

**By** the Committees on Budget; Budget Subcommittee on Health and Human Services Appropriations; and Health Regulation; and Senators Negrón, Gaetz, García, 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.; providing for alternatives to the statewide  
106 inpatient psychiatric program; requiring Medicaid-  
107 eligible children who have open child welfare cases  
108 and who reside in AHCA area 10 to be enrolled in  
109 specified capitated managed care plans; expanding the  
110 number of children eligible to receive behavioral  
111 health care services through a specialty prepaid plan;  
112 repealing provisions relating to a provider lock-in  
113 program; eliminating obsolete provisions and updating  
114 provisions; conforming cross-references; amending s.  
115 409.915, F.S.; conforming provisions to changes made  
116 by the act; transferring, renumbering, and amending s.

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117 409.9301, F.S.; conforming provisions to changes made  
118 by the act; amending s. 409.9126, F.S.; conforming a  
119 cross-reference; providing a directive to the Division  
120 of Statutory Revision; creating s. 409.961, F.S.;  
121 providing for statutory construction of provisions  
122 relating to Medicaid managed care; creating s.  
123 409.962, F.S.; providing definitions; creating s.  
124 409.963, F.S.; establishing the Medicaid managed care  
125 program as the statewide, integrated managed care  
126 program for medical assistance and long-term care  
127 services; directing the agency to apply for and  
128 implement waivers; providing for public notice and  
129 comment; providing for a limited managed care program  
130 if waivers are not approved; creating s. 409.964,  
131 F.S.; requiring all Medicaid recipients to be enrolled  
132 in Medicaid managed care; providing exemptions;  
133 prohibiting a recipient who has access to employer-  
134 sponsored health care from enrolling in Medicaid  
135 managed care; requiring the agency to develop a  
136 process to allow the Medicaid premium that would have  
137 been received to be used to pay employer premiums;  
138 requiring that the agency allow opt-out opportunities  
139 for certain recipients; providing for voluntary  
140 enrollment; creating s. 409.965, F.S.; providing  
141 requirements for qualified plans that provide services  
142 in the Medicaid managed care program; requiring the  
143 agency to issue an invitation to negotiate; requiring  
144 the agency to compile and publish certain information;  
145 establishing regions for separate procurement of

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

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

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



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233 finalizing implementation; creating s. 409.972, F.S.;

234 establishing minimum services for the managed medical

235 assistance; providing for optional services;

236 authorizing plans to customize benefit packages;

237 requiring the agency to provide certain services to

238 hemophiliacs; creating s. 409.973, F.S.; providing for

239 managed long-term care; providing deadlines for

240 beginning and finalizing implementation; providing

241 duties for the Department of Elderly Affairs relating

242 to the program; creating s. 409.974, F.S.; providing

243 recipient eligibility requirements for managed long-

244 term care; listing programs for which certain

245 recipients are eligible; specifying that an

246 entitlement to home and community-based services is

247 not created; creating s. 409.975, F.S.; establishing

248 minimum services for managed long-term care; creating

249 s. 409.976, F.S.; providing criteria for the selection

250 of plans to provide managed long-term care; creating

251 s. 409.977, F.S.; providing for managed long-term care

252 plan accountability; requiring the agency to establish

253 standards for specified providers; creating s.

254 409.978, F.S.; requiring that the agency operate the

255 Comprehensive Assessment and Review for Long-Term Care

256 Services program through an interagency agreement with

257 the Department of Elderly Affairs; providing duties of

258 the program; requiring the program to assign plan

259 enrollees to a level of care; providing for the

260 evaluation of dually eligible nursing home residents;

261 creating s. 409.980, F.S.; providing minimum

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262 requirements for prescription drug benefits provided  
263 by a qualified plan; transferring, renumbering, and  
264 amending ss. 409.91207, 409.91211, and 409.9122, F.S.;  
265 conforming provisions to changes made by the act;  
266 updating provisions and deleting obsolete provisions;  
267 transferring and renumbering ss. 409.9123 and  
268 409.9124, F.S.; amending s. 430.04, F.S.; eliminating  
269 outdated provisions; requiring the Department of  
270 Elderly Affairs to develop a transition plan for  
271 specified elders and disabled adults receiving long-  
272 term care Medicaid services if qualified plans become  
273 available; amending s. 430.2053, F.S.; eliminating  
274 outdated provisions; providing additional duties of  
275 aging resource centers; providing an additional  
276 exception to direct services that may not be provided  
277 by an aging resource center; providing for the  
278 cessation of specified payments by the department as  
279 qualified plans become available; eliminating  
280 provisions requiring reports; amending s. 641.316,  
281 F.S.; redefining the term "fiscal intermediary  
282 services organization" to include certain qualified  
283 plans that contract with health care professionals for  
284 fiscal intermediary services; amending s. 39.407,  
285 F.S.; requiring a motion by the Department of Children  
286 and Family Services to provide psychotropic medication  
287 to a child 10 years of age or younger to include a  
288 review by a child psychiatrist; providing that a court  
289 may not authorize the administration of such  
290 medication absent a finding of compelling state

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291 interest based on the review; amending s. 216.262,  
292 F.S.; providing that limitations on an agency's total  
293 number of positions does not apply to certain  
294 positions in the Department of Health; amending s.  
295 381.06014, F.S.; redefining the term "blood  
296 establishment" and defining the term "volunteer  
297 donor"; requiring that blood establishments disclose  
298 specified information on their Internet website;  
299 providing an exception for certain hospitals;  
300 authorizing the Department of Legal Affairs to assess  
301 a civil penalty against a blood establishment that  
302 fails to disclose the information; providing that the  
303 civil penalty accrues to the state and requiring that  
304 it be deposited into the General Revenue Fund;  
305 prohibiting local governments from restricting access  
306 to public facilities or infrastructure for certain  
307 activities based on whether a blood establishment is  
308 operating as a for-profit or not-for-profit  
309 organization; prohibiting a blood establishment from  
310 considering whether certain customers are operating as  
311 for-profit or not-for-profit organizations when  
312 determining service fees for blood or blood  
313 components; amending s. 395.4025, F.S.; providing  
314 additional time extensions to hospital applicants  
315 seeking to become trauma centers under certain  
316 circumstances; amending s. 400.023, F.S.; requiring  
317 the trial judge to conduct an evidentiary hearing to  
318 determine the sufficiency of evidence for claims  
319 against certain persons relating to a nursing home;

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320 limiting noneconomic damages in a wrongful death  
321 action against the nursing home; amending s. 400.0237,  
322 F.S.; revising provisions relating to punitive damages  
323 against a nursing home; authorizing a defendant to  
324 proffer admissible evidence to refute a claimant's  
325 proffer of evidence for punitive damages; requiring  
326 the trial judge to conduct an evidentiary hearing and  
327 the plaintiff to demonstrate that a reasonable basis  
328 exists for the recovery of punitive damages;  
329 prohibiting discovery of the defendant's financial  
330 worth until the judge approves the pleading on  
331 punitive damages; revising definitions; amending s.  
332 408.7057, F.S.; requiring that the dispute resolution  
333 program include a hearing in specified circumstances;  
334 providing that the dispute resolution program  
335 established to resolve claims disputes between  
336 providers and health plans does not provide an  
337 independent right of recovery; requiring that the  
338 conclusions of law in the written recommendation of  
339 the resolution organization identify certain  
340 information; amending s. 465.014, F.S.; providing that  
341 certain practitioners or anyone under the direct  
342 supervision of such practitioner may dispense drugs  
343 without being licensed as a medical technician;  
344 amending s. 456.0635, F.S.; revising the grounds under  
345 which the Department of Health or corresponding board  
346 is required to refuse to admit a candidate to an  
347 examination and to refuse to issue or renew a license,  
348 certificate, or registration of a health care

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349 practitioner; providing an exception; amending s.  
350 456.036, F.S.; requiring a delinquent licensee whose  
351 license becomes delinquent before the final resolution  
352 of a case regarding Medicaid fraud to affirmatively  
353 apply by submitting a complete application for active  
354 or inactive status during the licensure cycle in which  
355 the case achieves final resolution by order of the  
356 court; providing that failure by a delinquent licensee  
357 to become active or inactive before the expiration of  
358 that licensure cycle renders the license null;  
359 requiring that any subsequent licensure be as a result  
360 of applying for and meeting all requirements imposed  
361 on an applicant for new licensure; creating ss.  
362 458.3167 and 459.0078, F.S.; providing for an expert  
363 witness certificate for allopathic and osteopathic  
364 physicians licensed in other states or Canada which  
365 authorizes such physicians to provide expert medical  
366 opinions in this state; providing application  
367 requirements and timeframes for approval or denial by  
368 the Board of Medicine and Board of Osteopathic  
369 Medicine, respectively; requiring the boards to adopt  
370 rules and set fees; providing for expiration of a  
371 certificate; amending ss. 458.331 and 459.015, F.S.;  
372 providing grounds for disciplinary action for  
373 providing misleading, deceptive, or fraudulent expert  
374 witness testimony relating to the practice of medicine  
375 and of osteopathic medicine, respectively; providing  
376 for construction with respect to the doctrine of  
377 incorporation by reference; amending s. 499.003, F.S.;

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378 redefining the term "health care entity" to clarify  
379 that a blood establishment is a health care entity  
380 that may engage in certain activities; amending s.  
381 499.005, F.S.; clarifying provisions that prohibit the  
382 unauthorized wholesale distribution of a prescription  
383 drug that was purchased by a hospital or other health  
384 care entity or donated or supplied at a reduced price  
385 to a charitable organization, to conform to changes  
386 made by the act; amending s. 499.01, F.S.; exempting  
387 certain blood establishments from the requirements to  
388 be permitted as a prescription drug manufacturer and  
389 register products; requiring that certain blood  
390 establishments obtain a restricted prescription drug  
391 distributor permit under specified conditions;  
392 limiting the prescription drugs that a blood  
393 establishment may distribute under a restricted  
394 prescription drug distributor permit; authorizing the  
395 Department of Health to adopt rules regarding the  
396 distribution of prescription drugs by blood  
397 establishments; amending s. 626.9541, F.S.;

398 authorizing insurers to offer rewards or incentives to  
399 health benefit plan members to encourage or reward  
400 participation in wellness or health improvement  
401 programs; authorizing insurers to require plan members  
402 not participating in programs to provide verification  
403 that their medical condition warrants  
404 nonparticipation; providing application; amending s.  
405 627.4147, F.S.; deleting a requirement that a medical  
406 malpractice insurance contract include a clause

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407 authorizing an insurer to admit liability and make a  
408 settlement offer if the offer is within policy limits  
409 without the insured's permission; amending s. 641.19,  
410 F.S.; defining the term "provider service network";  
411 creating s. 641.2019, F.S.; providing that a provider  
412 service network that meets the requirements of ch.  
413 641, F.S., may obtain a certificate of authority under  
414 that chapter; amending s. 641.47, F.S.; redefining the  
415 term "organization" to include a provider service  
416 network; amending s. 641.49, F.S.; providing that a  
417 provider service network may apply for a health care  
418 provider certificate; amending s. 430.705, F.S.;  
419 conforming a cross-reference; amending s. 766.102,  
420 F.S.; providing that a physician who is an expert  
421 witness in a medical malpractice presuit action must  
422 meet certain requirements; amending s. 766.104, F.S.;  
423 requiring a good faith demonstration in a medical  
424 malpractice case that there has been a breach of the  
425 standard of care; amending s. 766.106, F.S.;  
426 clarifying that a physician acting as an expert  
427 witness is subject to disciplinary actions; amending  
428 s. 766.1115, F.S.; conforming provisions to changes  
429 made by the act; creating s. 766.1183, F.S.; defining  
430 terms; providing for the recovery of civil damages by  
431 Medicaid recipients according to a modified standard  
432 of care; providing for recovery of certain excess  
433 judgments by act of the Legislature; requiring the  
434 Department of Children and Family Services to provide  
435 notice to program applicants; creating s. 766.1184,

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436 F.S.; defining terms; providing for the recovery of  
437 civil damages by certain recipients of primary care  
438 services at primary care clinics receiving specified  
439 low-income pool funds according to a modified standard  
440 of care; providing for recovery of certain excess  
441 judgments by act of the Legislature; providing  
442 requirements of health care providers receiving such  
443 funds in order for the liability provisions to apply;  
444 requiring notice to low-income pool recipients;  
445 amending s. 766.202, F.S.; redefining the term "health  
446 care provider" to include persons licensed to provide  
447 orthotics, prosthetics, and pedorthics; amending s.  
448 766.203, F.S.; requiring the presuit investigations  
449 conducted by the claimant and the prospective  
450 defendant in a medical malpractice action to provide  
451 grounds for a breach of the standard of care; amending  
452 s. 768.28, F.S.; revising a definition; providing that  
453 certain colleges and universities that own or operate  
454 an accredited medical school and their employees and  
455 agents providing patient services in a teaching  
456 hospital pursuant to an affiliation agreement or  
457 contract with the teaching hospital are considered  
458 agents of the hospital for the purposes of sovereign  
459 immunity; providing definitions; requiring patients of  
460 such hospitals to be provided with notice of their  
461 remedies under sovereign immunity; providing an  
462 exception; providing that providers and vendors  
463 providing services to certain persons with  
464 disabilities on behalf of the state are agents of the



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465 state for the purposes of sovereign immunity;  
466 providing legislative findings and intent with respect  
467 to including certain colleges and universities and  
468 their employees and agents under sovereign immunity;  
469 providing a statement of public necessity; amending s.  
470 1004.41, F.S.; correcting the name of one of the  
471 health center's colleges; specifying that the  
472 University of Florida Board of Trustees shall lease  
473 Shands Teaching Hospital and Clinics on the  
474 Gainesville campus to Shands Teaching Hospital and  
475 Clinics, Inc.; specifying the primary purpose of  
476 Shands Teaching Hospital and Clinics, Inc.; providing  
477 requirements for the lease, contract, or agreement  
478 between the University of Florida Board of Trustees  
479 and Shands Teaching Hospital and Clinics, Inc.;

480 authorizing the creation of corporate subsidiaries and  
481 affiliates; providing the right of control; providing  
482 for sovereign immunity; providing that Shands  
483 Jacksonville Medical Center, Inc., and its parent,  
484 Shands Jacksonville HealthCare, Inc., are private not-  
485 for-profit corporations organized primarily to support  
486 the health affairs mission of the University of  
487 Florida Board of Trustees; authorizing the creation of  
488 corporate subsidiaries and affiliates; providing  
489 requirements for the lease, contract, or agreement  
490 between the University of Florida Board of Trustees  
491 and the corporations; providing the right of control;  
492 providing for sovereign immunity; repealing s.  
493 409.9121, F.S., relating to legislative intent

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494 concerning managed care; repealing s. 409.919, F.S.,  
495 relating to rule authority; repealing s. 624.915,  
496 F.S., relating to the Florida Healthy Kids Corporation  
497 operating fund; renumbering and transferring ss.  
498 409.942, 409.944, 409.945, 409.946, 409.953, and  
499 409.9531, F.S., as ss. 414.29, 163.464, 163.465,  
500 163.466, 402.81, and 402.82, F.S., respectively;  
501 amending s. 443.111, F.S.; conforming a cross-  
502 reference; directing the Agency for Health Care  
503 Administration to submit a reorganization plan to the  
504 Legislature; providing for the state's withdrawal from  
505 the Medicaid program under certain circumstances;  
506 providing for severability; providing an effective  
507 date.

508

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

510

511 Section 1. Paragraph (c) of subsection (2) of section  
512 163.387, Florida Statutes, is amended to read:

513 163.387 Redevelopment trust fund.—

514 (2)

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

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

519 2. A special district for which the sole available source  
520 of revenue the district has the authority to levy is ad valorem  
521 taxes at the time an ordinance is adopted under this section.  
522 However, revenues or aid that may be dispensed or appropriated

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523 to a district as defined in s. 388.011 at the discretion of an  
524 entity other than such district shall not be deemed available.

525 3. A library district, except a library district in a  
526 jurisdiction where the community redevelopment agency had  
527 validated bonds as of April 30, 1984.

528 4. A neighborhood improvement district created under the  
529 Safe Neighborhoods Act.

530 5. A metropolitan transportation authority.

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

532 7. A hospital district that is a special district as  
533 defined in s. 189.403, a county hospital that has taxing  
534 authority under chapter 155, or a public health trust  
535 established pursuant to s. 154.07.

536 Section 2. Section 200.186, Florida Statutes, is created to  
537 read:

538 200.186 Hospital districts.—Notwithstanding any special act  
539 or other law governing the expenditure of ad valorem revenues,  
540 ad valorem revenues raised pursuant to a special act  
541 establishing a hospital district, by a county hospital pursuant  
542 to chapter 155, or a public health trust established pursuant to  
543 s. 154.07, and disbursed by the district, county hospital, or  
544 trust to municipalities or other organizations, may be used only  
545 to pay for health care services.

546 Section 3. Present subsections (7) and (8) of section  
547 393.0661, Florida Statutes, are redesignated as subsections (8)  
548 and (9), respectively, a new subsection (7) is added to that  
549 section, and present subsection (7) of that section is amended,  
550 to read:

551 393.0661 Home and community-based services delivery system;

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552 comprehensive redesign.—The Legislature finds that the home and  
553 community-based services delivery system for persons with  
554 developmental disabilities and the availability of appropriated  
555 funds are two of the critical elements in making services  
556 available. Therefore, it is the intent of the Legislature that  
557 the Agency for Persons with Disabilities shall develop and  
558 implement a comprehensive redesign of the system.

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

562 (8) ~~(7) Nothing in This section or related in any~~  
563 ~~administrative rule does not shall be construed to prevent or~~  
564 ~~limit the Agency for Health Care Administration, in consultation~~  
565 ~~with the Agency for Persons with Disabilities, from adjusting~~  
566 ~~fees, reimbursement rates, lengths of stay, number of visits, or~~  
567 ~~number of services, or from limiting enrollment, or making any~~  
568 ~~other adjustment necessary to comply with the availability of~~  
569 ~~moneys and any limitations or directions provided for in the~~  
570 ~~General Appropriations Act or pursuant to s. 409.9022.~~

571 Section 4. The Division of Statutory Revision is requested  
572 to designate ss. 409.016-409.803, Florida Statutes, as part I of  
573 chapter 409, Florida Statutes, entitled "SOCIAL AND ECONOMIC  
574 ASSISTANCE."

575 Section 5. Section 409.016, Florida Statutes, is amended to  
576 read:

577 409.016 Definitions.—As used in this part, the term  
578 ~~chapter:~~

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

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581 (2) "Secretary" means the Secretary of ~~the Department of~~  
582 Children and Family Services.

583 (3) "Social and economic services," ~~within the meaning of~~  
584 ~~this chapter,~~ means the providing of financial assistance as  
585 well as preventive and rehabilitative social services for  
586 children, adults, and families.

587 Section 6. Section 409.16713, Florida Statutes, is created  
588 to read:

589 409.16713 Medical assistance for children in out-of-home  
590 care and adopted children.-

591 (1) A child who is eligible under Title IV-E of the Social  
592 Security Act, as amended, for subsidized board payments, foster  
593 care, or adoption subsidies, and a child for whom the state has  
594 assumed temporary or permanent responsibility and who does not  
595 qualify for Title IV-E assistance but is in foster care, shelter  
596 or emergency shelter care, or subsidized adoption is eligible  
597 for medical assistance as provided in s. 409.903(4). This  
598 includes a young adult who is eligible to receive services under  
599 s. 409.1451(5) until the young adult reaches 21 years of age,  
600 and a person who was eligible, as a child, under Title IV-E for  
601 foster care or the state-provided foster care and who is a  
602 participant in the Road-to-Independence Program.

603 (2) If medical assistance under Title XIX of the Social  
604 Security Act, as amended, is not available due to the refusal of  
605 the federal Department of Health and Human Services to provide  
606 federal funds, a child or young adult described in subsection  
607 (1) is eligible for medical services under the Medicaid managed  
608 care program established in s. 409.963. Such medical assistance  
609 shall be obtained by the community-based care lead agencies

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610 established under s. 409.1671 and is subject to the availability  
611 of funds appropriated for such purpose in the General  
612 Appropriations Act.

613 (3) It is the intent of the Legislature that the provision  
614 of medical assistance meet the requirements of s. 471(a)(21) of  
615 the Social Security Act, as amended, 42 U.S.C. s. 671(a)(21),  
616 related to eligibility for Title IV-E of the Social Security  
617 Act, and that compliance with such provisions meet the  
618 requirements of s. 402(a)(3) of the Social Security Act, as  
619 amended, 42 U.S.C. s. 602(a)(3), relating to the Temporary  
620 Assistance for Needy Families Block Grant Program.

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

624 Section 8. Section 624.91, Florida Statutes, is  
625 transferred, renumbered as section 409.8115, Florida Statutes,  
626 paragraph (b) of subsection (5) of that section is amended, and  
627 subsection (8) is added to that section, to read:

628 409.8115 ~~624.91~~ The Florida Healthy Kids Corporation Act.-

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

630 (b) The Florida Healthy Kids Corporation shall:

631 1. Arrange for the collection of any family, local  
632 contributions, or employer payment or premium, in an amount to  
633 be determined by the board of directors, to provide for payment  
634 of premiums for comprehensive insurance coverage and for the  
635 actual or estimated administrative expenses.

636 2. Arrange for the collection of any voluntary  
637 contributions ~~to provide~~ for payment of Florida Kidcare program  
638 premiums for children who are not eligible for medical

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639 assistance under Title XIX or Title XXI of the Social Security  
640 Act.

641 3. Subject to ~~the provisions of~~ s. 409.8134, accept  
642 voluntary supplemental local match contributions that comply  
643 with ~~the requirements of~~ Title XXI of the Social Security Act  
644 for the purpose of providing additional ~~Florida~~ Kidcare coverage  
645 in contributing counties under Title XXI.

646 4. Establish the administrative and accounting procedures  
647 for the operation of the corporation.

648 5. Establish, with consultation from appropriate  
649 professional organizations, standards for preventive health  
650 services and providers and comprehensive insurance benefits  
651 appropriate to children ~~if, provided that~~ such standards for  
652 rural areas do ~~shall~~ not limit primary care providers to board-  
653 certified pediatricians.

654 6. Determine eligibility for children seeking to  
655 participate in the Title XXI-funded components of the ~~Florida~~  
656 Kidcare program consistent with the requirements specified in s.  
657 409.814, as well as the non-Title-XXI-eligible children as  
658 provided in subsection (3).

659 7. Establish procedures under which providers of local  
660 match to, applicants to, and participants in the program may  
661 have grievances reviewed by an impartial body and reported to  
662 the board of directors of the corporation.

663 8. Establish participation criteria and, if appropriate,  
664 contract with an authorized insurer, health maintenance  
665 organization, or third-party administrator to provide  
666 administrative services to the corporation.

667 9. Establish enrollment criteria that include penalties or

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668 30-day waiting periods ~~of 30 days~~ for reinstatement of coverage  
669 upon voluntary cancellation for nonpayment of family premiums.

670 10. Contract with authorized insurers or providers ~~any~~  
671 ~~provider~~ of health care services, who meet ~~meeting~~ standards  
672 established by the corporation, for the provision of  
673 comprehensive insurance coverage to participants. Such standards  
674 must ~~shall~~ include criteria under which the corporation may  
675 contract with more than one provider of health care services in  
676 program sites. Health plans shall be selected through a  
677 competitive bid process. The Florida Healthy Kids Corporation  
678 shall purchase goods and services in the most cost-effective  
679 manner consistent with the delivery of quality medical care. The  
680 maximum administrative cost for a Florida Healthy Kids  
681 Corporation contract shall be 10 ~~15~~ percent. For health care  
682 contracts, the minimum medical loss ratio for a Florida Healthy  
683 Kids Corporation contract shall be 90 ~~85~~ percent. For dental  
684 contracts, the remaining compensation to be paid to the  
685 authorized insurer or provider must be at least 90 ~~under a~~  
686 ~~Florida Healthy Kids Corporation contract shall be no less than~~  
687 ~~an amount which is 85 percent of the premium, and,~~ to the extent  
688 any contract provision does not provide for this minimum  
689 compensation, this section prevails ~~shall prevail~~. The health  
690 plan selection criteria and scoring system, and the scoring  
691 results, shall be available upon request for inspection after  
692 the bids have been awarded.

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

695 12. Develop and implement a plan to publicize the Florida  
696 Kidcare program, the eligibility requirements of the program,



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697 and the procedures for enrollment in the program and to maintain  
698 public awareness of the corporation and the program. Such plan  
699 must include using the application form for the school lunch and  
700 breakfast programs as provided under s. 1006.06(7).

701 13. Secure staff necessary to properly administer the  
702 corporation. Staff costs shall be funded from state and local  
703 matching funds and such other private or public funds as become  
704 available. The board of directors shall determine the number of  
705 staff members necessary to administer the corporation.

706 14. In consultation with the partner agencies, provide an  
707 annual ~~a~~ report on the Florida Kidcare program ~~annually~~ to the  
708 Governor, the Chief Financial Officer, the Commissioner of  
709 Education, the President of the Senate, the Speaker of the House  
710 of Representatives, and the Minority Leaders of the Senate and  
711 the House of Representatives.

712 15. Provide information on a quarterly basis to the  
713 Legislature and the Governor which compares the costs and  
714 utilization of the full-pay enrolled population and the Title  
715 XXI-subsidized enrolled population in the Florida Kidcare  
716 program. ~~The information,~~ At a minimum, the information must  
717 include:

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

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

724

725 By February 1, 2010, the Florida Healthy Kids Corporation shall

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726 provide a study to the Legislature and the Governor on premium  
727 impacts to the subsidized portion of the program from the  
728 inclusion of the full-pay program, which must ~~shall~~ include  
729 recommendations on how to eliminate or mitigate possible impacts  
730 to the subsidized premiums.

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

734 (8) OPERATING FUND.—The Florida Healthy Kids Corporation  
735 may establish and manage an operating fund for the purposes of  
736 addressing the corporation's unique cash-flow needs and  
737 facilitating the fiscal management of the corporation. At any  
738 given time, the corporation may accumulate and maintain in the  
739 operating fund a cash balance reserve equal to no more than 25  
740 percent of its annualized operating expenses. Upon dissolution  
741 of the corporation, any remaining cash balances of state funds  
742 shall revert to the General Revenue Fund, or such other state  
743 funds consistent with the appropriated funding, as provided by  
744 law.

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

747 409.813 Health benefits coverage; program components;  
748 entitlement and nonentitlement.—

749 (1) The Florida Kidcare program includes health benefits  
750 coverage provided to children through the following program  
751 components, which shall be marketed as the Florida Kidcare  
752 program:

753 (a) Medicaid.~~‡~~

754 (b) Medikids as created in s. 409.8132.~~‡~~

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755 (c) The Florida Healthy Kids Corporation as created in s.  
756 409.8115. ~~624.91;~~

757 (d) Employer-sponsored group health insurance plans  
758 approved under this part. ~~ss. 409.810-409.821;~~ and

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

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

763 409.8132 Medikids program component.—

764 (4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The  
765 provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908,  
766 409.912, ~~409.9121, 409.9122, 409.9123, 409.9124,~~ 409.9127,  
767 409.9128, 409.913, 409.916, ~~409.919,~~ 409.920, ~~and~~ 409.9205,  
768 409.987, 409.988, and 409.989 apply to the administration of the  
769 Medikids program component of the Florida Kidcare program,  
770 except that s. 409.987 ~~409.9122~~ applies to Medikids as modified  
771 by ~~the provisions of~~ subsection (7).

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

774 409.815 Health benefits coverage; limitations.—

775 (1) MEDICAID BENEFITS.—For purposes of the Florida Kidcare  
776 program, benefits available under Medicaid and Medikids include  
777 those goods and services provided under the medical assistance  
778 program authorized by Title XIX of the Social Security Act, and  
779 regulations thereunder, as administered in this state by the  
780 agency. This includes those mandatory Medicaid services  
781 authorized under s. 409.905 and optional Medicaid services  
782 authorized under s. 409.906, rendered on behalf of eligible  
783 individuals by qualified providers, in accordance with federal

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784 requirements ~~for Title XIX~~, subject to any limitations or  
785 directions provided ~~for~~ in the General Appropriations Act, ~~or~~  
786 chapter 216, or s. 409.9022, and according to methodologies and  
787 limitations set forth in agency rules and policy manuals and  
788 handbooks incorporated by reference ~~thereto~~.

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

791 409.818 Administration.—In order to implement ss. 409.810-  
792 409.821, the following agencies shall have the following duties:

793 (5) The Florida Healthy Kids Corporation shall retain its  
794 functions as authorized in s. 409.8115 ~~624.91~~, including  
795 eligibility determination for participation in the Healthy Kids  
796 program.

797 Section 13. Paragraph (e) of subsection (2) of section  
798 154.503, Florida Statutes, is amended to read:

799 154.503 Primary Care for Children and Families Challenge  
800 Grant Program; creation; administration.—

801 (2) The department shall:

802 (e) Coordinate with the primary care program developed  
803 pursuant to s. 154.011, the Florida Healthy Kids Corporation  
804 program created in s. 409.8115 ~~624.91~~, the school health  
805 services program created in ss. 381.0056 and 381.0057, the  
806 Healthy Communities, Healthy People Program created in s.  
807 381.734, and the volunteer health care provider program  
808 established ~~developed~~ pursuant to s. 766.1115.

809 Section 14. Paragraph (c) of subsection (4) of section  
810 408.915, Florida Statutes, is amended to read:

811 408.915 Eligibility pilot project.—The Agency for Health  
812 Care Administration, in consultation with the steering committee

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813 established in s. 408.916, shall develop and implement a pilot  
814 project to integrate the determination of eligibility for health  
815 care services with information and referral services.

816 (4) The pilot project shall include eligibility  
817 determinations for the following programs:

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

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

822 1006.06 School food service programs.—

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

825 (a) At a minimum:

826 1. Provide application information about the Kidcare  
827 program or an application for Kidcare to students at the  
828 beginning of each school year.

829 2. Modify the school district's application form for the  
830 lunch program under subsection (4) and the breakfast program  
831 under subsection (5) to incorporate a provision that permits the  
832 school district to share data from the application form with the  
833 state agencies and the Florida Healthy Kids Corporation and its  
834 agents that administer the Kidcare program unless the child's  
835 parent or guardian opts out of the provision.

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

841 (c) Establish interagency agreements ensuring that data

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842 exchanged under this subsection is used only to enroll eligible  
843 children in the Florida Kidcare program and is protected from  
844 unauthorized disclosure pursuant to 42 U.S.C. s. 1758(b)(6).

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

848 Section 17. Section 409.901, Florida Statutes, is amended  
849 to read:

850 409.901 Definitions; ~~ss. 409.901-409.920.~~ As used in this  
851 part and part IV ss. 409.901-409.920, except as otherwise  
852 specifically provided, the term:

853 (1) "Affiliate" or "affiliated person" means any person who  
854 directly or indirectly manages, controls, or oversees the  
855 operation of a corporation or other business entity that is a  
856 Medicaid provider, regardless of whether such person is a  
857 partner, shareholder, owner, officer, director, agent, or  
858 employee of the entity.

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

862 (3) "Applicant" means an individual whose written  
863 application for medical assistance provided by Medicaid ~~under~~  
864 ~~ss. 409.903-409.906~~ has been submitted to the Department of  
865 Children and Family Services, or to the Social Security  
866 Administration if the application is for Supplemental Security  
867 Income, but has not received final action. The ~~This~~ term  
868 includes an individual, who need not be alive at the time of  
869 application, and whose application is submitted through a  
870 representative or a person acting for the individual.

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871 (4) "Benefit" means any benefit, assistance, aid,  
872 obligation, promise, debt, liability, or the like, related to  
873 any covered injury, illness, or necessary medical care, goods,  
874 or services.

875 (5) "Capitation" means a prospective per-member, per-month  
876 payment designed to represent, in the aggregate, an actuarially  
877 sound estimate of expenditures required for the management and  
878 provision of a specified set of medical services or long-term  
879 care services needed by members enrolled in a prepaid health  
880 plan.

881 (6) (5) "Change of ownership" has the same meaning as in s.  
882 408.803 and includes means:

883 ~~(a) An event in which the provider ownership changes to a~~  
884 ~~different individual entity as evidenced by a change in federal~~  
885 ~~employer identification number or taxpayer identification~~  
886 ~~number;~~

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

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

895  
896 ~~A change solely in the management company or board of directors~~  
897 ~~is not a change of ownership.~~

898 (7) (6) "Claim" means any communication, whether written or  
899 electronic (electronic impulse or magnetic), which is used by

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900 any person to apply for payment from the Medicaid program, ~~or~~  
901 its fiscal agent, or a qualified plan under part IV of this  
902 chapter for each item or service purported ~~by any person~~ to have  
903 been provided ~~by a person~~ to a any Medicaid recipient.

904 (8) ~~(7)~~ "Collateral" means:

905 (a) Any and all causes of action, suits, claims,  
906 counterclaims, and demands that accrue to a ~~the~~ recipient or to  
907 a ~~the~~ recipient's legal representative, related to any covered  
908 injury, illness, or necessary medical care, goods, or services  
909 that resulted in ~~neecessitated that~~ Medicaid providing ~~provide~~  
910 medical assistance.

