  
3567 comparison of the availability of providers to network adequacy

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3568 standards, and accept and display feedback from each provider's  
3569 patients.

3570 3. Provide for reasonable and adequate hours of operation,  
3571 including 24-hour availability of information, referral, and  
3572 treatment for emergency medical conditions.

3573 4. Assign each new enrollee to a primary care provider and  
3574 ensure that an appointment with that provider has been scheduled  
3575 within 30 days after the enrollment in the plan.

3576 5. Submit quarterly reports to the agency identifying the  
3577 number of enrollees assigned to each primary care provider.

3578 (b) Performance standards.—The agency shall establish  
3579 specific performance standards and expected milestones or  
3580 timelines for improving plan performance over the term of the  
3581 contract.

3582 1. Each plan shall establish an internal health care  
3583 quality improvement system that includes enrollee satisfaction  
3584 and disenrollment surveys and incentives and disincentives for  
3585 network providers.

3586 2. Each plan must collect and report the Health Plan  
3587 Employer Data and Information Set (HEDIS) measures, as specified  
3588 by the agency. These measures must be published on the plan's  
3589 website in a manner that allows recipients to reliably compare  
3590 the performance of plans. The agency shall use the HEDIS  
3591 measures as a tool to monitor plan performance.

3592 3. A qualified plan that is not accredited when the  
3593 contract is executed with the agency must become accredited or  
3594 have initiated the accreditation process within 1 year after the  
3595 contract is executed. If the plan is not accredited within 18  
3596 months after executing the contract, the plan shall be suspended

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3597 from automated enrollments pursuant to s. 409.969(2).

3598 4. In addition to agency standards, a qualified plan must  
3599 ensure that the agency is notified of the impending birth of a  
3600 child to an enrollee or as soon as practicable after the child's  
3601 birth. Upon the birth, the child is deemed enrolled with the  
3602 qualified plan, regardless of the administrative enrollment  
3603 procedures, and the qualified plan is responsible for providing  
3604 Medicaid services to the child on a capitated basis.

3605 (c) Program integrity.—Each plan shall establish program  
3606 integrity functions and activities in order to reduce the  
3607 incidence of fraud and abuse, including, at a minimum:

3608 1. A provider credentialing system and ongoing provider  
3609 monitoring. Each plan must verify at least annually that all  
3610 providers have a valid and unencumbered license or permit to  
3611 provide services to Medicaid recipients, and shall establish a  
3612 procedure for providers to notify the plan when the provider has  
3613 been notified by a licensing or regulatory agency that the  
3614 provider's license or permit is to be revoked or suspended, or  
3615 when an event has occurred which would prevent the provider from  
3616 renewing its license or permit. The provider must also notify  
3617 the plan if the license or permit is revoked or suspended, if  
3618 renewal of the license or permit is denied or expires by  
3619 operation of law, or if the provider requests that the license  
3620 or permit be inactivated. The plan must immediately exclude a  
3621 provider from the plan's provider network if the provider's  
3622 license is suspended or invalid. However, this section does not  
3623 preclude a plan from contracting with a provider that is  
3624 approved via a final order, has commenced construction, and will  
3625 be licensed and operational within 18 months after the effective

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3626 date of this act;

3627 2. An effective prepayment and postpayment review process  
3628 that includes, at a minimum, data analysis, system editing, and  
3629 auditing of network providers;

3630 3. Procedures for reporting instances of fraud and abuse  
3631 pursuant to s. 409.91212;

3632 4. The establishment of an anti-fraud plan pursuant to s.  
3633 409.91212; and

3634 5. Designation of a program integrity compliance officer.

3635 (d) *Encounter data.*—Each plan must comply with the agency's  
3636 reporting requirements for the Medicaid Encounter Data System  
3637 under s. 409.970. The agency shall assess a fine of \$5,000 per  
3638 day against a qualified plan for failing to comply with this  
3639 requirement. If a plan fails to comply for more than 30 days,  
3640 the agency shall assess a fine of \$10,000 per day beginning on  
3641 the 31st day. If a plan is fined \$300,000 or more for failing to  
3642 comply, in addition to paying the fine, the plan shall be  
3643 disqualified from the Medicaid managed care program for 3 years.  
3644 If the plan is disqualified, the plan shall be deemed to have  
3645 terminated its contract before the scheduled end date and shall  
3646 also be subject to applicable penalties under paragraph (1).  
3647 However, the agency may waive or reduce the fine upon a showing  
3648 of good cause for the failure to comply.

3649 (e) *Electronic claims and prior authorization requests.*—  
3650 Plans shall accept electronic claims that are in compliance with  
3651 federal standards and accept electronic prior authorization  
3652 requests from prescribers and pharmacists for medication  
3653 exceptions to the preferred drug list or formulary. The criteria  
3654 for the approval and the reasons for denial of prior

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3655 authorization requests shall be made readily available to  
3656 prescribers and pharmacists submitting the request.

3657 (f) Prompt payment.—All qualified plans must comply with  
3658 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay  
3659 nursing homes by the 10th day of the month for enrollees who are  
3660 residing in the nursing home on the 1st day of the month.  
3661 Payment for the month in which an enrollee initiates residency  
3662 in a nursing home shall be in accordance with s. 641.3155. On an  
3663 annual basis, qualified plans shall submit a report certifying  
3664 compliance with the prompt payment requirements for the plan  
3665 year.

3666 (g) Emergency services.—Qualified plans must pay for  
3667 emergency services and care required under ss. 395.1041 and  
3668 401.45 and rendered by a noncontracted provider in accordance  
3669 with the prompt payment standards established in s. 641.3155.  
3670 The payment rate shall be the fee-for-service rate the agency  
3671 would pay the noncontracted provider for such services, unless  
3672 the agency has developed an average rate for the noncontracted  
3673 provider for such services under s. 409.967(3)(c). If the agency  
3674 has developed an average rate for the noncontracted provider for  
3675 such services under s. 409.967(3)(c), the payment rate for such  
3676 services under this paragraph shall be the average rate  
3677 developed by the agency for the noncontracted provider for such  
3678 services under s. 409.967(3)(c).

3679 (h) Surety bond.—A qualified plan shall post and maintain a  
3680 surety bond with the agency, payable to the agency, or in lieu  
3681 of a surety bond, establish and maintain an irrevocable letter  
3682 of credit or a deposit in a trust account in a financial  
3683 institution, payable to the agency.

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3684       1. The amount of the surety bond, letter of credit, or  
3685 trust account shall be 125 percent of the estimated annual  
3686 guaranteed savings for each qualified plan, and at least \$2  
3687 million but no more than \$15 million for each qualified plan.  
3688 The estimated guaranteed savings shall be calculated before the  
3689 execution of the contract as follows:

3690       a. The agreed-upon monthly contractual capitated rate for  
3691 each level of acuity multiplied by the estimated population in  
3692 the region for the plan for each level of acuity, multiplied by  
3693 12 months, multiplied by 7 percent, multiplied by 125 percent.

3694       b. The estimated population in the region for the plan  
3695 under sub-subparagraph a. shall be based on the maximum enrollee  
3696 level that the agency initially authorizes. The factors that the  
3697 agency may consider in determining the maximum enrollee level  
3698 include, but are not limited to, requested capacity, projected  
3699 enrollment, network adequacy, and the available budget in the  
3700 General Appropriations Act.

3701       2. The purpose of the surety bond, letter of credit, or  
3702 trust account is to protect the agency if the entity terminates  
3703 its contract with the agency before the scheduled end date for  
3704 the contract, if the plan fails to comply with the terms of the  
3705 contract, including, but not limited to, the timely submission  
3706 of encounter data, if the agency imposes fines or penalties for  
3707 noncompliance, or if the plan fails to achieve the guaranteed  
3708 savings. If any of those events occurs, the agency shall first  
3709 request payment from the qualified plan. If the qualified plan  
3710 does not pay all costs, fines, penalties, or the differential in  
3711 the guaranteed savings in full within 30 days, the agency shall  
3712 pursue a claim against the surety bond, letter of credit, or



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3713 trust account for all applicable moneys and the legal and  
3714 administrative costs associated with pursuing such claim.

3715 (i) Grievance resolution.—Each plan shall establish and the  
3716 agency shall approve an internal process for reviewing and  
3717 responding to grievances from enrollees consistent with s.  
3718 641.511. Each plan shall submit quarterly reports to the agency  
3719 on the number, description, and outcome of grievances filed by  
3720 enrollees.

3721 (j) Solvency.—A qualified plan must meet and maintain the  
3722 surplus and solvency requirements under s. 409.912(17) and (18).  
3723 A provider service network may satisfy the surplus and solvency  
3724 requirements if the network's performance and financial  
3725 obligations are guaranteed in writing by an entity licensed by  
3726 the Office of Insurance Regulation which meets the surplus and  
3727 solvency requirements of s. 624.408 or s. 641.225.

3728 (k) Guaranteed savings.—During the first contract period, a  
3729 qualified plan must agree to provide a guaranteed minimum  
3730 savings of 7 percent to the state. The agency shall conduct a  
3731 cost reconciliation to determine the amount of cost savings  
3732 achieved by the qualified plan compared with the reimbursements  
3733 the agency would have incurred under fee-for-service provisions.

3734 (l) Costs and penalties.—Plans that reduce enrollment  
3735 levels or leave a region before the end of the contract term  
3736 must reimburse the agency for the cost of enrollment changes and  
3737 other transition activities. If more than one plan leaves a  
3738 region at the same time, costs shall be shared by the departing  
3739 plans proportionate to their enrollment. In addition to the  
3740 payment of costs, departing plans must pay a penalty of 1  
3741 month's payment calculated as an average of the past 12 months

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3742 of payments, or since inception if the plan has not contracted  
3743 with the agency for 12 months, plus the differential of the  
3744 guaranteed savings based on the original contract term and the  
3745 corresponding termination date. Plans must provide the agency  
3746 with at least 180 days' notice before withdrawing from a region.

3747 (m) Formulary.—Upon recommendation of the Medicaid  
3748 Pharmaceutical and Therapeutics Committee as defined in s.  
3749 409.91195, all qualified plans must adopt a standard minimum  
3750 preferred drug list as described in s. 409.912(39). A plan may  
3751 offer additional products on its formulary. Each plan must  
3752 publish an up-to-date listing of its formulary on a publicly  
3753 available website.

3754 (3) If the agency terminates more than one regional  
3755 contract with a qualified plan due to the plan's noncompliance  
3756 with one or more requirements of this section, the agency shall  
3757 terminate all regional contracts with the plan under the  
3758 Medicaid managed care program, as well as any other contracts or  
3759 agreements for other programs or services, and the plan may not  
3760 be awarded new contracts for 3 years.

3761 Section 40. Section 409.967, Florida Statutes, is created  
3762 to read:

3763 409.967 Plan accountability.—In addition to the contract  
3764 requirements of s. 409.966, plans and providers participating in  
3765 the Medicaid managed care program must comply with this section.

3766 (1) The agency shall require qualified plans to use a  
3767 uniform method of reporting and accounting for medical, direct  
3768 care management, and nonmedical costs and shall evaluate plan-  
3769 spending patterns after the plan completes 2 full years of  
3770 operation and at least annually thereafter.

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3771       (2) The agency shall establish and the qualified plans  
3772 shall use a uniform method for annually reporting premium  
3773 revenue, medical and administrative costs, and income or losses  
3774 across all state Medicaid prepaid plan lines of business in all  
3775 regions. The reports are due to the agency within 270 days after  
3776 the conclusion of the reporting period, and the agency may audit  
3777 the reports. Achieved savings rebates are due within 30 days  
3778 after the report is submitted.

3779       (a) Except as provided in paragraph (b), the achieved  
3780 savings rebate is established by determining pretax income as a  
3781 percentage of revenues and applying the following income sharing  
3782 ratios:

3783       1. One hundred percent of income up to and including 5  
3784 percent of revenue shall be retained by the plan.

3785       2. Fifty percent of income above 5 percent and up to 10  
3786 percent shall be retained by the plan, with the other 50 percent  
3787 refunded to the state.

3788       3. One hundred percent of income above 10 percent of  
3789 revenue shall be refunded to the state.

3790       (b) A plan that meets or exceeds agency defined quality  
3791 measures in the reporting period may retain an additional 1  
3792 percent of revenue.

3793       (c) The following expenses may not be included in  
3794 calculating income to the plan:

3795       1. Payment of achieved savings rebates.

3796       2. Any financial incentive payments made to the plan  
3797 outside of the capitation rate.

3798       3. Any financial disincentive payments levied by the state  
3799 or federal governments.

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3800 4. Expenses associated with lobbying activities.

3801 5. Administrative, reinsurance, and outstanding claims  
3802 expenses in excess of actuarially sound maximum amounts set by  
3803 the agency.

3804 (d) Qualified plans that incur a loss in the first contract  
3805 year may apply the full amount of the loss as an offset to  
3806 income in the second contract year.

3807 (e) If, after an audit or other reconciliation, the agency  
3808 determines that a qualified plan owes an additional rebate, the  
3809 plan has 30 days after notification to make payment. Upon  
3810 failure to timely pay the rebate, the agency shall withhold  
3811 future payments to the plan until the entire amount is recouped.  
3812 If the agency determines that a plan has made an overpayment,  
3813 the agency shall return the overpayment within 30 days.

3814 (3) Plans may limit the providers in their networks.

3815 (a) However, during the first year in which a qualified  
3816 plan is operating in a region after the initial plan procurement  
3817 for that region, the plan must offer a network contract to the  
3818 following providers in the region:

3819 1. Federally qualified health centers.

3820 2. Nursing homes if the plan is providing managed long-term  
3821 care services.

3822 3. Aging network service providers that have previously  
3823 participated in home and community-based waivers serving elders,  
3824 or community-service programs administered by the Department of  
3825 Elderly Affairs if the plan is providing managed long-term care  
3826 services.

3827 (b) After 12 months of active participation in a plan's  
3828 network, the plan may exclude any of the providers listed in

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3829 paragraph (a) from the network while maintaining the network  
3830 performance standards required under s. 409.966(2)(b). If the  
3831 plan excludes a nursing home that meets the standards for  
3832 ongoing Medicaid certification, the plan must provide an  
3833 alternative residence in that community for Medicaid recipients  
3834 residing in that nursing home. If a Medicaid recipient residing  
3835 in an excluded nursing home does not choose to change residence,  
3836 the plan must continue to pay for the recipient's care in that  
3837 nursing home. If the plan excludes a provider, the plan must  
3838 provide written notice to all enrollees who have chosen that  
3839 provider for care. Notice to excluded providers must be  
3840 delivered at least 30 days before the effective date of the  
3841 exclusion.

3842 (c) Notwithstanding the limitation provided in this  
3843 subsection, qualified plans must include the following essential  
3844 providers in their networks:

- 3845 1. Faculty plans of state medical schools;
- 3846 2. Regional perinatal intensive care centers as defined in  
3847 s. 383.16; and
- 3848 3. Hospitals licensed as a children's specialty hospital as  
3849 defined in s. 395.002.

3850

3851 Qualified plans that have not contracted with all statewide  
3852 essential providers as of the first date of recipient enrollment  
3853 must continue to negotiate in good faith. Payments to physicians  
3854 on the faculty of nonparticipating state medical schools must be  
3855 made at the applicable Medicaid rate. Payments for services  
3856 rendered by a regional perinatal intensive care center must be  
3857 at the applicable Medicaid rate as of the first day of the

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3858 contract between the agency and the plan. Payments to a  
3859 nonparticipating specialty children's hospital must equal the  
3860 highest rate established by contract between that provider and  
3861 any other Medicaid managed care plan.

3862 (d) Qualified plans and providers shall engage in good  
3863 faith negotiations to reach contract terms.

3864 1. If a qualified plan seeks to develop a provider network  
3865 in a county or region that, as of June 30, 2011, does not have a  
3866 capitated managed care plan providing comprehensive acute care  
3867 for Medicaid recipients, and the qualified plan has made at  
3868 least three documented, unsuccessful, good faith attempts to  
3869 contract with a specific provider, the plan may request the  
3870 agency to examine the negotiation process. During the  
3871 examination, the agency shall consider similar counties or  
3872 regions in which qualified plans have contracted with providers  
3873 under similar circumstances, as well as the contracted rates  
3874 between qualified plans and that provider and similar providers  
3875 in the same region. If the agency determines that the plan has  
3876 made three good faith attempts to contract with the provider,  
3877 the agency shall consider that provider to be part of the  
3878 qualified plan's provider network for the purpose of determining  
3879 network adequacy, and the plan shall pay the provider for  
3880 services to Medicaid recipients on a noncontracted basis at a  
3881 rate or rates determined by the agency to be the average of  
3882 rates for corresponding services paid by the qualified plan and  
3883 other qualified plans in the region and in similar counties or  
3884 regions under similar circumstances.

3885 2. The agency may continue to calculate Medicaid hospital  
3886 inpatient per diem rates and outpatient rates. However, these

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3887 rates may not be the basis for contract negotiations between a  
3888 managed care plan and a hospital.

3889 (4) Each qualified plan shall monitor the quality and  
3890 performance of each provider within its network based on metrics  
3891 established by the agency for evaluating and documenting  
3892 provider performance and determining continued participation in  
3893 the network. However, qualified plans are not required to  
3894 conduct surveys of health care facilities that the agency  
3895 surveys periodically for licensure or certification purposes and  
3896 shall accept the results of such surveys. The agency shall  
3897 establish requirements for qualified plans to report, at least  
3898 annually, provider performance data compiled under this  
3899 subsection. If a plan uses additional metrics to evaluate the  
3900 provider's performance and to determine continued participation  
3901 in the network, the plan must notify the network providers of  
3902 these metrics at the beginning of the contract period.

3903 (a) At a minimum, a qualified plan shall hold primary care  
3904 physicians responsible for the following activities:

3905 1. Supervision, coordination, and provision of care to each  
3906 assigned enrollee.

3907 2. Initiation of referrals for medically necessary  
3908 specialty care and other services.

3909 3. Maintaining continuity of care for each assigned  
3910 enrollee.

3911 4. Maintaining the enrollee's medical record, including  
3912 documentation of all medical services provided to the enrollee  
3913 by the primary care physician, as well as any specialty or  
3914 referral services.

3915 (b) Qualified plans shall establish and implement policies

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3916 and procedures to monitor primary care physician activities and  
3917 ensure that primary care physicians are adequately notified and  
3918 receive documentation of specialty and referral services  
3919 provided to enrollees by specialty physicians and other health  
3920 care providers within the plan's provider network.

3921 (5) Each qualified plan shall establish specific programs  
3922 and procedures to improve pregnancy outcomes and infant health,  
3923 including, but not limited to, coordination with the Healthy  
3924 Start program, immunization programs, and referral to the  
3925 Special Supplemental Nutrition Program for Women, Infants, and  
3926 Children, and the Children's Medical Services Program for  
3927 children with special health care needs.

3928 (a) Qualified plans must ensure that primary care  
3929 physicians who provide obstetrical care are available to  
3930 pregnant recipients and that an obstetrical care provider is  
3931 assigned to each pregnant recipient for the duration of her  
3932 pregnancy and postpartum care, by referral of the recipient's  
3933 primary care physician if necessary.

3934 (b) Qualified plans within the managed long-term care  
3935 component are exempt from this subsection.

3936 (6) Each qualified plan shall achieve an annual screening  
3937 rate for early and periodic screening, diagnosis, and treatment  
3938 services of at least 80 percent of those recipients continuously  
3939 enrolled for at least 8 months. Qualified plans within the  
3940 managed long-term care component are exempt from this  
3941 requirement.

3942 (7) Effective January 1, 2013, qualified plans must  
3943 compensate primary care physicians for primary care services at  
3944 payment rates that are equivalent to or greater than payments



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3945 under the federal Medicare program, whether compensation is made  
3946 on a fee-for-service basis or by sub-capitation.

3947 (8) In order to protect the continued operation of the  
3948 Medicaid managed care program, unresolved disputes, including  
3949 claim and other types of disputes, between a qualified plan and  
3950 a provider shall proceed in accordance with s. 408.7057. This  
3951 process may not be used to review or reverse a decision by a  
3952 qualified plan to exclude a provider from its network if the  
3953 decision does not conflict with s. 409.967(3).

3954 Section 41. Section 409.968, Florida Statutes, is created  
3955 to read:

3956 409.968 Plan payment.—Payments for managed medical  
3957 assistance and managed long-term care services under this part  
3958 shall be made in accordance with a capitated managed care model.  
3959 Qualified plans shall receive per-member, per-month payments  
3960 pursuant to the procurements described in s. 409.965 and annual  
3961 adjustments as described in s. 409.966(1). Payment rates must be  
3962 based on the acuity level for each member pursuant to ss.  
3963 409.972 and 409.978. Payment rates for managed long-term care  
3964 plans shall be combined with rates for managed medical  
3965 assistance plans.

3966 (1) The agency shall develop a methodology and request a  
3967 waiver that ensures the availability of intergovernmental  
3968 transfers and certified public expenditures in the Medicaid  
3969 managed care program to support providers that have historically  
3970 served Medicaid recipients. Such providers include, but are not  
3971 limited to, safety net providers, trauma hospitals, children's  
3972 hospitals, statutory teaching hospitals, and medical and  
3973 osteopathic physicians employed by or under contract with a

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3974 medical school in this state. The agency may develop a  
3975 supplemental capitation rate, risk pool, or incentive payment  
3976 for plans that contract with these providers. A plan is eligible  
3977 for a supplemental payment only if there are sufficient  
3978 intergovernmental transfers or certified public expenditures  
3979 available from allowable sources.

3980 (2) The agency shall evaluate the development of the rate  
3981 cell to accurately reflect the underlying utilization to the  
3982 maximum extent possible. This methodology may include interim  
3983 rate adjustments as permitted under federal regulations. Any  
3984 such methodology must preserve federal funding to these entities  
3985 and be actuarially sound. In the absence of federal approval of  
3986 the methodology, the agency may set an enhanced rate and require  
3987 that plans pay the rate if the agency determines the enhanced  
3988 rate is necessary to ensure access to care by the providers  
3989 described in this subsection.

3990 (3) The amount paid to the plans to make supplemental  
3991 payments or to enhance provider rates pursuant to this  
3992 subsection must be reconciled to the exact amounts the plans are  
3993 required to pay providers. The plans shall make the designated  
3994 payments to providers within 15 business days after notification  
3995 by the agency regarding provider-specific distributions.

3996 (4) The agency shall develop a methodology and request a  
3997 state plan amendment or waiver that ensures the availability of  
3998 certified public expenditures in the Medicaid managed care  
3999 program to support noninstitutional teaching faculty providers  
4000 that have historically served Medicaid recipients. Such  
4001 providers include allopathic and osteopathic physicians employed  
4002 by or under contract with a medical school in this state. The

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4003 agency shall directly make supplemental payments to teaching  
4004 faculty providers or to a statewide entity acting on behalf of  
4005 state medical schools and teaching faculty providers that  
4006 contract with qualified plans and provide care to Medicaid  
4007 recipients in recognition of the costs associated with graduate  
4008 medical education and training, educating medical school  
4009 students, and access to primary and specialty care provided to  
4010 Medicaid recipients. Physicians employed by or under contract  
4011 with a medical school in this state are eligible for a  
4012 supplemental payment only if there are sufficient certified  
4013 public expenditures available from allowable sources. The agency  
4014 shall evaluate the development of teaching faculty provider  
4015 payments for managed care to accurately reflect the historical  
4016 and underlying as well as current and prospective utilization to  
4017 the maximum extent possible. Any such methodology must preserve  
4018 federal funding to these entities.

4019 Section 42. Section 409.969, Florida Statutes, is created  
4020 to read:

4021 409.969 Enrollment; disenrollment; grievance procedure.—

4022 (1) Each Medicaid recipient may choose any available plan  
4023 within the region in which the recipient resides unless that  
4024 plan is a specialty plan for which the recipient does not  
4025 qualify. The agency may not provide or contract for choice  
4026 counseling services for persons enrolling in the Medicaid  
4027 managed care program.

4028 (2) If a recipient has not made a choice of plans within 30  
4029 days after having been notified to choose a plan, the agency  
4030 shall assign the recipient to a plan in accordance with the  
4031 following:

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4032       (a) A recipient who was previously enrolled in a plan  
4033 within the preceding 90 days shall automatically be enrolled in  
4034 the same plan, if available.

4035       (b) Newborns of eligible mothers enrolled in a plan at the  
4036 time of the child's birth shall be enrolled in the mother's  
4037 plan; however, the mother may choose another plan for the  
4038 newborn within 90 days after the child's birth.

4039       (c) If the recipient is diagnosed with HIV/AIDS and resides  
4040 in region 11, region 15, or region 16, the agency shall assign  
4041 the recipient to a plan that:

4042           1. Is a specialty plan under contract with the agency  
4043 pursuant to s. 409.965; and

4044           2. Offers a delivery system through a teaching- and  
4045 research-oriented organization that specializes in providing  
4046 health care services and treatment for individuals diagnosed  
4047 with HIV/AIDS.

4048  
4049 The agency shall assign recipients under this paragraph on an  
4050 even basis among all such plans within a region under contract  
4051 with the agency.

4052       (d) A recipient who is currently receiving Medicare  
4053 services from an entity qualified under 42 C.F.R. part 422 as a  
4054 Medicare Advantage preferred provider organization, Medicare  
4055 Advantage provider-sponsored organization, or Medicare Advantage  
4056 special needs plan that is under contract with the agency shall  
4057 be assigned to that plan for the Medicaid services not covered  
4058 by Medicare for which the recipient is eligible.

4059       (e) Other recipients shall be enrolled into a qualified  
4060 plan in accordance with an auto-assignment enrollment algorithm

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4061 that the agency develops by rule. The algorithm must heavily  
4062 weigh family continuity.

4063 1. Automatic enrollment of recipients in plans must be  
4064 based on the following criteria:

4065 a. Whether the plan has sufficient network capacity to meet  
4066 the needs of recipients.

4067 b. Whether the recipient has previously received services  
4068 from one of the plan's primary care providers.

4069 c. Whether primary care providers in one plan are more  
4070 geographically accessible to the recipient's residence than  
4071 providers in other plans.

4072 d. If a recipient is eligible for long-term care services,  
4073 whether the recipient has previously received services from one  
4074 of the plan's home and community-based service providers.

4075 e. If a recipient is eligible for long-term care services,  
4076 whether the home and community-based providers in one plan are  
4077 more geographically accessible to the recipient's residence than  
4078 providers in other plans.

4079 2. The agency shall automatically enroll recipients in  
4080 plans that meet or exceed the performance or quality standards  
4081 established pursuant to s. 409.967, and may not automatically  
4082 enroll recipients in a plan that is not meeting those standards.  
4083 Except as provided by law or rule, the agency may not engage in  
4084 practices that favor one qualified plan over another.

4085 (3) After a recipient has enrolled in a qualified plan, the  
4086 enrollee shall have 90 days to voluntarily disenroll and select  
4087 another plan. After 90 days, no further changes may be made  
4088 except for good cause. Good cause includes, but is not limited  
4089 to, poor quality of care, lack of access to necessary specialty

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4090 services, an unreasonable delay or denial of service, or  
4091 fraudulent enrollment. The agency shall determine whether good  
4092 cause exists. The agency may require an enrollee to use the  
4093 plan's grievance process before the agency makes a determination  
4094 of good cause, unless an immediate risk of permanent damage to  
4095 the enrollee's health is alleged.

4096 (a) If used, the qualified plan's internal grievance  
4097 process must be completed in time to allow the enrollee to  
4098 disenroll by the first day of the second month after the month  
4099 the disenrollment request was made. If the grievance process  
4100 approves an enrollee's request to disenroll, the agency is not  
4101 required to make a determination of good cause.

4102 (b) The agency must make a determination of good cause and  
4103 take final action on an enrollee's request so that disenrollment  
4104 occurs by the first day of the second month after the month the  
4105 request was made. If the agency fails to act within this  
4106 timeframe, the enrollee's request to disenroll is deemed  
4107 approved as of the date agency action was required. Enrollees  
4108 who disagree with the agency's finding that good cause for  
4109 disenrollment does not exist shall be advised of their right to  
4110 pursue a Medicaid fair hearing to dispute the agency's finding.

4111 (c) Medicaid recipients enrolled in a qualified plan after  
4112 the 90-day period must remain in the plan for the remainder of  
4113 the 12-month period. After 12 months, the enrollee may select  
4114 another plan. However, a recipient who is referred for nursing  
4115 home or assisted living facility services may change plans  
4116 within 30 days after such referral. An enrollee may change  
4117 primary care providers within the plan at any time.

4118 (d) On the first day of the next month after receiving

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4119 notice from a recipient that the recipient has moved to another  
4120 region, the agency shall automatically disenroll the recipient  
4121 from the plan the recipient is currently enrolled in and treat  
4122 the recipient as if the recipient is a new enrollee. At that  
4123 time, the recipient may choose another plan pursuant to the  
4124 enrollment process established in this section.

4125 Section 43. Section 409.970, Florida Statutes, is created  
4126 to read:

4127 409.970 Medicaid Encounter Data System.—The agency shall  
4128 maintain and operate the Medicaid Encounter Data System to  
4129 collect, process, and report on covered services provided to all  
4130 Medicaid recipients enrolled in qualified plans.

4131 (1) Qualified plans shall submit encounter data  
4132 electronically in a format that complies with provisions of the  
4133 federal Health Insurance Portability and Accountability Act for  
4134 electronic claims and in accordance with deadlines established  
4135 by the agency. Plans must certify that the data reported is  
4136 accurate and complete. The agency is responsible for validating  
4137 the data submitted by the plans.

4138 (2) The agency shall develop methods and protocols for  
4139 ongoing analysis of the encounter data, which must adjust for  
4140 differences in the characteristics of enrollees in order to  
4141 allow for the comparison of service utilization among plans. The  
4142 analysis shall be used to identify possible cases of systemic  
4143 overutilization, underutilization, inappropriate denials of  
4144 claims, and inappropriate utilization of covered services, such  
4145 as higher than expected emergency department and pharmacy  
4146 encounters. One of the primary focus areas for the analysis  
4147 shall be the use of prescription drugs.

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4148       (3) The agency shall provide periodic feedback to the plans  
4149 based on the analysis and establish corrective action plans if  
4150 necessary.

4151       (4) The agency shall make encounter data available to plans  
4152 accepting enrollees who are reassigned to them from other plans  
4153 leaving a region.

4154       (5) Beginning July 1, 2011, the agency shall conduct  
4155 appropriate tests and establish specific criteria for  
4156 determining whether the Medicaid Encounter Data System has  
4157 valid, complete, and sound data for a sufficient period of time  
4158 to provide qualified plans with a reliable basis for determining  
4159 and proposing actuarially sound payment rates.

4160       Section 44. Section 409.971, Florida Statutes, is created  
4161 to read:

4162       409.971 Managed care medical assistance.—Pursuant to s.  
4163 409.902, the agency shall administer the managed care medical  
4164 assistance component of the Medicaid managed care program  
4165 described in this section and s. 409.972. Unless otherwise  
4166 specified, the provisions of ss. 409.961-409.970 apply to the  
4167 provision of managed care medical assistance. By December 31,  
4168 2011, the agency shall begin implementation of managed care  
4169 medical assistance, and full implementation in all regions must  
4170 be completed by December 31, 2012.

4171       Section 45. Section 409.972, Florida Statutes, is created  
4172 to read:

4173       409.972 Managed care medical assistance services.—

4174       (1) Qualified plans providing managed care medical  
4175 assistance must, at a minimum, cover the following services:

4176       (a) Ambulatory patient services.



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

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4206 recipient who is 21 years of age or older.

4207 (2) Subject to specific appropriations, the agency may make  
4208 payments for services that are optional.

4209 (3) Qualified plans may customize benefit packages for  
4210 nonpregnant adults, vary cost-sharing provisions, and provide  
4211 coverage for additional services. The agency shall evaluate the  
4212 proposed benefit packages to ensure that services are sufficient  
4213 to meet the needs of the plans' enrollees and to verify  
4214 actuarial equivalence.

4215 (4) For Medicaid recipients diagnosed with hemophilia who  
4216 have been prescribed anti-hemophilic-factor replacement  
4217 products, the agency shall provide for those products and  
4218 hemophilia overlay services through the agency's hemophilia  
4219 disease management program authorized under s. 409.912.

4220 (5) Managed care medical assistance services provided under  
4221 this section must be medically necessary and provided in  
4222 accordance with state and federal law. This section does not  
4223 prevent the agency from adjusting fees, reimbursement rates,  
4224 lengths of stay, number of visits, or number of services, or  
4225 from making any other adjustments necessary to comply with the  
4226 availability of funding and any limitations or directions  
4227 provided in the General Appropriations Act, chapter 216, or s.  
4228 409.9022.

4229 Section 46. Section 409.973, Florida Statutes, is created  
4230 to read:

4231 409.973 Managed long-term care.—

4232 (1) Qualified plans providing managed care medical  
4233 assistance may also participate in the managed long-term care  
4234 component of the Medicaid managed care program. Unless otherwise

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4235 specified, the provisions of ss. 409.961-409.970 apply to the  
4236 managed long-term care component of the managed care program.

4237 (2) Pursuant to s. 409.902, the agency shall administer the  
4238 managed long-term care component described in this section and  
4239 ss. 409.974-409.978, but may delegate specific duties and  
4240 responsibilities to the Department of Elderly Affairs and other  
4241 state agencies. By March 31, 2012, the agency shall begin  
4242 implementation of the managed long-term care component, with  
4243 full implementation in all regions by March 31, 2013.

4244 (3) The Department of Elderly Affairs shall assist the  
4245 agency in developing specifications for use in the invitation to  
4246 negotiate and the model contract, determining clinical  
4247 eligibility for enrollment in managed long-term care plans,  
4248 monitoring plan performance and measuring quality of service  
4249 delivery, assisting clients and families in order to address  
4250 complaints with the plans, facilitating working relationships  
4251 between plans and providers serving elders and disabled adults,  
4252 and performing other functions specified in a memorandum of  
4253 agreement.

4254 Section 47. Section 409.974, Florida Statutes, is created  
4255 to read:

4256 409.974 Recipient eligibility for managed long-term care.-

4257 (1) Medicaid recipients shall receive covered long-term  
4258 care services through the managed long-term care component of  
4259 the Medicaid managed care program unless excluded pursuant to s.  
4260 409.964. In order to participate in the managed long-term care  
4261 component, the recipient must be:

4262 (a) Sixty-five years of age or older or eligible for  
4263 Medicaid by reason of a disability; and

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4264 (b) Determined by the Comprehensive Assessment and Review  
4265 for Long-Term Care Services (CARES) Program to meet the criteria  
4266 for nursing facility care.

4267 (2) Medicaid recipients who are enrolled in one of the  
4268 following Medicaid long-term care waiver programs on the date  
4269 that a managed long-term care plan becomes available in the  
4270 recipient's region may remain in that program if it is  
4271 operational on that date:

4272 (a) The Assisted Living for the Frail Elderly Waiver.

4273 (b) The Aged and Disabled Adult Waiver.

4274 (c) The Adult Day Health Care Waiver.

4275 (d) The Consumer-Directed Care Program as described in s.  
4276 409.221.

4277 (e) The Program of All-inclusive Care for the Elderly.

4278 (f) The Long-Term Care Community Diversion Pilot Project as  
4279 described in s. 430.705.

4280 (g) The Channeling Services Waiver for Frail Elders.

4281 (3) If a long-term care waiver program in which the  
4282 recipient is enrolled ceases to operate, the Medicaid recipient  
4283 may transfer to another long-term care waiver program or to the  
4284 Medicaid managed long-term care component of the Medicaid  
4285 managed care program. If no waivers are operational in the  
4286 recipient's region and the recipient continues to participate in  
4287 Medicaid, the recipient must transfer to the managed long-term  
4288 care component of the Medicaid managed care program.