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

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

915 (9) ~~(8)~~ "Convicted" or "conviction" means a finding of  
916 guilt, with or without an adjudication of guilt, in any federal  
917 or state trial court ~~of record relating to charges brought by~~  
918 ~~indictment or information~~, as a result of a jury verdict,  
919 nonjury trial, or entry of a plea of guilty or nolo contendere,  
920 regardless of whether an appeal from judgment is pending.

921 (10) ~~(9)~~ "Covered injury or illness" means any sickness,  
922 injury, disease, disability, deformity, abnormality disease,  
923 necessary medical care, pregnancy, or death for which a third  
924 party is, may be, could be, should be, or has been liable, and  
925 for which Medicaid is, or may be, obligated to provide, or has  
926 provided, medical assistance.

927 (11) ~~(10)~~ "Emergency medical condition" has the same meaning  
928 as in s. 395.002. ~~means:~~



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929 ~~(a) A medical condition manifesting itself by acute~~  
930 ~~symptoms of sufficient severity, which may include severe pain~~  
931 ~~or other acute symptoms, such that the absence of immediate~~  
932 ~~medical attention could reasonably be expected to result in any~~  
933 ~~of the following:~~

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

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

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

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

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

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

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

945 ~~(12)(11) "Emergency services and care" has the same meaning~~  
946 ~~as in s. 395.002 means medical screening, examination, and~~  
947 ~~evaluation by a physician, or, to the extent permitted by~~  
948 ~~applicable laws, by other appropriate personnel under the~~  
949 ~~supervision of a physician, to determine whether an emergency~~  
950 ~~medical condition exists and, if it does, the care, treatment,~~  
951 ~~or surgery for a covered service by a physician which is~~  
952 ~~necessary to relieve or eliminate the emergency medical~~  
953 ~~condition, within the service capability of a hospital.~~

954 ~~(13)(12) "Legal representative" means a guardian,~~  
955 ~~conservator, survivor, or personal representative of a recipient~~  
956 ~~or applicant, or of the property or estate of a recipient or~~  
957 ~~applicant.~~

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958        (14)~~(13)~~ "Managed care plan" means a health insurer  
959 authorized under chapter 624, an exclusive provider organization  
960 authorized under chapter 627, a health maintenance organization  
961 authorized under chapter 641, a provider service network  
962 authorized under s. 409.912(4)(d), or an accountable care  
963 organization authorized under federal law ~~health maintenance~~  
964 ~~organization authorized pursuant to chapter 641 or a prepaid~~  
965 ~~health plan authorized pursuant to s. 409.912.~~

966        (15)~~(14)~~ "Medicaid" or Medicaid program means the medical  
967 assistance program authorized by Title XIX of the Social  
968 Security Act, 42 U.S.C. s. 1396 et seq., and regulations  
969 thereunder, as administered in this state by the agency.

970        ~~(15) "Medicaid agency" or "agency" means the single state~~  
971 ~~agency that administers or supervises the administration of the~~  
972 ~~state Medicaid plan under federal law.~~

973        ~~(16) "Medicaid program" means the program authorized under~~  
974 ~~Title XIX of the federal Social Security Act which provides for~~  
975 ~~payments for medical items or services, or both, on behalf of~~  
976 ~~any person who is determined by the Department of Children and~~  
977 ~~Family Services, or, for Supplemental Security Income, by the~~  
978 ~~Social Security Administration, to be eligible on the date of~~  
979 ~~service for Medicaid assistance.~~

980        (16)~~(17)~~ "Medicaid provider" or "provider" means a person  
981 or entity that has a Medicaid provider agreement in effect with  
982 the agency and is in good standing with the agency. The term  
983 also includes a person or entity that provides medical services  
984 to a Medicaid recipient under the Medicaid managed care program  
985 in part IV of this chapter.

986        (17)~~(18)~~ "Medicaid provider agreement" or "provider

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987 agreement" means a contract between the agency and a provider  
988 for the provision of services or goods, or both, to Medicaid  
989 recipients pursuant to Medicaid.

990 (18)~~(19)~~ "Medicaid recipient" or "recipient" means an  
991 individual whom the Department of Children and Family Services,  
992 or, for Supplemental Security Income, ~~by~~ the Social Security  
993 Administration, determines is eligible, pursuant to federal and  
994 state law, to receive medical assistance and related services  
995 for which the agency may make payments under the Medicaid  
996 program. For the purposes of determining third-party liability,  
997 the term includes an individual formerly determined to be  
998 eligible for Medicaid, an individual who has received medical  
999 assistance under ~~the~~ Medicaid ~~program~~, or an individual on whose  
1000 behalf Medicaid has become obligated.

1001 (19)~~(20)~~ "Medicaid-related records" means records that  
1002 relate to the provider's business or profession and to a  
1003 Medicaid recipient. The term includes ~~Medicaid-related records~~  
1004 ~~include~~ records related to non-Medicaid customers, clients, or  
1005 patients but only to the extent that the documentation is shown  
1006 by the agency to be necessary for determining ~~to determine~~ a  
1007 provider's entitlement to payments under the Medicaid program.

1008 (20)~~(21)~~ "Medical assistance" means any provision of,  
1009 payment for, or liability for medical services or care by  
1010 Medicaid to, or on behalf of, a Medicaid ~~any~~ recipient.

1011 (21)~~(22)~~ "Medical services" or "medical care" means medical  
1012 or medically related institutional or noninstitutional care,  
1013 goods, or services covered by the Medicaid program. The term  
1014 includes any services authorized and funded in the General  
1015 Appropriations Act.

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1016        ~~(22)~~(23) "MediPass" means a primary care case management  
1017 program operated by the agency.

1018        ~~(23)~~(24) "Minority physician network" means a network of  
1019 primary care physicians with experience in managing Medicaid or  
1020 Medicare recipients which ~~that~~ is predominantly owned by  
1021 minorities, as defined in s. 288.703, and which may have a  
1022 collaborative partnership with a public college or university  
1023 and a tax-exempt charitable corporation.

1024        ~~(24)~~(25) "Payment," as it relates to third-party benefits,  
1025 means performance of a duty, promise, or obligation, or  
1026 discharge of a debt or liability, by the delivery, provision, or  
1027 transfer of third-party benefits for medical services. To "pay"  
1028 means to do any of the acts set forth in this subsection.

1029        ~~(25)~~(26) "Proceeds" means whatever is received upon the  
1030 sale, exchange, collection, or other disposition of the  
1031 collateral or proceeds thereon and includes insurance payable by  
1032 reason of loss or damage to the collateral or proceeds. Money,  
1033 checks, deposit accounts, and the like are "cash proceeds." All  
1034 other proceeds are "noncash proceeds."

1035        ~~(26)~~(27) "Third party" means an individual, entity, or  
1036 program, excluding Medicaid, that is, may be, could be, should  
1037 be, or has been liable for all or part of the cost of medical  
1038 services related to any medical assistance covered by Medicaid.  
1039 A third party includes a third-party administrator or a pharmacy  
1040 benefits manager.

1041        ~~(27)~~(28) "Third-party benefit" means any benefit that is or  
1042 may be available at any time through contract, court award,  
1043 judgment, settlement, agreement, or any arrangement between a  
1044 third party and any person or entity, including, without

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1045 limitation, a Medicaid recipient, a provider, another third  
1046 party, an insurer, or the agency, for any Medicaid-covered  
1047 injury, illness, goods, or services, including costs of medical  
1048 services related thereto, for personal injury or for death of  
1049 the recipient, but specifically excluding policies of life  
1050 insurance on the recipient, unless available under terms of the  
1051 policy to pay medical expenses prior to death. The term  
1052 includes, without limitation, collateral, as defined in this  
1053 section, health insurance, any benefit under a health  
1054 maintenance organization, a preferred provider arrangement, a  
1055 prepaid health clinic, liability insurance, uninsured motorist  
1056 insurance or personal injury protection coverage, medical  
1057 benefits under workers' compensation, and any obligation under  
1058 law or equity to provide medical support.

1059 Section 18. Section 409.902, Florida Statutes, is amended  
1060 to read:

1061 409.902 Designated single state agency; eligibility  
1062 determinations; rules ~~payment requirements; program title;~~  
1063 ~~release of medical records.-~~

1064 (1) The agency ~~for Health Care Administration~~ is designated  
1065 as the single state agency authorized to administer the Medicaid  
1066 state plan and to make payments for medical assistance and  
1067 related services under Title XIX of the Social Security Act.  
1068 These payments shall be made, subject to any limitations or  
1069 directions provided for in the General Appropriations Act, only  
1070 for services included in the Medicaid program, ~~shall be made~~  
1071 only on behalf of eligible individuals, and ~~shall be made~~ only  
1072 to qualified providers in accordance with federal requirements  
1073 under ~~for~~ Title XIX of the Social Security Act and ~~the~~

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1074 ~~provisions of state law.~~

1075 (a) The agency must notify the Legislature before seeking  
1076 an amendment to the state plan for purposes of implementing  
1077 provisions authorized by the Deficit Reduction Act of 2005.

1078 (b) The agency shall adopt any rules necessary to carry out  
1079 its statutory duties under this subsection and any other  
1080 statutory provisions related to its responsibility for the  
1081 Medicaid program and state compliance with federal Medicaid  
1082 requirements, including the Medicaid managed care program. ~~This~~  
1083 program of medical assistance is designated the "Medicaid  
1084 program."

1085 (2) The Department of Children and Family Services is  
1086 responsible for determining Medicaid eligibility determinations,  
1087 including, but not limited to, policy, rules, and the agreement  
1088 with the Social Security Administration for Medicaid eligibility  
1089 determinations for Supplemental Security Income recipients, as  
1090 well as the actual determination of eligibility. ~~As a condition~~  
1091 of Medicaid eligibility, subject to federal approval, the agency  
1092 for Health Care Administration and the Department of Children  
1093 and Family Services shall ensure that each recipient of Medicaid  
1094 consents to the release of her or his medical records to the  
1095 agency for Health Care Administration and the Medicaid Fraud  
1096 Control Unit of the Department of Legal Affairs.

1097 (a) Eligibility is restricted to United States citizens and  
1098 to lawfully admitted noncitizens who meet the criteria provided  
1099 in s. 414.095(3).

1100 1. Citizenship or immigration status must be verified. For  
1101 noncitizens, this includes verification of the validity of  
1102 documents with the United States Citizenship and Immigration

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1103 Services using the federal SAVE verification process.

1104 2. State funds may not be used to provide medical services  
1105 to individuals who do not meet the requirements of this  
1106 paragraph unless the services are necessary to treat an  
1107 emergency medical condition or are for pregnant women. Such  
1108 services are authorized only to the extent provided under  
1109 federal law and in accordance with federal regulations as  
1110 provided in 42 C.F.R. s. 440.255.

1111 (b) When adopting rules relating to eligibility for  
1112 institutional care services, hospice services, and home and  
1113 community-based waiver programs, and regardless of whether a  
1114 penalty will be applied due to the unlawful transfer of assets,  
1115 the payment of fair compensation by an applicant for a personal  
1116 care services contract entered into on or after October 1, 2011,  
1117 shall be evaluated using the following criteria:

1118 1. The contracted services do not duplicate services  
1119 available through other sources or providers, such as Medicaid,  
1120 Medicare, private insurance, or another legally obligated third  
1121 party;

1122 2. The contracted services directly benefit the individual  
1123 and are not services normally provided out of love and  
1124 consideration for the individual;

1125 3. The actual cost to deliver services is computed in a  
1126 manner that clearly reflects the actual number of hours to be  
1127 expended, and the contract clearly identifies each specific  
1128 service and the average number of hours of each service to be  
1129 delivered each month;

1130 4. The hourly rate for each contracted service is equal to  
1131 or less than the amount normally charged by a professional who

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1132 traditionally provides the same or similar services;

1133 5. The contracted services are provided on a prospective  
1134 basis only and not for services provided in the past; and

1135 6. The contract provides fair compensation to the  
1136 individual in his or her lifetime as set forth in life  
1137 expectancy tables adopted in rule 65A-1.716, Florida  
1138 Administrative Code.

1139 (c) The department shall adopt any rules necessary to carry  
1140 out its statutory duties under this subsection for receiving and  
1141 processing Medicaid applications and determining Medicaid  
1142 eligibility, and any other statutory provisions related to  
1143 responsibility for the determination of Medicaid eligibility.

1144 Section 19. Section 409.9021, Florida Statutes, is amended  
1145 to read:

1146 409.9021 Conditions for Medicaid ~~Forfeiture of eligibility~~  
1147 ~~agreement.~~—As a condition of Medicaid eligibility, subject to  
1148 federal regulation and approval:~~7~~

1149 (1) A Medicaid applicant must consent ~~shall agree~~ in  
1150 writing to:

1151 (a) Have her or his medical records released to the agency  
1152 and the Medicaid Fraud Control Unit of the Department of Legal  
1153 Affairs.

1154 (b) Forfeit all entitlements to any goods or services  
1155 provided through the Medicaid program for the next 10 years if  
1156 he or she has been found to have committed Medicaid fraud~~7~~  
1157 through judicial or administrative determination, ~~two times in a~~  
1158 ~~period of 5 years.~~ This provision applies only to the Medicaid  
1159 recipient found to have committed or participated in Medicaid  
1160 ~~the~~ fraud and does not apply to any family member of the



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1161 recipient who was not involved in the fraud.

1162 (2) A Medicaid applicant must pay a \$10 monthly premium  
1163 that covers all Medicaid-eligible recipients in the applicant's  
1164 family. However, an individual who is eligible for the  
1165 Supplemental Security Income related Medicaid and is receiving  
1166 institutional care payments is exempt from this requirement. The  
1167 agency shall seek a federal waiver to authorize the imposition  
1168 and collection of this premium effective December 31, 2011. Upon  
1169 approval, the agency shall establish by rule procedures for  
1170 collecting premiums from recipients, advance notice of  
1171 cancellation, and waiting periods for reinstatement of coverage  
1172 upon voluntary cancellation for nonpayment of premiums.

1173 (3) A Medicaid applicant must participate, in good faith,  
1174 in:

1175 (a) A medically approved smoking cessation program if the  
1176 applicant smokes.

1177 (b) A medically directed weight loss program if the  
1178 applicant is or becomes morbidly obese.

1179 (c) A medically approved alcohol or substance abuse  
1180 recovery program if the applicant is or becomes diagnosed as a  
1181 substance abuser.

1182  
1183 The agency shall seek a federal waiver to authorize the  
1184 implementation of this subsection in order to assist the  
1185 recipient in mitigating lifestyle choices and avoiding behaviors  
1186 associated with the use of high-cost medical services.

1187 (4) A person who is eligible for Medicaid services and who  
1188 has access to health care coverage through an employer-sponsored  
1189 health plan may not receive Medicaid services reimbursed under

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1190 s. 409.908, s. 409.912, or s. 409.986, but may use Medicaid  
1191 financial assistance to pay the cost of premiums for the  
1192 employer-sponsored health plan for the eligible person and his  
1193 or her Medicaid-eligible family members.

1194 (5) A Medicaid recipient who has access to other insurance  
1195 or coverage created pursuant to state or federal law may opt out  
1196 of the Medicaid services provided under s. 409.908, s. 409.912,  
1197 or s. 409.986 and use Medicaid financial assistance to pay the  
1198 cost of premiums for the recipient and the recipient's Medicaid  
1199 eligible family members.

1200 (6) Subsections (4) and (5) shall be administered by the  
1201 agency in accordance with s. 409.964(1)(j). The maximum amount  
1202 available for the Medicaid financial assistance shall be  
1203 calculated based on the Medicaid capitated rate as if the  
1204 Medicaid recipient and the recipient's eligible family members  
1205 participated in a qualified plan for Medicaid managed care under  
1206 part IV of this chapter.

1207 Section 20. Section 409.9022, Florida Statutes, is created  
1208 to read:

1209 409.9022 Limitations on Medicaid expenditures.-

1210 (1) Except as specifically authorized in this section, a  
1211 state agency may not obligate or expend funds for the Medicaid  
1212 program in excess of the amount appropriated in the General  
1213 Appropriations Act.

1214 (2) If, at any time during the fiscal year, a state agency  
1215 determines that Medicaid expenditures may exceed the amount  
1216 appropriated during the fiscal year, the state agency shall  
1217 notify the Social Services Estimating Conference, which shall  
1218 meet to estimate Medicaid expenditures for the remainder of the

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1219 fiscal year. If, pursuant to this paragraph or for any other  
1220 purpose, the conference determines that Medicaid expenditures  
1221 will exceed appropriations for the fiscal year, the state agency  
1222 shall develop and submit a plan for revising Medicaid  
1223 expenditures in order to remain within the annual appropriation.  
1224 The plan must include cost-mitigating strategies to negate the  
1225 projected deficit for the remainder of the fiscal year and shall  
1226 be submitted in the form of a budget amendment to the  
1227 Legislative Budget Commission. The conference shall also  
1228 estimate the amount of savings which will result from such cost-  
1229 mitigating strategies proposed by the state agency as well as  
1230 any other strategies the conference may consider and recommend.

1231 (3) In preparing the budget amendment to revise Medicaid  
1232 expenditures in order to remain within appropriations, a state  
1233 agency shall include the following revisions to the Medicaid  
1234 state plan, in the priority order listed below:

1235 (a) Reduction in administrative costs.

1236 (b) Elimination of optional benefits.

1237 (c) Elimination of optional eligibility groups.

1238 (d) Reduction to institutional and provider reimbursement  
1239 rates.

1240 (e) Reduction in the amount, duration, and scope of  
1241 mandatory benefits.

1242  
1243 The state agency may not implement any of these cost-containment  
1244 measures until the amendment is approved by the Legislative  
1245 Budget Commission.

1246 (4) In order to remedy a projected expenditure in excess of  
1247 the amount appropriated in a specific appropriation within the

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1248 Medicaid budget, a state agency may, consistent with chapter  
 1249 216:

1250 (a) Submit a budget amendment to transfer budget authority  
 1251 between appropriation categories;

1252 (b) Submit a budget amendment to increase federal trust  
 1253 authority or grants and donations trust authority if additional  
 1254 federal or local funds are available; or

1255 (c) Submit any other budget amendment consistent with  
 1256 chapter 216.

1257 (5) The agency shall amend the Medicaid state plan to  
 1258 incorporate the provisions of this section.

1259 (6) Chapter 216 does not permit the transfer of funds from  
 1260 any other program into the Medicaid program or the transfer of  
 1261 funds out of the Medicaid program into any other program.

1262 Section 21. Section 409.903, Florida Statutes, is amended  
 1263 to read:

1264 409.903 Mandatory payments for eligible persons.—The agency  
 1265 shall make payments for medical assistance and related services  
 1266 on behalf of the following categories of persons who the  
 1267 Department of Children and Family Services, or the Social  
 1268 Security Administration by contract with the department ~~of~~  
 1269 ~~Children and Family Services~~, determines to be eligible for  
 1270 Medicaid, subject to the income, assets, and categorical  
 1271 eligibility tests set forth in federal and state law. Payment on  
 1272 behalf of these recipients ~~Medicaid-eligible persons~~ is subject  
 1273 to the availability of moneys and any limitations established by  
 1274 the General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

1275 (1) Low-income families with children if ~~are eligible for~~  
 1276 ~~Medicaid provided~~ they meet the following requirements:

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1277 (a) The family includes a dependent child who is living  
1278 with a caretaker relative.

1279 (b) The family's income does not exceed the gross income  
1280 test limit.

1281 (c) The family's countable income and resources do not  
1282 exceed the applicable Aid to Families with Dependent Children  
1283 (AFDC) income and resource standards under the AFDC state plan  
1284 in effect on ~~in~~ July 1996, except as amended in the Medicaid  
1285 state plan to conform as closely as possible to the requirements  
1286 of the welfare transition program, to the extent permitted by  
1287 federal law.

1288 (2) A person who receives payments from, who is determined  
1289 eligible for, or who was eligible for but lost cash benefits  
1290 from the federal program known as the Supplemental Security  
1291 Income program (SSI). This ~~category~~ includes a low-income person  
1292 age 65 or over and a low-income person under age 65 considered  
1293 to be permanently and totally disabled.

1294 (3) A child under age 21 living in a low-income, two-parent  
1295 family, and a child under age 7 living with a nonrelative, if  
1296 the income and assets of the family or child, as applicable, do  
1297 not exceed the resource limits under the Temporary Cash  
1298 Assistance Program.

1299 (4) A child who is eligible under Title IV-E of the Social  
1300 Security Act for subsidized board payments, foster care, or  
1301 adoption subsidies, and a child for whom the state has assumed  
1302 temporary or permanent responsibility and who does not qualify  
1303 for Title IV-E assistance but is in foster care, shelter or  
1304 emergency shelter care, or subsidized adoption. This ~~category~~  
1305 includes a young adult who is eligible to receive services under

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1306 s. 409.1451(5), until the young adult reaches 21 years of age,  
1307 without regard to any income, resource, or categorical  
1308 eligibility test that is otherwise required. This ~~category~~ also  
1309 includes a person who as a child was eligible under Title IV-E  
1310 of the Social Security Act for foster care or the state-provided  
1311 foster care and who is a participant in the Road-to-Independence  
1312 Program.

1313 (5) A pregnant woman for the duration of her pregnancy and  
1314 for the postpartum period as defined in federal law and rule, or  
1315 a child under age 1, if either is living in a family that has an  
1316 income which is at or below ~~150 percent of the most current~~  
1317 ~~federal poverty level, or, effective January 1, 1992, that has~~  
1318 ~~an income which is at or below~~ 185 percent of the most current  
1319 federal poverty level. Such a person is not subject to an assets  
1320 test. ~~Further,~~ A pregnant woman who applies for eligibility for  
1321 the Medicaid program through a qualified Medicaid provider must  
1322 be offered the opportunity, subject to federal rules, to be made  
1323 presumptively eligible for the Medicaid program.

1324 (6) A child ~~born after September 30, 1983,~~ living in a  
1325 family that has an income which is at or below 100 percent of  
1326 the current federal poverty level, who has attained the age of  
1327 6, but has not attained the age of 19. In determining the  
1328 eligibility of such a child, an assets test is not required. A  
1329 child who is eligible ~~for Medicaid~~ under this subsection must be  
1330 offered the opportunity, subject to federal rules, to be made  
1331 presumptively eligible. A child who has been deemed  
1332 presumptively eligible may ~~for Medicaid shall~~ not be enrolled in  
1333 a managed care plan until the child's full eligibility  
1334 ~~determination~~ for Medicaid has been determined ~~completed~~.

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1335 (7) A child living in a family that has an income that  
1336 ~~which~~ is at or below 133 percent of the current federal poverty  
1337 level, who has attained the age of 1, but has not attained the  
1338 age of 6. In determining ~~the~~ eligibility ~~of such a child~~, an  
1339 assets test is not required. A child who is eligible ~~for~~  
1340 ~~Medicaid~~ under this subsection must be offered the opportunity,  
1341 subject to federal rules, to be made presumptively eligible. A  
1342 child who has been deemed presumptively eligible may for  
1343 ~~Medicaid shall~~ not be enrolled in a managed care plan until the  
1344 child's full eligibility ~~determination~~ for Medicaid has been  
1345 determined ~~completed~~.

1346 (8) A person who is age 65 or over or is determined by the  
1347 agency to be disabled, whose income is at or below 100 percent  
1348 of the most current federal poverty level and whose assets do  
1349 not exceed limitations established by the agency. However, the  
1350 agency may only pay for premiums, coinsurance, and deductibles,  
1351 as required by federal law, unless additional coverage is  
1352 provided for any or all members of this group under ~~by~~ s.  
1353 409.904(1).

1354 Section 22. Section 409.904, Florida Statutes, is amended  
1355 to read:

1356 409.904 Optional payments for eligible persons.—The agency  
1357 may make payments for medical assistance and related services on  
1358 behalf of the following categories of persons who are determined  
1359 to be eligible for Medicaid, subject to the income, assets, and  
1360 categorical eligibility tests set forth in federal and state  
1361 law. Payment on behalf of these ~~Medicaid-eligible~~ persons is  
1362 subject to the availability of moneys and any limitations  
1363 established by the General Appropriations Act, ~~or~~ chapter 216,

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1364 or s. 409.9022.

1365 (1) ~~Effective January 1, 2006,~~ and Subject to federal  
1366 waiver approval, a person who is age 65 or older or is  
1367 determined to be disabled, whose income is at or below 88  
1368 percent of the federal poverty level, whose assets do not exceed  
1369 established limitations, and who is not eligible for Medicare  
1370 or, if eligible for Medicare, is also eligible for and receiving  
1371 Medicaid-covered institutional care services, hospice services,  
1372 or home and community-based services. The agency shall seek  
1373 federal authorization through a waiver to provide this coverage.  
1374 This subsection expires June 30, 2011.

1375 (2) The following persons who are eligible for the Medicaid  
1376 nonpoverty medical subsidy, which includes the same services as  
1377 those provided to other Medicaid recipients, with the exception  
1378 of services in skilled nursing facilities and intermediate care  
1379 facilities for the developmentally disabled:

1380 (a) A family, a pregnant woman, a child under age 21, a  
1381 person age 65 or over, or a blind or disabled person, who would  
1382 be eligible under any group listed in s. 409.903(1), (2), or  
1383 (3), except that the income or assets of such family or person  
1384 exceed established limitations. For a family or person in one of  
1385 these coverage groups, medical expenses are deductible from  
1386 income in accordance with federal requirements in order to make  
1387 a determination of eligibility. ~~A family or person eligible~~  
1388 ~~under the coverage known as the "medically needy," is eligible~~  
1389 ~~to receive the same services as other Medicaid recipients, with~~  
1390 ~~the exception of services in skilled nursing facilities and~~  
1391 ~~intermediate care facilities for the developmentally disabled.~~  
1392 This paragraph expires June 30, 2011.



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1393 (b) Effective June 30 ~~July 1~~, 2011, a pregnant woman or a  
1394 child younger than 21 years of age who would be eligible under  
1395 any group listed in s. 409.903, except that the income or assets  
1396 of such group exceed established limitations. For a person in  
1397 one of these coverage groups, medical expenses are deductible  
1398 from income in accordance with federal requirements in order to  
1399 make a determination of eligibility. ~~A person eligible under the~~  
1400 ~~coverage known as the "medically needy" is eligible to receive~~  
1401 ~~the same services as other Medicaid recipients, with the~~  
1402 ~~exception of services in skilled nursing facilities and~~  
1403 ~~intermediate care facilities for the developmentally disabled.~~

1404 (c) A family, a person age 65 or older, or a blind or  
1405 disabled person, who would be eligible under any group listed in  
1406 s. 409.903(1), (2), or (3), except that the income or assets of  
1407 such family or person exceed established limitations. For a  
1408 family or person in one of these coverage groups, medical  
1409 expenses are deductible from income in accordance with federal  
1410 requirements in order to make a determination of eligibility. A  
1411 family, a person age 65 or older, or a blind or disabled person,  
1412 covered under the Medicaid nonpoverty medical subsidy, is  
1413 eligible to receive physician services only.

1414 (3) A person who is in need of the services of a licensed  
1415 nursing facility, a licensed intermediate care facility for the  
1416 developmentally disabled, or a state mental hospital, whose  
1417 income does not exceed 300 percent of the SSI income standard,  
1418 and who meets the assets standards established under federal and  
1419 state law. In determining the person's responsibility for the  
1420 cost of care, the following amounts must be deducted from the  
1421 person's income:

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1422 (a) The monthly personal allowance for residents as set  
1423 based on appropriations.

1424 (b) The reasonable costs of medically necessary services  
1425 and supplies that are not reimbursable by the Medicaid program.

1426 (c) The cost of premiums, copayments, coinsurance, and  
1427 deductibles for supplemental health insurance.

1428 (4) A low-income person who meets all other requirements  
1429 for Medicaid eligibility except citizenship and who is in need  
1430 of emergency medical services. The eligibility of such a  
1431 recipient is limited to the period of the emergency, in  
1432 accordance with federal regulations.

1433 (5) Subject to specific federal authorization, a woman  
1434 living in a family that has an income that is at or below 185  
1435 percent of the most current federal poverty level. Coverage is  
1436 limited to ~~is eligible for~~ family planning services as specified  
1437 in s. 409.905(3) for a period of up to 24 months following a  
1438 loss of Medicaid benefits.

1439 (6) A child who has not attained the age of 19 who has been  
1440 determined eligible for the Medicaid program is deemed to be  
1441 eligible for a total of 6 months, regardless of changes in  
1442 circumstances other than attainment of the maximum age.

1443 ~~Effective January 1, 1999,~~ A child who has not attained the age  
1444 of 5 and who has been determined eligible for the Medicaid  
1445 program is deemed to be eligible for a total of 12 months  
1446 regardless of changes in circumstances other than attainment of  
1447 the maximum age.

1448 (7) A child under 1 year of age who lives in a family that  
1449 has an income above 185 percent of the most recently published  
1450 federal poverty level, but which is at or below 200 percent of

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1451 such poverty level. In determining the eligibility ~~of such~~  
1452 ~~child~~, an assets test is not required. A child who is eligible  
1453 ~~for Medicaid~~ under this subsection must be offered the  
1454 opportunity, subject to federal rules, to be made presumptively  
1455 eligible.

1456 (8) An eligible person ~~A Medicaid-eligible individual~~ for  
1457 the individual's health insurance premiums, if the agency  
1458 determines that such payments are cost-effective.

1459 (9) Eligible women with incomes at or below 200 percent of  
1460 the federal poverty level and under age 65, for cancer treatment  
1461 pursuant to the federal Breast and Cervical Cancer Prevention  
1462 and Treatment Act of 2000, screened through the Mary Brogan  
1463 Breast and Cervical Cancer Early Detection Program established  
1464 under s. 381.93.

1465 Section 23. Section 409.905, Florida Statutes, is amended  
1466 to read:

1467 409.905 Mandatory Medicaid services.—The agency shall ~~may~~  
1468 make payments for the following services, which are required ~~of~~  
1469 ~~the state~~ by Title XIX of the Social Security Act, furnished by  
1470 Medicaid providers to recipients who are ~~determined to be~~  
1471 eligible on the dates on which the services were provided. Any  
1472 service under this section shall be provided only when medically  
1473 necessary and in accordance with state and federal law.

1474 Mandatory services rendered by providers in mobile units to  
1475 Medicaid recipients may be restricted by the agency. This  
1476 section does not ~~Nothing in this section shall be construed to~~  
1477 prevent or limit the agency from adjusting fees, reimbursement  
1478 rates, lengths of stay, number of visits, number of services, or  
1479 any other adjustments necessary to comply with the availability

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1480 of moneys and any limitations or directions provided ~~for~~ in the  
1481 General Appropriations Act, ~~or~~ chapter 216, or s. 409.9022.

1482 (1) ADVANCED REGISTERED NURSE PRACTITIONER SERVICES.—The  
1483 agency shall pay for services provided to a recipient by a  
1484 licensed advanced registered nurse practitioner who has a valid  
1485 collaboration agreement with a licensed physician on file with  
1486 the Department of Health or who provides anesthesia services in  
1487 accordance with established protocol required by state law and  
1488 approved by the medical staff of the facility in which the  
1489 ~~anesthetic~~ service is performed. Reimbursement for such services  
1490 must be provided in an amount that equals at least ~~not less than~~  
1491 80 percent of the reimbursement to a physician who provides the  
1492 same services, unless otherwise provided ~~for~~ in the General  
1493 Appropriations Act.

1494 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT  
1495 SERVICES.—The agency shall pay for early and periodic screening  
1496 and diagnosis of a recipient under age 21 to ascertain physical  
1497 and mental problems and conditions and ~~provide treatment to~~  
1498 ~~correct or ameliorate these problems and conditions. These~~  
1499 ~~services include~~ all services determined by the agency to be  
1500 medically necessary for the treatment, correction, or  
1501 amelioration of these problems and conditions, including  
1502 personal care, private duty nursing, durable medical equipment,  
1503 physical therapy, occupational therapy, speech therapy,  
1504 respiratory therapy, and immunizations.

1505 (3) FAMILY PLANNING SERVICES.—The agency shall pay for  
1506 services necessary to enable a recipient voluntarily to plan  
1507 family size or to space children. These services include  
1508 information; education; counseling regarding the availability,

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1509 benefits, and risks of each method of pregnancy prevention;  
1510 drugs and supplies; and necessary medical care and followup.  
1511 Each recipient participating in ~~the~~ family planning ~~portion of~~  
1512 ~~the Medicaid program~~ must be provided the choice of freedom to  
1513 ~~choose~~ any alternative method of family planning, as required by  
1514 federal law.

1515 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for  
1516 nursing and home health aide services, supplies, appliances, and  
1517 durable medical equipment, necessary to assist a recipient  
1518 living at home. An entity that provides such services must  
1519 ~~pursuant to this subsection shall~~ be licensed under part III of  
1520 chapter 400. These services, equipment, and supplies, or  
1521 reimbursement therefor, may be limited as provided in the  
1522 General Appropriations Act and do not include services,  
1523 equipment, or supplies provided to a person residing in a  
1524 hospital or nursing facility.