4289 (4) New enrollment in a waiver program ends on the date  
4290 that a managed long-term care plan becomes available in a  
4291 region.

4292 (5) Medicaid recipients who are residing in a nursing home

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4293 facility on the date that a managed long-term care plan becomes  
4294 available in the recipient's region are eligible for the long-  
4295 term care Medicaid waiver programs.

4296 (6) This section does not create an entitlement to any home  
4297 and community-based services provided under the managed long-  
4298 term care component.

4299 Section 48. Section 409.975, Florida Statutes, is created  
4300 to read:

4301 409.975 Managed long-term care services.-

4302 (1) Qualified plans participating in the managed long-term  
4303 care component of the Medicaid managed care program, at a  
4304 minimum, shall cover the following services:

4305 (a) The services listed in s. 409.972.

4306 (b) Nursing facility services.

4307 (c) Home and community-based services, including, but not  
4308 limited to, assisted living facility services.

4309 (2) Services provided under this section must be medically  
4310 necessary and provided in accordance with state and federal law.

4311 This section does not prevent the agency from adjusting fees,  
4312 reimbursement rates, lengths of stay, number of visits, or  
4313 number of services, or from making any other adjustments  
4314 necessary to comply with the availability of funding and any  
4315 limitations or directions provided in the General Appropriations  
4316 Act, chapter 216, or s. 409.9022.

4317 Section 49. Section 409.976, Florida Statutes, is created  
4318 to read:

4319 409.976 Qualified managed long-term care plans.-

4320 (1) For purposes of managed long-term care, qualified plans  
4321 also include:

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4322        (a) Entities who are qualified under 42 C.F.R. part 422 as  
4323 Medicare Advantage Preferred Provider Organizations, Medicare  
4324 Advantage Provider-sponsored Organizations, and Medicare  
4325 Advantage Special Needs Plans. Such plans may participate in the  
4326 managed long-term care component. A plan submitting a response  
4327 to the invitation to negotiate for the managed long-term care  
4328 component may reference one or more of these entities as part of  
4329 its demonstration of network adequacy for the provision of  
4330 services required under s. 409.972 for dually eligible  
4331 enrollees.

4332        (b) The Program of All-inclusive Care for the Elderly  
4333 (PACE). Participation by PACE shall be pursuant to a contract  
4334 with the agency and is not subject to the procurement  
4335 requirements of this section. PACE plans may continue to provide  
4336 services to recipients at such levels and enrollment caps as  
4337 authorized by the General Appropriations Act.

4338        (2) The agency shall select qualified plans through the  
4339 procurement described in s. 409.965. The agency shall notice the  
4340 invitation to negotiate by November 14, 2011.

4341        (3) In addition to the criteria established in s. 409.965,  
4342 the agency shall give preference to the following factors in  
4343 selecting qualified plans:

4344        (a) The plan's employment of executive managers having  
4345 expertise and experience in serving aged and disabled persons  
4346 who require long-term care.

4347        (b) The plan's establishment of a network of service  
4348 providers dispersed throughout the region and in sufficient  
4349 numbers to meet specific service standards established by the  
4350 agency for a continuum of care, beginning from the provision of

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4351 assistance with the activities of daily living at a recipient's  
4352 home and the provision of other home and community-based care  
4353 through the provision of nursing home care. These providers  
4354 include:

- 4355 1. Adult day centers.
- 4356 2. Adult family care homes.
- 4357 3. Assisted living facilities.
- 4358 4. Health care services pools.
- 4359 5. Home health agencies.
- 4360 6. Homemaker and companion services.
- 4361 7. Community Care for the Elderly lead agencies.
- 4362 8. Nurse registries.
- 4363 9. Nursing homes.

4364  
4365 All providers are not required to be located within the region;  
4366 however, the provider network must be sufficient to ensure that  
4367 services are available throughout the region.

4368 (c) Whether a plan offers consumer-directed care services  
4369 to enrollees pursuant to s. 409.221 or includes attendant care  
4370 or paid family caregivers in the benefit package. Consumer-  
4371 directed care services must provide a flexible budget, which is  
4372 managed by enrollees and their families or representatives, and  
4373 allows them to choose service providers, determine provider  
4374 rates of payment, and direct the delivery of services to best  
4375 meet their special long-term care needs. If all other factors  
4376 are equal among competing qualified plans, the agency shall give  
4377 preference to such plans.

4378 (d) Evidence that a qualified plan has written agreements  
4379 or signed contracts or has made substantial progress in

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4380 establishing relationships with providers before the plan  
4381 submits a response.

4382 (e) The availability and accessibility of case managers in  
4383 the plan and provider network.

4384 Section 50. Section 409.977, Florida Statutes, is created  
4385 to read:

4386 409.977 Managed long-term plan and provider  
4387 accountability.—In addition to the requirements of ss. 409.966  
4388 and 409.967, plans and providers participating in managed long-  
4389 term care must comply with s. 641.31(25) and with the specific  
4390 standards established by the agency for the number, type, and  
4391 regional distribution of the following providers in the plan's  
4392 network, which must include:

4393 (1) Adult day centers.

4394 (2) Adult family care homes.

4395 (3) Assisted living facilities.

4396 (4) Health care services pools.

4397 (5) Home health agencies.

4398 (6) Homemaker and companion services.

4399 (7) Community Care for the Elderly lead agencies.

4400 (8) Nurse registries.

4401 (9) Nursing homes.

4402 Section 51. Section 409.978, Florida Statutes, is created  
4403 to read:

4404 409.978 CARES program screening; levels of care.—

4405 (1) The agency shall operate the Comprehensive Assessment  
4406 and Review for Long-Term Care Services (CARES) preadmission  
4407 screening program to ensure that only recipients whose  
4408 conditions require long-term care services are enrolled in



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4409 managed long-term care plans.

4410 (2) The agency shall operate the CARES program through an  
4411 interagency agreement with the Department of Elderly Affairs.  
4412 The agency, in consultation with the department, may contract  
4413 for any function or activity of the CARES program, including any  
4414 function or activity required by 42 C.F.R. part 483.20, relating  
4415 to preadmission screening and review.

4416 (3) The CARES program shall determine if a recipient  
4417 requires nursing facility care and, if so, assign the recipient  
4418 to one of the following levels of care:

4419 (a) Level of care 1 consists of enrollees who require the  
4420 constant availability of routine medical and nursing treatment  
4421 and care, have a limited need for health-related care and  
4422 services, are mildly medically or physically incapacitated, and  
4423 cannot be managed at home due to inadequacy of home-based  
4424 services.

4425 (b) Level of care 2 consists of enrollees who require the  
4426 constant availability of routine medical and nursing treatment  
4427 and care, and require extensive health-related care and services  
4428 because of mental or physical incapacitation. Current enrollees  
4429 in home and community-based waiver programs for persons who are  
4430 elderly or adults with physical disability, or both, who remain  
4431 financially eligible for Medicaid are not required to meet new  
4432 level-of-care criteria except for immediate placement in a  
4433 nursing home.

4434 (c) Level of care 3 consists of enrollees residing in  
4435 nursing homes, or needing immediate placement in a nursing home,  
4436 and who have a priority score of 5 or above as determined by  
4437 CARES.

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4438       (4) For recipients whose nursing home stay is initially  
4439 funded by Medicare and Medicare coverage is being terminated for  
4440 lack of progress towards rehabilitation, CARES staff shall  
4441 consult with the person determining the recipient's progress  
4442 toward rehabilitation in order to ensure that the recipient is  
4443 not being inappropriately disqualified from Medicare coverage.  
4444 If, in their professional judgment, CARES staff believes that a  
4445 Medicare beneficiary is still making progress, they may assist  
4446 the Medicare beneficiary with appealing the disqualification  
4447 from Medicare coverage. The CARES teams may review Medicare  
4448 denials for coverage under this section only if it is determined  
4449 that such reviews qualify for federal matching funds through  
4450 Medicaid. The agency shall seek or amend federal waivers as  
4451 necessary to implement this section.

4452       Section 52. Section 409.91207, Florida Statutes, is  
4453 transferred, renumbered as section 409.985, Florida Statutes,  
4454 and subsection (1) of that section is amended to read:

4455       409.985 ~~409.91207~~ Medical home pilot project.—

4456       (1) The agency shall develop a plan to implement a medical  
4457 home pilot project that uses ~~utilizes~~ primary care case  
4458 management enhanced by medical home networks to provide  
4459 coordinated and cost-effective care that is reimbursed on a fee-  
4460 for-service basis and to compare the performance of the medical  
4461 home networks with other existing Medicaid managed care models.  
4462 The agency may ~~is authorized to~~ seek a federal Medicaid waiver  
4463 or an amendment to any existing Medicaid waiver, except for the  
4464 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,  
4465 as needed, to develop the pilot project created in this section  
4466 but must obtain approval of the Legislature before ~~prior to~~

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4467 implementing the pilot project.

4468 Section 53. Section 409.91211, Florida Statutes, is  
4469 transferred, renumbered as section 409.986, Florida Statutes,  
4470 and paragraph (aa) of subsection (3) and paragraph (a) of  
4471 subsection (4) of that section are amended, to read:

4472 409.986 ~~409.91211~~ Medicaid managed care pilot program.—

4473 (3) The agency shall have the following powers, duties, and  
4474 responsibilities with respect to the pilot program:

4475 (aa) To implement a mechanism whereby Medicaid recipients  
4476 who are already enrolled in a managed care plan or the MediPass  
4477 program in the pilot areas are ~~shall be~~ offered the opportunity  
4478 to change to capitated managed care plans on a staggered basis,  
4479 as defined by the agency. All Medicaid recipients shall have 30  
4480 days in which to make a choice of capitated managed care plans.  
4481 Those Medicaid recipients who do not make a choice shall be  
4482 assigned to a capitated managed care plan in accordance with  
4483 paragraph (4) (a) and shall be exempt from s. 409.987 ~~409.9122~~.  
4484 To facilitate continuity of care for a Medicaid recipient who is  
4485 also a recipient of Supplemental Security Income (SSI), prior to  
4486 assigning the SSI recipient to a capitated managed care plan,  
4487 the agency shall determine whether the SSI recipient has an  
4488 ongoing relationship with a provider or capitated managed care  
4489 plan, and, if so, the agency shall assign the SSI recipient to  
4490 that provider or capitated managed care plan where feasible.  
4491 Those SSI recipients who do not have such a provider  
4492 relationship shall be assigned to a capitated managed care plan  
4493 provider in accordance with paragraph (4) (a) and shall be exempt  
4494 from s. 409.987 ~~409.9122~~.

4495 (4) (a) A Medicaid recipient in the pilot area who is not

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4496 currently enrolled in a capitated managed care plan upon  
4497 implementation is not eligible for services as specified in ss.  
4498 409.905 and 409.906, for the amount of time that the recipient  
4499 does not enroll in a capitated managed care network. If a  
4500 Medicaid recipient has not enrolled in a capitated managed care  
4501 plan within 30 days after eligibility, the agency shall assign  
4502 the Medicaid recipient to a capitated managed care plan based on  
4503 the assessed needs of the recipient as determined by the agency  
4504 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When  
4505 making assignments, the agency shall take into account the  
4506 following criteria:

4507 1. A capitated managed care network has sufficient network  
4508 capacity to meet the needs of members.

4509 2. The capitated managed care network has previously  
4510 enrolled the recipient as a member, or one of the capitated  
4511 managed care network's primary care providers has previously  
4512 provided health care to the recipient.

4513 3. The agency has knowledge that the member has previously  
4514 expressed a preference for a particular capitated managed care  
4515 network as indicated by Medicaid fee-for-service claims data,  
4516 but has failed to make a choice.

4517 4. The capitated managed care network's primary care  
4518 providers are geographically accessible to the recipient's  
4519 residence.

4520 Section 54. Section 409.9122, Florida Statutes, is  
4521 transferred, renumbered as section 409.987, and paragraph (a) of  
4522 subsection (2) of that section is amended to read:

4523 409.987 ~~409.9122~~ Mandatory Medicaid managed care  
4524 enrollment; programs and procedures.-

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4525           (2) (a) The agency shall enroll all Medicaid recipients in a  
4526 managed care plan or MediPass ~~all Medicaid recipients~~, except  
4527 ~~those Medicaid recipients who are~~ in an institution, receiving  
4528 a Medicaid nonpoverty medical subsidy, ~~enrolled in the Medicaid~~  
4529 ~~medically needy Program~~, or eligible for both Medicaid and  
4530 Medicare. Upon enrollment, recipients may ~~individuals will be~~  
4531 ~~able to~~ change their managed care option during the 90-day opt  
4532 out period required by federal Medicaid regulations. The agency  
4533 ~~may is authorized to~~ seek the necessary Medicaid state plan  
4534 amendment to implement this policy. ~~However, to the extent~~

4535           1. If permitted by federal law, the agency may enroll in a  
4536 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt  
4537 from mandatory managed care enrollment in a managed care plan or  
4538 MediPass if, provided that:

4539           a.1. The recipient's decision to enroll in a managed care  
4540 plan or MediPass is voluntary;

4541           b.2. ~~If~~ The recipient chooses to enroll in a managed care  
4542 plan, the agency has determined that the ~~managed care plan~~  
4543 provides specific programs and services that ~~which~~ address the  
4544 special health needs of the recipient; and

4545           c.3. The agency receives the ~~any~~ necessary waivers from the  
4546 federal Centers for Medicare and Medicaid Services.

4547           2. The agency shall develop rules to establish policies by  
4548 which exceptions to the mandatory managed care enrollment  
4549 requirement may be made on a case-by-case basis. The rules must  
4550 ~~shall~~ include the specific criteria to be applied when  
4551 determining ~~making a determination as to~~ whether to exempt a  
4552 recipient from mandatory enrollment ~~in a managed care plan or~~  
4553 ~~MediPass~~.

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4554           3. School districts participating in the certified school  
4555 match program pursuant to ss. 409.908(21) and 1011.70 shall be  
4556 reimbursed by Medicaid, subject to the limitations of s.  
4557 1011.70(1), for a Medicaid-eligible child participating in the  
4558 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.  
4559 409.9071, regardless of whether the child is enrolled in  
4560 MediPass or a managed care plan. Managed care plans must ~~shall~~  
4561 make a good faith effort to execute agreements with school  
4562 districts regarding the coordinated provision of services  
4563 authorized under s. 1011.70.

4564           4. County health departments delivering school-based  
4565 services pursuant to ss. 381.0056 and 381.0057 shall be  
4566 reimbursed by Medicaid for the federal share for a Medicaid-  
4567 eligible child who receives Medicaid-covered services in a  
4568 school setting, regardless of whether the child is enrolled in  
4569 MediPass or a managed care plan. Managed care plans shall make a  
4570 good faith effort to execute agreements with county health  
4571 departments that coordinate the ~~regarding the coordinated~~  
4572 provision of services to a Medicaid-eligible child. To ensure  
4573 continuity of care for Medicaid patients, the agency, the  
4574 Department of Health, and the Department of Education shall  
4575 develop procedures for ensuring that a student's managed care  
4576 plan or MediPass provider receives information relating to  
4577 services provided in accordance with ss. 381.0056, 381.0057,  
4578 409.9071, and 1011.70.

4579           Section 55. Section 409.9123, Florida Statutes, is  
4580 transferred and renumbered as section 409.988, Florida Statutes.

4581           Section 56. Section 409.9124, Florida Statutes, is  
4582 transferred and renumbered as section 409.989.

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4583 Section 57. Subsection (15) of section 430.04, Florida  
4584 Statutes, is amended to read:

4585 430.04 Duties and responsibilities of the Department of  
4586 Elderly Affairs.—The Department of Elderly Affairs shall:

4587 (15) Administer all Medicaid waivers and programs relating  
4588 to elders and their appropriations. The waivers include, but are  
4589 not limited to:

4590 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~  
4591 ~~established in s. 430.502(7), (8), and (9).~~

4592 (a) ~~(b)~~ The Assisted Living for the Frail Elderly Waiver.

4593 (b) ~~(c)~~ The Aged and Disabled Adult Waiver.

4594 (c) ~~(d)~~ The Adult Day Health Care Waiver.

4595 (d) ~~(e)~~ The Consumer-Directed Care Plus Program as defined  
4596 in s. 409.221.

4597 (e) ~~(f)~~ The Program of All-inclusive Care for the Elderly.

4598 (f) ~~(g)~~ The Long-Term Care Community-Based Diversion Pilot  
4599 Project as described in s. 430.705.

4600 (g) ~~(h)~~ The Channeling Services Waiver for Frail Elders.

4601  
4602 The department shall develop a transition plan for recipients  
4603 receiving services under long-term care Medicaid waivers for  
4604 elders or disabled adults on the date qualified plans become  
4605 available in each recipient's region pursuant to s. 409.973(2)  
4606 in order to enroll those recipients in qualified plans.

4607 Section 58. Section 430.2053, Florida Statutes, is amended  
4608 to read:

4609 430.2053 Aging resource centers.—

4610 (1) The department, in consultation with the Agency for  
4611 Health Care Administration and the Department of Children and

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4612 Family Services, shall develop pilot projects for aging resource  
4613 centers. ~~By October 31, 2004, the department, in consultation~~  
4614 ~~with the agency and the Department of Children and Family~~  
4615 ~~Services, shall develop an implementation plan for aging~~  
4616 ~~resource centers and submit the plan to the Governor, the~~  
4617 ~~President of the Senate, and the Speaker of the House of~~  
4618 ~~Representatives. The plan must include qualifications for~~  
4619 ~~designation as a center, the functions to be performed by each~~  
4620 ~~center, and a process for determining that a current area agency~~  
4621 ~~on aging is ready to assume the functions of an aging resource~~  
4622 ~~center.~~

4623 ~~(2) Each area agency on aging shall develop, in~~  
4624 ~~consultation with the existing community care for the elderly~~  
4625 ~~lead agencies within their planning and service areas, a~~  
4626 ~~proposal that describes the process the area agency on aging~~  
4627 ~~intends to undertake to transition to an aging resource center~~  
4628 ~~prior to July 1, 2005, and that describes the area agency's~~  
4629 ~~compliance with the requirements of this section. The proposals~~  
4630 ~~must be submitted to the department prior to December 31, 2004.~~  
4631 ~~The department shall evaluate all proposals for readiness and,~~  
4632 ~~prior to March 1, 2005, shall select three area agencies on~~  
4633 ~~aging which meet the requirements of this section to begin the~~  
4634 ~~transition to aging resource centers. Those area agencies on~~  
4635 ~~aging which are not selected to begin the transition to aging~~  
4636 ~~resource centers shall, in consultation with the department and~~  
4637 ~~the existing community care for the elderly lead agencies within~~  
4638 ~~their planning and service areas, amend their proposals as~~  
4639 ~~necessary and resubmit them to the department prior to July 1,~~  
4640 ~~2005. The department may transition additional area agencies to~~



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4641 ~~aging resource centers as it determines that area agencies are~~  
4642 ~~in compliance with the requirements of this section.~~

4643 ~~(3) The Auditor General and the Office of Program Policy~~  
4644 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~  
4645 ~~review and assess the department's process for determining an~~  
4646 ~~area agency's readiness to transition to an aging resource~~  
4647 ~~center.~~

4648 ~~(a) The review must, at a minimum, address the~~  
4649 ~~appropriateness of the department's criteria for selection of an~~  
4650 ~~area agency to transition to an aging resource center, the~~  
4651 ~~instruments applied, the degree to which the department~~  
4652 ~~accurately determined each area agency's compliance with the~~  
4653 ~~readiness criteria, the quality of the technical assistance~~  
4654 ~~provided by the department to an area agency in correcting any~~  
4655 ~~weaknesses identified in the readiness assessment, and the~~  
4656 ~~degree to which each area agency overcame any identified~~  
4657 ~~weaknesses.~~

4658 ~~(b) Reports of these reviews must be submitted to the~~  
4659 ~~appropriate substantive and appropriations committees in the~~  
4660 ~~Senate and the House of Representatives on March 1 and September~~  
4661 ~~1 of each year until full transition to aging resource centers~~  
4662 ~~has been accomplished statewide, except that the first report~~  
4663 ~~must be submitted by February 1, 2005, and must address all~~  
4664 ~~readiness activities undertaken through December 31, 2004. The~~  
4665 ~~perspectives of all participants in this review process must be~~  
4666 ~~included in each report.~~

4667 ~~(2) (4)~~ The purposes of an aging resource center are ~~shall~~  
4668 ~~be:~~

4669 (a) To provide Florida's elders and their families with a

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4670 locally focused, coordinated approach to integrating information  
4671 and referral for all available services for elders with the  
4672 eligibility determination entities for state and federally  
4673 funded long-term-care services.

4674 (b) To provide for easier access to long-term-care services  
4675 by Florida's elders and their families by creating multiple  
4676 access points to the long-term-care network that flow through  
4677 one established entity with wide community recognition.

4678 (3) ~~(5)~~ The duties of an aging resource center are to:

4679 (a) Develop referral agreements with local community  
4680 service organizations, such as senior centers, existing elder  
4681 service providers, volunteer associations, and other similar  
4682 organizations, to better assist clients who do not need or do  
4683 not wish to enroll in programs funded by the department or the  
4684 agency. The referral agreements must also include a protocol,  
4685 developed and approved by the department, which provides  
4686 specific actions that an aging resource center and local  
4687 community service organizations must take when an elder or an  
4688 elder's representative seeking information on long-term-care  
4689 services contacts a local community service organization prior  
4690 to contacting the aging resource center. The protocol shall be  
4691 designed to ensure that elders and their families are able to  
4692 access information and services in the most efficient and least  
4693 cumbersome manner possible.

4694 (b) Provide an initial screening of all clients who request  
4695 long-term-care services to determine whether the person would be  
4696 most appropriately served through any combination of federally  
4697 funded programs, state-funded programs, locally funded or  
4698 community volunteer programs, or private funding for services.

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4699 (c) Determine eligibility for the programs and services  
4700 listed in subsection (9) ~~(11)~~ for persons residing within the  
4701 geographic area served by the aging resource center and  
4702 determine a priority ranking for services which is based upon  
4703 the potential recipient's frailty level and likelihood of  
4704 institutional placement without such services.

4705 (d) Manage the availability of financial resources for the  
4706 programs and services listed in subsection (9) ~~(11)~~ for persons  
4707 residing within the geographic area served by the aging resource  
4708 center.

4709 (e) If ~~When~~ financial resources become available, refer a  
4710 client to the most appropriate entity to begin receiving  
4711 services. The aging resource center shall make referrals to lead  
4712 agencies for service provision that ensure that individuals who  
4713 are vulnerable adults in need of services pursuant to s.  
4714 415.104(3)(b), or who are victims of abuse, neglect, or  
4715 exploitation in need of immediate services to prevent further  
4716 harm and are referred by the adult protective services program,  
4717 are given primary consideration for receiving community-care-  
4718 for-the-elderly services in compliance with the requirements of  
4719 s. 430.205(5)(a) and that other referrals for services are in  
4720 compliance with s. 430.205(5)(b).

4721 (f) Convene a work group to advise in the planning,  
4722 implementation, and evaluation of the aging resource center. The  
4723 work group shall be composed ~~comprised~~ of representatives of  
4724 local service providers, Alzheimer's Association chapters,  
4725 housing authorities, social service organizations, advocacy  
4726 groups, representatives of clients receiving services through  
4727 the aging resource center, and ~~any~~ other persons or groups as

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4728 determined by the department. The aging resource center, in  
4729 consultation with the work group, must develop annual program  
4730 improvement plans that shall be submitted to the department for  
4731 consideration. The department shall review each annual  
4732 improvement plan and make recommendations on how to implement  
4733 the components of the plan.

4734 (g) Enhance the existing area agency on aging in each  
4735 planning and service area by integrating, ~~either~~ physically or  
4736 virtually, the staff and services of the area agency on aging  
4737 with the staff of the department's local CARES Medicaid ~~nursing~~  
4738 ~~home~~ preadmission screening unit and a sufficient number of  
4739 staff from the Department of Children and Family Services'  
4740 Economic Self-Sufficiency Unit necessary to determine the  
4741 financial eligibility for all persons age 60 and older residing  
4742 within the area served by the aging resource center who that are  
4743 seeking Medicaid services, Supplemental Security Income, and  
4744 food assistance.

4745 (h) Assist clients who request long-term care services in  
4746 being evaluated for eligibility for the long-term care managed  
4747 care component of the Medicaid managed care program as qualified  
4748 plans become available in each of the regions pursuant to s.  
4749 409.973(2).

4750 (i) Provide enrollment and coverage information to Medicaid  
4751 managed long-term care enrollees as qualified plans become  
4752 available in each of the regions pursuant to s. 409.973(2).

4753 (j) Assist enrollees in the Medicaid long-term care managed  
4754 care program with informally resolving grievances with a managed  
4755 care network and in accessing the managed care network's formal  
4756 grievance process as qualified plans become available in each of

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4757 the regions pursuant to s. 409.973(2).

4758 (4)~~(6)~~ The department shall select the entities to become  
4759 aging resource centers based on each entity's readiness and  
4760 ability to perform the duties listed in subsection (3) ~~(5)~~ and  
4761 the entity's:

4762 (a) Expertise in the needs of each target population the  
4763 center proposes to serve and a thorough knowledge of the  
4764 providers that serve these populations.

4765 (b) Strong connections to service providers, volunteer  
4766 agencies, and community institutions.

4767 (c) Expertise in information and referral activities.

4768 (d) Knowledge of long-term-care resources, including  
4769 resources designed to provide services in the least restrictive  
4770 setting.

4771 (e) Financial solvency and stability.

4772 (f) Ability to collect, monitor, and analyze data in a  
4773 timely and accurate manner, along with systems that meet the  
4774 department's standards.

4775 (g) Commitment to adequate staffing by qualified personnel  
4776 to effectively perform all functions.

4777 (h) Ability to meet all performance standards established  
4778 by the department.

4779 (5)~~(7)~~ The aging resource center shall have a governing  
4780 body which shall be the same entity described in s. 20.41(7),  
4781 and an executive director who may be the same person as  
4782 described in s. 20.41(7). The governing body shall annually  
4783 evaluate the performance of the executive director.

4784 (6)~~(8)~~ The aging resource center may not be a provider of  
4785 direct services other than information and referral services,

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4786 and screening.

4787       (7)~~(9)~~ The aging resource center must agree to allow the  
4788 department to review any financial information the department  
4789 determines is necessary for monitoring or reporting purposes,  
4790 including financial relationships.

4791       (8)~~(10)~~ The duties and responsibilities of the community  
4792 care for the elderly lead agencies within each area served by an  
4793 aging resource center shall be to:

4794           (a) Develop strong community partnerships to maximize the  
4795 use of community resources for the purpose of assisting elders  
4796 to remain in their community settings for as long as it is  
4797 safely possible.

4798           (b) Conduct comprehensive assessments of clients that have  
4799 been determined eligible and develop a care plan consistent with  
4800 established protocols that ensures that the unique needs of each  
4801 client are met.

4802       (9)~~(11)~~ The services to be administered through the aging  
4803 resource center shall include those funded by the following  
4804 programs:

4805           (a) Community care for the elderly.

4806           (b) Home care for the elderly.

4807           (c) Contracted services.

4808           (d) Alzheimer's disease initiative.

4809           (e) Aged and disabled adult Medicaid waiver.

4810           (f) Assisted living for the frail elderly Medicaid waiver.

4811           (g) Older Americans Act.

4812       (10)~~(12)~~ The department shall, prior to designation of an  
4813 aging resource center, develop by rule operational and quality  
4814 assurance standards and outcome measures to ensure that clients

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4815 receiving services through all long-term-care programs  
4816 administered through an aging resource center are receiving the  
4817 appropriate care they require and that contractors and  
4818 subcontractors are adhering to the terms of their contracts and  
4819 are acting in the best interests of the clients they are  
4820 serving, consistent with the intent of the Legislature to reduce  
4821 the use of and cost of nursing home care. The department shall  
4822 by rule provide operating procedures for aging resource centers,  
4823 which shall include:

4824 (a) Minimum standards for financial operation, including  
4825 audit procedures.

4826 (b) Procedures for monitoring and sanctioning of service  
4827 providers.

4828 (c) Minimum standards for technology utilized by the aging  
4829 resource center.

4830 (d) Minimum staff requirements which shall ensure that the  
4831 aging resource center employs sufficient quality and quantity of  
4832 staff to adequately meet the needs of the elders residing within  
4833 the area served by the aging resource center.

4834 (e) Minimum accessibility standards, including hours of  
4835 operation.

4836 (f) Minimum oversight standards for the governing body of  
4837 the aging resource center to ensure its continuous involvement  
4838 in, and accountability for, all matters related to the  
4839 development, implementation, staffing, administration, and  
4840 operations of the aging resource center.

4841 (g) Minimum education and experience requirements for  
4842 executive directors and other executive staff positions of aging  
4843 resource centers.

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4844 (h) Minimum requirements regarding any executive staff  
4845 positions that the aging resource center must employ and minimum  
4846 requirements that a candidate must meet in order to be eligible  
4847 for appointment to such positions.

4848 (11)~~(13)~~ In an area in which the department has designated  
4849 an area agency on aging as an aging resource center, the  
4850 department and the agency may ~~shall~~ not make payments for the  
4851 services listed in subsection (9) ~~(11)~~ and the Long-Term Care  
4852 Community Diversion Project for ~~such~~ persons who were not  
4853 screened and enrolled through the aging resource center. The  
4854 department shall cease making these payments for enrollees in  
4855 qualified plans as qualified plans become available in each of  
4856 the regions pursuant to s. 409.973(2).

4857 (12)~~(14)~~ Each aging resource center shall enter into a  
4858 memorandum of understanding with the department for  
4859 collaboration with the CARES unit staff. The memorandum of  
4860 understanding must ~~shall~~ outline the staff person responsible  
4861 for each function and ~~shall~~ provide the staffing levels  
4862 necessary to carry out the functions of the aging resource  
4863 center.

4864 (13)~~(15)~~ Each aging resource center shall enter into a  
4865 memorandum of understanding with the Department of Children and  
4866 Family Services for collaboration with the Economic Self-  
4867 Sufficiency Unit staff. The memorandum of understanding must  
4868 ~~shall~~ outline which staff persons are responsible for which  
4869 functions and ~~shall~~ provide the staffing levels necessary to  
4870 carry out the functions of the aging resource center.

4871 (14)~~(16)~~ If any of the state activities described in this  
4872 section are outsourced, ~~either~~ in part or in whole, the contract



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4873 executing the outsourcing must ~~shall~~ mandate that the contractor  
4874 or its subcontractors shall, ~~either~~ physically or virtually,  
4875 execute the provisions of the memorandum of understanding  
4876 instead of the state entity whose function the contractor or  
4877 subcontractor now performs.

4878 (15)~~(17)~~ In order to be eligible to begin transitioning to  
4879 an aging resource center, an area agency on aging board must  
4880 ensure that the area agency on aging which it oversees meets all  
4881 of the minimum requirements set by law and in rule.

4882 ~~(18) The department shall monitor the three initial~~  
4883 ~~projects for aging resource centers and report on the progress~~  
4884 ~~of those projects to the Governor, the President of the Senate,~~  
4885 ~~and the Speaker of the House of Representatives by June 30,~~  
4886 ~~2005. The report must include an evaluation of the~~  
4887 ~~implementation process.~~

4888 (16)~~(19)~~ (a) Once an aging resource center is operational,  
4889 the department, in consultation with the agency, may develop  
4890 capitation rates for any of the programs administered through  
4891 the aging resource center. Capitation rates for programs must  
4892 ~~shall~~ be based on the historical cost experience of the state in  
4893 providing those same services to the population age 60 or older  
4894 residing within each area served by an aging resource center.  
4895 Each capitated rate may vary by geographic area as determined by  
4896 the department.

4897 (b) The department and the agency may determine for each  
4898 area served by an aging resource center whether it is  
4899 appropriate, consistent with federal and state laws and  
4900 regulations, to develop and pay separate capitated rates for  
4901 each program administered through the aging resource center or

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4902 to develop and pay capitated rates for service packages which  
4903 include more than one program or service administered through  
4904 the aging resource center.

4905 (c) Once capitation rates have been developed and certified  
4906 as actuarially sound, the department and the agency may pay  
4907 service providers the capitated rates for services if ~~when~~  
4908 appropriate.

4909 (d) The department, in consultation with the agency, shall  
4910 annually reevaluate and recertify the capitation rates,  
4911 adjusting forward to account for inflation, programmatic  
4912 changes.

4913 ~~(20) The department, in consultation with the agency, shall~~  
4914 ~~submit to the Governor, the President of the Senate, and the~~  
4915 ~~Speaker of the House of Representatives, by December 1, 2006, a~~  
4916 ~~report addressing the feasibility of administering the following~~  
4917 ~~services through aging resource centers beginning July 1, 2007:~~

- 4918 ~~(a) Medicaid nursing home services.~~  
4919 ~~(b) Medicaid transportation services.~~  
4920 ~~(c) Medicaid hospice care services.~~  
4921 ~~(d) Medicaid intermediate care services.~~  
4922 ~~(e) Medicaid prescribed drug services.~~  
4923 ~~(f) Medicaid assistive care services.~~  
4924 ~~(g) Any other long term care program or Medicaid service.~~

4925 (17) ~~(21)~~ This section does shall not be construed to allow  
4926 an aging resource center to restrict, manage, or impede the  
4927 local fundraising activities of service providers.

4928 Section 59. Paragraphs (c) and (d) of subsection (3) of  
4929 section 39.407, Florida Statutes, are amended to read:

4930 39.407 Medical, psychiatric, and psychological examination

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4931 and treatment of child; physical, mental, or substance abuse  
4932 examination of person with or requesting child custody.—

4933 (3)

4934 (c) Except as provided in paragraphs (b) and (e), the  
4935 department must file a motion seeking the court's authorization  
4936 to initially provide or continue to provide psychotropic  
4937 medication to a child in its legal custody. The motion must be  
4938 supported by a written report prepared by the department which  
4939 describes the efforts made to enable the prescribing physician  
4940 to obtain express and informed consent to provide ~~for providing~~  
4941 the medication to the child and other treatments considered or  
4942 recommended for the child. ~~In addition,~~ The motion must also be  
4943 supported by the prescribing physician's signed medical report  
4944 providing:

4945 1. The name of the child, the name and range of the dosage  
4946 of the psychotropic medication, and the ~~that there is a~~ need to  
4947 prescribe psychotropic medication to the child based upon a  
4948 diagnosed condition for which such medication is being  
4949 prescribed.

4950 2. A statement indicating that the physician has reviewed  
4951 all medical information concerning the child which has been  
4952 provided.

4953 3. A statement indicating that the psychotropic medication,  
4954 at its prescribed dosage, is appropriate for treating the  
4955 child's diagnosed medical condition, as well as the behaviors  
4956 and symptoms the medication, at its prescribed dosage, is  
4957 expected to address.

4958 4. An explanation of the nature and purpose of the  
4959 treatment; the recognized side effects, risks, and

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4960 contraindications of the medication; drug-interaction  
4961 precautions; the possible effects of stopping the medication;  
4962 and how the treatment will be monitored, followed by a statement  
4963 indicating that this explanation was provided to the child if  
4964 age appropriate and to the child's caregiver.

4965 5. Documentation addressing whether the psychotropic  
4966 medication will replace or supplement any other currently  
4967 prescribed medications or treatments; the length of time the  
4968 child is expected to be taking the medication; and any  
4969 additional medical, mental health, behavioral, counseling, or  
4970 other services that the prescribing physician recommends.

4971 6. For a child 10 years of age or younger who is in an out-  
4972 of-home placement, the results of a review of the administration  
4973 of the medication by a child psychiatrist who is licensed under  
4974 chapter 458 or chapter 459. The review must be provided to the  
4975 child and the parent or legal guardian before final express and  
4976 informed consent is given. The review must include a  
4977 determination of the following:

4978 a. The presence of a genetic psychiatric disorder or a  
4979 family history of a psychiatric disorder;

4980 b. Whether the cause of a psychiatric disorder is physical  
4981 or environmental; and

4982 c. The likelihood of the child being an imminent danger to  
4983 self or others.