1525 (a) ~~In providing home health care services,~~ The agency  
1526 shall may require prior authorization of home health services  
1527 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing  
1528 rates. ~~The agency shall require prior authorization for visits~~  
1529 ~~for home health services that are not associated with a skilled~~  
1530 ~~nursing visit when the home health agency billing rates exceed~~  
1531 ~~the state average by 50 percent or more.~~ The home health agency  
1532 must submit the recipient's plan of care and documentation that  
1533 supports the recipient's diagnosis to the agency when requesting  
1534 prior authorization.

1535 (b) The agency shall implement a comprehensive utilization  
1536 management program ~~that requires prior authorization~~ of all  
1537 private duty nursing services, an individualized treatment plan

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1538 that includes information about medication and treatment orders,  
1539 treatment goals, methods of care to be used, and plans for care  
1540 coordination by nurses and other health professionals. The  
1541 utilization management program must ~~shall~~ also include a process  
1542 for periodically reviewing the ongoing use of private duty  
1543 nursing services. The assessment of need shall be based on a  
1544 child's condition;; family support and care supplements;; a  
1545 family's ability to provide care;; ~~and~~ a family's and child's  
1546 schedule regarding work, school, sleep, and care for other  
1547 family dependents; and a determination of the medical necessity  
1548 for private duty nursing instead of other more cost-effective  
1549 in-home services. When implemented, the private duty nursing  
1550 utilization management program shall replace the current  
1551 authorization program used by the agency ~~for Health Care~~  
1552 ~~Administration~~ and the Children's Medical Services program of  
1553 the Department of Health. The agency may competitively bid ~~on~~ a  
1554 contract to select a qualified organization to provide  
1555 utilization management of private duty nursing services. The  
1556 agency may ~~is authorized to~~ seek federal waivers to implement  
1557 this initiative.

1558 (c) The agency may not pay for home health services unless  
1559 the services are medically necessary and:

1560 1. The services are ordered by a physician.

1561 2. The written prescription for the services is signed and  
1562 dated by the recipient's physician before the development of a  
1563 plan of care and before any request requiring prior  
1564 authorization.

1565 3. The physician ordering the services is not employed,  
1566 under contract with, or otherwise affiliated with the home

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1567 health agency rendering the services. However, this subparagraph  
1568 does not apply to a home health agency affiliated with a  
1569 retirement community, of which the parent corporation or a  
1570 related legal entity owns a rural health clinic certified under  
1571 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed  
1572 under part II of chapter 400, or an apartment or single-family  
1573 home for independent living. For purposes of this subparagraph,  
1574 the agency may, on a case-by-case basis, provide an exception  
1575 for medically fragile children who are younger than 21 years of  
1576 age.

1577 4. The physician ordering the services has examined the  
1578 recipient within the 30 days preceding the initial request for  
1579 the services and biannually thereafter.

1580 5. The written prescription for the services includes the  
1581 recipient's acute or chronic medical condition or diagnosis, the  
1582 home health service required, and, for skilled nursing services,  
1583 the frequency and duration of the services.

1584 6. The national provider identifier, Medicaid  
1585 identification number, or medical practitioner license number of  
1586 the physician ordering the services is listed on the written  
1587 prescription for the services, the claim for home health  
1588 reimbursement, and the prior authorization request.

1589 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for  
1590 all covered services provided for the medical care and treatment  
1591 of a recipient who is admitted as an inpatient by a licensed  
1592 physician or dentist to a hospital licensed under part I of  
1593 chapter 395. However, the agency shall limit the payment for  
1594 inpatient hospital services for a Medicaid recipient 21 years of  
1595 age or older to 45 days or the number of days necessary to

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1596 comply with the General Appropriations Act.

1597       (a) The agency may ~~is authorized to~~ implement reimbursement  
1598 and utilization management reforms in order to comply with any  
1599 limitations or directions in the General Appropriations Act,  
1600 which may include, but are not limited to: prior authorization  
1601 for inpatient psychiatric days; prior authorization for  
1602 nonemergency hospital inpatient admissions for individuals 21  
1603 years of age and older; authorization of emergency and urgent-  
1604 care admissions within 24 hours after admission; enhanced  
1605 utilization and concurrent review programs for highly utilized  
1606 services; reduction or elimination of covered days of service;  
1607 adjusting reimbursement ceilings for variable costs; adjusting  
1608 reimbursement ceilings for fixed and property costs; and  
1609 implementing target rates of increase. The agency may limit  
1610 prior authorization for hospital inpatient services to selected  
1611 diagnosis-related groups, based on an analysis of the cost and  
1612 potential for unnecessary hospitalizations represented by  
1613 certain diagnoses. Admissions for normal delivery and newborns  
1614 are exempt from requirements for prior authorization. In  
1615 implementing the provisions of this section related to prior  
1616 authorization, the agency must ~~shall~~ ensure that the process for  
1617 authorization is accessible 24 hours per day, 7 days per week  
1618 and that authorization is automatically granted if ~~when~~ not  
1619 denied within 4 hours after the request. Authorization  
1620 procedures must include steps for reviewing ~~review of~~ denials.  
1621 Upon implementing the prior authorization program for hospital  
1622 inpatient services, the agency shall discontinue its hospital  
1623 retrospective review program.

1624       (b) A licensed hospital maintained primarily for the care



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1625 and treatment of patients having mental disorders or mental  
1626 diseases may ~~is not eligible to~~ participate in the hospital  
1627 inpatient portion of the Medicaid program except as provided in  
1628 federal law. However, the Department of Children and Family  
1629 Services shall apply for a waiver, ~~within 9 months after June 5,~~  
1630 ~~1991,~~ designed to provide hospitalization services for mental  
1631 health reasons to children and adults in the most cost-effective  
1632 and lowest cost setting possible. Such waiver shall include a  
1633 request for the opportunity to pay for care in hospitals known  
1634 under federal law as "institutions for mental disease" or  
1635 "IMD's." The waiver proposal shall propose no additional  
1636 aggregate cost to the state or Federal Government, and shall be  
1637 conducted in Hillsborough County, Highlands County, Hardee  
1638 County, Manatee County, and Polk County. The waiver proposal may  
1639 incorporate competitive bidding for hospital services,  
1640 comprehensive brokering, prepaid capitated arrangements, or  
1641 other mechanisms deemed by the department to show promise in  
1642 reducing the cost of acute care and increasing the effectiveness  
1643 of preventive care. When developing the waiver proposal, the  
1644 department shall take into account price, quality,  
1645 accessibility, linkages of the hospital to community services  
1646 and family support programs, plans of the hospital to ensure the  
1647 earliest discharge possible, and the comprehensiveness of the  
1648 mental health and other health care services offered by  
1649 participating providers.

1650 (c) The agency shall adjust a hospital's current inpatient  
1651 per diem rate to reflect the cost of serving the Medicaid  
1652 population at that institution if:

1653 1. The hospital experiences an increase in Medicaid

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1654 caseload by more than 25 percent in any year, primarily  
1655 resulting from the closure of a hospital in the same service  
1656 area occurring after July 1, 1995;

1657 2. The hospital's Medicaid per diem rate is at least 25  
1658 percent below the Medicaid per patient cost for that year; or

1659 3. The hospital is located in a county that has six or  
1660 fewer general acute care hospitals, began offering obstetrical  
1661 services on or after September 1999, and has submitted a request  
1662 in writing to the agency for a rate adjustment after July 1,  
1663 2000, but before September 30, 2000, in which case such  
1664 hospital's Medicaid inpatient per diem rate shall be adjusted to  
1665 cost, effective July 1, 2002. By October 1 of each year, the  
1666 agency must provide estimated costs for any adjustment in a  
1667 hospital inpatient per diem rate to the Executive Office of the  
1668 Governor, the House of Representatives General Appropriations  
1669 Committee, and the Senate Appropriations Committee. Before the  
1670 agency implements a change in a hospital's inpatient per diem  
1671 rate pursuant to this paragraph, the Legislature must have  
1672 specifically appropriated sufficient funds in the General  
1673 Appropriations Act to support the increase in cost as estimated  
1674 by the agency.

1675 (d) The agency shall implement a hospitalist program in  
1676 nonteaching hospitals, select counties, or statewide. The  
1677 program shall require hospitalists to manage Medicaid  
1678 recipients' hospital admissions and lengths of stay. Individuals  
1679 who are dually eligible for Medicare and Medicaid are exempted  
1680 from this requirement. Medicaid participating physicians and  
1681 other practitioners with hospital admitting privileges shall  
1682 coordinate and review admissions of Medicaid recipients with the

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1683 hospitalist. The agency may competitively bid a contract for  
1684 selection of a single qualified organization to provide  
1685 hospitalist services. The agency may procure hospitalist  
1686 services by individual county or may combine counties in a  
1687 single procurement. The qualified organization shall contract  
1688 with or employ board-eligible physicians in Miami-Dade, Palm  
1689 Beach, Hillsborough, Pasco, and Pinellas Counties. The agency  
1690 may ~~is authorized to~~ seek federal waivers to implement this  
1691 program.

1692 (e) The agency shall implement a comprehensive utilization  
1693 management program for hospital neonatal intensive care stays in  
1694 certain high-volume participating hospitals, select counties, or  
1695 statewide, and shall replace existing hospital inpatient  
1696 utilization management programs for neonatal intensive care  
1697 admissions. The program shall be designed to manage the lengths  
1698 of stay for children being treated in neonatal intensive care  
1699 units and must seek the earliest medically appropriate discharge  
1700 to the child's home or other less costly treatment setting. The  
1701 agency may competitively bid a contract for selection of a  
1702 qualified organization to provide neonatal intensive care  
1703 utilization management services. The agency may ~~is authorized to~~  
1704 seek any federal waivers to implement this initiative.

1705 (f) The agency may develop and implement a program to  
1706 reduce the number of hospital readmissions among the non-  
1707 Medicare population eligible in areas 9, 10, and 11.

1708 (6) HOSPITAL OUTPATIENT SERVICES.—The agency shall pay for  
1709 preventive, diagnostic, therapeutic, or palliative care and  
1710 other services provided to a recipient in the outpatient portion  
1711 of a hospital licensed under part I of chapter 395, and provided

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1712 under the direction of a licensed physician or licensed dentist,  
1713 except that payment for such care and services is limited to  
1714 \$1,500 per state fiscal year per recipient, unless an exception  
1715 has been made by the agency, and with the exception of a  
1716 Medicaid recipient under age 21, in which case the only  
1717 limitation is medical necessity.

1718 (7) INDEPENDENT LABORATORY SERVICES.—The agency shall pay  
1719 for medically necessary diagnostic laboratory procedures ordered  
1720 by a licensed physician or other licensed health care  
1721 practitioner ~~of the healing arts~~ which are provided for a  
1722 recipient in a laboratory that meets the requirements for  
1723 Medicare participation and is licensed under chapter 483, if  
1724 required.

1725 (8) NURSING FACILITY SERVICES.—The agency shall pay for 24-  
1726 hour-a-day nursing and rehabilitative services for a recipient  
1727 in a nursing facility licensed under part II of chapter 400 or  
1728 in a rural hospital, as defined in s. 395.602, or in a Medicare  
1729 certified skilled nursing facility operated by a general  
1730 hospital, as defined in ~~by~~ s. 395.002(10), which ~~that~~ is  
1731 licensed under part I of chapter 395, and in accordance with  
1732 ~~provisions set forth in~~ s. 409.908(2)(a), which services are  
1733 ordered by and provided under the direction of a licensed  
1734 physician. However, if a nursing facility has been destroyed or  
1735 otherwise made uninhabitable by natural disaster or other  
1736 emergency and another nursing facility is not available, the  
1737 agency must pay for similar services temporarily in a hospital  
1738 licensed under part I of chapter 395 provided federal funding is  
1739 approved and available. The agency shall pay only for bed-hold  
1740 days if the facility has an occupancy rate of 95 percent or

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1741 greater. The agency is authorized to seek any federal waivers to  
1742 implement this policy.

1743 (9) PHYSICIAN SERVICES.—The agency shall pay for covered  
1744 services and procedures rendered to a Medicaid recipient by, or  
1745 under the personal supervision of, a person licensed under state  
1746 law to practice medicine or osteopathic medicine. These services  
1747 may be furnished in the physician's office, the ~~Medicaid~~  
1748 recipient's home, a hospital, a nursing facility, or elsewhere,  
1749 but must ~~shall~~ be medically necessary for the treatment of a  
1750 covered ~~an~~ injury or, illness, ~~or disease~~ within the scope of  
1751 the practice of medicine or osteopathic medicine as defined by  
1752 state law. The agency may ~~shall~~ not pay for services that are  
1753 clinically unproven, experimental, or for purely cosmetic  
1754 purposes.

1755 (10) PORTABLE X-RAY SERVICES.—The agency shall pay for  
1756 professional and technical portable radiological services  
1757 ordered by a licensed physician or other licensed health care  
1758 practitioner ~~of the healing arts~~ which are provided by a  
1759 licensed professional in a setting other than a hospital,  
1760 clinic, or office of a physician or practitioner ~~of the healing~~  
1761 ~~arts~~, on behalf of a recipient.

1762 (11) RURAL HEALTH CLINIC SERVICES.—The agency shall pay for  
1763 outpatient primary ~~health~~ care services for a recipient provided  
1764 by a clinic certified by and participating in the Medicare  
1765 program which is located in a federally designated, rural,  
1766 medically underserved area and has on its staff one or more  
1767 licensed primary care nurse practitioners or physician  
1768 assistants, and a licensed staff supervising physician or a  
1769 consulting supervising physician.

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1770 (12) TRANSPORTATION SERVICES.—The agency shall ensure that  
1771 appropriate transportation services are available for a Medicaid  
1772 recipient in need of transport to a qualified Medicaid provider  
1773 for medically necessary ~~and Medicaid-compensable~~ services, if  
1774 the recipient's ~~provided a client's~~ ability to choose a specific  
1775 transportation provider is ~~shall be~~ limited to those options  
1776 resulting from policies established by the agency to meet the  
1777 fiscal limitations of the General Appropriations Act. The agency  
1778 may pay for necessary transportation and other related travel  
1779 expenses ~~as necessary~~ only if these services are not otherwise  
1780 available.

1781 Section 24. Section 409.906, Florida Statutes, is amended  
1782 to read:

1783 409.906 Optional Medicaid services.—Subject to specific  
1784 appropriations, the agency may make payments for services which  
1785 are optional to the state under Title XIX of the Social Security  
1786 Act and are furnished by Medicaid providers to recipients who  
1787 are determined to be eligible on the dates on which the services  
1788 were provided. Any optional service that is provided shall be  
1789 provided only when medically necessary and in accordance with  
1790 state and federal law. Optional services rendered by providers  
1791 in mobile units to Medicaid recipients may be restricted or  
1792 prohibited by the agency. ~~Nothing in This section does not shall~~  
1793 ~~be construed to~~ prevent or limit the agency from adjusting fees,  
1794 reimbursement rates, lengths of stay, number of visits, or  
1795 number of services, or making any other adjustments necessary to  
1796 comply with the availability of moneys and any limitations or  
1797 directions provided for in the General Appropriations Act, ~~or~~  
1798 chapter 216, or s. 409.9022. ~~If necessary to safeguard the~~

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1799 ~~state's systems of providing services to elderly and disabled~~  
1800 ~~persons and subject to the notice and review provisions of s.~~  
1801 ~~216.177, the Governor may direct the Agency for Health Care~~  
1802 ~~Administration to amend the Medicaid state plan to delete the~~  
1803 ~~optional Medicaid service known as "Intermediate Care Facilities~~  
1804 ~~for the Developmentally Disabled."~~ Optional services may  
1805 include:

1806 (1) ADULT DENTAL SERVICES.—For a recipient who is 21 years  
1807 of age or older:

1808 (a) The agency may pay for medically necessary, emergency  
1809 dental procedures to alleviate pain or infection. Emergency  
1810 dental care is ~~shall be~~ limited to emergency oral examinations,  
1811 necessary radiographs, extractions, and incision and drainage of  
1812 abscess, ~~for a recipient who is 21 years of age or older.~~

1813 (b) ~~Beginning July 1, 2006,~~ The agency may pay for full or  
1814 partial dentures, the procedures required to seat full or  
1815 partial dentures, and the repair and reline of full or partial  
1816 dentures, provided by or under the direction of a licensed  
1817 dentist, ~~for a recipient who is 21 years of age or older.~~

1818 (c) ~~However,~~ Medicaid will not provide reimbursement for  
1819 dental services provided in a mobile dental unit, except for a  
1820 mobile dental unit:

1821 1. Owned by, operated by, or having a contractual agreement  
1822 with the Department of Health and complying with Medicaid's  
1823 county health department clinic services program specifications  
1824 as a county health department clinic services provider.

1825 2. Owned by, operated by, or having a contractual  
1826 arrangement with a federally qualified health center and  
1827 complying with Medicaid's federally qualified health center

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1828 specifications as a federally qualified health center provider.

1829 3. Rendering dental services to Medicaid recipients, 21  
1830 years of age and older, at nursing facilities.

1831 4. Owned by, operated by, or having a contractual agreement  
1832 with a state-approved dental educational institution.

1833 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay for  
1834 an annual routine physical examination, conducted by or under  
1835 the direction of a licensed physician, for a recipient age 21 or  
1836 older, without regard to medical necessity, in order to detect  
1837 and prevent disease, disability, or other health condition or  
1838 its progression.

1839 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may pay  
1840 for services provided to a recipient in an ambulatory surgical  
1841 center licensed under part I of chapter 395, by or under the  
1842 direction of a licensed physician or dentist.

1843 (4) BIRTH CENTER SERVICES.—The agency may pay for  
1844 examinations and delivery, recovery, ~~and~~ newborn assessment, and  
1845 related services, provided in a licensed birth center staffed  
1846 with licensed physicians, certified nurse midwives, and midwives  
1847 licensed in accordance with chapter 467, to a recipient expected  
1848 to experience a low-risk pregnancy and delivery.

1849 (5) CASE MANAGEMENT SERVICES.—The agency may pay for  
1850 primary care case management services rendered to a recipient  
1851 pursuant to a federally approved waiver, ~~and~~ targeted case  
1852 management services for specific groups of targeted recipients,  
1853 for which funding has been provided and which are rendered  
1854 pursuant to federal guidelines. The agency may ~~is authorized to~~  
1855 limit reimbursement for targeted case management services in  
1856 order to comply with any limitations or directions provided for



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1857 in the General Appropriations Act.

1858 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for  
1859 diagnostic, preventive, or corrective procedures, including  
1860 orthodontia in severe cases, provided to a recipient under age  
1861 21, by or under the supervision of a licensed dentist. Services  
1862 ~~provided under this program~~ include treatment of the teeth and  
1863 associated structures of the oral cavity, as well as treatment  
1864 of disease, injury, or impairment that may affect the oral or  
1865 general health of the individual. However, Medicaid may ~~will~~ not  
1866 provide reimbursement for dental services provided in a mobile  
1867 dental unit, except for a mobile dental unit:

1868 (a) Owned by, operated by, or having a contractual  
1869 agreement with the Department of Health and complying with  
1870 Medicaid's county health department clinic services program  
1871 specifications as a county health department clinic services  
1872 provider.

1873 (b) Owned by, operated by, or having a contractual  
1874 arrangement with a federally qualified health center and  
1875 complying with Medicaid's federally qualified health center  
1876 specifications as a federally qualified health center provider.

1877 (c) Rendering dental services to Medicaid recipients, 21  
1878 years of age and older, at nursing facilities.

1879 (d) Owned by, operated by, or having a contractual  
1880 agreement with a state-approved dental educational institution.

1881 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual  
1882 manipulation of the spine and initial services, screening, and X  
1883 rays provided to a recipient by a licensed chiropractic  
1884 physician.

1885 (8) COMMUNITY MENTAL HEALTH SERVICES.—

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1886           ~~(a)~~ The agency may pay for rehabilitative services provided  
1887 to a recipient by a mental health or substance abuse provider  
1888 under contract with the agency or the Department of Children and  
1889 Family Services to provide such services. ~~These~~ Services that  
1890 ~~which~~ are psychiatric in nature must ~~shall~~ be rendered or  
1891 recommended by a psychiatrist, and ~~those~~ services that ~~which~~ are  
1892 medical in nature must ~~shall~~ be rendered or recommended by a  
1893 physician or psychiatrist.

1894           (a) The agency shall ~~must~~ develop a provider enrollment  
1895 process for community mental health providers which bases  
1896 provider enrollment on an assessment of service need. The  
1897 provider enrollment process shall be designed to control costs,  
1898 prevent fraud and abuse, consider provider expertise and  
1899 capacity, and assess provider success in managing utilization of  
1900 care and measuring treatment outcomes. Providers must ~~will~~ be  
1901 selected through a competitive procurement or selective  
1902 contracting process. In addition ~~to other community mental~~  
1903 ~~health providers,~~ the agency shall consider enrolling for  
1904 ~~enrollment~~ mental health programs licensed under chapter 395 and  
1905 group practices licensed under chapter 458, chapter 459, chapter  
1906 490, or chapter 491. The agency may ~~is~~ also ~~authorized to~~  
1907 continue the operation of its behavioral health utilization  
1908 management program and may develop new services, ~~if these~~  
1909 ~~actions are necessary,~~ to ensure savings from the implementation  
1910 of the utilization management system. The agency shall  
1911 coordinate the implementation of this enrollment process with  
1912 the Department of Children and Family Services and the  
1913 Department of Juvenile Justice. The agency may use ~~is authorized~~  
1914 ~~to utilize~~ diagnostic criteria in setting reimbursement rates,

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1915 ~~to~~ preauthorize certain high-cost or highly utilized services,  
1916 ~~to~~ limit or eliminate coverage for certain services, or ~~to~~ make  
1917 any other adjustments necessary to comply with any limitations  
1918 or directions provided for in the General Appropriations Act.

1919 (b) The agency may ~~is authorized to~~ implement reimbursement  
1920 and use management reforms in order to comply with any  
1921 limitations or directions in the General Appropriations Act,  
1922 which may include, but are not limited to: prior authorization  
1923 of treatment and service plans; prior authorization of services;  
1924 enhanced use review programs for highly used services; and  
1925 limits on services for recipients ~~those~~ determined to be abusing  
1926 their benefit coverages.

1927 (9) DIALYSIS FACILITY SERVICES.—Subject to specific  
1928 appropriations being provided for this purpose, the agency may  
1929 pay a dialysis facility that is approved as a dialysis facility  
1930 in accordance with Title XVIII of the Social Security Act, for  
1931 dialysis services that are provided to a Medicaid recipient  
1932 under the direction of a physician licensed to practice medicine  
1933 or osteopathic medicine in this state, including dialysis  
1934 services provided in the recipient's home by a hospital-based or  
1935 freestanding dialysis facility.

1936 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize  
1937 and pay for certain durable medical equipment and supplies  
1938 provided to a Medicaid recipient as medically necessary.

1939 (11) HEALTHY START SERVICES.—The agency may pay for a  
1940 continuum of risk-appropriate medical and psychosocial services  
1941 for the Healthy Start program in accordance with a federal  
1942 waiver. The agency may not implement the federal waiver unless  
1943 the waiver permits the state to limit enrollment or the amount,

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1944 duration, and scope of services to ensure that expenditures will  
1945 not exceed funds appropriated by the Legislature or available  
1946 from local sources. If ~~the Health Care Financing Administration~~  
1947 ~~does not approve~~ a federal waiver for Healthy Start services is  
1948 not approved, the agency, in consultation with the Department of  
1949 Health and the Florida Association of Healthy Start Coalitions,  
1950 may ~~is authorized to~~ establish a Medicaid certified-match  
1951 program for Healthy Start services. Participation in the Healthy  
1952 Start certified-match program is ~~shall be~~ voluntary, and  
1953 reimbursement is ~~shall be~~ limited to the federal Medicaid share  
1954 provided to Medicaid-enrolled Healthy Start coalitions for  
1955 services provided to Medicaid recipients. The agency may not  
1956 ~~shall~~ take ~~no~~ action to implement a certified-match program  
1957 without ensuring that the amendment and review requirements of  
1958 ss. 216.177 and 216.181 have been met.

1959 (12) HEARING SERVICES.—The agency may pay for hearing and  
1960 related services, including hearing evaluations, hearing aid  
1961 devices, dispensing of the hearing aid, and related repairs, ~~if~~  
1962 provided to a recipient by a licensed hearing aid specialist,  
1963 otolaryngologist, otologist, audiologist, or physician.

1964 (13) HOME AND COMMUNITY-BASED SERVICES.—

1965 (a) The agency may pay for home-based or community-based  
1966 services that are rendered to a recipient in accordance with a  
1967 federally approved waiver program. The agency may limit or  
1968 eliminate coverage for certain services, preauthorize high-cost  
1969 or highly utilized services, or make any other adjustments  
1970 necessary to comply with any limitations or directions provided  
1971 ~~for~~ in the General Appropriations Act.

1972 (b) The agency may consolidate types of services offered in

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1973 the Aged and Disabled Waiver, the Channeling Waiver, the Project  
1974 AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury  
1975 Waiver programs in order to group similar services under a  
1976 single service, or continue a service upon evidence of the need  
1977 for including a particular service type in a particular waiver.  
1978 The agency may ~~is authorized to~~ seek a Medicaid state plan  
1979 amendment or federal waiver approval to implement this policy.

1980 (c) The agency may implement a utilization management  
1981 program designed to prior-authorize home and community-based  
1982 service plans which ~~and~~ includes, but is not limited to,  
1983 assessing proposed quantity and duration of services and  
1984 monitoring ongoing service use by participants in the program.  
1985 The agency may ~~is authorized to~~ competitively procure a  
1986 qualified organization to provide utilization management of home  
1987 and community-based services. The agency may ~~is authorized to~~  
1988 seek any federal waivers to implement this initiative.

1989 (d) The agency shall assess a fee against the parents of a  
1990 child who is being served by a waiver under this subsection if  
1991 the adjusted household income is greater than 100 percent of the  
1992 federal poverty level. The amount of the fee shall be calculated  
1993 using a sliding scale based on the size of the family, the  
1994 amount of the parent's adjusted gross income, and the federal  
1995 poverty guidelines. The agency shall seek a federal waiver to  
1996 implement this provision.

1997 (14) HOSPICE CARE SERVICES.—The agency may pay for all  
1998 reasonable and necessary services for the palliation or  
1999 management of a recipient's terminal illness, if the services  
2000 are provided by a hospice that is licensed under part IV of  
2001 chapter 400 and meets Medicare certification requirements.

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2002 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY  
2003 DISABLED SERVICES.—The agency may pay for health-related care  
2004 and services provided on a 24-hour-a-day basis by a facility  
2005 licensed and certified as a Medicaid Intermediate Care Facility  
2006 for the Developmentally Disabled, for a recipient who needs such  
2007 care because of a developmental disability. Payment may ~~shall~~  
2008 not include bed-hold days except in facilities with occupancy  
2009 rates of 95 percent or greater. The agency may ~~is authorized to~~  
2010 seek any federal waiver approvals to implement this policy. If  
2011 necessary to safeguard the state's systems of providing services  
2012 to elderly and disabled persons and subject to notice and review  
2013 under s. 216.177, the Governor may direct the agency to amend  
2014 the Medicaid state plan to delete these services.

2015 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for 24-  
2016 hour-a-day intermediate care nursing and rehabilitation services  
2017 rendered to a recipient in a nursing facility licensed under  
2018 part II of chapter 400~~7~~ if the services are ordered by and  
2019 provided under the direction of a physician.

2020 (17) OPTOMETRIC SERVICES.—The agency may pay for services  
2021 provided to a recipient, including examination, diagnosis,  
2022 treatment, and management, related to ocular pathology~~7~~ if the  
2023 services are provided by a licensed optometrist or physician.

2024 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for  
2025 all services provided to a recipient by a physician assistant  
2026 licensed under s. 458.347 or s. 459.022. Reimbursement for such  
2027 services must be at least ~~not less than~~ 80 percent of the  
2028 reimbursement that would be paid to a physician who provided the  
2029 same services.

2030 (19) PODIATRIC SERVICES.—The agency may pay for services,

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2031 including diagnosis and medical, surgical, palliative, and  
2032 mechanical treatment, related to ailments of the human foot and  
2033 lower leg, if provided to a recipient by a podiatric physician  
2034 licensed under state law.

2035 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for  
2036 medications that are prescribed for a recipient by a physician  
2037 or other licensed health care practitioner ~~of the healing arts~~  
2038 authorized to prescribe medications and that are dispensed to  
2039 the recipient by a licensed pharmacist or physician in  
2040 accordance with applicable state and federal law. However, the  
2041 agency may not pay for any psychotropic medication prescribed  
2042 for a child younger than the age for which the federal Food and  
2043 Drug Administration has approved its use.

2044 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency  
2045 may pay for all services provided to a recipient by a registered  
2046 nurse first assistant as described in s. 464.027. Reimbursement  
2047 for such services must be at least ~~may not be less than~~ 80  
2048 percent of the reimbursement that would be paid to a physician  
2049 providing the same services.

2050 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-  
2051 inclusive psychiatric inpatient hospital care provided to a  
2052 recipient age 65 or older in a state mental hospital.

2053 (23) VISUAL SERVICES.—The agency may pay for visual  
2054 examinations, eyeglasses, and eyeglass repairs for a recipient  
2055 if they are prescribed by a licensed physician specializing in  
2056 diseases of the eye or by a licensed optometrist. Eyeglass  
2057 frames for adult recipients are ~~shall be~~ limited to one pair per  
2058 recipient every 2 years, except a second pair may be provided  
2059 ~~during that period~~ after prior authorization. Eyeglass lenses

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2060 for adult recipients are ~~shall be~~ limited to one pair per year  
2061 except a second pair may be provided ~~during that period~~ after  
2062 prior authorization.

2063 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The agency ~~for~~  
2064 ~~Health Care Administration~~, in consultation with the Department  
2065 of Children and Family Services, may establish a targeted case-  
2066 management project in those counties identified by the  
2067 department ~~of Children and Family Services~~ and for all counties  
2068 with a community-based child welfare project, as authorized  
2069 under s. 409.1671, which have been specifically approved by the  
2070 department. The covered group that is ~~of individuals who are~~  
2071 eligible for ~~to receive~~ targeted case management include  
2072 children who are eligible for Medicaid; who are between the ages  
2073 of birth through 21; and who are under protective supervision or  
2074 postplacement supervision, under foster-care supervision, or in  
2075 shelter care or foster care. The number of eligible children  
2076 ~~individuals who are eligible to receive targeted case management~~  
2077 is limited to the number for whom the department ~~of Children and~~  
2078 ~~Family Services~~ has matching funds to cover the costs. The  
2079 general revenue funds required to match the funds for services  
2080 provided by the community-based child welfare projects are  
2081 limited to funds available for services described under s.  
2082 409.1671. The department ~~of Children and Family Services~~ may  
2083 transfer the general revenue matching funds as billed by the  
2084 agency ~~for Health Care Administration~~.

2085 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for  
2086 assistive-care services provided to recipients with functional  
2087 or cognitive impairments residing in assisted living facilities,  
2088 adult family-care homes, or residential treatment facilities.



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2089 These services may include health support, assistance with the  
2090 activities of daily living and the instrumental acts of daily  
2091 living, assistance with medication administration, and  
2092 arrangements for health care.

2093 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM  
2094 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency may ~~is~~  
2095 ~~authorized to~~ seek federal approval through a Medicaid waiver or  
2096 a state plan amendment for the provision of occupational  
2097 therapy, speech therapy, physical therapy, behavior analysis,  
2098 and behavior assistant services to individuals who are 5 years  
2099 of age and under and have a diagnosed developmental disability  
2100 as defined in s. 393.063, or autism spectrum disorder as defined  
2101 in s. 627.6686, ~~or Down syndrome, a genetic disorder caused by~~  
2102 ~~the presence of extra chromosomal material on chromosome 21.~~  
2103 ~~Causes of the syndrome may include Trisomy 21, Mosaicism,~~  
2104 ~~Robertsonian Translocation, and other duplications of a portion~~  
2105 ~~of chromosome 21.~~ Coverage for such services is ~~shall be~~ limited  
2106 to \$36,000 annually and may not exceed \$108,000 in total  
2107 lifetime benefits. The agency shall submit an annual report  
2108 beginning ~~on~~ January 1, 2009, to the President of the Senate,  
2109 the Speaker of the House of Representatives, and the relevant  
2110 committees of the Senate and the House of Representatives  
2111 regarding progress on obtaining federal approval and  
2112 recommendations for the implementation of these home and  
2113 community-based services. The agency may not implement this  
2114 subsection without prior legislative approval.

2115 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may  
2116 pay for all services provided to a recipient by an  
2117 anesthesiologist assistant licensed under s. 458.3475 or s.

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2118 459.023. Reimbursement for such services must be at least ~~not~~  
2119 ~~less than~~ 80 percent of the reimbursement that would be paid to  
2120 a physician who provided the same services.