4984 (d)~~1~~. The department must notify all parties of the  
4985 proposed action taken under paragraph (c) in writing or by  
4986 whatever other method best ensures that all parties receive  
4987 notification of the proposed action within 48 hours after the  
4988 motion is filed. If any party objects to the department's

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4989 motion, that party shall file the objection within 2 working  
4990 days after being notified of the department's motion. If any  
4991 party files an objection to the authorization of the proposed  
4992 psychotropic medication, the court shall hold a hearing as soon  
4993 as possible before authorizing the department to initially  
4994 provide or to continue providing psychotropic medication to a  
4995 child in the legal custody of the department.

4996 1. At such hearing and notwithstanding s. 90.803, the  
4997 medical report described in paragraph (c) is admissible in  
4998 evidence. The prescribing physician need not attend the hearing  
4999 or testify unless the court specifically orders such attendance  
5000 or testimony, or a party subpoenas the physician to attend the  
5001 hearing or provide testimony.

5002 2. If, after considering any testimony received, the court  
5003 finds that the department's motion and the physician's medical  
5004 report meet the requirements of this subsection and that it is  
5005 in the child's best interests, the court may order that the  
5006 department provide or continue to provide the psychotropic  
5007 medication to the child without additional testimony or  
5008 evidence.

5009 3. At any hearing held under this paragraph, the court  
5010 shall ~~further~~ inquire of the department as to whether additional  
5011 medical, mental health, behavioral, counseling, or other  
5012 services are being provided to the child by the department which  
5013 the prescribing physician considers to be necessary or  
5014 beneficial in treating the child's medical condition and which  
5015 the physician recommends or expects to provide to the child in  
5016 concert with the medication. The court may order additional  
5017 medical consultation, including consultation with the MedConsult

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5018 line at the University of Florida, if available, or require the  
5019 department to obtain a second opinion within a reasonable  
5020 timeframe as established by the court, not to exceed 21 calendar  
5021 days, ~~after such order~~ based upon consideration of the best  
5022 interests of the child. The department must make a referral for  
5023 an appointment for a second opinion with a physician within 1  
5024 working day.

5025 4. The court may not order the discontinuation of  
5026 prescribed psychotropic medication if such order is contrary to  
5027 the decision of the prescribing physician unless the court first  
5028 obtains an opinion from a licensed psychiatrist, if available,  
5029 or, if not available, a physician licensed under chapter 458 or  
5030 chapter 459, stating that more likely than not, discontinuing  
5031 the medication would not cause significant harm to the child.  
5032 If, however, the prescribing psychiatrist specializes in mental  
5033 health care for children and adolescents, the court may not  
5034 order the discontinuation of prescribed psychotropic medication  
5035 unless the required opinion is also from a psychiatrist who  
5036 specializes in mental health care for children and adolescents.  
5037 The court may also order the discontinuation of prescribed  
5038 psychotropic medication if a child's treating physician,  
5039 licensed under chapter 458 or chapter 459, states that  
5040 continuing the prescribed psychotropic medication would cause  
5041 significant harm to the child due to a diagnosed nonpsychiatric  
5042 medical condition.

5043 5. If a child who is in out-of-home placement is 10 years  
5044 of age or younger, psychotropic medication may not be authorized  
5045 by the court absent a finding of a compelling governmental  
5046 interest. In making such finding, the court shall review the

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5047 psychiatric review described in subparagraph (c) 6.

5048 ~~6.2.~~ The burden of proof at any hearing held under this  
5049 paragraph shall be by a preponderance of the evidence.

5050 Section 60. Paragraph (a) of subsection (1) of section  
5051 216.262, Florida Statutes, is amended to read:

5052 216.262 Authorized positions.—

5053 (1) (a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by  
5054 law, the total number of authorized positions may not exceed the  
5055 total provided in the appropriations acts. If a ~~In the event any~~  
5056 state agency or entity of the judicial branch finds that the  
5057 number of positions so provided is not sufficient to administer  
5058 its authorized programs, it may file an application with the  
5059 Executive Office of the Governor or the Chief Justice~~r~~ and, if  
5060 the Executive Office of the Governor or Chief Justice certifies  
5061 that there are no authorized positions available for addition,  
5062 deletion, or transfer within the agency or entity as provided in  
5063 paragraph (c), may recommend ~~and recommends~~ an increase in the  
5064 number of positions.~~r~~

5065 1. The Governor or the Chief Justice may recommend an  
5066 increase in the number of positions for the following reasons  
5067 only:

5068 ~~a.1.~~ To implement or provide for continuing federal grants  
5069 or changes in grants not previously anticipated.

5070 ~~b.2.~~ To meet emergencies pursuant to s. 252.36.

5071 ~~c.3.~~ To satisfy new federal regulations or changes therein.

5072 ~~d.4.~~ To take advantage of opportunities to reduce operating  
5073 expenditures or to increase the revenues of the state or local  
5074 government.

5075 ~~e.5.~~ To authorize positions that were not fixed by the

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5076 Legislature due to ~~through~~ error in drafting the appropriations  
5077 acts.

5078 2. Actions recommended pursuant to this paragraph are  
5079 subject to approval by the Legislative Budget Commission. The  
5080 certification and the final authorization shall be provided to  
5081 the Legislative Budget Commission, the legislative  
5082 appropriations committees, and the Auditor General.

5083 3. The provisions of this paragraph do not apply to  
5084 positions in the Department of Health which are funded by the  
5085 County Health Department Trust Fund.

5086 Section 61. Section 381.06014, Florida Statutes, is amended  
5087 to read:

5088 381.06014 Blood establishments.—

5089 (1) As used in this section, the term:

5090 (a) "Blood establishment" means any person, entity, or  
5091 organization, operating within the state, which examines an  
5092 individual for the purpose of blood donation or which collects,  
5093 processes, stores, tests, or distributes blood or blood  
5094 components collected from the human body for the purpose of  
5095 transfusion, for any other medical purpose, or for the  
5096 production of any biological product. A person, entity, or  
5097 organization that uses a mobile unit to conduct such activities  
5098 within the state is also a blood establishment.

5099 (b) "Volunteer donor" means a person who does not receive  
5100 remuneration, other than an incentive, for a blood donation  
5101 intended for transfusion, and the product container of the  
5102 donation from the person qualifies for labeling with the  
5103 statement "volunteer donor" under 21 C.F.R. s. 606.121.

5104 (2) An entity or organization may not hold itself out and



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5105 engage in the activities of a Any blood establishment in this  
5106 state ~~operating in the state may not conduct any activity~~  
5107 ~~defined in subsection (1) unless it operates in accordance that~~  
5108 ~~blood establishment is operated in a manner consistent with the~~  
5109 ~~provisions of Title 21 C.F.R. parts 211 and 600-640, Code of~~  
5110 ~~Federal Regulations.~~

5111 (3) A Any blood establishment determined to be operating in  
5112 the state in a manner not consistent with the provisions of  
5113 Title 21 C.F.R. parts 211 and 600-640, Code of Federal  
5114 Regulations, and in a manner that constitutes a danger to the  
5115 health or well-being of donors or recipients as evidenced by the  
5116 federal Food and Drug Administration's inspection reports and  
5117 the revocation of the blood establishment's license or  
5118 registration is shall be in violation of this chapter, and shall  
5119 immediately cease all operations in the state.

5120 (4) ~~The operation of a blood establishment in a manner not~~  
5121 ~~consistent with the provisions of Title 21 parts 211 and 600-~~  
5122 ~~640, Code of Federal Regulations, and in a manner that~~  
5123 ~~constitutes a danger to the health or well-being of blood donors~~  
5124 ~~or recipients as evidenced by the federal Food and Drug~~  
5125 ~~Administration's inspection process is declared a nuisance and~~  
5126 ~~inimical to the public health, welfare, and safety, and must~~  
5127 immediately cease all operations in this state. The Agency for  
5128 Health Care Administration or any state attorney may bring an  
5129 action for an injunction to restrain such operations or enjoin  
5130 the future operation of the blood establishment.

5131 (4) A local government may not restrict access to or the  
5132 use of any public facility or infrastructure for the collection  
5133 of blood or blood components from volunteer donors based on

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5134 whether the blood establishment is operating as a for-profit or  
5135 not-for-profit organization.

5136 (5) In determining the service fee of blood or blood  
5137 components received from volunteer donors and sold to hospitals  
5138 or other health care providers, a blood establishment may not  
5139 base the service fee of the blood or blood component solely on  
5140 whether the purchasing entity is a for-profit or not-for-profit  
5141 organization.

5142 (6) A blood establishment that collects blood or blood  
5143 components from volunteer donors must disclose the following  
5144 information on its Internet website in order to educate and  
5145 inform donors and the public about the blood establishment's  
5146 activities, and the information required to be disclosed may be  
5147 cumulative for all blood establishments within a business  
5148 entity:

5149 (a) A description of the steps involved in collecting,  
5150 processing, and distributing volunteer donations.

5151 (b) By March 1 of each year, the number of units of blood  
5152 components which were:

5153 1. Produced by the blood establishment during the preceding  
5154 calendar year;

5155 2. Obtained from other sources during the preceding  
5156 calendar year;

5157 3. Distributed during the preceding calendar year to health  
5158 care providers located outside this state. However, if the blood  
5159 establishment collects donations in a county outside this state,  
5160 distributions to health care providers in that county are  
5161 excluded. Such information shall be reported in the aggregate  
5162 for health care providers located within the United States and

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5163 its territories or outside the United States and its  
5164 territories; and

5165 4. Distributed during the preceding calendar year to  
5166 entities that are not health care providers. Such information  
5167 shall be reported in the aggregate for purchasers located within  
5168 the United States and its territories or outside the United  
5169 States and its territories.

5170 (c) The blood establishment's conflict-of-interest policy,  
5171 policy concerning related-party transactions, whistleblower  
5172 policy, and policy for determining executive compensation. If a  
5173 change occurs to any of these documents, the revised document  
5174 must be available on the blood establishment's website by the  
5175 following March 1.

5176 (d) Except for a hospital that collects blood or blood  
5177 components from volunteer donors:

5178 1. The most recent 3 years of the Return of Organization  
5179 Exempt from Income Tax, Internal Revenue Service Form 990, if  
5180 the business entity for the blood establishment is eligible to  
5181 file such return. The Form 990 must be available on the blood  
5182 establishment's website within 60 calendar days after it is  
5183 filed with the Internal Revenue Service; or

5184 2. If the business entity for the blood establishment is  
5185 not eligible to file the Form 990 return, a balance sheet,  
5186 income statement, and statement of changes in cash flow, along  
5187 with the expression of an opinion thereon by an independent  
5188 certified public accountant who audited or reviewed such  
5189 financial statements. Such documents must be available on the  
5190 blood establishment's website within 120 days after the end of  
5191 the blood establishment's fiscal year and must remain on the

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5192 blood establishment's website for at least 36 months.

5193  
5194 A hospital that collects blood or blood components to be used  
5195 only by that hospital's licensed facilities or by a health care  
5196 provider that is a part of the hospital's business entity is  
5197 exempt from the disclosure requirements of this subsection.

5198 (7) A blood establishment is liable for a civil penalty for  
5199 failing to make the disclosures required under subsection (6).  
5200 The Department of Legal Affairs may assess a civil penalty  
5201 against the blood establishment for each day that it fails to  
5202 make such required disclosures, but the penalty may not exceed  
5203 \$10,000 per year. If multiple blood establishments operated by a  
5204 single business entity fail to meet such disclosure  
5205 requirements, the civil penalty may be assessed against only one  
5206 of the business entity's blood establishments. The Department of  
5207 Legal Affairs may terminate an action if the blood establishment  
5208 agrees to pay a stipulated civil penalty. A civil penalty so  
5209 collected accrues to the state and shall be deposited as  
5210 received into the General Revenue Fund unallocated. The  
5211 Department of Legal Affairs may terminate the action and waive  
5212 the civil penalty upon a showing of good cause by the blood  
5213 establishment as to why the required disclosures were not made.

5214 Section 62. Subsection (9) of section 393.063, Florida  
5215 Statutes, is amended, present subsections (13) through (40) of  
5216 that section are redesignated as subsections (14) through (41),  
5217 respectively, and a new subsection (13) is added to that  
5218 section, to read:

5219 393.063 Definitions.—For the purposes of this chapter, the  
5220 term:

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5221 (9) "Developmental disability" means a disorder or syndrome  
5222 that is attributable to retardation, cerebral palsy, autism,  
5223 spina bifida, Down syndrome, or Prader-Willi syndrome; that  
5224 manifests before the age of 18; and that constitutes a  
5225 substantial handicap that can reasonably be expected to continue  
5226 indefinitely.

5227 (13) "Down syndrome" means a disorder that is caused by the  
5228 presence of an extra chromosome 21.

5229 Section 63. Section 400.023, Florida Statutes, is reordered  
5230 and amended to read:

5231 400.023 Civil enforcement.—

5232 (1) A Any resident who whose alleges negligence or a  
5233 violation of rights as specified in this part has are violated  
5234 shall have a cause of action against the licensee or its  
5235 management company, as identified in the state application for  
5236 nursing home licensure. However, the cause of action may not be  
5237 asserted individually against an officer, director, owner,  
5238 including an owner designated as having a controlling interest  
5239 on the state application for nursing home licensure, or agent of  
5240 a licensee or management company unless, following an  
5241 evidentiary hearing, the court determines there is sufficient  
5242 evidence in the record or proffered by the claimant which  
5243 establishes a reasonable basis for finding that the person or  
5244 entity breached, failed to perform, or acted outside the scope  
5245 of duties as an officer, director, owner, or agent, and that the  
5246 breach, failure to perform, or action outside the scope of  
5247 duties is a legal cause of actual loss, injury, death, or damage  
5248 to the resident.

5249 (2) The action may be brought by the resident or his or her

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5250 guardian, by a person or organization acting on behalf of a  
5251 resident with the consent of the resident or his or her  
5252 guardian, or by the personal representative of the estate of a  
5253 deceased resident regardless of the cause of death.

5254 (5) If the action alleges a claim for the resident's rights  
5255 or for negligence that:

5256 (a) Caused the death of the resident, the claimant must  
5257 ~~shall be required to~~ elect either survival damages pursuant to  
5258 s. 46.021 or wrongful death damages pursuant to s. 768.21. If  
5259 the claimant elects wrongful death damages, total noneconomic  
5260 damages may not exceed \$250,000, regardless of the number of  
5261 claimants.

5262 ~~(b) If the action alleges a claim for the resident's rights~~  
5263 ~~or for negligence that~~ Did not cause the death of the resident,  
5264 the personal representative of the estate may recover damages  
5265 for the negligence that caused injury to the resident.

5266 (3) The action may be brought in any court of competent  
5267 jurisdiction to enforce such rights and to recover actual and  
5268 punitive damages for any violation of the rights of a resident  
5269 or for negligence.

5270 (10) Any resident who prevails in seeking injunctive relief  
5271 or a claim for an administrative remedy may ~~is entitled to~~  
5272 recover the costs of the action, and a reasonable attorney's fee  
5273 assessed against the defendant not to exceed \$25,000. Fees shall  
5274 be awarded solely for the injunctive or administrative relief  
5275 and not for any claim or action for damages whether such claim  
5276 or action is brought together with a request for an injunction  
5277 or administrative relief or as a separate action, except as  
5278 provided under s. 768.79 or the Florida Rules of Civil

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5279 Procedure. Sections 400.023-400.0238 provide the exclusive  
 5280 remedy for a cause of action for recovery of damages for the  
 5281 personal injury or death of a nursing home resident arising out  
 5282 of negligence or a violation of rights specified in s. 400.022.  
 5283 This section does not preclude theories of recovery not arising  
 5284 out of negligence or s. 400.022 which are available to a  
 5285 resident or to the agency. The provisions of chapter 766 do not  
 5286 apply to any cause of action brought under ss. 400.023-400.0238.

5287 (6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part  
 5288 alleges ~~alleging~~ a violation of resident's rights or negligence  
 5289 causing injury to or the death of a resident, the claimant shall  
 5290 have the burden of proving, by a preponderance of the evidence,  
 5291 that:

5292 (a) The defendant owed a duty to the resident;

5293 (b) The defendant breached the duty to the resident;

5294 (c) The breach of the duty is a legal cause of loss,  
 5295 injury, death, or damage to the resident; and

5296 (d) The resident sustained loss, injury, death, or damage  
 5297 as a result of the breach.

5298 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~  
 5299 create strict liability. A violation of the rights set forth in  
 5300 s. 400.022 or in any other standard or guidelines specified in  
 5301 this part or in any applicable administrative standard or  
 5302 guidelines of this state or a federal regulatory agency is ~~shall~~  
 5303 ~~be~~ evidence of negligence but may ~~shall~~ not be considered  
 5304 negligence per se.

5305 (7) ~~(3)~~ In any claim brought pursuant to this section, a  
 5306 licensee, person, or entity has ~~shall have~~ a duty to exercise  
 5307 reasonable care. Reasonable care is that degree of care which a

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5308 reasonably careful licensee, person, or entity would use under  
5309 like circumstances.

5310 (9)~~(4)~~ In any claim for resident's rights violation or  
5311 negligence by a nurse licensed under part I of chapter 464, such  
5312 nurse has a ~~shall have the~~ duty to exercise care consistent with  
5313 the prevailing professional standard of care for a nurse. The  
5314 prevailing professional standard of care for a nurse is ~~shall be~~  
5315 that level of care, skill, and treatment which, in light of all  
5316 relevant surrounding circumstances, is recognized as acceptable  
5317 and appropriate by reasonably prudent similar nurses.

5318 (8)~~(5)~~ A licensee is ~~shall not be~~ liable for the medical  
5319 negligence of any physician rendering care or treatment to the  
5320 resident except for the administrative services of a medical  
5321 director as required in this part. ~~Nothing in~~ This subsection  
5322 does not ~~shall be construed to~~ protect a licensee, person, or  
5323 entity from liability for failure to provide a resident with  
5324 appropriate observation, assessment, nursing diagnosis,  
5325 planning, intervention, and evaluation of care by nursing staff.

5326 (4)~~(6)~~ The resident or the resident's legal representative  
5327 shall serve a copy of any complaint alleging in whole or in part  
5328 a violation of any rights specified in this part to the agency  
5329 ~~for Health Care Administration~~ at the time of filing the initial  
5330 complaint with the clerk of the court for the county in which  
5331 the action is pursued. ~~The requirement of~~ Providing a copy of  
5332 the complaint to the agency does not impair the resident's legal  
5333 rights or ability to seek relief for his or her claim.

5334 (11)~~(7)~~ An action under this part for a violation of rights  
5335 or negligence ~~recognized herein~~ is not a claim for medical  
5336 malpractice, and the provisions of s. 768.21(8) do not apply to



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5337 a claim alleging death of the resident.

5338 Section 64. Subsections (1), (2), and (3) of section  
5339 400.0237, Florida Statutes, are amended to read:

5340 400.0237 Punitive damages; pleading; burden of proof.—

5341 (1) In any action ~~for damages~~ brought under this part, a ne  
5342 claim for punitive damages is not shall be permitted unless,  
5343 based on admissible there is a reasonable showing by evidence in  
5344 the record or proffered by the claimant, which would provide a  
5345 reasonable basis for recovery of such damages is demonstrated  
5346 upon applying the criteria set forth in this section. The  
5347 defendant may proffer admissible evidence to refute the  
5348 claimant's proffer of evidence to recover punitive damages. The  
5349 trial judge shall conduct an evidentiary hearing and weigh the  
5350 admissible evidence proffered by the claimant and the defendant  
5351 to ensure that there is a reasonable basis to believe that the  
5352 claimant, at trial, will be able to demonstrate by clear and  
5353 convincing evidence that the recovery of such damages is  
5354 warranted. The claimant may move to amend her or his complaint  
5355 to assert a claim for punitive damages as allowed by the rules  
5356 of civil procedure. The rules of civil procedure shall be  
5357 liberally construed so as to allow the claimant discovery of  
5358 evidence which appears reasonably calculated to lead to  
5359 admissible evidence on the issue of punitive damages. No  
5360 Discovery of financial worth may not shall proceed until after  
5361 the trial judge approves the pleading on concerning punitive  
5362 damages is permitted.

5363 (2) A defendant, including the licensee or management  
5364 company, against whom punitive damages is sought may be held  
5365 liable for punitive damages only if the trier of fact, based on

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5366 clear and convincing evidence, finds that a specific individual  
5367 or corporate defendant actively and knowingly participated in  
5368 intentional misconduct, or engaged in conduct that constituted  
5369 gross negligence, and that conduct contributed to the loss,  
5370 damages, or injury suffered by the claimant ~~the defendant was~~  
5371 ~~personally guilty of intentional misconduct or gross negligence.~~

5372 As used in this section, the term:

5373 (a) "Intentional misconduct" means that the defendant  
5374 against whom a claim for punitive damages is sought had actual  
5375 knowledge of the wrongfulness of the conduct and the high  
5376 probability that injury or damage to the claimant would result  
5377 and, despite that knowledge, intentionally pursued that course  
5378 of conduct, resulting in injury or damage.

5379 (b) "Gross negligence" means that the defendant's conduct  
5380 was so reckless or wanting in care that it constituted a  
5381 conscious disregard or indifference to the life, safety, or  
5382 rights of persons exposed to such conduct.

5383 (3) In the case of vicarious liability of an employer,  
5384 principal, corporation, or other legal entity, punitive damages  
5385 may not be imposed for the conduct of an identified employee or  
5386 agent unless ~~only if~~ the conduct of the employee or agent meets  
5387 the criteria specified in subsection (2) and officers,  
5388 directors, or managers of the actual employer corporation or  
5389 legal entity condoned, ratified, or consented to the specific  
5390 conduct as alleged by the claimant in subsection (2).÷

5391 ~~(a) The employer, principal, corporation, or other legal~~  
5392 ~~entity actively and knowingly participated in such conduct;~~

5393 ~~(b) The officers, directors, or managers of the employer,~~  
5394 ~~principal, corporation, or other legal entity condoned,~~

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5395 ~~ratified, or consented to such conduct; or~~

5396 ~~(c) The employer, principal, corporation, or other legal~~  
5397 ~~entity engaged in conduct that constituted gross negligence and~~  
5398 ~~that contributed to the loss, damages, or injury suffered by the~~  
5399 ~~claimant.~~

5400 Section 65. Subsections (3) and (4) of section 408.7057,  
5401 Florida Statutes, are amended, present subsection (7) of that  
5402 section is redesignated as subsection (8), and a new subsection  
5403 (7) is added to that section, to read:

5404 408.7057 Statewide provider and health plan claim dispute  
5405 resolution program.—

5406 (3) The agency shall adopt rules to establish a process to  
5407 be used by the resolution organization in considering claim  
5408 disputes submitted by a provider or health plan which must  
5409 include a hearing, if requested by the respondent, and the  
5410 issuance by the resolution organization of a written  
5411 recommendation, supported by findings of fact and conclusions of  
5412 law, to the agency within 60 days after the requested  
5413 information is received by the resolution organization within  
5414 the timeframes specified by the resolution organization. ~~In no~~  
5415 ~~event shall~~ The review time may not exceed 90 days following  
5416 receipt of the initial claim dispute submission by the  
5417 resolution organization.

5418 (4) Within 30 days after receipt of the recommendation of  
5419 the resolution organization, the agency shall adopt the  
5420 recommendation as a final order subject to chapter 120.

5421 (7) This section creates a procedure for dispute resolution  
5422 and not an independent right of recovery. The conclusions of law  
5423 contained in the written recommendation of the resolution

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5424 organization must identify the provisions of law or contract  
5425 which, under the particular facts and circumstances of the case,  
5426 entitle the provider or health plan to the amount awarded, if  
5427 any.

5428 Section 66. Section 458.3167, Florida Statutes, is created  
5429 to read:

5430 458.3167 Expert witness certificate.-

5431 (1) A physician who holds an active and valid license to  
5432 practice allopathic medicine in any other state or in Canada,  
5433 who submits an application form prescribed by the board to  
5434 obtain a certificate to provide expert testimony and pays the  
5435 application fee, and who has not had a previous expert witness  
5436 certificate revoked by the board shall be issued a certificate  
5437 to provide expert testimony.

5438 (2) A physician possessing an expert witness certificate  
5439 may use the certificate only to give a verified written medical  
5440 expert opinion as provided in s. 766.203 and to provide expert  
5441 testimony concerning the prevailing professional standard of  
5442 care for medical negligence litigation pending in this state  
5443 against a physician licensed under this chapter or chapter 459.

5444 (3) An application for an expert witness certificate must  
5445 be approved or denied within 5 business days after receipt of a  
5446 completed application. An application that is not approved or  
5447 denied within the required time period is deemed approved. An  
5448 applicant seeking to claim certification by default shall notify  
5449 the board, in writing, of the intent to rely on the default  
5450 certification provision of this subsection. In such case, s.  
5451 458.327 does not apply, and the applicant may provide expert  
5452 testimony as provided in subsection (2).

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5453       (4) All licensure fees, other than the initial certificate  
5454 application fee, including the neurological injury compensation  
5455 assessment, are waived for those persons obtaining an expert  
5456 witness certificate. The possession of an expert witness  
5457 certificate alone does not entitle the physician to engage in  
5458 the practice of medicine as defined in s. 458.305.

5459       (5) The board shall adopt rules to administer this section,  
5460 including rules setting the amount of the expert witness  
5461 certificate application fee, which may not exceed \$50. An expert  
5462 witness certificate expires 2 years after the date of issuance.

5463       Section 67. Subsection (11) is added to section 458.331,  
5464 Florida Statutes, present paragraphs (oo) through (qq) of  
5465 subsection (1) of that section are redesignated as paragraphs  
5466 (pp) through (rr), respectively, and a new paragraph (oo) is  
5467 added to that subsection, to read:

5468       458.331 Grounds for disciplinary action; action by the  
5469 board and department.—

5470       (1) The following acts constitute grounds for denial of a  
5471 license or disciplinary action, as specified in s. 456.072(2):

5472       (oo) Providing misleading, deceptive, or fraudulent expert  
5473 witness testimony related to the practice of medicine.

5474       (11) The purpose of this section is to facilitate uniform  
5475 discipline for those acts made punishable under this section  
5476 and, to this end, a reference to this section constitutes a  
5477 general reference under the doctrine of incorporation by  
5478 reference.

5479       Section 68. Section 459.0078, Florida Statutes, is created  
5480 to read:

5481       459.0078 Expert witness certificate.—

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5482       (1) A physician who holds an active and valid license to  
5483 practice osteopathic medicine in any other state or in Canada,  
5484 who submits an application form prescribed by the board to  
5485 obtain a certificate to provide expert testimony and pays the  
5486 application fee, and who has not had a previous expert witness  
5487 certificate revoked by the board shall be issued a certificate  
5488 to provide expert testimony.

5489       (2) A physician possessing an expert witness certificate  
5490 may use the certificate only to give a verified written medical  
5491 expert opinion as provided in s. 766.203 and to provide expert  
5492 testimony concerning the prevailing professional standard of  
5493 care for medical negligence litigation pending in this state  
5494 against a physician licensed under this chapter or chapter 458.

5495       (3) An application for an expert witness certificate must  
5496 be approved or denied within 5 business days after receipt of a  
5497 completed application. An application that is not approved or  
5498 denied within the required time period is deemed approved. An  
5499 applicant seeking to claim certification by default shall notify  
5500 the board, in writing, of the intent to rely on the default  
5501 certification provision of this subsection. In such case, s.  
5502 459.013 does not apply, and the applicant may provide expert  
5503 testimony as provided in subsection (2).

5504       (4) All licensure fees, other than the initial certificate  
5505 application fee, including the neurological injury compensation  
5506 assessment, are waived for those persons obtaining an expert  
5507 witness certificate. The possession of an expert witness  
5508 certificate alone does not entitle the physician to engage in  
5509 the practice of osteopathic medicine as defined in s. 459.003.

5510       (5) The board shall adopt rules to administer this section,

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5511 including rules setting the amount of the expert witness  
5512 certificate application fee, which may not exceed \$50. An expert  
5513 witness certificate expires 2 years after the date of issuance.

5514 Section 69. Subsection (11) is added to section 459.015,  
5515 Florida Statutes, present paragraphs (qq) through (ss) of  
5516 subsection (1) of that section are redesignated as paragraphs  
5517 (rr) through (tt), respectively, and a new paragraph (qq) is  
5518 added to that subsection, to read:

5519 459.015 Grounds for disciplinary action; action by the  
5520 board and department.—

5521 (1) The following acts constitute grounds for denial of a  
5522 license or disciplinary action, as specified in s. 456.072(2):

5523 (qq) Providing misleading, deceptive, or fraudulent expert  
5524 witness testimony related to the practice of osteopathic  
5525 medicine.

5526 (11) The purpose of this section is to facilitate uniform  
5527 discipline for those acts made punishable under this section  
5528 and, to this end, a reference to this section constitutes a  
5529 general reference under the doctrine of incorporation by  
5530 reference.

5531 Section 70. Subsection (23) of section 499.003, Florida  
5532 Statutes, is amended to read:

5533 499.003 Definitions of terms used in this part.—As used in  
5534 this part, the term:

5535 (23) "Health care entity" means a closed pharmacy or any  
5536 person, organization, or business entity that provides  
5537 diagnostic, medical, surgical, or dental treatment or care, or  
5538 chronic or rehabilitative care, but does not include any  
5539 wholesale distributor or retail pharmacy licensed under state

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5540 law to deal in prescription drugs. However, a blood  
5541 establishment is a health care entity that may engage in the  
5542 wholesale distribution of prescription drugs under s.  
5543 499.01(2)(g)1.c.

5544 Section 71. Subsection (21) of section 499.005, Florida  
5545 Statutes, is amended to read:

5546 499.005 Prohibited acts.—It is unlawful for a person to  
5547 perform or cause the performance of any of the following acts in  
5548 this state:

5549 (21) The wholesale distribution of any prescription drug  
5550 that was:

5551 (a) Purchased by a public or private hospital or other  
5552 health care entity; or

5553 (b) Donated or supplied at a reduced price to a charitable  
5554 organization,

5555  
5556 unless the wholesale distribution of the prescription drug is  
5557 authorized in s. 499.01(2)(g)1.c.

5558 Section 72. Paragraphs (a) and (g) of subsection (2) of  
5559 section 499.01, Florida Statutes, are amended to read:

5560 499.01 Permits.—

5561 (2) The following permits are established:

5562 (a) *Prescription drug manufacturer permit.*—A prescription  
5563 drug manufacturer permit is required for any person that is a  
5564 manufacturer of a prescription drug and that manufactures or  
5565 distributes such prescription drugs in this state.

5566 1. A person that operates an establishment permitted as a  
5567 prescription drug manufacturer may engage in wholesale  
5568 distribution of prescription drugs manufactured at that



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5569 establishment and must comply with all of the provisions of this  
5570 part, except s. 499.01212, and the rules adopted under this  
5571 part, except s. 499.01212, which ~~that~~ apply to a wholesale  
5572 distributor.

5573 2. A prescription drug manufacturer must comply with all  
5574 appropriate state and federal good manufacturing practices.

5575 3. A blood establishment, as defined in s. 381.06014,  
5576 operating in a manner consistent with the provisions of Title 21  
5577 C.F.R. parts 211 and 600-640 and manufacturing only the  
5578 prescription drugs described in s. 499.003(54)(d) is not  
5579 required to be permitted as a prescription drug manufacturer  
5580 under this paragraph or to register its products under s.  
5581 499.015.

5582 (g) *Restricted prescription drug distributor permit.-*

5583 1. A restricted prescription drug distributor permit is  
5584 required for:

5585 a. Any person located in this state that engages in the  
5586 distribution of a prescription drug, which distribution is not  
5587 considered "wholesale distribution" under s. 499.003(54)(a).

5588 ~~b.1.~~ Any A person located in this state who engages in the  
5589 receipt or distribution of a prescription drug in this state for  
5590 the purpose of processing its return or its destruction ~~must~~  
5591 ~~obtain a permit as a restricted prescription drug distributor~~ if  
5592 such person is not the person initiating the return, the  
5593 prescription drug wholesale supplier of the person initiating  
5594 the return, or the manufacturer of the drug.

5595 c. A blood establishment located in this state which  
5596 collects blood and blood components only from volunteer donors  
5597 as defined in s. 381.06014 or pursuant to an authorized

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5598 practitioner's order for medical treatment or therapy and  
5599 engages in the wholesale distribution of a prescription drug not  
5600 described in s. 499.003(54) (d) to a health care entity. The  
5601 health care entity receiving a prescription drug distributed  
5602 under this sub-subparagraph must be licensed as a closed  
5603 pharmacy or provide health care services at that establishment.  
5604 The blood establishment must operate in accordance with s.  
5605 381.06014 and may distribute only:

5606 (I) Prescription drugs indicated for a bleeding or clotting  
5607 disorder or anemia;

5608 (II) Blood-collection containers approved under s. 505 of  
5609 the federal act;

5610 (III) Drugs that are blood derivatives, or a recombinant or  
5611 synthetic form of a blood derivative;

5612 (IV) Prescription drugs that are identified in rules  
5613 adopted by the department and that are essential to services  
5614 performed or provided by blood establishments and authorized for  
5615 distribution by blood establishments under federal law; or

5616 (V) To the extent authorized by federal law, drugs  
5617 necessary to collect blood or blood components from volunteer  
5618 blood donors; for blood establishment personnel to perform  
5619 therapeutic procedures under the direction and supervision of a  
5620 licensed physician; and to diagnose, treat, manage, and prevent  
5621 any reaction of either a volunteer blood donor or a patient  
5622 undergoing a therapeutic procedure performed under the direction  
5623 and supervision of a licensed physician,

5624  
5625 as long as all of the health care services provided by the blood  
5626 establishment are related to its activities as a registered

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5627 blood establishment or the health care services consist of  
5628 collecting, processing, storing, or administering human  
5629 hematopoietic stem cells or progenitor cells or performing  
5630 diagnostic testing of specimens if such specimens are tested  
5631 together with specimens undergoing routine donor testing.

5632       2. Storage, handling, and recordkeeping of these  
5633 distributions by a person required to be permitted as a  
5634 restricted prescription drug distributor must comply with the  
5635 requirements for wholesale distributors under s. 499.0121, but  
5636 not those set forth in s. 499.01212 if the distribution occurs  
5637 pursuant to sub-subparagraph 1.a. or sub-subparagraph 1.b.

5638       3. A person who applies for a permit as a restricted  
5639 prescription drug distributor, or for the renewal of such a  
5640 permit, must provide to the department the information required  
5641 under s. 499.012.

5642       4. The department may adopt rules regarding the  
5643 distribution of prescription drugs by hospitals, health care  
5644 entities, charitable organizations, ~~or~~ other persons not  
5645 involved in wholesale distribution, and blood establishments,  
5646 which rules are necessary for the protection of the public  
5647 health, safety, and welfare.

5648       Section 73. Subsection (4) is added to section 626.9541,  
5649 Florida Statutes, to read:

5650       626.9541 Unfair methods of competition and unfair or  
5651 deceptive acts or practices defined.—

5652       (4) WELLNESS OR HEALTH IMPROVEMENT PROGRAMS.—

5653       (a) An insurer issuing a group or individual health benefit  
5654 plan may offer a voluntary wellness or health improvement  
5655 program and may encourage or reward participation in the program

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5656 by authorizing rewards or incentives, including, but not limited  
5657 to, merchandise, gift cards, debit cards, premium discounts or  
5658 rebates, contributions to a member's health savings account, or  
5659 modifications to copayment, deductible, or coinsurance amounts.