2121 Section 25. Section 409.9062, Florida Statutes, is amended  
2122 to read:

2123 409.9062 Lung transplant services for Medicaid recipients.—  
2124 Subject to the availability of funds and ~~subject to~~ any  
2125 limitations or directions provided ~~for~~ in the General  
2126 Appropriations Act, ~~or~~ chapter 216, or s. 409.9022, the ~~Agency~~  
2127 ~~for Health Care Administration~~ Medicaid program shall pay for  
2128 medically necessary lung transplant services for Medicaid  
2129 recipients. These payments must be used to reimburse approved  
2130 lung transplant facilities a global fee for providing lung  
2131 transplant services to Medicaid recipients.

2132 Section 26. Paragraph (h) of subsection (3) of section  
2133 409.907, Florida Statutes, is amended to read:

2134 409.907 Medicaid provider agreements.—The agency may make  
2135 payments for medical assistance and related services rendered to  
2136 Medicaid recipients only to an individual or entity who has a  
2137 provider agreement in effect with the agency, who is performing  
2138 services or supplying goods in accordance with federal, state,  
2139 and local law, and who agrees that no person shall, on the  
2140 grounds of handicap, race, color, or national origin, or for any  
2141 other reason, be subjected to discrimination under any program  
2142 or activity for which the provider receives payment from the  
2143 agency.

2144 (3) The provider agreement developed by the agency, in  
2145 addition to the requirements specified in subsections (1) and  
2146 (2), shall require the provider to:

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2147 (h) Be liable for and indemnify, defend, and hold the  
2148 agency harmless from all claims, suits, judgments, or damages,  
2149 including court costs and attorney's fees, arising out of the  
2150 negligence or omissions of the provider in the course of  
2151 providing services to a recipient or a person believed to be a  
2152 recipient, subject to s. 766.1183 or s. 766.1184.

2153 Section 27. Section 409.908, Florida Statutes, is amended  
2154 to read:

2155 409.908 Reimbursement of Medicaid providers.—Subject to  
2156 specific appropriations, the agency shall reimburse Medicaid  
2157 providers, in accordance with state and federal law, according  
2158 to methodologies set forth in the rules of the agency and in  
2159 policy manuals and handbooks incorporated by reference therein.  
2160 These methodologies may include fee schedules, reimbursement  
2161 methods based on cost reporting, negotiated fees, competitive  
2162 bidding pursuant to s. 287.057, and other mechanisms the agency  
2163 considers efficient and effective for purchasing services or  
2164 goods on behalf of recipients. ~~If a provider is reimbursed based  
2165 on cost reporting and submits a cost report late and that cost  
2166 report would have been used to set a lower reimbursement rate  
2167 for a rate semester, then the provider's rate for that semester  
2168 shall be retroactively calculated using the new cost report, and  
2169 full payment at the recalculated rate shall be effected  
2170 retroactively. Medicare-granted extensions for filing cost  
2171 reports, if applicable, shall also apply to Medicaid cost  
2172 reports.~~ Payment for Medicaid compensable services made on  
2173 behalf of Medicaid eligible persons is subject to the  
2174 availability of moneys and any limitations or directions  
2175 provided ~~for~~ in the General Appropriations Act, ~~or~~ chapter 216,

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2176 or s. 409.9022. Further, ~~nothing in~~ This section does not shall  
 2177 ~~be construed to~~ prevent or limit the agency from adjusting fees,  
 2178 reimbursement rates, lengths of stay, number of visits, or  
 2179 number of services, or making any other adjustments necessary to  
 2180 comply with the availability of moneys and any limitations or  
 2181 directions provided ~~for~~ in the General Appropriations Act if,  
 2182 ~~provided~~ the adjustment is consistent with legislative intent.

2183 (1) HOSPITAL SERVICES.—Reimbursement to hospitals licensed  
 2184 under part I of chapter 395 must be made prospectively or on the  
 2185 basis of negotiation.

2186 (a) Inpatient care.—

2187 1. Reimbursement for inpatient care is limited as provided  
 2188 ~~for~~ in s. 409.905(5), except for:

2189 a.1. ~~The raising of rate reimbursement caps, excluding~~  
 2190 rural hospitals.

2191 b.2. ~~Recognition of the costs of graduate medical~~  
 2192 education.

2193 c.3. ~~Other methodologies recognized in the General~~  
 2194 Appropriations Act.

2195 2. ~~If During the years~~ funds are transferred from the  
 2196 Department of Health, any reimbursement supported by such funds  
 2197 is shall be subject to certification by the Department of Health  
 2198 that the hospital has complied with s. 381.0403. The agency may  
 2199 ~~is authorized to~~ receive funds from state entities, including,  
 2200 but not limited to, the Department of Health, local governments,  
 2201 and other local political subdivisions, for the purpose of  
 2202 making special exception payments, including federal matching  
 2203 funds, through the Medicaid inpatient reimbursement  
 2204 methodologies. Funds received from state entities or local

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2205 governments for this purpose shall be separately accounted for  
2206 and may ~~shall~~ not be commingled with other state or local funds  
2207 in any manner. The agency may certify all local governmental  
2208 funds used as state match under Title XIX of the Social Security  
2209 Act, to the extent that the identified local health care  
2210 provider that is otherwise entitled to and is contracted to  
2211 receive such local funds is the benefactor under the state's  
2212 Medicaid program as determined under the General Appropriations  
2213 Act and pursuant to an agreement between the agency ~~for Health~~  
2214 ~~Care Administration~~ and the local governmental entity. The local  
2215 governmental entity shall use a certification form prescribed by  
2216 the agency. At a minimum, the certification form must ~~shall~~  
2217 identify the amount being certified and describe the  
2218 relationship between the certifying local governmental entity  
2219 and the local health care provider. The agency shall prepare an  
2220 annual statement of impact which documents the specific  
2221 activities undertaken during the previous fiscal year pursuant  
2222 to this paragraph, to be submitted to the Legislature annually  
2223 by no later than January 1, ~~annually~~.

2224 (b) Outpatient care.—

2225 1. Reimbursement for hospital outpatient care is limited to  
2226 \$1,500 per state fiscal year per recipient, except for:

2227 a.1. ~~Such~~ Care provided to a Medicaid recipient under age  
2228 21, in which case the only limitation is medical necessity.

2229 b.2. Renal dialysis services.

2230 c.3. Other exceptions made by the agency.

2231 2. The agency may ~~is authorized to~~ receive funds from state  
2232 entities, including, but not limited to, the Department of  
2233 Health, the Board of Governors of the State University System,

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2234 local governments, and other local political subdivisions, for  
2235 the purpose of making payments, including federal matching  
2236 funds, through the Medicaid outpatient reimbursement  
2237 methodologies. Funds received ~~from state entities and local~~  
2238 ~~governments~~ for this purpose shall be separately accounted for  
2239 and may ~~shall~~ not be commingled with other state or local funds  
2240 ~~in any manner.~~

2241 3. The agency may limit inflationary increases for  
2242 outpatient hospital services as directed by the General  
2243 Appropriations Act.

2244 (c) Disproportionate share.—Hospitals that provide services  
2245 to a disproportionate share of low-income Medicaid recipients,  
2246 ~~or~~ that participate in the regional perinatal intensive care  
2247 center program under chapter 383, or that participate in the  
2248 statutory teaching hospital disproportionate share program may  
2249 receive additional reimbursement. The total amount of payment  
2250 for disproportionate share hospitals shall be fixed by the  
2251 General Appropriations Act. The computation of these payments  
2252 must comply ~~be made in compliance~~ with all federal regulations  
2253 and the methodologies described in ss. 409.911, 409.9112, and  
2254 409.9113.

2255 ~~(d) The agency is authorized to limit inflationary~~  
2256 ~~increases for outpatient hospital services as directed by the~~  
2257 ~~General Appropriations Act.~~

2258 (2) NURSING HOME CARE.—

2259 ~~(a)1.~~ Reimbursement to nursing homes licensed under part II  
2260 of chapter 400 and state-owned-and-operated intermediate care  
2261 facilities for the developmentally disabled licensed under part  
2262 VIII of chapter 400 must be made prospectively.

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2263        (a)2- Unless otherwise limited or directed in the General  
2264 Appropriations Act, reimbursement to hospitals licensed under  
2265 part I of chapter 395 for ~~the provision of~~ swing-bed nursing  
2266 home services must be based ~~made~~ on ~~the basis of~~ the average  
2267 statewide nursing home payment, and reimbursement to a hospital  
2268 ~~licensed under part I of chapter 395 for the provision of~~  
2269 skilled nursing services must be based ~~made~~ on ~~the basis of~~ the  
2270 average nursing home payment for those services in the county in  
2271 which the hospital is located. If ~~When~~ a hospital is located in  
2272 a county that does not have any community nursing homes,  
2273 reimbursement shall be determined by averaging the nursing home  
2274 payments in counties that surround the county in which the  
2275 hospital is located. Reimbursement to hospitals, including  
2276 Medicaid payment of Medicare copayments, for skilled nursing  
2277 services is ~~shall be~~ limited to 30 days, unless a prior  
2278 authorization has been obtained from the agency. Medicaid  
2279 reimbursement may be extended by the agency beyond 30 days, and  
2280 approval must be based upon verification by the patient's  
2281 physician that the patient requires short-term rehabilitative  
2282 and recuperative services only, in which case an extension of no  
2283 more than 15 days may be approved. Reimbursement to a hospital  
2284 ~~licensed under part I of chapter 395 for the temporary provision~~  
2285 of skilled nursing services to nursing home residents who have  
2286 been displaced as the result of a natural disaster or other  
2287 emergency may not exceed the average county nursing home payment  
2288 for those services in the county in which the hospital is  
2289 located and is limited to the period of time which the agency  
2290 considers necessary for continued placement of the nursing home  
2291 residents in the hospital.

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2292 (b) Subject to any limitations or directions provided ~~for~~  
2293 in the General Appropriations Act, the agency shall establish  
2294 and implement a Florida Title XIX Long-Term Care Reimbursement  
2295 Plan (Medicaid) for nursing home care in order to provide care  
2296 and services that conform to ~~in conformance with the~~ applicable  
2297 state and federal laws, rules, regulations, and quality and  
2298 safety standards and to ensure that individuals eligible for  
2299 medical assistance have reasonable geographic access to such  
2300 care.

2301 1. The agency shall amend the long-term care reimbursement  
2302 plan and cost reporting system to create direct care and  
2303 indirect care subcomponents of the patient care component of the  
2304 per diem rate. These two subcomponents together must ~~shall~~ equal  
2305 the patient care component of the per diem rate. Separate cost-  
2306 based ceilings shall be calculated for each patient care  
2307 subcomponent. The direct care subcomponent of the per diem rate  
2308 is ~~shall be~~ limited by the cost-based class ceiling, and the  
2309 indirect care subcomponent may be limited by the lower of the  
2310 cost-based class ceiling, the target rate class ceiling, or the  
2311 individual provider target.

2312 2. The direct care subcomponent includes ~~shall include~~  
2313 salaries and benefits of direct care staff providing nursing  
2314 services, including registered nurses, licensed practical  
2315 nurses, and certified nursing assistants who deliver care  
2316 directly to residents in the nursing home facility. This  
2317 excludes nursing administration, minimum data set, and care plan  
2318 coordinators, staff development, and the staffing coordinator.  
2319 The direct care subcomponent also includes medically necessary  
2320 dental care, vision care, hearing care, and podiatric care.



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2321           3. All other patient care costs are ~~shall be~~ included in  
2322 the indirect care cost subcomponent of the patient care per diem  
2323 rate. ~~There shall be no~~ Costs may not be directly or indirectly  
2324 allocated to the direct care subcomponent from a home office or  
2325 management company.

2326           4. On July 1 of each year, the agency shall report to the  
2327 Legislature direct and indirect care costs, including average  
2328 direct and indirect care costs per resident per facility and  
2329 direct care and indirect care salaries and benefits per category  
2330 of staff member per facility.

2331           5. In order to offset the cost of general and professional  
2332 liability insurance, the agency shall amend the plan to allow  
2333 for interim rate adjustments to reflect increases in the cost of  
2334 general or professional liability insurance for nursing homes.  
2335 This provision shall be implemented to the extent existing  
2336 appropriations are available.

2337  
2338 It is the intent of the Legislature that the reimbursement plan  
2339 achieve the goal of providing access to health care for nursing  
2340 home residents who require large amounts of care while  
2341 encouraging diversion services as an alternative to nursing home  
2342 care for residents who can be served within the community. The  
2343 agency shall base the establishment of any maximum rate of  
2344 payment, whether overall or component, on the available moneys  
2345 ~~as~~ provided ~~for~~ in the General Appropriations Act. The agency  
2346 may base the maximum rate of payment on the results of  
2347 scientifically valid analysis and conclusions derived from  
2348 objective statistical data pertinent to the particular maximum  
2349 rate of payment.

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2350       (c) The agency shall request and implement Medicaid waivers  
2351 approved by the federal Centers for Medicare and Medicaid  
2352 Services to advance and treat a portion of the Medicaid nursing  
2353 home per diem as capital for creating and operating a risk-  
2354 retention group for self-insurance purposes, consistent with  
2355 federal and state laws and rules.

2356       (3) FEE-FOR-SERVICE REIMBURSEMENT.—Subject to any  
2357 limitations or directions provided ~~for~~ in the General  
2358 Appropriations Act, the following Medicaid services and goods  
2359 may be reimbursed on a fee-for-service basis. For each allowable  
2360 service or goods furnished in accordance with Medicaid rules,  
2361 policy manuals, handbooks, and state and federal law, the  
2362 payment shall be the amount billed by the provider, the  
2363 provider's usual and customary charge, or the maximum allowable  
2364 fee established by the agency, whichever amount is less, with  
2365 the exception of those services or goods for which the agency  
2366 makes payment using a methodology based on capitation rates,  
2367 average costs, or negotiated fees.

- 2368       (a) Advanced registered nurse practitioner services.  
2369       (b) Birth center services.  
2370       (c) Chiropractic services.  
2371       (d) Community mental health services.  
2372       (e) Dental services, including oral and maxillofacial  
2373 surgery.  
2374       (f) Durable medical equipment.  
2375       (g) Hearing services.  
2376       (h) Occupational therapy for Medicaid recipients under age  
2377 21.  
2378       (i) Optometric services.

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- 2379 (j) Orthodontic services.
- 2380 (k) Personal care for Medicaid recipients under age 21.
- 2381 (l) Physical therapy for Medicaid recipients under age 21.
- 2382 (m) Physician assistant services.
- 2383 (n) Podiatric services.
- 2384 (o) Portable X-ray services.
- 2385 (p) Private-duty nursing for Medicaid recipients under age  
2386 21.
- 2387 (q) Registered nurse first assistant services.
- 2388 (r) Respiratory therapy for Medicaid recipients under age  
2389 21.
- 2390 (s) Speech therapy for Medicaid recipients under age 21.
- 2391 (t) Visual services.
- 2392 (4) MANAGED CARE SERVICES.—Subject to any limitations or  
2393 directions provided ~~for~~ in the General Appropriations Act,  
2394 alternative health plans, health maintenance organizations, and  
2395 prepaid health plans shall be reimbursed a fixed, prepaid amount  
2396 negotiated, or competitively bid pursuant to s. 287.057, by the  
2397 agency and prospectively paid to the provider monthly for each  
2398 Medicaid recipient enrolled. The amount may not exceed the  
2399 average amount the agency determines it would have paid, based  
2400 on claims experience, for recipients in the same or similar  
2401 category of eligibility. The agency shall calculate capitation  
2402 rates on a regional basis and, ~~beginning September 1, 1995,~~  
2403 ~~shall~~ include age-band differentials in such calculations.
- 2404 (5) AMBULATORY SURGICAL CENTERS.—An ambulatory surgical  
2405 center shall be reimbursed the lesser of the amount billed by  
2406 the provider or the Medicare-established allowable amount for  
2407 the facility.

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2408           (6) EPSDT SERVICES.—A provider of early and periodic  
2409 screening, diagnosis, and treatment services to Medicaid  
2410 recipients who are ~~children~~ under age 21 shall be reimbursed  
2411 using an all-inclusive rate stipulated in a fee schedule  
2412 established by the agency. A provider of the visual, dental, and  
2413 hearing components of such services shall be reimbursed the  
2414 lesser of the amount billed by the provider or the Medicaid  
2415 maximum allowable fee established by the agency.

2416           (7) FAMILY PLANNING SERVICES.—A provider of family planning  
2417 services shall be reimbursed the lesser of the amount billed by  
2418 the provider or an all-inclusive amount per type of visit for  
2419 physicians and advanced registered nurse practitioners, as  
2420 established by the agency in a fee schedule.

2421           (8) HOME OR COMMUNITY-BASED SERVICES.—A provider of home-  
2422 based or community-based services rendered pursuant to a  
2423 federally approved waiver shall be reimbursed based on an  
2424 established or negotiated rate for each service. These rates  
2425 shall be established according to an analysis of the expenditure  
2426 history and prospective budget developed by each contract  
2427 provider participating in the waiver program, or under any other  
2428 methodology adopted by the agency and approved by the Federal  
2429 Government in accordance with the waiver. Privately owned and  
2430 operated community-based residential facilities that ~~which~~ meet  
2431 agency requirements and ~~which~~ formerly received Medicaid  
2432 reimbursement for the optional intermediate care facility for  
2433 the mentally retarded service may participate in the  
2434 developmental services waiver as part of a home-and-community-  
2435 based continuum of care for Medicaid recipients who receive  
2436 waiver services.

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2437           (9) HOME HEALTH SERVICES AND MEDICAL SUPPLIES.—A provider  
2438 of home health care services or of medical supplies and  
2439 appliances shall be reimbursed on the basis of competitive  
2440 bidding or for the lesser of the amount billed by the provider  
2441 or the agency's established maximum allowable amount, except  
2442 that, ~~in the case of the rental of durable medical equipment,~~  
2443 the total rental payments for durable medical equipment may not  
2444 exceed the purchase price of the equipment over its expected  
2445 useful life or the agency's established maximum allowable  
2446 amount, whichever amount is less.

2447           (10) HOSPICE.—A hospice shall be reimbursed through a  
2448 prospective system for each Medicaid hospice patient at Medicaid  
2449 rates using the methodology established for hospice  
2450 reimbursement pursuant to Title XVIII of the federal Social  
2451 Security Act.

2452           (11) LABORATORY SERVICES.—A provider of independent  
2453 laboratory services shall be reimbursed on the basis of  
2454 competitive bidding or for the least of the amount billed by the  
2455 provider, the provider's usual and customary charge, or the  
2456 Medicaid maximum allowable fee established by the agency.

2457           (12) PHYSICIAN SERVICES.—

2458           (a) A physician shall be reimbursed the lesser of the  
2459 amount billed by the provider or the Medicaid maximum allowable  
2460 fee established by the agency.

2461           (b) The agency shall adopt a fee schedule, subject to any  
2462 limitations or directions provided ~~for~~ in the General  
2463 Appropriations Act, based on a resource-based relative value  
2464 scale for pricing Medicaid physician services. Under the ~~this~~  
2465 fee schedule, physicians shall be paid a dollar amount for each

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2466 service based on the average resources required to provide the  
2467 service, including, but not limited to, estimates of average  
2468 physician time and effort, practice expense, and the costs of  
2469 professional liability insurance. The fee schedule must ~~shall~~  
2470 provide increased reimbursement for preventive and primary care  
2471 services and lowered reimbursement for specialty services by  
2472 using at least two conversion factors, one for cognitive  
2473 services and another for procedural services. The fee schedule  
2474 may ~~shall~~ not increase total Medicaid physician expenditures  
2475 unless moneys are available. The agency ~~for Health Care~~  
2476 ~~Administration~~ shall seek the advice of a 16-member advisory  
2477 panel in formulating and adopting the fee schedule. The panel  
2478 shall consist of Medicaid physicians licensed under chapters 458  
2479 and 459 and ~~shall~~ be composed of 50 percent primary care  
2480 physicians and 50 percent specialty care physicians.

2481 (c) Notwithstanding paragraph (b), reimbursement fees to  
2482 physicians for providing total obstetrical services to Medicaid  
2483 recipients, which include prenatal, delivery, and postpartum  
2484 care, must ~~shall~~ be at least \$1,500 per delivery for a pregnant  
2485 woman with low medical risk and at least \$2,000 per delivery for  
2486 a pregnant woman with high medical risk. However, reimbursement  
2487 to physicians working in regional perinatal intensive care  
2488 centers designated pursuant to chapter 383, for services to  
2489 ~~certain~~ pregnant Medicaid recipients with a high medical risk,  
2490 may be made according to obstetrical care and neonatal care  
2491 groupings and rates established by the agency. Nurse midwives  
2492 licensed under part I of chapter 464 or midwives licensed under  
2493 chapter 467 shall be reimbursed at least ~~no less than~~ 80 percent  
2494 of the low medical risk fee. The agency shall by rule determine,

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2495 for the purpose of this paragraph, what constitutes a high or  
2496 low medical risk pregnant woman and may ~~shall~~ not pay more based  
2497 solely on the fact that a caesarean section was performed,  
2498 rather than a vaginal delivery. The agency shall by rule  
2499 determine a prorated payment for obstetrical services ~~in cases~~  
2500 where only part of the total prenatal, delivery, or postpartum  
2501 care was performed. The Department of Health shall adopt rules  
2502 for appropriate insurance coverage for midwives licensed under  
2503 chapter 467. Before issuing and renewing ~~Prior to the issuance~~  
2504 ~~and renewal of~~ an active license, or reactivating ~~reactivation~~  
2505 ~~of~~ an inactive license for midwives licensed under chapter 467,  
2506 such licensees must ~~shall~~ submit proof of coverage with each  
2507 application.

2508 (d) Effective January 1, 2013, Medicaid fee-for-service  
2509 payments to primary care physicians for primary care services  
2510 must be at least 100 percent of the Medicare payment rate for  
2511 such services.

2512 (13) DUALLY ELIGIBLE RECIPIENTS.—Medicare premiums for  
2513 persons eligible for both Medicare and Medicaid coverage shall  
2514 be paid at the rates established by Title XVIII of the Social  
2515 Security Act. For Medicare services rendered to Medicaid-  
2516 eligible persons, Medicaid shall pay Medicare deductibles and  
2517 coinsurance as follows:

2518 (a) Medicaid's financial obligation for deductibles and  
2519 coinsurance payments shall be based on Medicare allowable fees,  
2520 not on a provider's billed charges.

2521 (b) Medicaid may not ~~will~~ pay any ~~no~~ portion of Medicare  
2522 deductibles and coinsurance if ~~when~~ payment that Medicare has  
2523 made for the service equals or exceeds what Medicaid would have

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2524 paid if it had been the sole payor. The combined payment of  
2525 Medicare and Medicaid may ~~shall~~ not exceed the amount Medicaid  
2526 would have paid had it been the sole payor. The Legislature  
2527 finds that there has been confusion regarding the reimbursement  
2528 for services rendered to dually eligible Medicare beneficiaries.  
2529 Accordingly, the Legislature clarifies that it has always been  
2530 the intent of the Legislature before and after 1991 that, in  
2531 reimbursing in accordance with fees established by Title XVIII  
2532 for premiums, deductibles, and coinsurance for Medicare services  
2533 rendered by physicians to Medicaid eligible persons, physicians  
2534 be reimbursed at the lesser of the amount billed by the  
2535 physician or the Medicaid maximum allowable fee established by  
2536 the agency ~~for Health Care Administration~~, as is permitted by  
2537 federal law. It has never been the intent of the Legislature  
2538 ~~with regard to such services rendered by physicians that~~  
2539 Medicaid be required to provide any payment for deductibles,  
2540 coinsurance, or copayments for Medicare cost sharing, or any  
2541 expenses incurred relating thereto, in excess of the payment  
2542 amount provided for under the State Medicaid plan for physician  
2543 services ~~such service~~. This payment methodology is applicable  
2544 even in those situations in which the payment for Medicare cost  
2545 sharing for a qualified Medicare beneficiary with respect to an  
2546 item or service is reduced or eliminated. This expression of the  
2547 Legislature clarifies ~~is in clarification of~~ existing law and  
2548 applies ~~shall apply~~ to payment for, and with respect to provider  
2549 agreements with respect to, items or services furnished on or  
2550 after July 1, 2000 ~~the effective date of this act~~. This  
2551 paragraph applies to payment by Medicaid for items and services  
2552 furnished before July 1, 2000, ~~the effective date of this act~~ if



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2553 such payment is the subject of a lawsuit that is based on ~~the~~  
2554 ~~provisions of~~ this section, and that is pending as of, or is  
2555 initiated after that date, ~~the effective date of this act.~~

2556 (c) Notwithstanding paragraphs (a) and (b):

2557 1. Medicaid payments for Nursing Home Medicare part A  
2558 coinsurance are limited to the Medicaid nursing home per diem  
2559 rate less any amounts paid by Medicare, but only up to the  
2560 amount of Medicare coinsurance. The Medicaid per diem rate is  
2561 ~~shall be~~ the rate in effect for the dates of service of the  
2562 crossover claims and may not be subsequently adjusted due to  
2563 subsequent per diem rate adjustments.

2564 2. Medicaid shall pay all deductibles and coinsurance for  
2565 Medicare-eligible recipients receiving freestanding end stage  
2566 renal dialysis center services.

2567 3. Medicaid payments for general and specialty hospital  
2568 inpatient services are limited to the Medicare deductible and  
2569 coinsurance per spell of illness. Medicaid payments for hospital  
2570 Medicare Part A coinsurance are ~~shall be~~ limited to the Medicaid  
2571 hospital per diem rate less any amounts paid by Medicare, but  
2572 only up to the amount of Medicare coinsurance. Medicaid payments  
2573 for coinsurance are ~~shall be~~ limited to the Medicaid per diem  
2574 rate in effect for the dates of service of the crossover claims  
2575 and may not be subsequently adjusted due to subsequent per diem  
2576 adjustments.

2577 4. Medicaid shall pay all deductibles and coinsurance for  
2578 Medicare emergency transportation services provided by  
2579 ambulances licensed pursuant to chapter 401.

2580 5. Medicaid shall pay all deductibles and coinsurance for  
2581 portable X-ray Medicare Part B services provided in a nursing

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2582 home.

2583 (14) PRESCRIBED DRUGS.—A provider of prescribed drugs shall  
2584 be reimbursed the least of the amount billed by the provider,  
2585 the provider's usual and customary charge, or the Medicaid  
2586 maximum allowable fee established by the agency, plus a  
2587 dispensing fee. The Medicaid maximum allowable fee for  
2588 ingredient cost must ~~will~~ be based on the lower of the ~~the~~ average  
2589 wholesale price (AWP) minus 16.4 percent, wholesaler acquisition  
2590 cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the  
2591 state maximum allowable cost (SMAC), or the usual and customary  
2592 (UAC) charge billed by the provider.

2593 (a) Medicaid providers must ~~are required to~~ dispense  
2594 generic drugs if available at lower cost and the agency has not  
2595 determined that the branded product is more cost-effective,  
2596 unless the prescriber has requested and received approval to  
2597 require the branded product.

2598 (b) The agency shall ~~is directed to~~ implement a variable  
2599 dispensing fee for ~~payments for~~ prescribed medicines while  
2600 ensuring continued access for Medicaid recipients. The variable  
2601 dispensing fee may be based upon, but not limited to, either or  
2602 both the volume of prescriptions dispensed by a specific  
2603 pharmacy provider, the volume of prescriptions dispensed to an  
2604 individual recipient, and dispensing of preferred-drug-list  
2605 products.

2606 (c) The agency may increase the pharmacy dispensing fee  
2607 authorized by statute and in the ~~annual~~ General Appropriations  
2608 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-  
2609 list product and reduce the pharmacy dispensing fee by \$0.50 for  
2610 the dispensing of a Medicaid product that is not included on the

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2611 preferred drug list.

2612 (d) The agency may establish a supplemental pharmaceutical  
2613 dispensing fee to be paid to providers returning unused unit-  
2614 dose packaged medications to stock and crediting the Medicaid  
2615 program for the ingredient cost of those medications if the  
2616 ingredient costs to be credited exceed the value of the  
2617 supplemental dispensing fee.

2618 (e) The agency may ~~is authorized to~~ limit reimbursement for  
2619 prescribed medicine in order to comply with any limitations or  
2620 directions provided ~~for~~ in the General Appropriations Act, which  
2621 may include implementing a prospective or concurrent utilization  
2622 review program.

2623 (15) PRIMARY CARE CASE MANAGEMENT.—A provider of primary  
2624 care case management services rendered pursuant to a federally  
2625 approved waiver shall be reimbursed by payment of a fixed,  
2626 prepaid monthly sum for each Medicaid recipient enrolled with  
2627 the provider.

2628 (16) RURAL HEALTH CLINICS.—A provider of rural health  
2629 clinic services and federally qualified health center services  
2630 shall be reimbursed a rate per visit based on total reasonable  
2631 costs of the clinic, as determined by the agency in accordance  
2632 with federal regulations.

2633 (17) TARGETED CASE MANAGEMENT.—A provider of targeted case  
2634 management services shall be reimbursed pursuant to an  
2635 established fee, except where the Federal Government requires a  
2636 public provider be reimbursed on the basis of average actual  
2637 costs.

2638 (18) TRANSPORTATION.—Unless otherwise provided ~~for~~ in the  
2639 General Appropriations Act, a provider of transportation

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2640 services shall be reimbursed the lesser of the amount billed by  
2641 the provider or the Medicaid maximum allowable fee established  
2642 by the agency, except if ~~when~~ the agency has entered into a  
2643 direct contract with the provider, or with a community  
2644 transportation coordinator, for the provision of an all-  
2645 inclusive service, or if ~~when~~ services are provided pursuant to  
2646 an agreement negotiated between the agency and the provider. ~~The~~  
2647 ~~agency, as provided for in s. 427.0135, shall purchase~~  
2648 ~~transportation services through the community coordinated~~  
2649 ~~transportation system, if available, unless the agency, after~~  
2650 ~~consultation with the commission, determines that it cannot~~  
2651 ~~reach mutually acceptable contract terms with the commission.~~  
2652 ~~The agency may then contract for the same transportation~~  
2653 ~~services provided in a more cost-effective manner and of~~  
2654 ~~comparable or higher quality and standards. Nothing in~~

2655       (a) This subsection does not ~~shall be construed to~~ limit or  
2656 preclude the agency from contracting for services using a  
2657 prepaid capitation rate or from establishing maximum fee  
2658 schedules, individualized reimbursement policies by provider  
2659 type, negotiated fees, prior authorization, competitive bidding,  
2660 increased use of mass transit, or any other mechanism that the  
2661 agency considers efficient and effective for the purchase of  
2662 services on behalf of Medicaid clients, including implementing a  
2663 transportation eligibility process.

2664       (b) The agency may ~~shall not be required to~~ contract with  
2665 any community transportation coordinator or transportation  
2666 operator that has been determined by the agency, the Department  
2667 of Legal Affairs Medicaid Fraud Control Unit, or any other state  
2668 or federal agency to have engaged in any abusive or fraudulent

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2669 billing activities.

2670 (c) The agency shall ~~is authorized to~~ competitively procure  
2671 transportation services or make other changes necessary to  
2672 secure approval of federal waivers needed to permit federal  
2673 financing of Medicaid transportation services at the service  
2674 matching rate rather than the administrative matching rate.  
2675 ~~Notwithstanding chapter 427, the agency is authorized to~~  
2676 ~~continue contracting for Medicaid nonemergency transportation~~  
2677 ~~services in agency service area 11 with managed care plans that~~  
2678 ~~were under contract for those services before July 1, 2004.~~

2679 (d) Transportation to access covered services provided by a  
2680 qualified plan pursuant to part IV of this chapter shall be  
2681 contracted for by the plan. A qualified plan is not required to  
2682 purchase such services through a coordinated transportation  
2683 system established pursuant to part I of chapter 427.

2684 (19) COUNTY HEALTH DEPARTMENTS.—County health department  
2685 services shall be reimbursed a rate per visit based on total  
2686 reasonable costs of the clinic, as determined by the agency in  
2687 accordance with federal regulations under the authority of 42  
2688 C.F.R. s. 431.615.

2689 (20) DIALYSIS.—A renal dialysis facility that provides  
2690 dialysis services under s. 409.906(9) must be reimbursed the  
2691 lesser of the amount billed by the provider, the provider's  
2692 usual and customary charge, or the maximum allowable fee  
2693 established by the agency, whichever ~~amount~~ is less.