5660 (b) An insurer may require a health benefit plan member to  
5661 provide verification, such as an affirming statement from the  
5662 member's physician, that the member's medical condition makes it  
5663 unreasonably difficult or inadvisable to participate in the  
5664 wellness or health improvement program.

5665 (c) A reward or incentive offered under this subsection is  
5666 not an insurance benefit or violation of this section if it is  
5667 disclosed in the policy or certificate. This subsection does not  
5668 prohibit insurers from offering other incentives or rewards for  
5669 adherence to a wellness or health improvement program if  
5670 otherwise authorized by state or federal law.

5671 Section 74. Paragraph (b) of subsection (1) of section  
5672 627.4147, Florida Statutes, is amended to read:

5673 627.4147 Medical malpractice insurance contracts.—

5674 (1) In addition to any other requirements imposed by law,  
5675 each self-insurance policy ~~as~~ authorized under s. 627.357 or s.  
5676 624.462 or insurance policy providing coverage for claims  
5677 arising out of the rendering of, or the failure to render,  
5678 medical care or services, including those of the Florida Medical  
5679 Malpractice Joint Underwriting Association, must ~~shall~~ include:

5680 ~~(b)1. Except as provided in subparagraph 2., a clause~~  
5681 ~~authorizing the insurer or self-insurer to determine, to make,~~  
5682 ~~and to conclude, without the permission of the insured, any~~  
5683 ~~offer of admission of liability and for arbitration pursuant to~~  
5684 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~

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5685 ~~is within the policy limits. It is against public policy for any~~  
5686 ~~insurance or self-insurance policy to contain a clause giving~~  
5687 ~~the insured the exclusive right to veto any offer for admission~~  
5688 ~~of liability and for arbitration made pursuant to s. 766.106,~~  
5689 ~~settlement offer, or offer of judgment, when such offer is~~  
5690 ~~within the policy limits. However, any offer of admission of~~  
5691 ~~liability, settlement offer, or offer of judgment made by an~~  
5692 ~~insurer or self-insurer shall be made in good faith and in the~~  
5693 ~~best interests of the insured.~~

5694 1.2.a. With respect to dentists licensed under chapter 466,  
5695 a clause clearly stating whether or not the insured has the  
5696 exclusive right to veto any offer of admission of liability and  
5697 for arbitration pursuant to s. 766.106, settlement offer, or  
5698 offer of judgment if the offer is within policy limits. An  
5699 insurer or self-insurer may ~~shall~~ not make or conclude, without  
5700 the permission of the insured, any offer of admission of  
5701 liability and for arbitration pursuant to s. 766.106, settlement  
5702 offer, or offer of judgment, if such offer is outside the policy  
5703 limits. However, any offer for admission of liability and for  
5704 arbitration made under s. 766.106, settlement offer, or offer of  
5705 judgment made by an insurer or self-insurer must ~~shall~~ be made  
5706 in good faith and in the best interest of the insured.

5707 ~~2.b.~~ If the policy contains a clause stating the insured  
5708 does not have the exclusive right to veto any offer or admission  
5709 of liability and for arbitration made pursuant to s. 766.106,  
5710 settlement offer or offer of judgment, the insurer or self-  
5711 insurer shall provide to the insured or the insured's legal  
5712 representative by certified mail, return receipt requested, a  
5713 copy of the final offer of admission of liability and for

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5714 arbitration made pursuant to s. 766.106, settlement offer or  
5715 offer of judgment and at the same time such offer is provided to  
5716 the claimant. A copy of any final agreement reached between the  
5717 insurer and claimant shall also be provided to the insurer or  
5718 his or her legal representative by certified mail, return  
5719 receipt requested within ~~not more than~~ 10 days after affecting  
5720 such agreement.

5721 Section 75. Present subsection (12) of section 766.102,  
5722 Florida Statutes, is redesignated as subsection (13), and a new  
5723 subsection (12) is added to that section, to read:

5724 766.102 Medical negligence; standards of recovery; expert  
5725 witness.—

5726 (12) If a physician licensed under chapter 458 or chapter  
5727 459 is a party against whom, or on whose behalf, expert  
5728 testimony about the prevailing professional standard of care is  
5729 offered, the expert witness must otherwise meet the requirements  
5730 of this section and be licensed as a physician under chapter 458  
5731 or chapter 459, or must possess a valid expert witness  
5732 certificate issued under s. 458.3167 or s. 459.0078.

5733 Section 76. Subsection (1) of section 766.104, Florida  
5734 Statutes, is amended to read:

5735 766.104 Pleading in medical negligence cases; claim for  
5736 punitive damages; authorization for release of records for  
5737 investigation.—

5738 (1) An ~~No~~ action ~~shall be filed~~ for personal injury or  
5739 wrongful death arising out of medical negligence, whether in  
5740 tort or in contract, may not be filed unless the attorney filing  
5741 the action has made a reasonable investigation, as permitted by  
5742 the circumstances, to determine that there are grounds for a

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5743 good faith belief that there has been negligence in the care or  
5744 treatment of the claimant.

5745 (a) The complaint or initial pleading must ~~shall~~ contain a  
5746 certificate of counsel that such reasonable investigation gave  
5747 rise to a good faith belief that grounds exist for an action  
5748 against each named defendant. For purposes of this section, good  
5749 faith may be shown ~~to exist~~ if the claimant or his or her  
5750 counsel has received a written opinion, ~~which shall~~ not be  
5751 subject to discovery by an opposing party, of an expert as  
5752 defined in s. 766.102 that there appears to be evidence of  
5753 medical negligence. If the court determines that the such  
5754 certificate of counsel was not made in good faith and that no  
5755 justiciable issue was presented against a health care provider  
5756 that fully cooperated in providing informal discovery, the court  
5757 shall award attorney's fees and taxable costs against claimant's  
5758 counsel, ~~and shall~~ submit the matter to The Florida Bar for  
5759 disciplinary review of the attorney.

5760 (b) If the cause of action requires the plaintiff to  
5761 establish the breach of a standard of care other than negligence  
5762 in order to impose liability or secure specified damages arising  
5763 out of the rendering of, or the failure to render, medical care  
5764 or services, and the plaintiff intends to pursue such liability  
5765 or damages, the investigation and certification required by this  
5766 subsection must demonstrate grounds for a good faith belief that  
5767 the requirement is satisfied.

5768 Section 77. Subsection (5) of section 766.106, Florida  
5769 Statutes, is amended to read:

5770 766.106 Notice before filing action for medical negligence;  
5771 presuit screening period; offers for admission of liability and

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5772 for arbitration; informal discovery; review.—

5773 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,  
5774 written document, report, or other work product generated by the  
5775 presuit screening process is discoverable or admissible in any  
5776 civil action for any purpose by the opposing party. All  
5777 participants, including, but not limited to, physicians,  
5778 investigators, witnesses, and employees or associates of the  
5779 defendant, are immune from civil liability arising from  
5780 participation in the presuit screening process. This subsection  
5781 does not prohibit a physician licensed under chapter 458 or  
5782 chapter 459, or a physician who holds a certificate to provide  
5783 expert testimony under s. 458.3167 or s. 459.0078, who submits a  
5784 verified written expert medical opinion from being subject to  
5785 disciplinary action pursuant to s. 456.073.

5786 Section 78. Subsection (11) of section 766.1115, Florida  
5787 Statutes, is amended to read:

5788 766.1115 Health care providers; creation of agency  
5789 relationship with governmental contractors.—

5790 (11) APPLICABILITY.—

5791 (a) This section applies to incidents occurring on or after  
5792 April 17, 1992.

5793 (b) This section does not apply to any health care contract  
5794 entered into by the Department of Corrections which is subject  
5795 to s. 768.28(10) (a).

5796 (c) This section does not apply to any affiliation  
5797 agreement or other contract subject to s. 768.28(10) (f).

5798 (d) ~~Nothing in~~ This section does not reduce or limit in any  
5799 way reduces or limits the rights of the state or any of its  
5800 agencies or subdivisions to any benefit currently provided under



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5801 s. 768.28.

5802 Section 79. Section 766.1183, Florida Statutes, is created  
5803 to read:5804 766.1183 Standard of care for Medicaid providers.-5805 (1) As used in this section:5806 (a) The terms "applicant," "medical assistance," "medical  
5807 services," and "Medicaid recipient" have the same meaning as in  
5808 s. 409.901.5809 (b) The term "provider" means a health care provider as  
5810 defined in s. 766.202, an ambulance provider licensed under  
5811 chapter 401, or an entity that qualifies for an exemption under  
5812 s. 400.9905(4)(e). The term includes:5813 1. Any person or entity for whom a provider is vicariously  
5814 liable; and5815 2. Any person or entity whose liability is based solely on  
5816 such person or entity being vicariously liable for the actions  
5817 of a provider.5818 (c) The term "wrongful manner" means in bad faith or with  
5819 malicious purpose or in a manner exhibiting wanton and willful  
5820 disregard of human rights, safety, or property, and shall be  
5821 construed in conformity with the standard set forth in s.  
5822 768.28(9)(a).5823 (2) A provider is not liable in excess of \$200,000 per  
5824 claimant or \$300,000 per occurrence for any cause of action  
5825 arising out of the rendering of, or the failure to render,  
5826 medical services to a Medicaid recipient, except as provided  
5827 under subsection (3). However, a judgment may be claimed and  
5828 rendered in excess of the amounts set forth in this subsection.  
5829 That portion of the judgment that exceeds these amounts may be

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5830 reported to the Legislature, but may be paid in part or in whole  
5831 by the state only by further act of the Legislature.

5832 (3) A provider may be liable for an amount in excess of  
5833 \$200,000 per claimant or \$300,000 per occurrence only if the  
5834 claimant pleads and proves, by clear and convincing evidence,  
5835 that the provider acted in a wrongful manner. If the claimant so  
5836 pleads, the court, after a reasonable opportunity for discovery,  
5837 shall conduct a hearing before trial to determine if there is a  
5838 reasonable basis in evidence to conclude that the provider acted  
5839 in a wrongful manner. A claim for wrongful conduct is not  
5840 permitted, to the extent it exceeds the amounts set forth in  
5841 subsection (2), unless the claimant makes the showing required  
5842 by this subsection.

5843 (4) At the time an application for medical assistance is  
5844 submitted, the Department of Children and Family Services shall  
5845 furnish the applicant with written notice of the provisions of  
5846 this section.

5847 (5) This section does not limit or exclude the application  
5848 of any law, including s. 766.118, which places limitations upon  
5849 the recovery of civil damages.

5850 (6) This section does not apply to any claim for damages to  
5851 which s. 768.28 applies.

5852 Section 80. Section 766.1184, Florida Statutes, is created  
5853 to read:

5854 766.1184 Standard of care; low-income pool recipient.-

5855 (1) As used in this section, the term:

5856 (a) "Low-income pool recipient" means a low-income  
5857 individual who is uninsured or underinsured and who receives  
5858 primary care services from a provider which are delivered

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5859 exclusively using funding received by that provider under  
5860 proviso language accompanying specific appropriation 191 of the  
5861 2010-2011 fiscal year General Appropriations Act to establish  
5862 new or expand existing primary care clinics for low-income  
5863 persons who are uninsured or underinsured.

5864 (b) "Provider" means a health care provider, as defined in  
5865 s. 766.202, which received funding under proviso language  
5866 accompanying specific appropriation 191 of the fiscal year 2010-  
5867 11 General Appropriations Act to establish new or expand  
5868 existing primary care clinics for low-income persons who are  
5869 uninsured or underinsured. The term includes:

5870 1. Any person or entity for whom a provider is vicariously  
5871 liable; and

5872 2. Any person or entity whose liability is based solely on  
5873 such person or entity being vicariously liable for the actions  
5874 of a provider.

5875 (c) "Wrongful manner" means in bad faith or with malicious  
5876 purpose or in a manner exhibiting wanton and willful disregard  
5877 of human rights, safety, or property, and shall be construed in  
5878 conformity with the standard set forth in s. 768.28(9)(a).

5879  
5880 The funding of the provider's primary care clinic must have been  
5881 awarded pursuant to a plan approved by the Legislative Budget  
5882 Commission, and must be the subject of an agreement between the  
5883 provider and the Agency for Health Care Administration,  
5884 following the competitive solicitation of proposals to use low-  
5885 income pool grant funds to provide primary care services in  
5886 general acute hospitals, county health departments, faith-based  
5887 and community clinics, and federally qualified health centers to

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5888 uninsured or underinsured persons.

5889 (2) A provider is not liable in excess of \$200,000 per  
5890 claimant or \$300,000 per occurrence for any cause of action  
5891 arising out of the rendering of, or the failure to render,  
5892 primary care services to a low-income pool recipient, except as  
5893 provided under subsection (3). However, a judgment may be  
5894 claimed and rendered in excess of the amounts set forth in this  
5895 subsection. That portion of the judgment that exceeds these  
5896 amounts may be reported to the Legislature, but may be paid in  
5897 part or in whole by the state only by further act of the  
5898 Legislature.

5899 (3) A provider may be liable for an amount in excess of  
5900 \$200,000 per claimant or \$300,000 per occurrence only if the  
5901 claimant pleads and proves, by clear and convincing evidence,  
5902 that the provider acted in a wrongful manner. If the claimant so  
5903 pleads, the court, after a reasonable opportunity for discovery,  
5904 shall conduct a hearing before trial to determine if there is a  
5905 reasonable basis in evidence to conclude that the provider acted  
5906 in a wrongful manner. A claim for wrongful conduct is not  
5907 permitted, to the extent it exceeds the amounts set forth in  
5908 subsection (2), unless the claimant makes the showing required  
5909 by this subsection.

5910 (4) In order for this section to apply, the provider must:

5911 (a) Develop, implement, and maintain policies and  
5912 procedures to:

5913 1. Ensure that funds described in subsection (1) are used  
5914 exclusively to serve low-income persons who are uninsured or  
5915 underinsured;

5916 2. Determine whether funds described in subsection (1) are

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5917 being used to provide primary care services to a particular  
5918 person; and

5919 3. Identify whether an individual receiving primary care  
5920 services is a low-income pool recipient to whom the provisions  
5921 of this section apply.

5922 (b) Furnish a low-income pool recipient with written notice  
5923 of the provisions of this section before providing primary care  
5924 services to the recipient.

5925 (c) Be in compliance with the terms of any agreement  
5926 between the provider and the Agency for Health Care  
5927 Administration governing the receipt of the funds described in  
5928 subsection (1).

5929 (5) This section does not limit or exclude the application  
5930 of any law, including s. 766.118, which places limitations upon  
5931 the recovery of civil damages.

5932 (6) This section does not apply to any claim for damages to  
5933 which s. 768.28 applies.

5934 Section 81. Subsection (5) is added to section 766.203,  
5935 Florida Statutes, to read:

5936 766.203 Presuit investigation of medical negligence claims  
5937 and defenses by prospective parties.-

5938 (5) STANDARDS OF CARE.-If the cause of action that is the  
5939 basis for the litigation requires the plaintiff to establish the  
5940 breach of a standard of care other than negligence in order to  
5941 impose liability or secure specified damages arising out of the  
5942 rendering of, or the failure to render, medical care or  
5943 services, and the plaintiff intends to pursue such liability or  
5944 damages, the presuit investigations required of the claimant and  
5945 the prospective defendant by this section must ascertain that

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5946 there are reasonable grounds to believe that the requirement is  
5947 satisfied.

5948 Section 82. Paragraph (b) of subsection (9) of section  
5949 768.28, Florida Statutes, is amended, and paragraphs (f) and (g)  
5950 are added to subsection (10) of that section, to read:

5951 768.28 Waiver of sovereign immunity in tort actions;  
5952 recovery limits; limitation on attorney fees; statute of  
5953 limitations; exclusions; indemnification; risk management  
5954 programs.—

5955 (9)

5956 (b) As used in this subsection, the term:

5957 1. "Employee" includes any volunteer firefighter.

5958 2. "Officer, employee, or agent" includes, but is not  
5959 limited to, any health care provider when providing services  
5960 pursuant to s. 766.1115; ~~;~~ any member of the Florida Health  
5961 Services Corps, as defined in s. 381.0302, who provides  
5962 uncompensated care to medically indigent persons referred by the  
5963 Department of Health; any nonprofit independent college or  
5964 university located and chartered in this state which owns or  
5965 operates an accredited medical school, and its employees or  
5966 agents, when providing patient services pursuant to paragraph  
5967 (10) (f); ~~;~~ and any public defender or her or his employee or  
5968 agent, including, among others, an assistant public defender and  
5969 an investigator.

5970 (10)

5971 (f) For purposes of this section, any nonprofit independent  
5972 college or university located and chartered in this state which  
5973 owns or operates an accredited medical school, or any of its  
5974 employees or agents, and which has agreed in an affiliation

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5975 agreement or other contract to provide, or to permit its  
5976 employees or agents to provide, patient services as agents of a  
5977 teaching hospital, is considered an agent of the teaching  
5978 hospital while acting within the scope of and pursuant to  
5979 guidelines established in the contract. To the extent allowed by  
5980 law, the contract must provide for the indemnification of the  
5981 state, up to the limits set out in this chapter, by the agent  
5982 for any liability incurred which was caused by the negligence of  
5983 the college or university or its employees or agents.

5984 1. For purposes of this paragraph, the term:

5985 a. "Employee or agent" means an officer, employee, agent,  
5986 or servant of a nonprofit independent college or university  
5987 located and chartered in this state which owns or operates an  
5988 accredited medical school, including, but not limited to, the  
5989 faculty of the medical school, any health care practitioner or  
5990 licensee as defined in s. 456.001 for which the college or  
5991 university is vicariously liable, and the staff or administrator  
5992 of the medical school.