2694 (21) SCHOOL-BASED SERVICES.—The agency shall reimburse  
2695 school districts that ~~which~~ certify the state match pursuant to  
2696 ss. 409.9071 and 1011.70 for the federal portion of the school  
2697 district's allowable costs to deliver the services, based on the

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2698 reimbursement schedule. The school district shall determine the  
2699 costs for delivering services as authorized in ss. 409.9071 and  
2700 1011.70 for which the state match will be certified.  
2701 Reimbursement of school-based providers is contingent on such  
2702 providers being enrolled as Medicaid providers and meeting the  
2703 qualifications contained in 42 C.F.R. s. 440.110, unless  
2704 otherwise waived by the federal Centers for Medicare and  
2705 Medicaid Services Health Care Financing Administration. Speech  
2706 therapy providers who are certified through the Department of  
2707 Education pursuant to rule 6A-4.0176, Florida Administrative  
2708 Code, are eligible for reimbursement for services that are  
2709 provided on school premises. Any employee of the school district  
2710 who has been fingerprinted and has received a criminal  
2711 background check in accordance with Department of Education  
2712 rules and guidelines is ~~shall be~~ exempt from any agency  
2713 requirements relating to criminal background checks.

2714 ~~(22) The agency shall request and implement Medicaid~~  
2715 ~~waivers from the federal Health Care Financing Administration to~~  
2716 ~~advance and treat a portion of the Medicaid nursing home per~~  
2717 ~~diem as capital for creating and operating a risk retention~~  
2718 ~~group for self insurance purposes, consistent with federal and~~  
2719 ~~state laws and rules.~~

2720 (22) (23) (a) LIMITATION ON REIMBURSEMENT RATES.—The agency  
2721 shall establish rates at a level that ensures no increase in  
2722 statewide expenditures resulting from a change in unit costs for  
2723 2 fiscal years effective July 1, 2009. Reimbursement rates for  
2724 the 2 fiscal years shall be as provided in the General  
2725 Appropriations Act.

2726 (a) (b) This subsection applies to the following provider

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2727 types:

- 2728 1. Inpatient hospitals.  
2729 2. Outpatient hospitals.  
2730 3. Nursing homes.  
2731 4. County health departments.  
2732 5. Community intermediate care facilities for the  
2733 developmentally disabled.  
2734 6. Prepaid health plans.

2735 (b) The agency shall apply ~~the effect of~~ this subsection to  
2736 the reimbursement rates for nursing home diversion programs.

2737 ~~(c) The agency shall create a workgroup on hospital  
2738 reimbursement, a workgroup on nursing facility reimbursement,  
2739 and a workgroup on managed care plan payment. The workgroups  
2740 shall evaluate alternative reimbursement and payment  
2741 methodologies for hospitals, nursing facilities, and managed  
2742 care plans, including prospective payment methodologies for  
2743 hospitals and nursing facilities. The nursing facility workgroup  
2744 shall also consider price-based methodologies for indirect care  
2745 and acuity adjustments for direct care. The agency shall submit  
2746 a report on the evaluated alternative reimbursement  
2747 methodologies to the relevant committees of the Senate and the  
2748 House of Representatives by November 1, 2009.~~

2749 (c) ~~(d)~~ This subsection expires June 30, 2011.

2750 (23) PAYMENT METHODOLOGIES.-If a provider is reimbursed  
2751 based on cost reporting and submits a cost report late and that  
2752 cost report would have been used to set a lower reimbursement  
2753 rate for a rate semester, the provider's rate for that semester  
2754 shall be retroactively calculated using the new cost report, and  
2755 full payment at the recalculated rate shall be applied

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2756 retroactively. Medicare-granted extensions for filing cost  
2757 reports, if applicable, also apply to Medicaid cost reports.

2758 (24) RETURN OF PAYMENTS.—If a provider fails to notify the  
2759 agency within 5 business days after suspension or disenrollment  
2760 from Medicare, sanctions may be imposed pursuant to this  
2761 chapter, and the provider may be required to return funds paid  
2762 to the provider during the period of time that the provider was  
2763 suspended or disenrolled ~~as a Medicare provider.~~

2764 Section 28. Subsection (1) of section 409.9081, Florida  
2765 Statutes, is amended to read:

2766 409.9081 Copayments.—

2767 (1) ~~The agency shall require,~~ Subject to federal  
2768 regulations and limitations, each Medicaid recipient must ~~to~~ pay  
2769 at the time of service a nominal copayment for the following  
2770 Medicaid services:

2771 (a) Hospital outpatient services: up to \$3 for each  
2772 hospital outpatient visit.

2773 (b) Physician services: up to \$2 copayment for each visit  
2774 with a primary care physician and up to \$3 copayment for each  
2775 visit with a specialty care physician licensed under chapter  
2776 ~~458, chapter 459, chapter 460, chapter 461, or chapter 463.~~

2777 (c) Hospital emergency department visits for nonemergency  
2778 care: 5 percent of up to the first \$300 of the Medicaid payment  
2779 for emergency room services, not to exceed \$15. The agency shall  
2780 seek a federal waiver of the requirement that cost-sharing  
2781 amounts for nonemergency services and care furnished in a  
2782 hospital emergency department be nominal. Upon waiver approval,  
2783 a Medicaid recipient who requests such services and care, must  
2784 pay a \$100 copayment to the hospital for the nonemergency



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2785 services and care provided in the hospital emergency department.

2786 (d) Prescription drugs: a coinsurance equal to 2.5 percent  
2787 of the Medicaid cost of the prescription drug at the time of  
2788 purchase. The maximum coinsurance is ~~shall be~~ \$7.50 per  
2789 prescription drug purchased.

2790 Section 29. Paragraphs (b) and (d) of subsection (4) and  
2791 subsections (8), (34), (44), (47), and (53) of section 409.912,  
2792 Florida Statutes, are amended, and subsections (48) through (52)  
2793 of that section are renumbered as subsections (47) through (51)  
2794 respectively, to read:

2795 409.912 Cost-effective purchasing of health care.—The  
2796 agency shall purchase goods and services for Medicaid recipients  
2797 in the most cost-effective manner consistent with the delivery  
2798 of quality medical care. To ensure that medical services are  
2799 effectively utilized, the agency may, in any case, require a  
2800 confirmation or second physician's opinion of the correct  
2801 diagnosis for purposes of authorizing future services under the  
2802 Medicaid program. This section does not restrict access to  
2803 emergency services or poststabilization care services as defined  
2804 in 42 C.F.R. part 438.114. Such confirmation or second opinion  
2805 shall be rendered in a manner approved by the agency. The agency  
2806 shall maximize the use of prepaid per capita and prepaid  
2807 aggregate fixed-sum basis services when appropriate and other  
2808 alternative service delivery and reimbursement methodologies,  
2809 including competitive bidding pursuant to s. 287.057, designed  
2810 to facilitate the cost-effective purchase of a case-managed  
2811 continuum of care. The agency shall also require providers to  
2812 minimize the exposure of recipients to the need for acute  
2813 inpatient, custodial, and other institutional care and the

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2814 inappropriate or unnecessary use of high-cost services. The  
2815 agency shall contract with a vendor to monitor and evaluate the  
2816 clinical practice patterns of providers in order to identify  
2817 trends that are outside the normal practice patterns of a  
2818 provider's professional peers or the national guidelines of a  
2819 provider's professional association. The vendor must be able to  
2820 provide information and counseling to a provider whose practice  
2821 patterns are outside the norms, in consultation with the agency,  
2822 to improve patient care and reduce inappropriate utilization.  
2823 The agency may mandate prior authorization, drug therapy  
2824 management, or disease management participation for certain  
2825 populations of Medicaid beneficiaries, certain drug classes, or  
2826 particular drugs to prevent fraud, abuse, overuse, and possible  
2827 dangerous drug interactions. The Pharmaceutical and Therapeutics  
2828 Committee shall make recommendations to the agency on drugs for  
2829 which prior authorization is required. The agency shall inform  
2830 the Pharmaceutical and Therapeutics Committee of its decisions  
2831 regarding drugs subject to prior authorization. The agency is  
2832 authorized to limit the entities it contracts with or enrolls as  
2833 Medicaid providers by developing a provider network through  
2834 provider credentialing. The agency may competitively bid single-  
2835 source-provider contracts if procurement of goods or services  
2836 results in demonstrated cost savings to the state without  
2837 limiting access to care. The agency may limit its network based  
2838 on the assessment of beneficiary access to care, provider  
2839 availability, provider quality standards, time and distance  
2840 standards for access to care, the cultural competence of the  
2841 provider network, demographic characteristics of Medicaid  
2842 beneficiaries, practice and provider-to-beneficiary standards,

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2843 appointment wait times, beneficiary use of services, provider  
2844 turnover, provider profiling, provider licensure history,  
2845 previous program integrity investigations and findings, peer  
2846 review, provider Medicaid policy and billing compliance records,  
2847 clinical and medical record audits, and other factors. Providers  
2848 shall not be entitled to enrollment in the Medicaid provider  
2849 network. The agency shall determine instances in which allowing  
2850 Medicaid beneficiaries to purchase durable medical equipment and  
2851 other goods is less expensive to the Medicaid program than long-  
2852 term rental of the equipment or goods. The agency may establish  
2853 rules to facilitate purchases in lieu of long-term rentals in  
2854 order to protect against fraud and abuse in the Medicaid program  
2855 as defined in s. 409.913. The agency may seek federal waivers  
2856 necessary to administer these policies.

2857 (4) The agency may contract with:

2858 (b) An entity that is providing comprehensive behavioral  
2859 health care services to ~~certain~~ Medicaid recipients through a  
2860 capitated, prepaid arrangement pursuant to the federal waiver  
2861 authorized under s. 409.905(5)(b) ~~provided for by s. 409.905(5)~~.  
2862 Such entity must be licensed under chapter 624, chapter 636, or  
2863 chapter 641, or authorized under paragraph (c) or paragraph (d),  
2864 and must possess the clinical systems and operational competence  
2865 to manage risk and provide comprehensive behavioral health care  
2866 to Medicaid recipients. As used in this paragraph, the term  
2867 "comprehensive behavioral health care services" means covered  
2868 mental health and substance abuse treatment services that are  
2869 available to Medicaid recipients. The Secretary ~~of the~~  
2870 ~~Department~~ of Children and Family Services must ~~shall~~ approve  
2871 ~~provisions of~~ procurements related to children in the

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2872 department's care or custody before enrolling such children in a  
2873 prepaid behavioral health plan. Any contract awarded under this  
2874 paragraph must be competitively procured. ~~In developing~~ The  
2875 behavioral health care prepaid plan procurement document must  
2876 require, ~~the agency shall ensure that the procurement document~~  
2877 ~~requires~~ the contractor to develop and implement a plan to  
2878 ensure compliance with s. 394.4574 related to services provided  
2879 to residents of licensed assisted living facilities that hold a  
2880 limited mental health license. Except as provided in  
2881 subparagraph 5. 8-, and except in counties where the Medicaid  
2882 managed care pilot program is authorized pursuant to s. 409.986  
2883 ~~409.91211~~, the agency shall seek federal approval to contract  
2884 with a single entity ~~meeting these requirements~~ to provide  
2885 comprehensive behavioral health care services to all Medicaid  
2886 recipients not enrolled in a Medicaid managed care plan  
2887 authorized under s. 409.986 ~~409.91211~~, a provider service  
2888 network authorized under paragraph (d), or a Medicaid health  
2889 maintenance organization in an AHCA area. In an AHCA area where  
2890 the Medicaid managed care pilot program is authorized pursuant  
2891 to s. 409.986 ~~409.91211~~ in one or more counties, the agency may  
2892 procure a contract with a single entity to serve the remaining  
2893 counties as an AHCA area or the remaining counties may be  
2894 included with an adjacent AHCA area and are subject to this  
2895 paragraph. Each entity must offer a ~~sufficient~~ choice of  
2896 providers in its network to ensure recipient access to care and  
2897 the opportunity to select a provider with whom they are  
2898 satisfied. The network shall include all public mental health  
2899 hospitals. To ensure unimpaired access to behavioral health care  
2900 services by Medicaid recipients, all contracts issued pursuant

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2901 to this paragraph must require that 90 ~~80~~ percent of the  
2902 capitation paid to the managed care plan, including health  
2903 maintenance organizations and capitated provider service  
2904 networks, ~~to~~ be expended for the provision of behavioral health  
2905 care services. If the managed care plan expends less than 90 ~~80~~  
2906 percent ~~of the capitation paid~~ for the provision of behavioral  
2907 health care services, the difference shall be returned to the  
2908 agency. The agency shall provide the plan with a certification  
2909 letter indicating the amount of capitation paid during each  
2910 calendar year for behavioral health care services pursuant to  
2911 this section. The agency may reimburse ~~for~~ substance abuse  
2912 treatment services on a fee-for-service basis until the agency  
2913 finds that adequate funds are available for capitated, prepaid  
2914 arrangements.

2915 1. ~~By January 1, 2001,~~ The agency shall modify the  
2916 contracts with the entities providing comprehensive inpatient  
2917 and outpatient mental health care services to Medicaid  
2918 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk  
2919 Counties, to include substance abuse treatment services.

2920 2. ~~By July 1, 2003, the agency and the Department of~~  
2921 ~~Children and Family Services shall execute a written agreement~~  
2922 ~~that requires collaboration and joint development of all policy,~~  
2923 ~~budgets, procurement documents, contracts, and monitoring plans~~  
2924 ~~that have an impact on the state and Medicaid community mental~~  
2925 ~~health and targeted case management programs.~~

2926 2.3. Except as provided in subparagraph 5. 8., ~~by July 1,~~  
2927 ~~2006,~~ the agency and the Department of Children and Family  
2928 Services shall contract with managed care entities in each AHCA  
2929 area ~~except area 6~~ or arrange to provide comprehensive inpatient

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2930 and outpatient mental health and substance abuse services  
2931 through capitated prepaid arrangements to all Medicaid  
2932 recipients who are eligible to participate in such plans under  
2933 federal law and regulation. In AHCA areas where there are fewer  
2934 than 150,000 eligible individuals ~~number less than 150,000~~, the  
2935 agency shall contract with a single managed care plan to provide  
2936 comprehensive behavioral health services to all recipients who  
2937 are not enrolled in a Medicaid health maintenance organization,  
2938 a provider service network authorized under paragraph (d), or a  
2939 Medicaid capitated managed care plan authorized under s. 409.986  
2940 ~~409.91211~~. The agency may contract with more than one  
2941 comprehensive behavioral health provider to provide care to  
2942 recipients who are not enrolled in a Medicaid capitated managed  
2943 care plan authorized under s. 409.986 ~~409.91211~~, a provider  
2944 service network authorized under paragraph (d), or a Medicaid  
2945 health maintenance organization in AHCA areas where the eligible  
2946 population exceeds 150,000. In an AHCA area where the Medicaid  
2947 managed care pilot program is authorized pursuant to s. 409.986  
2948 ~~409.91211~~ in one or more counties, the agency may procure a  
2949 contract with a single entity to serve the remaining counties as  
2950 an AHCA area or the remaining counties may be included with an  
2951 adjacent AHCA area and shall be subject to this paragraph.  
2952 Contracts for comprehensive behavioral health providers awarded  
2953 pursuant to this section must ~~shall~~ be competitively procured.  
2954 Both for-profit and not-for-profit corporations are eligible to  
2955 compete. Managed care plans contracting with the agency under  
2956 subsection (3) or paragraph (d), shall provide and receive  
2957 payment for the same comprehensive behavioral health benefits as  
2958 provided in AHCA rules, including handbooks incorporated by

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2959 reference. In AHCA area 11, the agency shall contract with at  
2960 least two comprehensive behavioral health care providers to  
2961 provide behavioral health care to recipients ~~in that area~~ who  
2962 are enrolled in, or assigned to, the MediPass program. One of  
2963 the ~~behavioral health care~~ contracts must be with the existing  
2964 provider service network pilot project, as described in  
2965 paragraph (d), for the purpose of demonstrating the cost-  
2966 effectiveness of the provision of quality mental health services  
2967 through a public hospital-operated managed care model. Payment  
2968 shall be at an agreed-upon capitated rate to ensure cost  
2969 savings. Of the recipients in area 11 who are assigned to  
2970 MediPass ~~under s. 409.9122(2)(k)~~, a minimum of 50,000 of those  
2971 MediPass-enrolled recipients shall be assigned to the existing  
2972 provider service network in area 11 for their behavioral care.

2973 ~~4. By October 1, 2003, the agency and the department shall~~  
2974 ~~submit a plan to the Governor, the President of the Senate, and~~  
2975 ~~the Speaker of the House of Representatives which provides for~~  
2976 ~~the full implementation of capitated prepaid behavioral health~~  
2977 ~~care in all areas of the state.~~

2978 ~~a. Implementation shall begin in 2003 in those AHCA areas~~  
2979 ~~of the state where the agency is able to establish sufficient~~  
2980 ~~capitation rates.~~

2981 ~~b. If the agency determines that the proposed capitation~~  
2982 ~~rate in any area is insufficient to provide appropriate~~  
2983 ~~services, the agency may adjust the capitation rate to ensure~~  
2984 ~~that care will be available. The agency and the department may~~  
2985 ~~use existing general revenue to address any additional required~~  
2986 ~~match but may not over-obligate existing funds on an annualized~~  
2987 ~~basis.~~

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2988 ~~e. Subject to any limitations provided in the General~~  
2989 ~~Appropriations Act, the agency, in compliance with appropriate~~  
2990 ~~federal authorization, shall develop policies and procedures~~  
2991 ~~that allow for certification of local and state funds.~~

2992 3.5. Children residing in a statewide inpatient psychiatric  
2993 program, or in a Department of Juvenile Justice or a Department  
2994 of Children and Family Services residential program approved as  
2995 a Medicaid behavioral health overlay services provider may not  
2996 be included in a behavioral health care prepaid health plan or  
2997 any other Medicaid managed care plan pursuant to this paragraph.

2998 ~~6. In converting to a prepaid system of delivery, the~~  
2999 ~~agency shall in its procurement document require an entity~~  
3000 ~~providing only comprehensive behavioral health care services to~~  
3001 ~~prevent the displacement of indigent care patients by enrollees~~  
3002 ~~in the Medicaid prepaid health plan providing behavioral health~~  
3003 ~~care services from facilities receiving state funding to provide~~  
3004 ~~indigent behavioral health care, to facilities licensed under~~  
3005 ~~chapter 395 which do not receive state funding for indigent~~  
3006 ~~behavioral health care, or reimburse the unsubsidized facility~~  
3007 ~~for the cost of behavioral health care provided to the displaced~~  
3008 ~~indigent care patient.~~

3009 4.7. Traditional community mental health providers under  
3010 contract with the Department of Children and Family Services  
3011 pursuant to part IV of chapter 394, ~~child welfare providers~~  
3012 ~~under contract with the Department of Children and Family~~  
3013 ~~Services in areas 1 and 6,~~ and inpatient mental health providers  
3014 licensed pursuant to chapter 395 must be offered an opportunity  
3015 to accept or decline a contract to participate in any provider  
3016 network for prepaid behavioral health services.



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3017 ~~5.8.~~ All Medicaid-eligible children, except children in  
3018 area 1 and children in ~~Highlands County, Hardee County, Polk~~  
3019 ~~County, or~~ Manatee County in of area 6, whose cases that are  
3020 open for child welfare services in the statewide automated child  
3021 welfare information HomeSafeNet system, shall receive their  
3022 behavioral health care services through a specialty prepaid plan  
3023 operated by community-based lead agencies through a single  
3024 agency or formal agreements among several agencies. The agency  
3025 shall work with the specialty plan to develop clinically  
3026 effective, evidence-based alternatives as a downward  
3027 substitution for the statewide inpatient psychiatric program and  
3028 similar residential care and institutional services. The  
3029 specialty prepaid plan must result in savings to the state  
3030 comparable to savings achieved in other Medicaid managed care  
3031 and prepaid programs. Such plan must provide mechanisms to  
3032 maximize state and local revenues. The specialty prepaid plan  
3033 shall be developed by the agency and the Department of Children  
3034 and Family Services. The agency may seek federal waivers to  
3035 implement this initiative. Medicaid-eligible children whose  
3036 cases are open for child welfare services in the statewide  
3037 automated child welfare information HomeSafeNet system and who  
3038 reside in AHCA area 10 shall be enrolled in a capitated managed  
3039 care plan, which includes provider service networks, which, in  
3040 coordination with available community-based care providers  
3041 specified in s. 409.1671, shall provide sufficient medical,  
3042 developmental, behavioral, and emotional services to meet the  
3043 needs of these children, subject to funding as provided in the  
3044 General Appropriations Act ~~are exempt from the specialty prepaid~~  
3045 ~~plan upon the development of a service delivery mechanism for~~

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3046 ~~children who reside in area 10 as specified in s.~~  
3047 ~~409.91211(3)(dd).~~

3048 (d) A provider service network, which may be reimbursed on  
3049 a fee-for-service or prepaid basis.

3050 1. A provider service network that ~~which~~ is reimbursed by  
3051 the agency on a prepaid basis is ~~shall be~~ exempt from parts I  
3052 and III of chapter 641, but must comply with the solvency  
3053 requirements in s. 641.2261(2) and meet appropriate financial  
3054 reserve, quality assurance, and patient rights requirements ~~as~~  
3055 established by the agency.

3056 2. ~~Medicaid recipients assigned to a provider service~~  
3057 ~~network shall be chosen equally from those who would otherwise~~  
3058 ~~have been assigned to prepaid plans and MediPass.~~ The agency may  
3059 ~~is authorized to~~ seek federal Medicaid waivers as necessary to  
3060 implement ~~the provisions of~~ this section. ~~Any contract~~  
3061 ~~previously awarded to a provider service network operated by a~~  
3062 ~~hospital pursuant to this subsection shall remain in effect for~~  
3063 ~~a period of 3 years following the current contract expiration~~  
3064 ~~date, regardless of any contractual provisions to the contrary.~~

3065 3. A provider service network is a network established or  
3066 organized and operated by a health care provider, or group of  
3067 affiliated health care providers, including minority physician  
3068 networks and emergency room diversion programs that meet the  
3069 requirements of s. 409.986 ~~409.91211~~, which provides a  
3070 substantial proportion of the health care items and services  
3071 under a contract directly through the provider or affiliated  
3072 group of providers and may make arrangements with physicians or  
3073 other health care professionals, health care institutions, or  
3074 any combination of such individuals or institutions to assume

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3075 all or part of the financial risk on a prospective basis for the  
3076 provision of basic health services by the physicians, by other  
3077 health professionals, or through the institutions. The health  
3078 care providers must have a controlling interest in the governing  
3079 body of the provider service network organization.

3080 (8) ~~(a)~~ The agency may contract on a prepaid or fixed-sum  
3081 basis with an exclusive provider organization to provide health  
3082 care services to Medicaid recipients if provided that the  
3083 exclusive provider organization meets applicable managed care  
3084 plan requirements in this section, ss. 409.987, 409.988  
3085 ~~409.9122, 409.9123,~~ 409.9128, and 627.6472, and other applicable  
3086 provisions of law.

3087 ~~(b) For a period of no longer than 24 months after the~~  
3088 ~~effective date of this paragraph, when a member of an exclusive~~  
3089 ~~provider organization that is contracted by the agency to~~  
3090 ~~provide health care services to Medicaid recipients in rural~~  
3091 ~~areas without a health maintenance organization obtains services~~  
3092 ~~from a provider that participates in the Medicaid program in~~  
3093 ~~this state, the provider shall be paid in accordance with the~~  
3094 ~~appropriate fee schedule for services provided to eligible~~  
3095 ~~Medicaid recipients. The agency may seek waiver authority to~~  
3096 ~~implement this paragraph.~~

3097 (34) The agency and entities that contract with the agency  
3098 to provide health care services to Medicaid recipients under  
3099 this section or ss. 409.986 and 409.987 ~~409.91211 and 409.9122~~  
3100 must comply with the provisions of s. 641.513 in providing  
3101 emergency services and care to Medicaid recipients and MediPass  
3102 recipients. Where feasible, safe, and cost-effective, the agency  
3103 shall encourage hospitals, emergency medical services providers,

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3104 and other public and private health care providers to work  
3105 together in their local communities to enter into agreements or  
3106 arrangements to ensure access to alternatives to emergency  
3107 services and care for those Medicaid recipients who need  
3108 nonemergent care. The agency shall coordinate with hospitals,  
3109 emergency medical services providers, private health plans,  
3110 capitated managed care networks as established in s. 409.986  
3111 ~~409.91211~~, and other public and private health care providers to  
3112 implement the provisions of ss. 395.1041(7), 409.91255(3)(g),  
3113 627.6405, and 641.31097 to develop and implement emergency  
3114 department diversion programs for Medicaid recipients.

3115 (44) The agency ~~for Health Care Administration~~ shall ensure  
3116 that any Medicaid managed care plan as defined in s.  
3117 409.987(2)(f) ~~409.9122(2)(f)~~, whether paid on a capitated basis  
3118 or a shared savings basis, is cost-effective. For purposes of  
3119 this subsection, the term "cost-effective" means that a  
3120 network's per-member, per-month costs to the state, including,  
3121 but not limited to, fee-for-service costs, administrative costs,  
3122 and case-management fees, if any, must be no greater than the  
3123 state's costs associated with contracts for Medicaid services  
3124 established under subsection (3), which may be adjusted for  
3125 health status. The agency shall conduct actuarially sound  
3126 adjustments for health status in order to ensure such cost-  
3127 effectiveness and shall annually publish the results on its  
3128 Internet website. Contracts established pursuant to this  
3129 subsection which are not cost-effective may not be renewed.

3130 ~~(47) The agency shall conduct a study of available~~  
3131 ~~electronic systems for the purpose of verifying the identity and~~  
3132 ~~eligibility of a Medicaid recipient. The agency shall recommend~~

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3133 ~~to the Legislature a plan to implement an electronic~~  
 3134 ~~verification system for Medicaid recipients by January 31, 2005.~~

3135 ~~(53) Before seeking an amendment to the state plan for~~  
 3136 ~~purposes of implementing programs authorized by the Deficit~~  
 3137 ~~Reduction Act of 2005, the agency shall notify the Legislature.~~

3138 Section 30. Paragraph (a) of subsection (1) of section  
 3139 409.915, Florida Statutes, is amended to read:

3140 409.915 County contributions to Medicaid.—Although the  
 3141 state is responsible for the full portion of the state share of  
 3142 the matching funds required for the Medicaid program, in order  
 3143 to acquire a certain portion of these funds, the state shall  
 3144 charge the counties for certain items of care and service as  
 3145 provided in this section.

3146 (1) Each county shall participate in the following items of  
 3147 care and service:

3148 (a) For both health maintenance members and fee-for-service  
 3149 beneficiaries, payments for inpatient hospitalization in excess  
 3150 of 10 days, but not in excess of 45 days, with the exception of  
 3151 pregnant women and children whose income is greater than ~~in~~  
 3152 ~~excess of~~ the federal poverty level and who do not receive a  
 3153 Medicaid nonpoverty medical subsidy ~~participate in the Medicaid~~  
 3154 ~~medically needy Program~~, and for adult lung transplant services.

3155 Section 31. Section 409.9301, Florida Statutes, is  
 3156 transferred, renumbered as section 409.9067, Florida Statutes,  
 3157 and subsections (1) and (2) of that section are amended, to  
 3158 read:

3159 409.9067 ~~409.9301~~ Pharmaceutical expense assistance.—

3160 (1) PROGRAM ESTABLISHED.—A program is established in the  
 3161 agency ~~for Health Care Administration~~ to provide pharmaceutical

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3162 expense assistance to individuals diagnosed with cancer or  
3163 individuals who have obtained ~~received~~ organ transplants who  
3164 received a Medicaid nonpoverty medical subsidy before ~~were~~  
3165 ~~medically needy recipients prior to~~ January 1, 2006.

3166 (2) ELIGIBILITY.—Eligibility for the program is limited to  
3167 an individual who:

3168 (a) Is a resident of this state;

3169 (b) Was a Medicaid recipient who received a nonpoverty  
3170 medical subsidy before ~~under the Florida Medicaid medically~~  
3171 ~~needy program prior to~~ January 1, 2006;

3172 (c) Is eligible for Medicare;

3173 (d) Is a cancer patient or an organ transplant recipient;  
3174 and

3175 (e) Requests to be enrolled in the program.

3176 Section 32. Subsection (1) of section 409.9126, Florida  
3177 Statutes, is amended to read:

3178 409.9126 Children with special health care needs.—

3179 (1) Except as provided in subsection (4), children eligible  
3180 for Children's Medical Services who receive Medicaid benefits,  
3181 and other Medicaid-eligible children with special health care  
3182 needs, are ~~shall be~~ exempt from ~~the provisions of~~ s. 409.987  
3183 ~~409.9122~~ and shall be served through the Children's Medical  
3184 Services network established in chapter 391.

3185 Section 33. The Division of Statutory Revision is requested  
3186 to create part IV of chapter 409, Florida Statutes, consisting  
3187 of sections 409.961-409.978, Florida Statutes, entitled  
3188 "MEDICAID MANAGED CARE."

3189 Section 34. Section 409.961, Florida Statutes, is created  
3190 to read:

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3191       409.961 Construction; applicability.—It is the intent of  
3192 the Legislature that if any conflict exists between ss. 409.961-  
3193 409.978 and other parts or sections of this chapter, the  
3194 provisions in ss. 409.961-409.978 control. Sections 409.961-  
3195 409.978 apply only to the Medicaid managed care program, as  
3196 provided in this part.

3197       Section 35. Section 409.962, Florida Statutes, is created  
3198 to read:

3199       409.962 Definitions.—As used in this part, and including  
3200 the terms defined in s. 409.901, the term:

3201       (1) "Direct care management" means care management  
3202 activities that involve direct interaction between providers and  
3203 patients.

3204       (2) "Home and community-based services" means a specific  
3205 set of services designed to assist recipients qualifying under  
3206 s. 409.974 in avoiding institutionalization.

3207       (3) "Medicaid managed care program" means the integrated,  
3208 statewide Medicaid program created in this part, which includes  
3209 the provision of managed care medical assistance services  
3210 described in ss. 409.971 and 409.972 and managed long-term care  
3211 services described in ss. 409.973-409.978.

3212       (4) "Provider service network" means an entity of which a  
3213 controlling interest is owned by, or a controlling interest in  
3214 the governing body of the entity is composed of, a health care  
3215 provider, a group of affiliated providers, or a public agency or  
3216 entity that delivers health services. For purposes of this  
3217 chapter, health care providers include Florida-licensed health  
3218 care professionals, Florida-licensed health care facilities,  
3219 federally qualified health centers, and home health care

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3220 agencies.

3221 (5) "Qualified plan" means a managed care plan that is  
3222 determined eligible to participate in the Medicaid managed care  
3223 program pursuant to s. 409.965.

3224 (6) "Specialty plan" means a qualified plan that serves  
3225 Medicaid recipients who meet specified criteria based on age,  
3226 medical condition, or diagnosis.

3227 Section 36. Section 409.963, Florida Statutes, is created  
3228 to read:

3229 409.963 Medicaid managed care program.—The Medicaid managed  
3230 care program is established as a statewide, integrated managed  
3231 care program for all covered medical assistance services and  
3232 long-term care services as provided under this part. Pursuant to  
3233 s. 409.902, the program shall be administered by the agency, and  
3234 eligibility for the program shall be determined by the  
3235 Department of Children and Family Services.

3236 (1) The agency shall submit amendments to the Medicaid  
3237 state plan or to existing waivers, or submit new waiver requests  
3238 under section 1115 or other applicable sections of the Social  
3239 Security Act, by August 1, 2011, as needed to implement the  
3240 managed care program. At a minimum, the waiver requests must  
3241 include a waiver that allows home and community-based services  
3242 to be preferred over nursing home services for persons who can  
3243 be safely managed in the home and community, and a waiver that  
3244 requires dually eligible recipients to participate in the  
3245 Medicaid managed care program. The waiver requests must also  
3246 include provisions authorizing the state to limit enrollment in  
3247 managed long-term care, establish waiting lists, and limit the  
3248 amount, duration, and scope of home and community-based services



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3249 to ensure that expenditures for persons eligible for managed  
3250 long-term care services do not exceed funds provided in the  
3251 General Appropriations Act.

3252 (a) The agency shall initiate any necessary procurements  
3253 required to implement the managed care program as soon as  
3254 practicable, but no later than July 1, 2011, in anticipation of  
3255 prompt approval of the waivers needed for the managed care  
3256 program by the United States Department of Health and Human  
3257 Services.

3258 (b) In submitting waivers, the agency shall work with the  
3259 federal Centers for Medicare and Medicaid Services to accomplish  
3260 approval of all waivers by December 1, 2011, in order to begin  
3261 implementation of the managed care program by December 31, 2011.

3262 (c) Before seeking a waiver, the agency shall provide  
3263 public notice and the opportunity for public comment and include  
3264 public feedback in the waiver application.

3265 (2) The agency shall begin implementation of the Medicaid  
3266 managed care program on December 31, 2011. If waiver approval is  
3267 obtained, the program shall be implemented in accordance with  
3268 the terms and conditions of the waiver. If necessary waivers  
3269 have not been timely received, the agency shall notify the  
3270 Centers for Medicare and Medicaid Services of the state's  
3271 implementation of the managed care program and request the  
3272 federal agency to continue providing federal funds equivalent to  
3273 the funding level provided under the Federal Medical Assistance  
3274 Percentage in order to implement the managed care program.

3275 (a) If the Centers for Medicare and Medicaid Services  
3276 refuses to continue providing federal funds, the managed care  
3277 program shall be implemented as a state-only funded program to

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3278 the extent state funds are available.

3279 (b) If implemented as a state-only funded program, priority  
3280 shall be given to providing:

3281 1. Nursing home services to persons eligible for nursing  
3282 home care.

3283 2. Medical services to persons served by the Agency for  
3284 Persons with Disabilities.

3285 3. Medical services to pregnant women.

3286 4. Physician and hospital services to persons who are  
3287 determined to be eligible for Medicaid subject to the income,  
3288 assets, and categorical eligibility tests set forth in federal  
3289 and state law.

3290 5. Services provided under the Healthy Start waiver.

3291 6. Medical services provided to persons in the Nursing Home  
3292 Diversion waiver.

3293 7. Medical services provided to persons in intermediate  
3294 care facilities for the developmentally disabled.

3295 8. Services to children in the child welfare system whose  
3296 medical care is provided in accordance with s. 409.16713, as  
3297 authorized by the General Appropriations Act.

3298 (c) If implemented as a state-only funded program pursuant  
3299 to paragraph (b), provisions related to the eligibility  
3300 standards of the state and federally funded Medicaid program  
3301 remain in effect, except as otherwise provided under the managed  
3302 care program.

3303 (d) If implemented as a state-only funded program pursuant  
3304 to paragraph (a), provider agreements and other contracts that  
3305 provide for Medicaid services to recipients identified in  
3306 paragraph (b) continue in effect.

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3307 Section 37. Section 409.964, Florida Statutes, is created  
3308 to read:

3309 409.964 Enrollment.—All Medicaid recipients shall receive  
3310 medical services through the Medicaid managed care program  
3311 established under this part unless excluded under this section.

3312 (1) The following recipients are excluded from  
3313 participation in the Medicaid managed care program:

3314 (a) Women who are eligible only for family planning  
3315 services.

3316 (b) Women who are eligible only for breast and cervical  
3317 cancer services.

3318 (c) Persons who have a developmental disability as defined  
3319 in s. 393.063.

3320 (d) Persons who are eligible for a Medicaid nonpoverty  
3321 medical subsidy.

3322 (e) Persons who receive eligible services under emergency  
3323 Medicaid for aliens.

3324 (f) Persons who are residing in a nursing home facility or  
3325 are considered residents under the nursing home's bed-hold  
3326 policy on or before July 1, 2011.

3327 (g) Persons who are eligible for and receiving prescribed  
3328 pediatric extended care.

3329 (h) Persons who are dependent on a respirator by medical  
3330 necessity and who meet the definition of a medically dependent  
3331 or technologically dependent child under s. 400.902.

3332 (i) Persons who select the Medicaid hospice benefit and are  
3333 receiving hospice services from a hospice licensed under part IV  
3334 of chapter 400.

3335 (j) Children residing in a statewide inpatient psychiatric

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3336 program.

3337 (k) A person who is eligible for services under the  
3338 Medicaid program who has access to health care coverage through  
3339 an employer-sponsored health plan. Such person may not receive  
3340 Medicaid services under the fee-for-service program but may use  
3341 Medicaid financial assistance to pay the cost of premiums for  
3342 the employer-sponsored health plan. For purposes of this  
3343 paragraph, access to health care coverage through an employer-  
3344 sponsored health plan means that the Medicaid financial  
3345 assistance available to the person is sufficient to pay the  
3346 premium for the employer-sponsored health plan for the eligible  
3347 person and his or her Medicaid eligible family members.

3348 1. The agency shall develop a process that allows a  
3349 recipient who has access to employer-sponsored health coverage  
3350 to use Medicaid financial assistance to pay the cost of the  
3351 premium for the recipient and the recipient's Medicaid-eligible  
3352 family members for such coverage. The amount of financial  
3353 assistance may not exceed the Medicaid capitated rate that would  
3354 have been paid to a qualified plan for that recipient and the  
3355 recipient's family members.

3356 2. Contingent upon federal approval, the agency shall also  
3357 allow recipients who have access to other insurance or coverage  
3358 created pursuant to state or federal law to opt out of Medicaid  
3359 managed care and apply the Medicaid capitated rate that would  
3360 have been paid to a qualified plan for that recipient and the  
3361 recipient's family to pay for the other insurance product.

3362 (2) The following Medicaid recipients are exempt from  
3363 mandatory enrollment in the managed care program but may  
3364 volunteer to participate in the program:

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3365 (a) Recipients residing in residential commitment  
3366 facilities operated through the Department of Juvenile Justice,  
3367 group care facilities operated by the Department of Children and  
3368 Family Services, or treatment facilities funded through the  
3369 substance abuse and mental health program of the Department of  
3370 Children and Family Services.

3371 (b) Persons eligible for refugee assistance.

3372 (3) Medicaid recipients who are exempt from mandatory  
3373 participation under this section and who do not choose to enroll  
3374 in the Medicaid managed care program shall be served through the  
3375 Medicaid fee-for-service program as provided under part III of  
3376 this chapter.

3377 Section 38. Section 409.965, Florida Statutes, is created  
3378 to read:

3379 409.965 Qualified plans; regions; selection criteria.-  
3380 Services in the Medicaid managed care program shall be provided  
3381 by qualified plans.

3382 (1) The agency shall select qualified plans to participate  
3383 in the Medicaid managed care program using an invitation to  
3384 negotiate issued pursuant to s. 287.057.

3385 (a) The agency shall notice separate invitations to  
3386 negotiate for the managed medical assistance component and the  
3387 managed long-term care component of the managed care program.

3388 (b) At least 30 days before noticing the invitation to  
3389 negotiate and annually thereafter, the agency shall compile and  
3390 publish a databook consisting of a comprehensive set of  
3391 utilization and spending data for the 3 most recent contract  
3392 years, consistent with the rate-setting periods for all Medicaid  
3393 recipients by region and county. Pursuant to s. 409.970, the

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3394 source of the data must include both historic fee-for-service  
3395 claims and validated data from the Medicaid Encounter Data  
3396 System. The report shall be made available electronically and  
3397 must delineate utilization by age, gender, eligibility group,  
3398 geographic area, and acuity level.

3399 (2) Separate and simultaneous procurements shall be  
3400 conducted in each of the following regions:

3401 (a) Region 1, which consists of Escambia, Okaloosa, Santa  
3402 Rosa, and Walton counties.

3403 (b) Region 2, which consists of Franklin, Gadsden,  
3404 Jefferson, Leon, Liberty, and Wakulla counties.

3405 (c) Region 3, which consists of Columbia, Dixie, Hamilton,  
3406 Lafayette, Madison, Suwannee, and Taylor counties.

3407 (d) Region 4, which consists of Baker, Clay, Duval, and  
3408 Nassau counties.

3409 (e) Region 5, which consists of Citrus, Hernando, Lake,  
3410 Marion, and Sumter counties.

3411 (f) Region 6, which consists of Pasco and Pinellas  
3412 counties.

3413 (g) Region 7, which consists of Flagler, Putnam, St. Johns,  
3414 and Volusia counties.

3415 (h) Region 8, which consists of Alachua, Bradford,  
3416 Gilchrist, Levy, and Union counties.

3417 (i) Region 9, which consists of Orange and Osceola  
3418 counties.

3419 (j) Region 10, which consists of Hardee, Highlands, and  
3420 Polk counties.

3421 (k) Region 11, which consists of Miami-Dade and Monroe  
3422 counties.

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3423 (l) Region 12, which consists of DeSoto, Manatee, and  
3424 Sarasota counties.

3425 (m) Region 13, which consists of Hillsborough County.

3426 (n) Region 14, which consists of Bay, Calhoun, Gulf,  
3427 Holmes, Jackson, and Washington counties.

3428 (o) Region 15, which consists of Palm Beach County.

3429 (p) Region 16, which consists of Broward County.

3430 (q) Region 17, which consists of Brevard and Seminole  
3431 counties.

3432 (r) Region 18, which consists of Indian River, Martin,  
3433 Okeechobee, and St. Lucie counties.

3434 (s) Region 19, which consists of Charlotte, Collier,  
3435 Glades, Hendry, and Lee counties.

3436 (3) The invitation to negotiate must specify the criteria  
3437 and the relative weight of the criteria to be used for  
3438 determining the acceptability of a reply and guiding the  
3439 selection of qualified plans with which the agency shall  
3440 contract. In addition to other criteria developed by the agency,  
3441 the agency shall give preference to the following factors in  
3442 selecting qualified plans:

3443 (a) Accreditation by the National Committee for Quality  
3444 Assurance or another nationally recognized accrediting body.

3445 (b) Experience serving similar populations, including the  
3446 organization's record in achieving specific quality standards  
3447 for similar populations.

3448 (c) Availability and accessibility of primary care and  
3449 specialty physicians in the provider network.

3450 (d) Establishment of partnerships with community providers  
3451 that provide community-based services.

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3452       (e) The organization's commitment to quality improvement  
3453 and documentation of achievements in specific quality-  
3454 improvement projects, including active involvement by the  
3455 organization's leadership.

3456       (f) Provision of additional benefits, particularly dental  
3457 care for all recipients, disease management, and other programs  
3458 offering additional benefits.

3459       (g) Establishment of incentive programs that reward  
3460 specific behaviors with health-related benefits not otherwise  
3461 covered by the organizations' benefit plan. Such behaviors may  
3462 include participation in smoking-cessation programs, weight-loss  
3463 programs, or other activities designed to mitigate lifestyle  
3464 choices and avoid behaviors associated with the use of high-cost  
3465 medical services.

3466       (h) Organizations without a history of voluntary or  
3467 involuntary withdrawal from any state Medicaid program or  
3468 program area.

3469       (i) Evidence that an organization has written agreements or  
3470 signed contracts or has made substantial progress in  
3471 establishing relationships with providers before the  
3472 organization submits a reply. The agency shall evaluate such  
3473 evidence based on the following factors:

3474       1. Contracts with primary care and specialty physicians in  
3475 sufficient numbers to meet the specific performance standards  
3476 established pursuant to s. 409.966(2) (b).

3477       2. Specific arrangements that provide evidence that the  
3478 compensation offered by the plan is sufficient to retain primary  
3479 care and specialty physicians in sufficient numbers to comply  
3480 with the performance standards established pursuant to s.



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3481 409.966(2) throughout the 5-year contract term. The agency shall  
3482 give preference to plans that provide evidence that primary care  
3483 physicians within the plan's provider network will be  
3484 compensated for primary care services with payments equivalent  
3485 to or greater than payments for such services under the Medicare  
3486 program, whether compensation is made on a fee-for-service basis  
3487 or by sub-capitation.

3488 3. Contracts with community pharmacies located in rural  
3489 areas; contracts with community pharmacies serving specialty  
3490 disease populations, including, but not limited to, HIV/AIDS  
3491 patients, hemophiliacs, patients suffering from end-stage renal  
3492 disease, diabetes, or cancer; community pharmacies located  
3493 within distinct cultural communities that reflect the unique  
3494 cultural dynamics of such communities, including, but not  
3495 limited to, languages spoken, ethnicities served, unique disease  
3496 states serviced, and geographic location within the  
3497 neighborhoods of culturally distinct populations; and community  
3498 pharmacies providing value-added services to patients, such as  
3499 free delivery, immunizations, disease management, diabetes  
3500 education, and medication utilization review.

3501 4. Contracts with cancer disease management programs that  
3502 have a proven record of clinical efficiencies and cost savings.

3503 5. Contracts with diabetes disease management programs that  
3504 have a proven record of clinical efficiencies and cost savings.

3505 (j) The capitated rates provided in the reply to the  
3506 invitation to negotiate.

3507 (k) Establishment of a claims payment process to ensure  
3508 that claims that are not contested or denied will be paid within  
3509 20 days after receipt.

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3510       (1) Utilizing a tiered approach, organizations that are  
3511 based in Florida and have operational functions performed in  
3512 Florida, either performed in-house or through contractual  
3513 arrangements, by Florida-employed staff. The highest number of  
3514 points shall be awarded to any plan with all or substantially  
3515 all of its operational functions performed in the state. The  
3516 second highest number of points shall be awarded to any plan  
3517 with a majority of its operational functions performed in the  
3518 state. The agency may establish a third tier; however, no  
3519 preference points shall be awarded to plans that perform only  
3520 community outreach, medical director functions, and state  
3521 administrative functions in the state. For purposes of this  
3522 paragraph, operational functions include claims processing,  
3523 member services, provider relations, utilization and prior  
3524 authorization, case management, disease and quality functions,  
3525 and finance and administration. For purposes of this paragraph,  
3526 "based in Florida" means that the entity's principal office is  
3527 in Florida and the plan is not a subsidiary, directly or  
3528 indirectly through one or more subsidiaries of, or a joint  
3529 venture with, any other entity whose principal office is not  
3530 located in the state.

3531       (m) For long-term care plans, additional criteria as  
3532 specified in s. 409.976(3).

3533       (4) Acceptable replies to the invitation to negotiate for  
3534 each region shall be ranked, and the agency shall select the  
3535 number of qualified plans with which to contract in each region.

3536       (a) The agency may not select more than one plan per 20,000  
3537 Medicaid recipients residing in the region who are subject to  
3538 mandatory managed care enrollment, except that, in addition to

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3539 the Children's Medical Services Network, a region may not have  
3540 fewer than three or more than 10 qualified plans for the managed  
3541 medical assistance or the managed long-term care components of  
3542 the program.

3543 (b) If the funding available in the General Appropriations  
3544 Act is not adequate to meet the proposed statewide requirement  
3545 under the Medicaid managed care program, the agency shall enter  
3546 into negotiations with qualified plans that responded to the  
3547 invitation to negotiate. The negotiation process may alter the  
3548 rank of a qualified plan. If negotiations are conducted, the  
3549 agency shall select qualified plans that are responsive and  
3550 provide the best value to the state.

3551 (5) The agency may issue a new invitation to negotiate in  
3552 any region:

3553 (a) At any time if:

3554 1. Data becomes available to the agency indicating that the  
3555 population of recipients residing in the region who are subject  
3556 to mandatory managed care enrollment cannot be served by the  
3557 plans under contract with the agency in that region or has  
3558 increased by more than 20,000 since the most recent invitation  
3559 to negotiate was issued in that region; and

3560 2. The agency has not contracted with the maximum number of  
3561 plans authorized for that region.

3562 (b) At any time during the first 2 years after the initial  
3563 contract period and upon the request of a qualified plan under  
3564 contract in one or more regions if:

3565 1. Data becomes available to the agency indicating that the  
3566 population of Medicaid recipients residing in the region who are  
3567 subject to mandatory managed care enrollment has increased by

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3568 more than 20,000 since the initial invitation to negotiate was  
3569 issued for the contract period; and

3570 2. The agency has not contracted with the maximum number of  
3571 plans authorized for that region.

3572  
3573 The term of a contract executed under this subsection shall be  
3574 for the remainder of the 5-year contract cycle.

3575 (6) The Children's Medical Services Network authorized  
3576 under chapter 391 is a qualified plan for purposes of the  
3577 managed care medical assistance component of the Medicaid  
3578 managed care program. Participation by the network shall be  
3579 pursuant to a single statewide contract with the agency which is  
3580 not subject to the procurement requirements of this section. The  
3581 network must meet all other plan requirements for the managed  
3582 care medical assistance component of the program.

3583 (7) In order to allow a provider service network in rural  
3584 areas sufficient time to develop an adequate provider network to  
3585 participate in the Medicaid managed care program on a capitated  
3586 basis, the network may submit an application or invitation to  
3587 negotiate after July 1, 2011, as required by the agency, for a  
3588 region where there was no Medicaid-contracted health maintenance  
3589 organization or provider service network on July 1, 2011. For  
3590 the first 12 months that the network operates in the region, the  
3591 agency shall assign existing Medicaid provider agreements to the  
3592 provider service network for purposes of administering managed  
3593 care services and building an adequate provider network to meet  
3594 the access standards established by the agency.

3595 Section 39. Section 409.966, Florida Statutes, is created  
3596 to read:

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3597 409.966 Plan contracts.—

3598 (1) The agency shall execute a 5-year contract with each  
3599 qualified plan selected through the procurement process  
3600 described in s. 409.965. A contract between the agency and the  
3601 qualified plan may be amended annually, or as needed, to reflect  
3602 capitated rate adjustments due to funding availability pursuant  
3603 to the General Appropriations Act and ss. 409.9022, 409.972, and  
3604 409.975(2).

3605 (a) A plan contract may not be renewed; however, the agency  
3606 may extend the term of a contract, keeping intact all  
3607 operational provisions in the contract, including capitation  
3608 rates, to cover any delays in transitioning to a new plan.

3609 (b) If a plan applies for a rate increase that is not the  
3610 result of a solicitation from the agency and the application for  
3611 rate increase is not timely withdrawn, the plan will be deemed  
3612 to have submitted a notice of intent to leave the region before  
3613 the end of the contract term.

3614 (2) The agency shall establish such contract requirements  
3615 as are necessary for the operation of the Medicaid managed care  
3616 program. In addition to any other provisions the agency may deem  
3617 necessary, the contract must require:

3618 (a) Access.—The agency shall establish specific standards  
3619 for the number, type, and regional distribution of providers in  
3620 plan networks in order to ensure access to care. Each qualified  
3621 plan shall:

3622 1. Maintain a network of providers in sufficient numbers to  
3623 meet the access standards for specified services for all  
3624 recipients enrolled in the plan.

3625 2. Establish and maintain an accurate and complete

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3626 electronic database of contracted providers, including  
3627 information about licensure or registration, locations and hours  
3628 of operation, specialty credentials and other certifications,  
3629 specific performance indicators, and such other information as  
3630 the agency deems necessary. The provider database must be  
3631 available online to both the agency and the public and allow  
3632 comparison of the availability of providers to network adequacy  
3633 standards, and accept and display feedback from each provider's  
3634 patients.

3635 3. Provide for reasonable and adequate hours of operation,  
3636 including 24-hour availability of information, referral, and  
3637 treatment for emergency medical conditions.

3638 4. Assign each new enrollee to a primary care provider and  
3639 ensure that an appointment with that provider has been scheduled  
3640 within 30 days after the enrollment in the plan.

3641 5. Submit quarterly reports to the agency identifying the  
3642 number of enrollees assigned to each primary care provider.

3643 (b) Performance standards.—The agency shall establish  
3644 specific performance standards and expected milestones or  
3645 timelines for improving plan performance over the term of the  
3646 contract.

3647 1. Each plan shall establish an internal health care  
3648 quality improvement system that includes enrollee satisfaction  
3649 and disenrollment surveys and incentives and disincentives for  
3650 network providers.

3651 2. Each plan must collect and report the Health Plan  
3652 Employer Data and Information Set (HEDIS) measures, as specified  
3653 by the agency. These measures must be published on the plan's  
3654 website in a manner that allows recipients to reliably compare

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3655 the performance of plans. The agency shall use the HEDIS  
3656 measures as a tool to monitor plan performance.

3657 3. A qualified plan that is not accredited when the  
3658 contract is executed with the agency must become accredited or  
3659 have initiated the accreditation process within 1 year after the  
3660 contract is executed. If the plan is not accredited within 18  
3661 months after executing the contract, the plan shall be suspended  
3662 from automated enrollments pursuant to s. 409.969(2).

3663 4. In addition to agency standards, a qualified plan must  
3664 ensure that the agency is notified of the impending birth of a  
3665 child to an enrollee or as soon as practicable after the child's  
3666 birth. Upon the birth, the child is deemed enrolled with the  
3667 qualified plan, regardless of the administrative enrollment  
3668 procedures, and the qualified plan is responsible for providing  
3669 Medicaid services to the child on a capitated basis.

3670 (c) Program integrity.—Each plan shall establish program  
3671 integrity functions and activities in order to reduce the  
3672 incidence of fraud and abuse, including, at a minimum:

3673 1. A provider credentialing system and ongoing provider  
3674 monitoring. Each plan must maintain written provider  
3675 credentialing policies and procedures that are compliant with  
3676 federal and agency guidelines. Each plan must verify at least  
3677 annually that all providers have a valid and unencumbered  
3678 license or permit to provide services to Medicaid recipients,  
3679 and shall establish a procedure for providers to notify the plan  
3680 when the provider has been notified by a licensing or regulatory  
3681 agency that the provider's license or permit is to be revoked or  
3682 suspended, or when an event has occurred which would prevent the  
3683 provider from renewing its license or permit. The provider must

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3684 also notify the plan if the license or permit is revoked or  
3685 suspended, if renewal of the license or permit is denied or  
3686 expires by operation of law, or if the provider requests that  
3687 the license or permit be inactivated. The plan must immediately  
3688 exclude a provider from the plan's provider network if the  
3689 provider's license is suspended or invalid. However, this  
3690 section does not preclude a plan from contracting with a  
3691 provider that is approved via a final order, has commenced  
3692 construction, and will be licensed and operational within 18  
3693 months after the effective date of this act;

3694 2. An effective prepayment and postpayment review process  
3695 that includes, at a minimum, data analysis, system editing, and  
3696 auditing of network providers;

3697 3. Procedures for reporting instances of fraud and abuse  
3698 pursuant to s. 409.91212;

3699 4. The establishment of an anti-fraud plan pursuant to s.  
3700 409.91212; and

3701 5. Designation of a program integrity compliance officer.

3702 (d) Encounter data.—Each plan must comply with the agency's  
3703 reporting requirements for the Medicaid Encounter Data System  
3704 under s. 409.970. The agency shall assess a fine of \$5,000 per  
3705 day against a qualified plan for failing to comply with this  
3706 requirement. If a plan fails to comply for more than 30 days,  
3707 the agency shall assess a fine of \$10,000 per day beginning on  
3708 the 31st day. If a plan is fined \$300,000 or more for failing to  
3709 comply, in addition to paying the fine, the plan shall be  
3710 disqualified from the Medicaid managed care program for 3 years.  
3711 If the plan is disqualified, the plan shall be deemed to have  
3712 terminated its contract before the scheduled end date and shall



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3713 also be subject to applicable penalties under paragraph (l).  
3714 However, the agency may waive or reduce the fine upon a showing  
3715 of good cause for the failure to comply.

3716 (e) *Electronic claims and prior authorization requests.*—  
3717 Plans shall accept electronic claims that are in compliance with  
3718 federal standards and accept electronic prior authorization  
3719 requests from prescribers and pharmacists for medication  
3720 exceptions to the preferred drug list or formulary. The criteria  
3721 for the approval and the reasons for denial of prior  
3722 authorization requests shall be made readily available to  
3723 prescribers and pharmacists submitting the request. Plans shall  
3724 require any vendor or subcontractor providing fiscal  
3725 intermediary services to the plan pursuant to s. 641.316, which  
3726 involve the acceptance of provider claims, to accept electronic  
3727 claims in compliance with federal standards.

3728 (f) *Prompt payment.*—All qualified plans must comply with  
3729 ss. 641.315, 641.3155, and 641.513. Qualified plans shall pay  
3730 nursing homes by the 10th day of the month for enrollees who are  
3731 residing in the nursing home on the 1st day of the month.  
3732 Payment for the month in which an enrollee initiates residency  
3733 in a nursing home shall be in accordance with s. 641.3155. On an  
3734 annual basis, qualified plans shall submit a report certifying  
3735 compliance with the prompt payment requirements for the plan  
3736 year.

3737 (g) *Emergency services.*—Qualified plans must pay for  
3738 emergency services and care required under ss. 395.1041 and  
3739 401.45 and rendered by a noncontracted provider in accordance  
3740 with the prompt payment standards established in s. 641.3155.  
3741 The payment rate shall be the fee-for-service rate the agency

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3742 would pay the noncontracted provider for such services, unless  
3743 the agency has developed an average rate for the noncontracted  
3744 provider for such services under s. 409.967(3)(c). If the agency  
3745 has developed an average rate for the noncontracted provider for  
3746 such services under s. 409.967(3)(c), the payment rate for such  
3747 services under this paragraph shall be the average rate  
3748 developed by the agency for the noncontracted provider for such  
3749 services under s. 409.967(3)(c).

3750 (h) Surety bond.—A qualified plan shall post and maintain a  
3751 surety bond with the agency, payable to the agency, or in lieu  
3752 of a surety bond, establish and maintain an irrevocable letter  
3753 of credit or a deposit in a trust account in a financial  
3754 institution, payable to the agency.

3755 1. The amount of the surety bond, letter of credit, or  
3756 trust account shall be 125 percent of the estimated annual  
3757 guaranteed savings for each qualified plan, and at least \$2  
3758 million but no more than \$15 million for each qualified plan.  
3759 The estimated guaranteed savings shall be calculated before the  
3760 execution of the contract as follows:

3761 a. The agreed-upon monthly contractual capitated rate for  
3762 each level of acuity multiplied by the estimated population in  
3763 the region for the plan for each level of acuity, multiplied by  
3764 12 months, multiplied by 7 percent, multiplied by 125 percent.

3765 b. The estimated population in the region for the plan  
3766 under sub-subparagraph a. shall be based on the maximum enrollee  
3767 level that the agency initially authorizes. The factors that the  
3768 agency may consider in determining the maximum enrollee level  
3769 include, but are not limited to, requested capacity, projected  
3770 enrollment, network adequacy, and the available budget in the

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3771 General Appropriations Act.

3772 2. The purpose of the surety bond, letter of credit, or  
3773 trust account is to protect the agency if the entity terminates  
3774 its contract with the agency before the scheduled end date for  
3775 the contract, if the plan fails to comply with the terms of the  
3776 contract, including, but not limited to, the timely submission  
3777 of encounter data, if the agency imposes fines or penalties for  
3778 noncompliance, or if the plan fails to achieve the guaranteed  
3779 savings. If any of those events occurs, the agency shall first  
3780 request payment from the qualified plan. If the qualified plan  
3781 does not pay all costs, fines, penalties, or the differential in  
3782 the guaranteed savings in full within 30 days, the agency shall  
3783 pursue a claim against the surety bond, letter of credit, or  
3784 trust account for all applicable moneys and the legal and  
3785 administrative costs associated with pursuing such claim.

3786 (i) Grievance resolution.—Each plan shall establish and the  
3787 agency shall approve an internal process for reviewing and  
3788 responding to grievances from enrollees consistent with s.  
3789 641.511. Each plan shall submit quarterly reports to the agency  
3790 on the number, description, and outcome of grievances filed by  
3791 enrollees.

3792 (j) Solvency.—A qualified plan must meet and maintain the  
3793 surplus and solvency requirements under s. 409.912(17) and (18).  
3794 A provider service network may satisfy the surplus and solvency  
3795 requirements if the network's performance and financial  
3796 obligations are guaranteed in writing by an entity licensed by  
3797 the Office of Insurance Regulation which meets the surplus and  
3798 solvency requirements of s. 624.408 or s. 641.225.

3799 (k) Guaranteed savings.—During the first contract period, a

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3800 qualified plan must agree to provide a guaranteed minimum  
3801 savings of 7 percent to the state. The agency shall conduct a  
3802 cost reconciliation to determine the amount of cost savings  
3803 achieved by the qualified plan compared with the reimbursements  
3804 the agency would have incurred under fee-for-service provisions.

3805 (l) *Costs and penalties.*—Plans that reduce enrollment  
3806 levels or leave a region before the end of the contract term  
3807 must reimburse the agency for the cost of enrollment changes and  
3808 other transition activities. If more than one plan leaves a  
3809 region at the same time, costs shall be shared by the departing  
3810 plans proportionate to their enrollment. In addition to the  
3811 payment of costs, departing plans must pay a penalty of 1  
3812 month's payment calculated as an average of the past 12 months  
3813 of payments, or since inception if the plan has not contracted  
3814 with the agency for 12 months, plus the differential of the  
3815 guaranteed savings based on the original contract term and the  
3816 corresponding termination date. Plans must provide the agency  
3817 with at least 180 days' notice before withdrawing from a region.

3818 (m) *Formulary.*—Upon recommendation of the Medicaid  
3819 Pharmaceutical and Therapeutics Committee as defined in s.  
3820 409.91195, all qualified plans must adopt a standard minimum  
3821 preferred drug list as described in s. 409.912(39). A plan may  
3822 offer additional products on its formulary. Each plan must  
3823 publish an up-to-date listing of its formulary on a publicly  
3824 available website.

3825 (n) *Fiscal intermediary services.*—If a qualified plan  
3826 contracts for fiscal intermediary services as defined in s.  
3827 641.316(1), the plan shall contract only with a fiscal  
3828 intermediary services organization registered with the Office of

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3829 Insurance Regulation as required under s. 641.316(6). All  
3830 noncapitated payments to a health care provider by a fiscal  
3831 intermediary services organization under contract with a  
3832 qualified plan must include an explanation of benefits for which  
3833 payment is being made and include, at a minimum, the enrollee's  
3834 name, the date of service, the procedure code, the amount of  
3835 reimbursement, and the identification of the qualified plan on  
3836 whose behalf the payment is being made.

3837 (3) If the agency terminates more than one regional  
3838 contract with a qualified plan due to the plan's noncompliance  
3839 with one or more requirements of this section, the agency shall  
3840 terminate all regional contracts with the plan under the  
3841 Medicaid managed care program, as well as any other contracts or  
3842 agreements for other programs or services, and the plan may not  
3843 be awarded new contracts for 3 years.

3844 Section 40. Section 409.967, Florida Statutes, is created  
3845 to read:

3846 409.967 Plan accountability.—In addition to the contract  
3847 requirements of s. 409.966, plans and providers participating in  
3848 the Medicaid managed care program must comply with this section.

3849 (1) The agency shall require qualified plans to use a  
3850 uniform method of reporting and accounting for medical, direct  
3851 care management, and nonmedical costs and shall evaluate plan-  
3852 spending patterns after the plan completes 2 full years of  
3853 operation and at least annually thereafter.

3854 (2) The agency shall implement the following thresholds and  
3855 consequences of various spending patterns for qualified plans  
3856 under the managed medical assistance component of the Medicaid  
3857 managed care program:

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3858 (a) The minimum medical loss ratio shall be 90 percent.

3859 (b) A plan and its subcontractors that spend less than 90  
3860 percent of the plan's Medicaid capitation revenue on medical  
3861 services and direct care management, as determined by the  
3862 agency, must pay back to the agency a share of the dollar  
3863 difference between the plan's actual medical loss ratio and the  
3864 minimum medical loss ratio, as follows:

3865 1. If the plan's actual medical loss ratio is not lower  
3866 than 87 percent, the plan must pay back 50 percent of the dollar  
3867 difference between the actual medical loss ratio and the minimum  
3868 medical loss ratio of 90 percent.

3869 2. If the plan's actual medical loss ratio is lower than 87  
3870 percent, the plan must pay back 50 percent of the dollar  
3871 difference between a medical loss ratio of 87 percent and the  
3872 minimum medical loss ratio of 90 percent, plus 100 percent of  
3873 the dollar difference between the actual medical loss ratio and  
3874 a medical loss ratio of 87 percent.

3875 (c) To administer this subsection, the agency shall adopt  
3876 rules that specify a methodology for calculating medical loss  
3877 ratios and the requirements for plans to annually report  
3878 information related to medical loss ratios. Repayments required  
3879 by this subsection must be made annually.

3880 (3) Plans may limit the providers in their networks.

3881 (a) However, during the first year in which a qualified  
3882 plan is operating in a region after the initial plan procurement  
3883 for that region, the plan must offer a network contract to the  
3884 following providers in the region:

3885 1. Federally qualified health centers.

3886 2. Nursing homes if the plan is providing managed long-term

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3887 care services.

3888 3. Aging network service providers that have previously  
3889 participated in home and community-based waivers serving elders,  
3890 or community-service programs administered by the Department of  
3891 Elderly Affairs if the plan is providing managed long-term care  
3892 services.

3893 (b) After 12 months of active participation in a plan's  
3894 network, the plan may exclude any of the providers listed in  
3895 paragraph (a) from the network while maintaining the network  
3896 performance standards required under s. 409.966(2)(b). If the  
3897 plan excludes a nursing home that meets the standards for  
3898 ongoing Medicaid certification, the plan must provide an  
3899 alternative residence in that community for Medicaid recipients  
3900 residing in that nursing home. If a Medicaid recipient residing  
3901 in an excluded nursing home does not choose to change residence,  
3902 the plan must continue to pay for the recipient's care in that  
3903 nursing home. If the plan excludes a provider, the plan must  
3904 provide written notice to all enrollees who have chosen that  
3905 provider for care. Notice to excluded providers must be  
3906 delivered at least 30 days before the effective date of the  
3907 exclusion.

3908 (c) Notwithstanding the limitation provided in this  
3909 subsection, qualified plans must include the following essential  
3910 providers in their networks:

3911 1. Faculty plans of state medical schools, unless the  
3912 medical school and an affiliated teaching hospital owns or  
3913 collaboratively operates a provider service network in the  
3914 region; and

3915 2. Hospitals licensed as a children's specialty hospital as

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3916 defined in s. 395.002.

3917

3918 Qualified plans that have not contracted with all statewide  
3919 essential providers as of the first date of recipient enrollment  
3920 must continue to negotiate in good faith. Payments to a  
3921 nonparticipating essential provider must be equal to the highest  
3922 rate established by contract between that provider and any other  
3923 Medicaid managed care plan.