5993 b. "Patient services" mean:

5994 (I) Comprehensive health care services as defined in s.  
5995 641.19, including any related administrative service, provided  
5996 to patients in a teaching hospital or in a health care facility  
5997 that is a part of a nonprofit independent college or university  
5998 located and chartered in this state which owns or operates an  
5999 accredited medical school, pursuant to an affiliation agreement  
6000 or other contract with a teaching hospital;

6001 (II) Training and supervision of interns, residents, and  
6002 fellows providing patient services in a teaching hospital or in  
6003 a health care facility that is a part of a nonprofit independent

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6004 college or university located and chartered in this state which  
6005 owns or operates an accredited medical school, pursuant to an  
6006 affiliation agreement or other contract with a teaching  
6007 hospital;

6008 (III) Participation in medical research protocols; or

6009 (IV) Training and supervision of medical students in a  
6010 teaching hospital or in a health care facility owned by a not-  
6011 for-profit college or university that owns or operates an  
6012 accredited medical school, pursuant to an affiliation agreement  
6013 or other contract with a teaching hospital.

6014 c. "Teaching hospital" means a teaching hospital as defined  
6015 in s. 408.07 which is owned or operated by the state, a county  
6016 or municipality, a public health trust, a special taxing  
6017 district, a governmental entity having health care  
6018 responsibilities, or a not-for-profit entity that operates such  
6019 facilities as an agent of the state or a political subdivision  
6020 of the state under a lease or other contract.

6021 2. The teaching hospital or the medical school, or its  
6022 employees or agents, must provide written notice to each  
6023 patient, or the patient's legal representative, receipt of which  
6024 must be acknowledged in writing, that the college or university  
6025 that owns or operates the medical school and the employees or  
6026 agents of that college or university are acting as agents of the  
6027 teaching hospital and that the exclusive remedy for injury or  
6028 damage suffered as the result of any act or omission of the  
6029 teaching hospital, the college or university that owns or  
6030 operates the medical school, or the employees or agents of the  
6031 college or university while acting within the scope of duties  
6032 pursuant to the affiliation agreement or other contract with a



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6033 teaching hospital, is by commencement of an action pursuant to  
6034 the provisions of this section.

6035 3. This paragraph does not designate any employee providing  
6036 contracted patient services in a teaching hospital as an  
6037 employee or agent of the state for purposes of chapter 440.

6038 (g) Providers or vendors, 75 percent of whose client  
6039 population consists of individuals with a developmental  
6040 disability as defined in ss. 393.063 and 400.960, individuals  
6041 who are blind or severely handicapped individuals as defined in  
6042 s. 413.033, individuals who have a mental illness as defined  
6043 under s. 394.455, or individuals who have any combination of  
6044 these conditions, which have contractually agreed to act on  
6045 behalf of the Agency for Persons with Disabilities, the Agency  
6046 for Health Care Administration, the Division of Blind Services  
6047 in the Department of Education, or the Mental Health Program  
6048 Office of the Department of Children and Family Services to  
6049 provide services to such individuals, and their employees or  
6050 agents, are considered agents of the state, solely with respect  
6051 to the provision of such services while acting within the scope  
6052 of and pursuant to guidelines established by contract, a  
6053 Medicaid waiver agreement, or rule. The contracts for such  
6054 services must provide for the indemnification of the state by  
6055 the agent for any liabilities incurred up to the limits  
6056 specified in this section.

6057 Section 83. Legislative findings and intent.-

6058 (1) The Legislature finds that:

6059 (a) Access to high-quality, comprehensive, and affordable  
6060 health care for all persons in this state is a necessary state  
6061 goal and that teaching hospitals play an intrinsic and essential

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6062 role in providing that access.

6063 (b) Graduate medical education, provided by nonprofit  
6064 independent colleges and universities located and chartered in  
6065 this state which own or operate medical schools, helps provide  
6066 the comprehensive specialty training needed by medical school  
6067 graduates to develop and refine the skills essential to the  
6068 provision of high-quality health care for our state residents.  
6069 Much of that education and training is provided in teaching  
6070 hospitals under the direct supervision of medical faculty who  
6071 provide guidance, training, and oversight, and serve as role  
6072 models to their students.

6073 (c) A large proportion of medical care is provided in  
6074 teaching hospitals that serve as safety nets for many indigent  
6075 and underserved patients who otherwise might not receive the  
6076 medical help they need. Resident physician training that takes  
6077 place in such hospitals provides much of the care provided to  
6078 this population. Medical faculty, supervising such training and  
6079 care, are a vital link between educating and training resident  
6080 physicians and ensuring the provision of quality care for  
6081 indigent and underserved residents. Physicians that assume this  
6082 role are often called upon to juggle the demands of patient  
6083 care, teaching, research, health policy, and budgetary issues  
6084 related to the programs they administer.

6085 (d) While teaching hospitals are afforded sovereign  
6086 immunity protections under s. 768.28, Florida Statutes, the  
6087 nonprofit independent colleges and universities located and  
6088 chartered in this state which own or operate medical schools and  
6089 which enter into affiliation agreements or contracts with the  
6090 teaching hospitals to provide patient services are not afforded

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6091 such sovereign immunity protections.

6092 (e) The employees or agents of nonprofit independent  
6093 colleges and universities located and chartered in this state  
6094 which enter into affiliation agreements or contracts with  
6095 teaching hospitals to provide patient services do not have the  
6096 same level of protection against liability claims as teaching  
6097 hospitals and their employees and agents that provide the same  
6098 patient services to the same patients. Thus, these colleges and  
6099 universities and their employees and agents are  
6100 disproportionately affected by claims arising out of alleged  
6101 medical malpractice and other allegedly negligent acts. Given  
6102 the recent growth in medical schools and medical education  
6103 programs and ongoing efforts to support, strengthen, and  
6104 increase physician residency training positions and medical  
6105 faculty in both existing and newly designated teaching  
6106 hospitals, this exposure and the consequent disparity in  
6107 liability exposure will continue to increase. The vulnerability  
6108 of these colleges and universities to claims of medical  
6109 malpractice will only add to the current physician workforce  
6110 crisis in Florida and can be alleviated only through legislative  
6111 action.

6112 (f) Ensuring that the employees and agents of nonprofit  
6113 independent colleges and universities located and chartered in  
6114 this state which own or operated medical schools are able to  
6115 continue to treat patients, provide graduate medical education,  
6116 supervise medical students, engage in research, and provide  
6117 administrative support and services in teaching hospitals is an  
6118 overwhelming public necessity.

6119 (2) The Legislature intends that:

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6120       (a) Employees and agents of nonprofit independent colleges  
6121 and universities located and chartered in this state which own  
6122 or operate medical schools, who provide patient services as  
6123 agents of a teaching hospital be immune from lawsuits in the  
6124 same manner and to the same extent as employees and agents of  
6125 teaching hospitals in this state under existing law, and that  
6126 such colleges and universities and their employees and agents  
6127 not be held personally liable in tort or named as a party  
6128 defendant in an action while providing patient services in a  
6129 teaching hospital, unless such services are provided in bad  
6130 faith, with malicious purpose, or in a manner exhibiting wanton  
6131 and willful disregard of human rights, safety, or property.

6132       (b) Nonprofit independent private colleges and universities  
6133 located and chartered in this state which own or operate medical  
6134 schools and which permit their employees or agents to provide  
6135 patient services in teaching hospitals pursuant to an  
6136 affiliation agreement or other contract, be afforded sovereign  
6137 immunity protections under s. 768.28, Florida Statutes.

6138       (3) The Legislature declares that there is an overwhelming  
6139 public necessity for extending the state's sovereign immunity to  
6140 nonprofit independent colleges and universities located and  
6141 chartered in this state which own or operate medical schools and  
6142 provide patient services in teaching hospitals, and to their  
6143 employees and agents, and that there is no alternative method of  
6144 meeting such public necessity.

6145       (4) The terms "employee or agent," "patient services," and  
6146 "teaching hospital" used in this section have the same meaning  
6147 as the terms defined in s. 768.28, Florida Statutes, as amended  
6148 by this act.

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6149 Section 84. Section 1004.41, Florida Statutes, is amended  
6150 to read:

6151 1004.41 University of Florida; J. Hillis Miller Health  
6152 Center.—

6153 (1) There is established the J. Hillis Miller Health Center  
6154 at the University of Florida, including campuses at Gainesville  
6155 and Jacksonville and affiliated teaching hospitals, which shall  
6156 include the following colleges:

6157 (a) College of Dentistry.

6158 (b) College of Public Health and Health Professions.

6159 (c) College of Medicine.

6160 (d) College of Nursing.

6161 (e) College of Pharmacy.

6162 (f) College of Veterinary Medicine and related teaching  
6163 hospitals.

6164 (2) Each college of the health center shall be ~~se~~  
6165 maintained and operated so as to comply with the standards  
6166 approved by a nationally recognized association for  
6167 accreditation.

6168 (3) (a) The University of Florida Health Center Operations  
6169 and Maintenance Trust Fund shall be administered by the  
6170 University of Florida Board of Trustees. Funds shall be credited  
6171 to the trust fund from the sale of goods and services performed  
6172 by the University of Florida Veterinary Medicine Teaching  
6173 Hospital. The purpose of the trust fund is to support the  
6174 instruction, research, and service missions of the University of  
6175 Florida College of Veterinary Medicine.

6176 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and  
6177 pursuant to s. 216.351, any balance in the trust fund at the end

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6178 of any fiscal year shall remain in the trust fund and ~~shall~~ be  
6179 available for carrying out the purposes of the trust fund.

6180 (4) (a) The University of Florida Board of Trustees shall  
6181 lease the hospital facilities of the health center known as the  
6182 Shands Teaching Hospital and Clinics on the Gainesville campus  
6183 of the University of Florida and all furnishings, equipment, and  
6184 other chattels or choses in action used in the operation of the  
6185 hospital, to Shands Teaching Hospital and Clinics, Inc., a  
6186 private not-for-profit corporation organized ~~solely~~ for the  
6187 primary purpose of supporting operating the University of  
6188 Florida Board of Trustees' health affairs mission of community  
6189 service and patient care, education and training of health  
6190 professionals, and clinical research. In furtherance of that  
6191 purpose, Shands Teaching Hospital and Clinics, Inc., shall  
6192 operate the hospital and ancillary health care facilities as  
6193 deemed of the health center and other health care facilities and  
6194 programs determined to be necessary by the board of Shands  
6195 Teaching Hospital and Clinics, Inc. the nonprofit corporation.  
6196 The rental for the hospital facilities shall be an amount equal  
6197 to the debt service on bonds or revenue certificates issued  
6198 solely for capital improvements to the hospital facilities or as  
6199 otherwise provided by law.

6200 (b) The University of Florida Board of Trustees shall  
6201 provide in the lease or by separate contract or agreement with  
6202 Shands Teaching Hospital and Clinics, Inc., the not-for-profit  
6203 corporation for the following:

6204 1. Approval of the articles of incorporation of Shands  
6205 Teaching Hospital and Clinics, Inc., the not-for-profit  
6206 corporation by the University of Florida Board of Trustees and

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6207 the governance of that ~~the~~ not-for-profit corporation by a board  
6208 of directors appointed, subject to removal, and chaired by the  
6209 President of the University of Florida, or his or her designee,  
6210 and vice chaired by the Vice President for Health Affairs of the  
6211 University of Florida, or his or her designee.

6212 2. The use of hospital facilities and personnel in support  
6213 of community service and patient care, ~~the~~ research programs,  
6214 and ~~of the~~ teaching roles ~~role~~ of the health center.

6215 3. The continued recognition of the collective bargaining  
6216 units and collective bargaining agreements as currently composed  
6217 and recognition of the certified labor organizations  
6218 representing those units and agreements.

6219 4. The use of hospital facilities and personnel in  
6220 connection with research programs conducted by the health  
6221 center.

6222 5. Reimbursement to the hospital for indigent patients,  
6223 state-mandated programs, underfunded state programs, and costs  
6224 to the hospital for support of the teaching and research  
6225 programs of the health center. Such reimbursement shall be  
6226 appropriated to either the health center or the hospital each  
6227 year by the Legislature after review and approval of the request  
6228 for funds.

6229 (c) The University of Florida Board of Trustees may, with  
6230 the approval of the Legislature, increase the hospital  
6231 facilities or remodel or renovate them, provided that the rental  
6232 paid by the hospital for such new, remodeled, or renovated  
6233 facilities is sufficient to amortize the costs thereof over a  
6234 reasonable period of time or fund the debt service for any bonds  
6235 or revenue certificates issued to finance such improvements.

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6236 (d) The University of Florida Board of Trustees is  
6237 authorized to provide to Shands Teaching Hospital and Clinics,  
6238 Inc., ~~the not-for-profit corporation leasing the hospital~~  
6239 ~~facilities~~ and its not-for-profit subsidiaries and affiliates  
6240 comprehensive general liability insurance including professional  
6241 liability from a self-insurance trust program established  
6242 pursuant to s. 1004.24.

6243 (e) Shands Teaching Hospital and Clinics, Inc., may, in  
6244 support of the health affairs mission of the University of  
6245 Florida Board of Trustees and with its prior approval, create  
6246 for-profit or not-for-profit corporate subsidiaries and  
6247 affiliates, or both. The University of Florida Board of  
6248 Trustees, which may act through the President of the University  
6249 of Florida or his or her designee, has the right to control  
6250 Shands Teaching Hospital and Clinics, Inc. Shands Teaching  
6251 Hospital and Clinics, Inc., and any not-for-profit subsidiaries  
6252 are conclusively deemed corporations primarily acting as  
6253 instrumentalities of the state, pursuant to s. 768.28(2), for  
6254 purposes of sovereign immunity.

6255 (f) ~~(e) If in the event that~~ the lease of the hospital  
6256 facilities to Shands Teaching Hospital and Clinics, Inc., ~~the~~  
6257 ~~not-for-profit corporation~~ is terminated for any reason, the  
6258 University of Florida Board of Trustees shall resume management  
6259 and operation of the hospital facilities. In such event, the  
6260 University of Florida Board of Trustees is authorized to utilize  
6261 revenues generated from the operation of the hospital facilities  
6262 to pay the costs and expenses of operating the hospital facility  
6263 for the remainder of the fiscal year in which such termination  
6264 occurs.



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6265        (5)~~(f)~~ Shands Jacksonville Medical Center, Inc., and its  
6266 parent Shands Jacksonville Healthcare, Inc., are private not-  
6267 for-profit corporations organized primarily to support the  
6268 health affairs mission of the University of Florida Board of  
6269 Trustees in community service and patient care, education and  
6270 training of health affairs professionals, and clinical research.  
6271 Shands Jacksonville Medical Center, Inc., is a teaching hospital  
6272 affiliated with the University of Florida Board of Trustees,  
6273 located on the Jacksonville Campus of the University of Florida.  
6274 Shands Jacksonville Medical Center, Inc., and Shands  
6275 Jacksonville Healthcare, Inc., may, in support of the health  
6276 affairs mission of the University of Florida Board of Trustees  
6277 and with its prior approval, create for-profit or not-for-profit  
6278 corporate subsidiaries and affiliates, or both.

6279        (a) The University of Florida Board of Trustees, which may  
6280 act through the President of the University of Florida or his or  
6281 her designee, has the right to control Shands Jacksonville  
6282 Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.  
6283 Shands Jacksonville Medical Center, Inc., Shands Jacksonville  
6284 Healthcare, Inc., and any not-for-profit subsidiary of Shands  
6285 Jacksonville Medical Center, Inc., are conclusively deemed  
6286 corporations primarily acting as instrumentalities of the state,  
6287 pursuant to s. 768.28(2), for purposes of sovereign immunity.

6288        (b) The University of Florida Board of Trustees is  
6289 authorized to provide to Shands Jacksonville Healthcare, Inc.,  
6290 and its not-for-profit subsidiaries and affiliates and any  
6291 successor corporation that acts in support of the board of  
6292 trustees, comprehensive general liability coverage, including  
6293 professional liability, from the self-insurance programs

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6294 established pursuant to s. 1004.24.

6295 Section 85. Sections 409.9121, 409.919, and 624.915,  
6296 Florida Statutes, are repealed.

6297 Section 86. Section 409.942, Florida Statutes, is  
6298 transferred and renumbered as section 414.29, Florida Statutes.

6299 Section 87. Paragraph (a) of subsection (1) of section  
6300 443.111, Florida Statutes, is amended to read:

6301 443.111 Payment of benefits.—

6302 (1) MANNER OF PAYMENT.—Benefits are payable from the fund  
6303 in accordance with rules adopted by the Agency for Workforce  
6304 Innovation, subject to the following requirements:

6305 (a) Benefits are payable by mail or electronically.

6306 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a  
6307 system for the payment of benefits by electronic funds transfer,  
6308 including, but not limited to, debit cards, electronic payment  
6309 cards, or any other means of electronic payment that the agency  
6310 deems to be commercially viable or cost-effective. Commodities  
6311 or services related to the development of such a system shall be  
6312 procured by competitive solicitation, unless they are purchased  
6313 from a state term contract pursuant to s. 287.056. The agency  
6314 shall adopt rules necessary to administer the system.

6315 Section 88. Sections 409.944, 409.945, and 409.946, Florida  
6316 Statutes, are transferred and renumbered as sections 163.464,  
6317 163.465, and 163.466, Florida Statutes, respectively.

6318 Section 89. Sections 409.953 and 409.9531, Florida  
6319 Statutes, are transferred and renumbered as sections 402.81 and  
6320 402.82, Florida Statutes, respectively.

6321 Section 90. The Agency for Health Care Administration shall  
6322 submit a reorganizational plan to the Governor, the Speaker of

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6323 the House of Representatives, and the President of the Senate by  
6324 January 1, 2012, which converts the agency from a check-writing  
6325 and fraud-chasing agency into a contract compliance and  
6326 monitoring agency.

6327       Section 91. Effective December 1, 2011, if the Legislature  
6328 has not received a letter from the Governor stating that the  
6329 federal Centers for Medicare and Medicaid has approved the  
6330 waivers necessary to implement the Medicaid managed care reforms  
6331 contained in this act, the State of Florida shall withdraw from  
6332 the Medicaid program effective December 31, 2011.

6333       Section 92. If any provision of this act or its application  
6334 to any person or circumstance is held invalid, the invalidity  
6335 does not affect other provisions or applications of the act  
6336 which can be given effect without the invalid provision or  
6337 application, and to this end the provisions of this act are  
6338 severable.

6339       Section 93. This act shall take effect upon becoming a law.