3924 (d) Qualified plans and providers shall engage in good  
3925 faith negotiations to reach contract terms.

3926 1. If a qualified plan seeks to develop a provider network  
3927 in a county or region that, as of June 30, 2011, does not have a  
3928 capitated managed care plan providing comprehensive acute care  
3929 for Medicaid recipients, and the qualified plan has made at  
3930 least three documented, unsuccessful, good faith attempts to  
3931 contract with a specific provider, the plan may request the  
3932 agency to examine the negotiation process. During the  
3933 examination, the agency shall consider similar counties or  
3934 regions in which qualified plans have contracted with providers  
3935 under similar circumstances, as well as the contracted rates  
3936 between qualified plans and that provider and similar providers  
3937 in the same region. If the agency determines that the plan has  
3938 made three good faith attempts to contract with the provider,  
3939 the agency shall consider that provider to be part of the  
3940 qualified plan's provider network for the purpose of determining  
3941 network adequacy, and the plan shall pay the provider for  
3942 services to Medicaid recipients on a noncontracted basis at a  
3943 rate or rates determined by the agency to be the average of  
3944 rates for corresponding services paid by the qualified plan and



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3945 other qualified plans in the region and in similar counties or  
3946 regions under similar circumstances.

3947 2. The agency may continue to calculate Medicaid hospital  
3948 inpatient per diem rates and outpatient rates. However, these  
3949 rates may not be the basis for contract negotiations between a  
3950 managed care plan and a hospital.

3951 (4) Each qualified plan shall monitor the quality and  
3952 performance of each provider within its network based on metrics  
3953 established by the agency for evaluating and documenting  
3954 provider performance and determining continued participation in  
3955 the network. However, qualified plans are not required to  
3956 conduct surveys of health care facilities that the agency  
3957 surveys periodically for licensure or certification purposes and  
3958 shall accept the results of such surveys. The agency shall  
3959 establish requirements for qualified plans to report, at least  
3960 annually, provider performance data compiled under this  
3961 subsection. If a plan uses additional metrics to evaluate the  
3962 provider's performance and to determine continued participation  
3963 in the network, the plan must notify the network providers of  
3964 these metrics at the beginning of the contract period.

3965 (a) At a minimum, a qualified plan shall hold primary care  
3966 physicians responsible for the following activities:

3967 1. Supervision, coordination, and provision of care to each  
3968 assigned enrollee.

3969 2. Initiation of referrals for medically necessary  
3970 specialty care and other services.

3971 3. Maintaining continuity of care for each assigned  
3972 enrollee.

3973 4. Maintaining the enrollee's medical record, including

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3974 documentation of all medical services provided to the enrollee  
3975 by the primary care physician, as well as any specialty or  
3976 referral services.

3977 (b) Qualified plans shall establish and implement policies  
3978 and procedures to monitor primary care physician activities and  
3979 ensure that primary care physicians are adequately notified and  
3980 receive documentation of specialty and referral services  
3981 provided to enrollees by specialty physicians and other health  
3982 care providers within the plan's provider network.

3983 (5) Each qualified plan shall establish specific programs  
3984 and procedures to improve pregnancy outcomes and infant health,  
3985 including, but not limited to, coordination with the Healthy  
3986 Start program, immunization programs, and referral to the  
3987 Special Supplemental Nutrition Program for Women, Infants, and  
3988 Children, and the Children's Medical Services Program for  
3989 children with special health care needs.

3990 (a) Qualified plans must ensure that primary care  
3991 physicians who provide obstetrical care are available to  
3992 pregnant recipients and that an obstetrical care provider is  
3993 assigned to each pregnant recipient for the duration of her  
3994 pregnancy and postpartum care, by referral of the recipient's  
3995 primary care physician if necessary.

3996 (b) Qualified plans within the managed long-term care  
3997 component are exempt from this subsection.

3998 (6) Each qualified plan shall achieve an annual screening  
3999 rate for early and periodic screening, diagnosis, and treatment  
4000 services of at least 80 percent of those recipients continuously  
4001 enrolled for at least 8 months. Qualified plans within the  
4002 managed long-term care component are exempt from this

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4003 requirement.

4004 (7) Effective January 1, 2013, qualified plans must  
4005 compensate primary care physicians for primary care services at  
4006 payment rates that are equivalent to or greater than payments  
4007 under the federal Medicare program, whether compensation is made  
4008 on a fee-for-service basis or by sub-capitation.

4009 (8) In order to protect the continued operation of the  
4010 Medicaid managed care program, unresolved disputes, including  
4011 claim and other types of disputes, between a qualified plan and  
4012 a provider shall proceed in accordance with s. 408.7057. This  
4013 process may not be used to review or reverse a decision by a  
4014 qualified plan to exclude a provider from its network if the  
4015 decision does not conflict with s. 409.967(3).

4016 Section 41. Section 409.968, Florida Statutes, is created  
4017 to read:

4018 409.968 Plan payment.—Payments for managed medical  
4019 assistance and managed long-term care services under this part  
4020 shall be made in accordance with a capitated managed care model.  
4021 Qualified plans shall receive per-member, per-month payments  
4022 pursuant to the procurements described in s. 409.965 and annual  
4023 adjustments as described in s. 409.966(1). Payment rates must be  
4024 based on the acuity level for each member pursuant to ss.  
4025 409.972 and 409.978, and must encourage plans to use the most  
4026 cost-effective modalities for the treatment of chronic disease,  
4027 such as peritoneal dialysis over hemodialysis if the patient and  
4028 physician choose this form of treatment. Payment rates for  
4029 managed long-term care plans shall be combined with rates for  
4030 managed medical assistance plans.

4031 (1) The agency shall develop a methodology and request a

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4032 waiver that ensures the availability of intergovernmental  
4033 transfers in the Medicaid managed care program to support  
4034 providers that have historically served Medicaid recipients.  
4035 Such providers include, but are not limited to, safety net  
4036 providers, trauma hospitals, children's hospitals, and statutory  
4037 teaching hospitals. The agency may develop a supplemental  
4038 capitation rate, risk pool, or incentive payment for plans that  
4039 contract with these providers. A plan is eligible for a  
4040 supplemental payment only if there are sufficient  
4041 intergovernmental transfers available from allowable sources.

4042 (2) The agency shall evaluate the development of the rate  
4043 cell to accurately reflect the underlying utilization to the  
4044 maximum extent possible. This methodology may include interim  
4045 rate adjustments as permitted under federal regulations. Any  
4046 such methodology must preserve federal funding to these entities  
4047 and be actuarially sound. In the absence of federal approval of  
4048 the methodology, the agency may set an enhanced rate and require  
4049 that plans pay the rate if the agency determines the enhanced  
4050 rate is necessary to ensure access to care by the providers  
4051 described in this subsection.

4052 (3) The amount paid to the plans to make supplemental  
4053 payments or to enhance provider rates pursuant to this  
4054 subsection must be reconciled to the exact amounts the plans are  
4055 required to pay providers. The plans shall make the designated  
4056 payments to providers within 15 business days after notification  
4057 by the agency regarding provider-specific distributions.

4058 (4) The agency shall develop a methodology and request a  
4059 state plan amendment or waiver that ensures the availability of  
4060 certified public expenditures in the Medicaid managed care

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4061 program to support noninstitutional teaching faculty providers  
4062 that have historically served Medicaid recipients. Such  
4063 providers include allopathic and osteopathic physicians employed  
4064 by or under contract with a medical school in this state. The  
4065 agency shall directly make supplemental payments to teaching  
4066 faculty providers or to a statewide entity acting on behalf of  
4067 state medical schools and teaching faculty providers that  
4068 contract with qualified plans and provide care to Medicaid  
4069 recipients in recognition of the costs associated with graduate  
4070 medical education and training, educating medical school  
4071 students, and access to primary and specialty care provided to  
4072 Medicaid recipients. Physicians employed by or under contract  
4073 with a medical school in this state are eligible for a  
4074 supplemental payment only if there are sufficient certified  
4075 public expenditures available from allowable sources. The agency  
4076 shall evaluate the development of teaching faculty provider  
4077 payments for managed care to accurately reflect the historical  
4078 and underlying as well as current and prospective utilization to  
4079 the maximum extent possible. Any such methodology must preserve  
4080 federal funding to these entities.

4081 Section 42. Section 409.969, Florida Statutes, is created  
4082 to read:

4083 409.969 Enrollment; disenrollment; grievance procedure.—

4084 (1) Each Medicaid recipient may choose any available plan  
4085 within the region in which the recipient resides unless that  
4086 plan is a specialty plan for which the recipient does not  
4087 qualify. The agency may not provide or contract for choice  
4088 counseling services for persons enrolling in the Medicaid  
4089 managed care program.

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4090       (2) If a recipient has not made a choice of plans within 30  
4091 days after having been notified to choose a plan, the agency  
4092 shall assign the recipient to a plan in accordance with the  
4093 following:

4094       (a) A recipient who was previously enrolled in a plan  
4095 within the preceding 90 days shall automatically be enrolled in  
4096 the same plan, if available.

4097       (b) Newborns of eligible mothers enrolled in a plan at the  
4098 time of the child's birth shall be enrolled in the mother's  
4099 plan; however, the mother may choose another plan for the  
4100 newborn within 90 days after the child's birth.

4101       (c) If the recipient is diagnosed with HIV/AIDS and resides  
4102 in region 11, region 15, or region 16, the agency shall assign  
4103 the recipient to a plan that:

4104           1. Is a specialty plan under contract with the agency  
4105 pursuant to s. 409.965; and

4106           2. Offers a delivery system through a teaching- and  
4107 research-oriented organization that specializes in providing  
4108 health care services and treatment for individuals diagnosed  
4109 with HIV/AIDS.

4110  
4111       The agency shall assign recipients under this paragraph on an  
4112 even basis among all such plans within a region under contract  
4113 with the agency.

4114       (d) A recipient who is currently receiving Medicare  
4115 services from an entity qualified under 42 C.F.R. part 422 as a  
4116 Medicare Advantage health maintenance organization, Medicare  
4117 Advantage coordinated care plan, Medicare Advantage preferred  
4118 provider organization, Medicare Advantage provider-sponsored

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4119 organization, or Medicare Advantage special needs plan that is  
4120 under contract with the agency shall be assigned to that plan  
4121 for the Medicaid services not covered by Medicare for which the  
4122 recipient is eligible.

4123 (e) Other recipients shall be enrolled into a qualified  
4124 plan in accordance with an auto-assignment enrollment algorithm  
4125 that the agency develops by rule. The algorithm must heavily  
4126 weigh family continuity.

4127 1. Automatic enrollment of recipients in plans must be  
4128 based on the following criteria:

4129 a. Whether the plan has sufficient network capacity to meet  
4130 the needs of recipients.

4131 b. Whether the recipient has previously received services  
4132 from one of the plan's primary care providers.

4133 c. Whether primary care providers in one plan are more  
4134 geographically accessible to the recipient's residence than  
4135 providers in other plans.

4136 d. If a recipient is eligible for long-term care services,  
4137 whether the recipient has previously received services from one  
4138 of the plan's home and community-based service providers.

4139 e. If a recipient is eligible for long-term care services,  
4140 whether the home and community-based providers in one plan are  
4141 more geographically accessible to the recipient's residence than  
4142 providers in other plans.

4143 2. The agency shall automatically enroll recipients in  
4144 plans that meet or exceed the performance or quality standards  
4145 established pursuant to s. 409.967, and may not automatically  
4146 enroll recipients in a plan that is not meeting those standards.  
4147 Except as provided by law or rule, the agency may not engage in

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4148 practices that favor one qualified plan over another.

4149 (3) After a recipient has enrolled in a qualified plan, the  
4150 enrollee shall have 90 days to voluntarily disenroll and select  
4151 another plan. After 90 days, no further changes may be made  
4152 except for good cause. Good cause includes, but is not limited  
4153 to, poor quality of care, lack of access to necessary specialty  
4154 services, an unreasonable delay or denial of service, or  
4155 fraudulent enrollment. The agency shall determine whether good  
4156 cause exists. The agency may require an enrollee to use the  
4157 plan's grievance process before the agency makes a determination  
4158 of good cause, unless an immediate risk of permanent damage to  
4159 the enrollee's health is alleged.

4160 (a) If used, the qualified plan's internal grievance  
4161 process must be completed in time to allow the enrollee to  
4162 disenroll by the first day of the second month after the month  
4163 the disenrollment request was made. If the grievance process  
4164 approves an enrollee's request to disenroll, the agency is not  
4165 required to make a determination of good cause.

4166 (b) The agency must make a determination of good cause and  
4167 take final action on an enrollee's request so that disenrollment  
4168 occurs by the first day of the second month after the month the  
4169 request was made. If the agency fails to act within this  
4170 timeframe, the enrollee's request to disenroll is deemed  
4171 approved as of the date agency action was required. Enrollees  
4172 who disagree with the agency's finding that good cause for  
4173 disenrollment does not exist shall be advised of their right to  
4174 pursue a Medicaid fair hearing to dispute the agency's finding.

4175 (c) Medicaid recipients enrolled in a qualified plan after  
4176 the 90-day period must remain in the plan for the remainder of



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4177 the 12-month period. After 12 months, the enrollee may select  
4178 another plan. However, a recipient who is referred for nursing  
4179 home or assisted living facility services may change plans  
4180 within 30 days after such referral. An enrollee may change  
4181 primary care providers within the plan at any time.

4182 (d) On the first day of the next month after receiving  
4183 notice from a recipient that the recipient has moved to another  
4184 region, the agency shall automatically disenroll the recipient  
4185 from the plan the recipient is currently enrolled in and treat  
4186 the recipient as if the recipient is a new enrollee. At that  
4187 time, the recipient may choose another plan pursuant to the  
4188 enrollment process established in this section.

4189 Section 43. Section 409.970, Florida Statutes, is created  
4190 to read:

4191 409.970 Medicaid Encounter Data System.—The agency shall  
4192 maintain and operate the Medicaid Encounter Data System to  
4193 collect, process, and report on covered services provided to all  
4194 Medicaid recipients enrolled in qualified plans.

4195 (1) Qualified plans shall submit encounter data  
4196 electronically in a format that complies with provisions of the  
4197 federal Health Insurance Portability and Accountability Act for  
4198 electronic claims and in accordance with deadlines established  
4199 by the agency. Plans must certify that the data reported is  
4200 accurate and complete. The agency is responsible for validating  
4201 the data submitted by the plans.

4202 (2) The agency shall develop methods and protocols for  
4203 ongoing analysis of the encounter data, which must adjust for  
4204 differences in the characteristics of enrollees in order to  
4205 allow for the comparison of service utilization among plans. The

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4206 analysis shall be used to identify possible cases of systemic  
4207 overutilization, underutilization, inappropriate denials of  
4208 claims, and inappropriate utilization of covered services, such  
4209 as higher than expected emergency department and pharmacy  
4210 encounters. One of the primary focus areas for the analysis  
4211 shall be the use of prescription drugs.

4212 (3) The agency shall provide periodic feedback to the plans  
4213 based on the analysis and establish corrective action plans if  
4214 necessary.

4215 (4) The agency shall make encounter data available to plans  
4216 accepting enrollees who are reassigned to them from other plans  
4217 leaving a region.

4218 (5) Beginning July 1, 2011, the agency shall conduct  
4219 appropriate tests and establish specific criteria for  
4220 determining whether the Medicaid Encounter Data System has  
4221 valid, complete, and sound data for a sufficient period of time  
4222 to provide qualified plans with a reliable basis for determining  
4223 and proposing actuarially sound payment rates.

4224 Section 44. Section 409.971, Florida Statutes, is created  
4225 to read:

4226 409.971 Managed care medical assistance.—Pursuant to s.  
4227 409.902, the agency shall administer the managed care medical  
4228 assistance component of the Medicaid managed care program  
4229 described in this section and s. 409.972. Unless otherwise  
4230 specified, the provisions of ss. 409.961-409.970 apply to the  
4231 provision of managed care medical assistance. By December 31,  
4232 2011, the agency shall begin implementation of managed care  
4233 medical assistance, and full implementation in all regions must  
4234 be completed by December 31, 2012.

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4235 Section 45. Section 409.972, Florida Statutes, is created  
4236 to read:

4237 409.972 Managed care medical assistance services.—

4238 (1) Qualified plans providing managed care medical  
4239 assistance must, at a minimum, cover the following services:

4240 (a) Ambulatory patient services.

4241 (b) Dental services for a recipient who is under age 21.

4242 (c) Dental services as provided in s. 627.419(7) for a  
4243 recipient who is 21 years of age or older.

4244 (d) Dialysis services.

4245 (e) Durable medical equipment and supplies.

4246 (f) Early periodic screening diagnosis and treatment  
4247 services, hearing services and hearing aids, and vision services  
4248 and eyeglasses for enrollees under age 21.

4249 (g) Emergency services.

4250 (h) Family planning services. Pursuant to 42 C.F.R. s.  
4251 438.102, plans may elect to not provide this service due to an  
4252 objection on moral or religious grounds, and must notify the  
4253 agency of that election when submitting a reply to the  
4254 invitation to negotiate pursuant to s. 409.963.

4255 (i) Hearing services for a recipient who is under age 21.

4256 (j) Hearing services that are medically indicated for a  
4257 recipient who is 21 years of age or older.

4258 (k) Home health services.

4259 (l) Hospital inpatient services.

4260 (m) Hospital outpatient services.

4261 (n) Laboratory and imaging services.

4262 (o) Maternity and newborn care and birth center services.

4263 (p) Mental health services, substance abuse disorder

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4264 services, and behavioral health treatment.

4265 (q) Prescription drugs.

4266 (r) Primary care service, referred specialty care services,  
4267 preventive services, and wellness services.

4268 (s) Skilled nursing facility or inpatient rehabilitation  
4269 facility services.

4270 (t) Transplant services.

4271 (u) Transportation to access covered services.

4272 (v) Vision services for a recipient who is under age 21.

4273 (w) Vision services that are medically indicated for a  
4274 recipient who is 21 years of age or older.

4275 (2) Subject to specific appropriations, the agency may make  
4276 payments for services that are optional.

4277 (3) Qualified plans may customize benefit packages for  
4278 nonpregnant adults, vary cost-sharing provisions, and provide  
4279 coverage for additional services. The agency shall evaluate the  
4280 proposed benefit packages to ensure that services are sufficient  
4281 to meet the needs of the plans' enrollees and to verify  
4282 actuarial equivalence.

4283 (4) For Medicaid recipients diagnosed with hemophilia who  
4284 have been prescribed anti-hemophilic-factor replacement  
4285 products, the agency shall provide for those products and  
4286 hemophilia overlay services through the agency's hemophilia  
4287 disease management program authorized under s. 409.912.

4288 (5) Managed care medical assistance services provided under  
4289 this section must be medically necessary and provided in  
4290 accordance with state and federal law. This section does not  
4291 prevent the agency from adjusting fees, reimbursement rates,  
4292 lengths of stay, number of visits, or number of services, or

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4293 from making any other adjustments necessary to comply with the  
4294 availability of funding and any limitations or directions  
4295 provided in the General Appropriations Act, chapter 216, or s.  
4296 409.9022.

4297 Section 46. Section 409.973, Florida Statutes, is created  
4298 to read:

4299 409.973 Managed long-term care.—

4300 (1) Qualified plans providing managed care medical  
4301 assistance may also participate in the managed long-term care  
4302 component of the Medicaid managed care program. Unless otherwise  
4303 specified, the provisions of ss. 409.961-409.970 apply to the  
4304 managed long-term care component of the managed care program.

4305 (2) Pursuant to s. 409.902, the agency shall administer the  
4306 managed long-term care component described in this section and  
4307 ss. 409.974-409.978, but may delegate specific duties and  
4308 responsibilities to the Department of Elderly Affairs and other  
4309 state agencies. By March 31, 2012, the agency shall begin  
4310 implementation of the managed long-term care component, with  
4311 full implementation in all regions by March 31, 2013.

4312 (3) The Department of Elderly Affairs shall assist the  
4313 agency in developing specifications for use in the invitation to  
4314 negotiate and the model contract, determining clinical  
4315 eligibility for enrollment in managed long-term care plans,  
4316 monitoring plan performance and measuring quality of service  
4317 delivery, assisting clients and families in order to address  
4318 complaints with the plans, facilitating working relationships  
4319 between plans and providers serving elders and disabled adults,  
4320 and performing other functions specified in a memorandum of  
4321 agreement.

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4322 Section 47. Section 409.974, Florida Statutes, is created  
4323 to read:

4324 409.974 Recipient eligibility for managed long-term care.-

4325 (1) Medicaid recipients shall receive covered long-term  
4326 care services through the managed long-term care component of  
4327 the Medicaid managed care program unless excluded pursuant to s.  
4328 409.964. In order to participate in the managed long-term care  
4329 component, the recipient must be:

4330 (a) Sixty-five years of age or older or eligible for  
4331 Medicaid by reason of a disability; and

4332 (b) Determined by the Comprehensive Assessment and Review  
4333 for Long-Term Care Services (CARES) Program to meet the criteria  
4334 for nursing facility care.

4335 (2) Medicaid recipients who are enrolled in one of the  
4336 following Medicaid long-term care waiver programs on the date  
4337 that a managed long-term care plan becomes available in the  
4338 recipient's region may remain in that program if it is  
4339 operational on that date:

4340 (a) The Assisted Living for the Frail Elderly Waiver.

4341 (b) The Aged and Disabled Adult Waiver.

4342 (c) The Adult Day Health Care Waiver.

4343 (d) The Consumer-Directed Care Program as described in s.  
4344 409.221.

4345 (e) The Program of All-inclusive Care for the Elderly.

4346 (f) The Long-Term Care Community Diversion Pilot Project as  
4347 described in s. 430.705.

4348 (g) The Channeling Services Waiver for Frail Elders.

4349 (3) If a long-term care waiver program in which the  
4350 recipient is enrolled ceases to operate, the Medicaid recipient

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4351 may transfer to another long-term care waiver program or to the  
4352 Medicaid managed long-term care component of the Medicaid  
4353 managed care program. If no waivers are operational in the  
4354 recipient's region and the recipient continues to participate in  
4355 Medicaid, the recipient must transfer to the managed long-term  
4356 care component of the Medicaid managed care program.

4357 (4) New enrollment in a waiver program ends on the date  
4358 that a managed long-term care plan becomes available in a  
4359 region.

4360 (5) Medicaid recipients who are residing in a nursing home  
4361 facility on the date that a managed long-term care plan becomes  
4362 available in the recipient's region are eligible for the long-  
4363 term care Medicaid waiver programs.

4364 (6) This section does not create an entitlement to any home  
4365 and community-based services provided under the managed long-  
4366 term care component.

4367 Section 48. Section 409.975, Florida Statutes, is created  
4368 to read:

4369 409.975 Managed long-term care services.—

4370 (1) Qualified plans participating in the managed long-term  
4371 care component of the Medicaid managed care program, at a  
4372 minimum, shall cover the following services:

4373 (a) The services listed in s. 409.972.

4374 (b) Nursing facility services.

4375 (c) Home and community-based services, including, but not  
4376 limited to, assisted living facility services.

4377 (2) Services provided under this section must be medically  
4378 necessary and provided in accordance with state and federal law.

4379 This section does not prevent the agency from adjusting fees,

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4380 reimbursement rates, lengths of stay, number of visits, or  
4381 number of services, or from making any other adjustments  
4382 necessary to comply with the availability of funding and any  
4383 limitations or directions provided in the General Appropriations  
4384 Act, chapter 216, or s. 409.9022.

4385 Section 49. Section 409.976, Florida Statutes, is created  
4386 to read:

4387 409.976 Qualified managed long-term care plans.-

4388 (1) For purposes of managed long-term care, qualified plans  
4389 also include:

4390 (a) Entities who are qualified under 42 C.F.R. part 422 as  
4391 Medicare Advantage Preferred Provider Organizations, Medicare  
4392 Advantage Provider-sponsored Organizations, and Medicare  
4393 Advantage Special Needs Plans. Such plans may participate in the  
4394 managed long-term care component. A plan submitting a response  
4395 to the invitation to negotiate for the managed long-term care  
4396 component may reference one or more of these entities as part of  
4397 its demonstration of network adequacy for the provision of  
4398 services required under s. 409.972 for dually eligible  
4399 enrollees.

4400 (b) The Program of All-inclusive Care for the Elderly  
4401 (PACE). Participation by PACE shall be pursuant to a contract  
4402 with the agency and is not subject to the procurement  
4403 requirements of this section. PACE plans may continue to provide  
4404 services to recipients at such levels and enrollment caps as  
4405 authorized by the General Appropriations Act.

4406 (c) Provider service networks formed by community care for  
4407 the elderly lead agencies. Participation by such networks must  
4408 be pursuant to a contract with the agency and is not subject to



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4409 the procurement requirements of this section.

4410 (2) The agency shall select qualified plans through the  
4411 procurement described in s. 409.965. The agency shall notice the  
4412 invitation to negotiate by November 14, 2011.

4413 (3) In addition to the criteria established in s. 409.965,  
4414 the agency shall give preference to the following factors in  
4415 selecting qualified plans:

4416 (a) The plan's employment of executive managers having  
4417 expertise and experience in serving aged and disabled persons  
4418 who require long-term care.

4419 (b) The plan's establishment of a network of service  
4420 providers dispersed throughout the region and in sufficient  
4421 numbers to meet specific service standards established by the  
4422 agency for a continuum of care, beginning from the provision of  
4423 assistance with the activities of daily living at a recipient's  
4424 home and the provision of other home and community-based care  
4425 through the provision of nursing home care. These providers  
4426 include:

- 4427 1. Adult day centers.
- 4428 2. Adult family care homes.
- 4429 3. Assisted living facilities.
- 4430 4. Health care services pools.
- 4431 5. Home health agencies.
- 4432 6. Homemaker and companion services.
- 4433 7. Community Care for the Elderly lead agencies.
- 4434 8. Nurse registries.
- 4435 9. Nursing homes.

4436

4437 All providers are not required to be located within the region;

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4438 however, the provider network must be sufficient to ensure that  
4439 services are available throughout the region.

4440 (c) Whether a plan offers consumer-directed care services  
4441 to enrollees pursuant to s. 409.221 or includes attendant care  
4442 or paid family caregivers in the benefit package. Consumer-  
4443 directed care services must provide a flexible budget, which is  
4444 managed by enrollees and their families or representatives, and  
4445 allows them to choose service providers, determine provider  
4446 rates of payment, and direct the delivery of services to best  
4447 meet their special long-term care needs. If all other factors  
4448 are equal among competing qualified plans, the agency shall give  
4449 preference to such plans.

4450 (d) Evidence that a qualified plan has written agreements  
4451 or signed contracts or has made substantial progress in  
4452 establishing relationships with providers before the plan  
4453 submits a response.

4454 (e) The availability and accessibility of case managers in  
4455 the plan and provider network.

4456 Section 50. Section 409.977, Florida Statutes, is created  
4457 to read:

4458 409.977 Managed long-term plan and provider  
4459 accountability.—In addition to the requirements of ss. 409.966  
4460 and 409.967, plans and providers participating in managed long-  
4461 term care must comply with s. 641.31(25) and with the specific  
4462 standards established by the agency for the number, type, and  
4463 regional distribution of the following providers in the plan's  
4464 network, which must include:

4465 (1) Adult day centers.

4466 (2) Adult family care homes.

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- 4467       (3) Assisted living facilities.  
4468       (4) Health care services pools.  
4469       (5) Home health agencies.  
4470       (6) Homemaker and companion services.  
4471       (7) Community Care for the Elderly lead agencies.  
4472       (8) Nurse registries.  
4473       (9) Nursing homes.

4474       Section 51. Section 409.978, Florida Statutes, is created  
4475 to read:

4476       409.978 CARES program screening; levels of care.—

4477       (1) The agency shall operate the Comprehensive Assessment  
4478 and Review for Long-Term Care Services (CARES) preadmission  
4479 screening program to ensure that only recipients whose  
4480 conditions require long-term care services are enrolled in  
4481 managed long-term care plans.

4482       (2) The agency shall operate the CARES program through an  
4483 interagency agreement with the Department of Elderly Affairs.  
4484 The agency, in consultation with the department, may contract  
4485 for any function or activity of the CARES program, including any  
4486 function or activity required by 42 C.F.R. part 483.20, relating  
4487 to preadmission screening and review.

4488       (3) The CARES program shall determine if a recipient  
4489 requires nursing facility care and, if so, assign the recipient  
4490 to one of the following levels of care:

4491       (a) Level of care 1 consists of enrollees who require the  
4492 constant availability of routine medical and nursing treatment  
4493 and care, have a limited need for health-related care and  
4494 services, are mildly medically or physically incapacitated, and  
4495 cannot be managed at home due to inadequacy of home-based

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4496 services.

4497 (b) Level of care 2 consists of enrollees who require the  
4498 constant availability of routine medical and nursing treatment  
4499 and care, and require extensive health-related care and services  
4500 because of mental or physical incapacitation. Current enrollees  
4501 in home and community-based waiver programs for persons who are  
4502 elderly or adults with physical disability, or both, who remain  
4503 financially eligible for Medicaid are not required to meet new  
4504 level-of-care criteria except for immediate placement in a  
4505 nursing home.

4506 (c) Level of care 3 consists of enrollees residing in  
4507 nursing homes, or needing immediate placement in a nursing home,  
4508 and who have a priority score of 5 or above as determined by  
4509 CARES.

4510 (4) For recipients whose nursing home stay is initially  
4511 funded by Medicare and Medicare coverage is being terminated for  
4512 lack of progress towards rehabilitation, CARES staff shall  
4513 consult with the person determining the recipient's progress  
4514 toward rehabilitation in order to ensure that the recipient is  
4515 not being inappropriately disqualified from Medicare coverage.  
4516 If, in their professional judgment, CARES staff believes that a  
4517 Medicare beneficiary is still making progress, they may assist  
4518 the Medicare beneficiary with appealing the disqualification  
4519 from Medicare coverage. The CARES teams may review Medicare  
4520 denials for coverage under this section only if it is determined  
4521 that such reviews qualify for federal matching funds through  
4522 Medicaid. The agency shall seek or amend federal waivers as  
4523 necessary to implement this section.

4524 Section 52. Section 409.980, Florida Statutes, is created

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4525 to read:

4526 409.980 Prescribed drug services for qualified plans.—The  
4527 agency shall ensure that a qualified plan has transparency and  
4528 patient protections in its prescription drug benefit. The  
4529 qualified plan must, at a minimum:

4530 (1) Include at least two products, when available, in each  
4531 therapeutic class.

4532 (2) Make available those drugs and dosage forms listed in  
4533 its preferred drug list.

4534 (3) Ensure that the prior-authorization process is readily  
4535 available to health care providers, including posting  
4536 appropriate contact information on its website and providing  
4537 timely responses to providers.

4538 (4) Not arbitrarily deny or reduce the amount, duration, or  
4539 scope of prescriptions based solely on the enrollee's diagnosis,  
4540 type of illness, or condition. The qualified plan may place  
4541 appropriate limits on prescriptions based on criteria such as  
4542 medical necessity, or for the purpose of utilization control, if  
4543 the plan reasonably expects such limits to achieve the purpose  
4544 of the prescribed drug services set forth in the Medicaid state  
4545 plan.

4546 (5) Make available those drugs not on its preferred drug  
4547 list, when requested and approved, if drugs on the list have  
4548 been used in a step therapy sequence or if other medical  
4549 documentation is provided.

4550 (6) Cover the cost of a brand name drug if the prescriber  
4551 writes in his or her own handwriting on the prescription that  
4552 the brand name drug is medically necessary and submits a  
4553 completed multisource drug and miscellaneous prior authorization

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4554 form to the qualified plan indicating that the enrollee has had  
4555 an adverse reaction to a generic drug or has had, in the  
4556 prescriber's medical opinion, better results when taking the  
4557 brand name drug.

4558 (7) Ensure that antiretroviral agents are not subject to  
4559 the preferred drug list.

4560 Section 53. Section 409.91207, Florida Statutes, is  
4561 transferred, renumbered as section 409.985, Florida Statutes,  
4562 and subsection (1) of that section is amended to read:

4563 409.985 ~~409.91207~~ Medical home pilot project.—

4564 (1) The agency shall develop a plan to implement a medical  
4565 home pilot project that uses ~~utilizes~~ primary care case  
4566 management enhanced by medical home networks to provide  
4567 coordinated and cost-effective care that is reimbursed on a fee-  
4568 for-service basis and to compare the performance of the medical  
4569 home networks with other existing Medicaid managed care models.  
4570 The agency may ~~is authorized to~~ seek a federal Medicaid waiver  
4571 or an amendment to any existing Medicaid waiver, except for the  
4572 current 1115 Medicaid waiver authorized in s. 409.986 ~~409.91211~~,  
4573 as needed, to develop the pilot project created in this section  
4574 but must obtain approval of the Legislature before ~~prior to~~  
4575 implementing the pilot project.

4576 Section 54. Section 409.91211, Florida Statutes, is  
4577 transferred, renumbered as section 409.986, Florida Statutes,  
4578 and paragraph (aa) of subsection (3) and paragraph (a) of  
4579 subsection (4) of that section are amended, to read:

4580 409.986 ~~409.91211~~ Medicaid managed care pilot program.—

4581 (3) The agency shall have the following powers, duties, and  
4582 responsibilities with respect to the pilot program:

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4583 (aa) To implement a mechanism whereby Medicaid recipients  
4584 who are already enrolled in a managed care plan or the MediPass  
4585 program in the pilot areas are ~~shall be~~ offered the opportunity  
4586 to change to capitated managed care plans on a staggered basis,  
4587 as defined by the agency. All Medicaid recipients shall have 30  
4588 days in which to make a choice of capitated managed care plans.  
4589 Those Medicaid recipients who do not make a choice shall be  
4590 assigned to a capitated managed care plan in accordance with  
4591 paragraph (4) (a) and shall be exempt from s. 409.987 ~~409.9122~~.  
4592 To facilitate continuity of care for a Medicaid recipient who is  
4593 also a recipient of Supplemental Security Income (SSI), prior to  
4594 assigning the SSI recipient to a capitated managed care plan,  
4595 the agency shall determine whether the SSI recipient has an  
4596 ongoing relationship with a provider or capitated managed care  
4597 plan, and, if so, the agency shall assign the SSI recipient to  
4598 that provider or capitated managed care plan where feasible.  
4599 Those SSI recipients who do not have such a provider  
4600 relationship shall be assigned to a capitated managed care plan  
4601 provider in accordance with paragraph (4) (a) and shall be exempt  
4602 from s. 409.987 ~~409.9122~~.

4603 (4) (a) A Medicaid recipient in the pilot area who is not  
4604 currently enrolled in a capitated managed care plan upon  
4605 implementation is not eligible for services as specified in ss.  
4606 409.905 and 409.906, for the amount of time that the recipient  
4607 does not enroll in a capitated managed care network. If a  
4608 Medicaid recipient has not enrolled in a capitated managed care  
4609 plan within 30 days after eligibility, the agency shall assign  
4610 the Medicaid recipient to a capitated managed care plan based on  
4611 the assessed needs of the recipient as determined by the agency

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4612 and the recipient shall be exempt from s. 409.987 ~~409.9122~~. When  
4613 making assignments, the agency shall take into account the  
4614 following criteria:

4615 1. A capitated managed care network has sufficient network  
4616 capacity to meet the needs of members.

4617 2. The capitated managed care network has previously  
4618 enrolled the recipient as a member, or one of the capitated  
4619 managed care network's primary care providers has previously  
4620 provided health care to the recipient.

4621 3. The agency has knowledge that the member has previously  
4622 expressed a preference for a particular capitated managed care  
4623 network as indicated by Medicaid fee-for-service claims data,  
4624 but has failed to make a choice.

4625 4. The capitated managed care network's primary care  
4626 providers are geographically accessible to the recipient's  
4627 residence.

4628 Section 55. Section 409.9122, Florida Statutes, is  
4629 transferred, renumbered as section 409.987, and paragraph (a) of  
4630 subsection (2) of that section is amended to read:

4631 409.987 ~~409.9122~~ Mandatory Medicaid managed care  
4632 enrollment; programs and procedures.-

4633 (2) (a) The agency shall enroll all Medicaid recipients in a  
4634 managed care plan or MediPass ~~all Medicaid recipients~~, except  
4635 ~~those Medicaid recipients who are~~ in an institution, receiving  
4636 a Medicaid nonpoverty medical subsidy, ~~enrolled in the Medicaid~~  
4637 ~~medically needy Program,~~ or eligible for both Medicaid and  
4638 Medicare. Upon enrollment, recipients may ~~individuals will be~~  
4639 ~~able to~~ change their managed care option during the 90-day opt  
4640 out period required by federal Medicaid regulations. The agency



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4641 ~~may is authorized to~~ seek the necessary Medicaid state plan  
4642 amendment to implement this policy. ~~However, to the extent~~

4643 1. If permitted by federal law, the agency may enroll ~~in a~~  
4644 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt  
4645 from mandatory managed care enrollment in a managed care plan or  
4646 MediPass if, provided that:

4647 a.1. ~~The~~ recipient's decision to enroll in a managed care  
4648 plan or MediPass is voluntary;

4649 b.2. ~~If~~ The recipient chooses to enroll in a managed care  
4650 plan, the agency has determined that the ~~managed care~~ plan  
4651 provides specific programs and services that ~~which~~ address the  
4652 special health needs of the recipient; and

4653 c.3. The agency receives the ~~any~~ necessary waivers from the  
4654 federal Centers for Medicare and Medicaid Services.

4655 2. The agency shall develop rules to establish policies by  
4656 which exceptions to the mandatory managed care enrollment  
4657 requirement may be made on a case-by-case basis. The rules must  
4658 ~~shall~~ include the specific criteria to be applied when  
4659 determining ~~making a determination as to~~ whether to exempt a  
4660 recipient from mandatory enrollment ~~in a managed care plan or~~  
4661 ~~MediPass~~.

4662 3. School districts participating in the certified school  
4663 match program pursuant to ss. 409.908(21) and 1011.70 shall be  
4664 reimbursed by Medicaid, subject to the limitations of s.  
4665 1011.70(1), for a Medicaid-eligible child participating in the  
4666 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.  
4667 409.9071, regardless of whether the child is enrolled in  
4668 MediPass or a managed care plan. Managed care plans must ~~shall~~  
4669 make a good faith effort to execute agreements with school

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4670 districts regarding the coordinated provision of services  
4671 authorized under s. 1011.70.

4672 4. County health departments delivering school-based  
4673 services pursuant to ss. 381.0056 and 381.0057 shall be  
4674 reimbursed by Medicaid for the federal share for a Medicaid-  
4675 eligible child who receives Medicaid-covered services in a  
4676 school setting, regardless of whether the child is enrolled in  
4677 MediPass or a managed care plan. Managed care plans shall make a  
4678 good faith effort to execute agreements with county health  
4679 departments that coordinate the ~~regarding the coordinated~~  
4680 provision of services to a Medicaid-eligible child. To ensure  
4681 continuity of care for Medicaid patients, the agency, the  
4682 Department of Health, and the Department of Education shall  
4683 develop procedures for ensuring that a student's managed care  
4684 plan or MediPass provider receives information relating to  
4685 services provided in accordance with ss. 381.0056, 381.0057,  
4686 409.9071, and 1011.70.

4687 Section 56. Section 409.9123, Florida Statutes, is  
4688 transferred and renumbered as section 409.988, Florida Statutes.

4689 Section 57. Section 409.9124, Florida Statutes, is  
4690 transferred and renumbered as section 409.989.

4691 Section 58. Subsection (15) of section 430.04, Florida  
4692 Statutes, is amended to read:

4693 430.04 Duties and responsibilities of the Department of  
4694 Elderly Affairs.—The Department of Elderly Affairs shall:

4695 (15) Administer all Medicaid waivers and programs relating  
4696 to elders and their appropriations. The waivers include, but are  
4697 not limited to:

4698 ~~(a) The Alzheimer's Dementia-Specific Medicaid Waiver as~~

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4699 established in ~~s. 430.502(7), (8), and (9)~~.

4700 ~~(a)(b)~~ The Assisted Living for the Frail Elderly Waiver.

4701 ~~(b)(c)~~ The Aged and Disabled Adult Waiver.

4702 ~~(c)(d)~~ The Adult Day Health Care Waiver.

4703 ~~(d)(e)~~ The Consumer-Directed Care Plus Program as defined  
4704 in s. 409.221.

4705 ~~(e)(f)~~ The Program of All-inclusive Care for the Elderly.

4706 ~~(f)(g)~~ The Long-Term Care Community-Based Diversion Pilot  
4707 Project as described in s. 430.705.

4708 ~~(g)(h)~~ The Channeling Services Waiver for Frail Elders.

4709

4710 The department shall develop a transition plan for recipients  
4711 receiving services under long-term care Medicaid waivers for  
4712 elders or disabled adults on the date qualified plans become  
4713 available in each recipient's region pursuant to s. 409.973(2)  
4714 in order to enroll those recipients in qualified plans.

4715 Section 59. Section 430.2053, Florida Statutes, is amended  
4716 to read:

4717 430.2053 Aging resource centers.—

4718 (1) The department, in consultation with the Agency for  
4719 Health Care Administration and the Department of Children and  
4720 Family Services, shall develop pilot projects for aging resource  
4721 centers. ~~By October 31, 2004, the department, in consultation~~  
4722 ~~with the agency and the Department of Children and Family~~  
4723 ~~Services, shall develop an implementation plan for aging~~  
4724 ~~resource centers and submit the plan to the Governor, the~~  
4725 ~~President of the Senate, and the Speaker of the House of~~  
4726 ~~Representatives. The plan must include qualifications for~~  
4727 ~~designation as a center, the functions to be performed by each~~

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4728 center, and a process for determining that a current area agency  
4729 on aging is ready to assume the functions of an aging resource  
4730 center.

4731 (2) Each area agency on aging shall develop, in  
4732 consultation with the existing community care for the elderly  
4733 lead agencies within their planning and service areas, a  
4734 proposal that describes the process the area agency on aging  
4735 intends to undertake to transition to an aging resource center  
4736 prior to July 1, 2005, and that describes the area agency's  
4737 compliance with the requirements of this section. The proposals  
4738 must be submitted to the department prior to December 31, 2004.  
4739 The department shall evaluate all proposals for readiness and,  
4740 prior to March 1, 2005, shall select three area agencies on  
4741 aging which meet the requirements of this section to begin the  
4742 transition to aging resource centers. Those area agencies on  
4743 aging which are not selected to begin the transition to aging  
4744 resource centers shall, in consultation with the department and  
4745 the existing community care for the elderly lead agencies within  
4746 their planning and service areas, amend their proposals as  
4747 necessary and resubmit them to the department prior to July 1,  
4748 2005. The department may transition additional area agencies to  
4749 aging resource centers as it determines that area agencies are  
4750 in compliance with the requirements of this section.

4751 (3) The Auditor General and the Office of Program Policy  
4752 Analysis and Government Accountability (OPPAGA) shall jointly  
4753 review and assess the department's process for determining an  
4754 area agency's readiness to transition to an aging resource  
4755 center.

4756 (a) The review must, at a minimum, address the

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4757 ~~appropriateness of the department's criteria for selection of an~~  
4758 ~~area agency to transition to an aging resource center, the~~  
4759 ~~instruments applied, the degree to which the department~~  
4760 ~~accurately determined each area agency's compliance with the~~  
4761 ~~readiness criteria, the quality of the technical assistance~~  
4762 ~~provided by the department to an area agency in correcting any~~  
4763 ~~weaknesses identified in the readiness assessment, and the~~  
4764 ~~degree to which each area agency overcame any identified~~  
4765 ~~weaknesses.~~

4766 ~~(b) Reports of these reviews must be submitted to the~~  
4767 ~~appropriate substantive and appropriations committees in the~~  
4768 ~~Senate and the House of Representatives on March 1 and September~~  
4769 ~~1 of each year until full transition to aging resource centers~~  
4770 ~~has been accomplished statewide, except that the first report~~  
4771 ~~must be submitted by February 1, 2005, and must address all~~  
4772 ~~readiness activities undertaken through December 31, 2004. The~~  
4773 ~~perspectives of all participants in this review process must be~~  
4774 ~~included in each report.~~

4775 ~~(2)(4)~~ The purposes of an aging resource center ~~are shall~~  
4776 ~~be:~~

4777 (a) To provide Florida's elders and their families with a  
4778 locally focused, coordinated approach to integrating information  
4779 and referral for all available services for elders with the  
4780 eligibility determination entities for state and federally  
4781 funded long-term-care services.

4782 (b) To provide for easier access to long-term-care services  
4783 by Florida's elders and their families by creating multiple  
4784 access points to the long-term-care network that flow through  
4785 one established entity with wide community recognition.

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4786        (3)~~(5)~~ The duties of an aging resource center are to:

4787            (a) Develop referral agreements with local community  
4788 service organizations, such as senior centers, existing elder  
4789 service providers, volunteer associations, and other similar  
4790 organizations, to better assist clients who do not need or do  
4791 not wish to enroll in programs funded by the department or the  
4792 agency. The referral agreements must also include a protocol,  
4793 developed and approved by the department, which provides  
4794 specific actions that an aging resource center and local  
4795 community service organizations must take when an elder or an  
4796 elder's representative seeking information on long-term-care  
4797 services contacts a local community service organization prior  
4798 to contacting the aging resource center. The protocol shall be  
4799 designed to ensure that elders and their families are able to  
4800 access information and services in the most efficient and least  
4801 cumbersome manner possible.

4802            (b) Provide an initial screening of all clients who request  
4803 long-term-care services to determine whether the person would be  
4804 most appropriately served through any combination of federally  
4805 funded programs, state-funded programs, locally funded or  
4806 community volunteer programs, or private funding for services.

4807            (c) Determine eligibility for the programs and services  
4808 listed in subsection (9) ~~(11)~~ for persons residing within the  
4809 geographic area served by the aging resource center and  
4810 determine a priority ranking for services which is based upon  
4811 the potential recipient's frailty level and likelihood of  
4812 institutional placement without such services.

4813            (d) Manage the availability of financial resources for the  
4814 programs and services listed in subsection (9) ~~(11)~~ for persons

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4815 residing within the geographic area served by the aging resource  
4816 center.

4817 (e) If ~~When~~ financial resources become available, refer a  
4818 client to the most appropriate entity to begin receiving  
4819 services. The aging resource center shall make referrals to lead  
4820 agencies for service provision that ensure that individuals who  
4821 are vulnerable adults in need of services pursuant to s.  
4822 415.104(3)(b), or who are victims of abuse, neglect, or  
4823 exploitation in need of immediate services to prevent further  
4824 harm and are referred by the adult protective services program,  
4825 are given primary consideration for receiving community-care-  
4826 for-the-elderly services in compliance with the requirements of  
4827 s. 430.205(5)(a) and that other referrals for services are in  
4828 compliance with s. 430.205(5)(b).

4829 (f) Convene a work group to advise in the planning,  
4830 implementation, and evaluation of the aging resource center. The  
4831 work group shall be composed ~~comprised~~ of representatives of  
4832 local service providers, Alzheimer's Association chapters,  
4833 housing authorities, social service organizations, advocacy  
4834 groups, representatives of clients receiving services through  
4835 the aging resource center, and ~~any~~ other persons or groups as  
4836 determined by the department. The aging resource center, in  
4837 consultation with the work group, must develop annual program  
4838 improvement plans that shall be submitted to the department for  
4839 consideration. The department shall review each annual  
4840 improvement plan and make recommendations on how to implement  
4841 the components of the plan.

4842 (g) Enhance the existing area agency on aging in each  
4843 planning and service area by integrating, ~~either~~ physically or

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4844 virtually, the staff and services of the area agency on aging  
4845 with the staff of the department's local CARES Medicaid ~~nursing~~  
4846 ~~home~~ preadmission screening unit and a sufficient number of  
4847 staff from the Department of Children and Family Services'  
4848 Economic Self-Sufficiency Unit necessary to determine the  
4849 financial eligibility for all persons age 60 and older residing  
4850 within the area served by the aging resource center who ~~that~~ are  
4851 seeking Medicaid services, Supplemental Security Income, and  
4852 food assistance.

4853 (h) Assist clients who request long-term care services in  
4854 being evaluated for eligibility for the long-term care managed  
4855 care component of the Medicaid managed care program as qualified  
4856 plans become available in each of the regions pursuant to s.  
4857 409.973(2).

4858 (i) Provide enrollment and coverage information to Medicaid  
4859 managed long-term care enrollees as qualified plans become  
4860 available in each of the regions pursuant to s. 409.973(2).

4861 (j) Assist enrollees in the Medicaid long-term care managed  
4862 care program with informally resolving grievances with a managed  
4863 care network and in accessing the managed care network's formal  
4864 grievance process as qualified plans become available in each of  
4865 the regions pursuant to s. 409.973(2).

4866 (4) ~~(6)~~ The department shall select the entities to become  
4867 aging resource centers based on each entity's readiness and  
4868 ability to perform the duties listed in subsection (3) ~~(5)~~ and  
4869 the entity's:

4870 (a) Expertise in the needs of each target population the  
4871 center proposes to serve and a thorough knowledge of the  
4872 providers that serve these populations.



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4873 (b) Strong connections to service providers, volunteer  
4874 agencies, and community institutions.

4875 (c) Expertise in information and referral activities.

4876 (d) Knowledge of long-term-care resources, including  
4877 resources designed to provide services in the least restrictive  
4878 setting.

4879 (e) Financial solvency and stability.

4880 (f) Ability to collect, monitor, and analyze data in a  
4881 timely and accurate manner, along with systems that meet the  
4882 department's standards.

4883 (g) Commitment to adequate staffing by qualified personnel  
4884 to effectively perform all functions.

4885 (h) Ability to meet all performance standards established  
4886 by the department.

4887 (5)~~(7)~~ The aging resource center shall have a governing  
4888 body which shall be the same entity described in s. 20.41(7),  
4889 and an executive director who may be the same person as  
4890 described in s. 20.41(7). The governing body shall annually  
4891 evaluate the performance of the executive director.

4892 (6)~~(8)~~ The aging resource center may not be a provider of  
4893 direct services other than information and referral services,  
4894 and screening.

4895 (7)~~(9)~~ The aging resource center must agree to allow the  
4896 department to review any financial information the department  
4897 determines is necessary for monitoring or reporting purposes,  
4898 including financial relationships.

4899 (8)~~(10)~~ The duties and responsibilities of the community  
4900 care for the elderly lead agencies within each area served by an  
4901 aging resource center shall be to:

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4902 (a) Develop strong community partnerships to maximize the  
4903 use of community resources for the purpose of assisting elders  
4904 to remain in their community settings for as long as it is  
4905 safely possible.

4906 (b) Conduct comprehensive assessments of clients that have  
4907 been determined eligible and develop a care plan consistent with  
4908 established protocols that ensures that the unique needs of each  
4909 client are met.

4910 (9)~~(11)~~ The services to be administered through the aging  
4911 resource center shall include those funded by the following  
4912 programs:

4913 (a) Community care for the elderly.

4914 (b) Home care for the elderly.

4915 (c) Contracted services.

4916 (d) Alzheimer's disease initiative.

4917 (e) Aged and disabled adult Medicaid waiver.

4918 (f) Assisted living for the frail elderly Medicaid waiver.

4919 (g) Older Americans Act.

4920 (10)~~(12)~~ The department shall, prior to designation of an  
4921 aging resource center, develop by rule operational and quality  
4922 assurance standards and outcome measures to ensure that clients  
4923 receiving services through all long-term-care programs  
4924 administered through an aging resource center are receiving the  
4925 appropriate care they require and that contractors and  
4926 subcontractors are adhering to the terms of their contracts and  
4927 are acting in the best interests of the clients they are  
4928 serving, consistent with the intent of the Legislature to reduce  
4929 the use of and cost of nursing home care. The department shall  
4930 by rule provide operating procedures for aging resource centers,

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4931 which shall include:

4932 (a) Minimum standards for financial operation, including  
4933 audit procedures.

4934 (b) Procedures for monitoring and sanctioning of service  
4935 providers.

4936 (c) Minimum standards for technology utilized by the aging  
4937 resource center.

4938 (d) Minimum staff requirements which shall ensure that the  
4939 aging resource center employs sufficient quality and quantity of  
4940 staff to adequately meet the needs of the elders residing within  
4941 the area served by the aging resource center.

4942 (e) Minimum accessibility standards, including hours of  
4943 operation.

4944 (f) Minimum oversight standards for the governing body of  
4945 the aging resource center to ensure its continuous involvement  
4946 in, and accountability for, all matters related to the  
4947 development, implementation, staffing, administration, and  
4948 operations of the aging resource center.

4949 (g) Minimum education and experience requirements for  
4950 executive directors and other executive staff positions of aging  
4951 resource centers.

4952 (h) Minimum requirements regarding any executive staff  
4953 positions that the aging resource center must employ and minimum  
4954 requirements that a candidate must meet in order to be eligible  
4955 for appointment to such positions.

4956 (11)~~(13)~~ In an area in which the department has designated  
4957 an area agency on aging as an aging resource center, the  
4958 department and the agency may ~~shall~~ not make payments for the  
4959 services listed in subsection (9) ~~(11)~~ and the Long-Term Care

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4960 Community Diversion Project for ~~such~~ persons who were not  
4961 screened and enrolled through the aging resource center. The  
4962 department shall cease making these payments for enrollees in  
4963 qualified plans as qualified plans become available in each of  
4964 the regions pursuant to s. 409.973(2).

4965 (12)~~(14)~~ Each aging resource center shall enter into a  
4966 memorandum of understanding with the department for  
4967 collaboration with the CARES unit staff. The memorandum of  
4968 understanding must ~~shall~~ outline the staff person responsible  
4969 for each function and ~~shall~~ provide the staffing levels  
4970 necessary to carry out the functions of the aging resource  
4971 center.

4972 (13)~~(15)~~ Each aging resource center shall enter into a  
4973 memorandum of understanding with the Department of Children and  
4974 Family Services for collaboration with the Economic Self-  
4975 Sufficiency Unit staff. The memorandum of understanding must  
4976 ~~shall~~ outline which staff persons are responsible for which  
4977 functions and ~~shall~~ provide the staffing levels necessary to  
4978 carry out the functions of the aging resource center.

4979 (14)~~(16)~~ If any of the state activities described in this  
4980 section are outsourced, ~~either~~ in part or in whole, the contract  
4981 executing the outsourcing must ~~shall~~ mandate that the contractor  
4982 or its subcontractors shall, ~~either~~ physically or virtually,  
4983 execute the provisions of the memorandum of understanding  
4984 instead of the state entity whose function the contractor or  
4985 subcontractor now performs.

4986 (15)~~(17)~~ In order to be eligible to begin transitioning to  
4987 an aging resource center, an area agency on aging board must  
4988 ensure that the area agency on aging which it oversees meets all

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4989 of the minimum requirements set by law and in rule.

4990 ~~(18) The department shall monitor the three initial~~  
4991 ~~projects for aging resource centers and report on the progress~~  
4992 ~~of those projects to the Governor, the President of the Senate,~~  
4993 ~~and the Speaker of the House of Representatives by June 30,~~  
4994 ~~2005. The report must include an evaluation of the~~  
4995 ~~implementation process.~~

4996 (16)~~(19)~~ (a) Once an aging resource center is operational,  
4997 the department, in consultation with the agency, may develop  
4998 capitation rates for any of the programs administered through  
4999 the aging resource center. Capitation rates for programs must  
5000 ~~shall~~ be based on the historical cost experience of the state in  
5001 providing those same services to the population age 60 or older  
5002 residing within each area served by an aging resource center.  
5003 Each capitated rate may vary by geographic area as determined by  
5004 the department.

5005 (b) The department and the agency may determine for each  
5006 area served by an aging resource center whether it is  
5007 appropriate, consistent with federal and state laws and  
5008 regulations, to develop and pay separate capitated rates for  
5009 each program administered through the aging resource center or  
5010 to develop and pay capitated rates for service packages which  
5011 include more than one program or service administered through  
5012 the aging resource center.

5013 (c) Once capitation rates have been developed and certified  
5014 as actuarially sound, the department and the agency may pay  
5015 service providers the capitated rates for services if ~~when~~  
5016 appropriate.

5017 (d) The department, in consultation with the agency, shall

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5018 annually reevaluate and recertify the capitation rates,  
 5019 adjusting forward to account for inflation, programmatic  
 5020 changes.

5021 ~~(20) The department, in consultation with the agency, shall~~  
 5022 ~~submit to the Governor, the President of the Senate, and the~~  
 5023 ~~Speaker of the House of Representatives, by December 1, 2006, a~~  
 5024 ~~report addressing the feasibility of administering the following~~  
 5025 ~~services through aging resource centers beginning July 1, 2007:~~

5026 ~~(a) Medicaid nursing home services.~~

5027 ~~(b) Medicaid transportation services.~~

5028 ~~(c) Medicaid hospice care services.~~

5029 ~~(d) Medicaid intermediate care services.~~

5030 ~~(e) Medicaid prescribed drug services.~~

5031 ~~(f) Medicaid assistive care services.~~

5032 ~~(g) Any other long-term care program or Medicaid service.~~

5033 ~~(17)~~(21) This section does ~~shall~~ not be construed to allow  
 5034 an aging resource center to restrict, manage, or impede the  
 5035 local fundraising activities of service providers.

5036 Section 60. Paragraph (b) of subsection (2) of section  
 5037 641.316, Florida Statutes, is amended to read:

5038 641.316 Fiscal intermediary services.-

5039 (2)

5040 (b) The term "fiscal intermediary services organization"  
 5041 means a person or entity that performs fiduciary or fiscal  
 5042 intermediary services to health care professionals who contract  
 5043 with health maintenance organizations other than a hospital  
 5044 licensed under chapter 395, an insurer licensed under chapter  
 5045 624, a third-party administrator licensed under chapter 626, a  
 5046 prepaid limited health service organization licensed under

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5047 chapter 636, a health maintenance organization licensed under  
5048 this chapter, a qualified plan authorized under part IV of  
5049 chapter 409, or a physician group practice as defined in s.  
5050 456.053(3) ~~(h)~~ which provides services under the scope of  
5051 licenses of the members of the group practice.

5052 Section 61. Paragraphs (c) and (d) of subsection (3) of  
5053 section 39.407, Florida Statutes, are amended to read:

5054 39.407 Medical, psychiatric, and psychological examination  
5055 and treatment of child; physical, mental, or substance abuse  
5056 examination of person with or requesting child custody.—

5057 (3)

5058 (c) Except as provided in paragraphs (b) and (e), the  
5059 department must file a motion seeking the court's authorization  
5060 to initially provide or continue to provide psychotropic  
5061 medication to a child in its legal custody. The motion must be  
5062 supported by a written report prepared by the department which  
5063 describes the efforts made to enable the prescribing physician  
5064 to obtain express and informed consent to provide ~~for providing~~  
5065 the medication to the child and other treatments considered or  
5066 recommended for the child. ~~In addition,~~ The motion must also be  
5067 supported by the prescribing physician's signed medical report  
5068 providing:

5069 1. The name of the child, the name and range of the dosage  
5070 of the psychotropic medication, and the ~~that there is a~~ need to  
5071 prescribe psychotropic medication to the child based upon a  
5072 diagnosed condition for which such medication is being  
5073 prescribed.

5074 2. A statement indicating that the physician has reviewed  
5075 all medical information concerning the child which has been

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5076 provided.

5077 3. A statement indicating that the psychotropic medication,  
5078 at its prescribed dosage, is appropriate for treating the  
5079 child's diagnosed medical condition, as well as the behaviors  
5080 and symptoms the medication, at its prescribed dosage, is  
5081 expected to address.

5082 4. An explanation of the nature and purpose of the  
5083 treatment; the recognized side effects, risks, and  
5084 contraindications of the medication; drug-interaction  
5085 precautions; the possible effects of stopping the medication;  
5086 and how the treatment will be monitored, followed by a statement  
5087 indicating that this explanation was provided to the child if  
5088 age appropriate and to the child's caregiver.

5089 5. Documentation addressing whether the psychotropic  
5090 medication will replace or supplement any other currently  
5091 prescribed medications or treatments; the length of time the  
5092 child is expected to be taking the medication; and any  
5093 additional medical, mental health, behavioral, counseling, or  
5094 other services that the prescribing physician recommends.

5095 6. For a child 10 years of age or younger who is in an out-  
5096 of-home placement, the results of a review of the administration  
5097 of the medication by a child psychiatrist who is licensed under  
5098 chapter 458 or chapter 459. The review must be provided to the  
5099 child and the parent or legal guardian before final express and  
5100 informed consent is given. The review must include a  
5101 determination of the following:

5102 a. The presence of a genetic psychiatric disorder or a  
5103 family history of a psychiatric disorder;

5104 b. Whether the cause of a psychiatric disorder is physical



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5105 or environmental; and

5106 c. The likelihood of the child being an imminent danger to  
5107 self or others.

5108 (d)~~1.~~ The department must notify all parties of the  
5109 proposed action taken under paragraph (c) in writing or by  
5110 whatever other method best ensures that all parties receive  
5111 notification of the proposed action within 48 hours after the  
5112 motion is filed. If any party objects to the department's  
5113 motion, that party shall file the objection within 2 working  
5114 days after being notified of the department's motion. If any  
5115 party files an objection to the authorization of the proposed  
5116 psychotropic medication, the court shall hold a hearing as soon  
5117 as possible before authorizing the department to initially  
5118 provide or to continue providing psychotropic medication to a  
5119 child in the legal custody of the department.

5120 1. At such hearing and notwithstanding s. 90.803, the  
5121 medical report described in paragraph (c) is admissible in  
5122 evidence. The prescribing physician need not attend the hearing  
5123 or testify unless the court specifically orders such attendance  
5124 or testimony, or a party subpoenas the physician to attend the  
5125 hearing or provide testimony.

5126 2. If, after considering any testimony received, the court  
5127 finds that the department's motion and the physician's medical  
5128 report meet the requirements of this subsection and that it is  
5129 in the child's best interests, the court may order that the  
5130 department provide or continue to provide the psychotropic  
5131 medication to the child without additional testimony or  
5132 evidence.

5133 3. At any hearing held under this paragraph, the court

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5134 shall ~~further~~ inquire of the department as to whether additional  
5135 medical, mental health, behavioral, counseling, or other  
5136 services are being provided to the child by the department which  
5137 the prescribing physician considers to be necessary or  
5138 beneficial in treating the child's medical condition and which  
5139 the physician recommends or expects to provide to the child in  
5140 concert with the medication. The court may order additional  
5141 medical consultation, including consultation with the MedConsult  
5142 line at the University of Florida, if available, or require the  
5143 department to obtain a second opinion within a reasonable  
5144 timeframe as established by the court, not to exceed 21 calendar  
5145 days, ~~after such order~~ based upon consideration of the best  
5146 interests of the child. The department must make a referral for  
5147 an appointment for a second opinion with a physician within 1  
5148 working day.

5149 4. The court may not order the discontinuation of  
5150 prescribed psychotropic medication if such order is contrary to  
5151 the decision of the prescribing physician unless the court first  
5152 obtains an opinion from a licensed psychiatrist, if available,  
5153 or, if not available, a physician licensed under chapter 458 or  
5154 chapter 459, stating that more likely than not, discontinuing  
5155 the medication would not cause significant harm to the child.  
5156 If, however, the prescribing psychiatrist specializes in mental  
5157 health care for children and adolescents, the court may not  
5158 order the discontinuation of prescribed psychotropic medication  
5159 unless the required opinion is also from a psychiatrist who  
5160 specializes in mental health care for children and adolescents.  
5161 The court may also order the discontinuation of prescribed  
5162 psychotropic medication if a child's treating physician,

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5163 licensed under chapter 458 or chapter 459, states that  
5164 continuing the prescribed psychotropic medication would cause  
5165 significant harm to the child due to a diagnosed nonpsychiatric  
5166 medical condition.

5167 5. If a child who is in out-of-home placement is 10 years  
5168 of age or younger, psychotropic medication may not be authorized  
5169 by the court absent a finding of a compelling governmental  
5170 interest. In making such finding, the court shall review the  
5171 psychiatric review described in subparagraph (c)6.

5172 6.2. The burden of proof at any hearing held under this  
5173 paragraph shall be by a preponderance of the evidence.

5174 Section 62. Paragraph (a) of subsection (1) of section  
5175 216.262, Florida Statutes, is amended to read:

5176 216.262 Authorized positions.—

5177 (1) (a) Except as ~~Unless~~ otherwise ~~expressly~~ provided by  
5178 law, the total number of authorized positions may not exceed the  
5179 total provided in the appropriations acts. If a ~~In the event any~~  
5180 state agency or entity of the judicial branch finds that the  
5181 number of positions so provided is not sufficient to administer  
5182 its authorized programs, it may file an application with the  
5183 Executive Office of the Governor or the Chief Justice~~r~~ and, if  
5184 the Executive Office of the Governor or Chief Justice certifies  
5185 that there are no authorized positions available for addition,  
5186 deletion, or transfer within the agency or entity as provided in  
5187 paragraph (c), may recommend ~~and recommends~~ an increase in the  
5188 number of positions.r

5189 1. The Governor or the Chief Justice may recommend an  
5190 increase in the number of positions for the following reasons  
5191 only:

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5192        ~~a.1.~~ To implement or provide for continuing federal grants  
5193 or changes in grants not previously anticipated.

5194        ~~b.2.~~ To meet emergencies pursuant to s. 252.36.

5195        ~~c.3.~~ To satisfy new federal regulations or changes therein.

5196        ~~d.4.~~ To take advantage of opportunities to reduce operating  
5197 expenditures or to increase the revenues of the state or local  
5198 government.

5199        ~~e.5.~~ To authorize positions that were not fixed by the  
5200 Legislature due to ~~through~~ error in drafting the appropriations  
5201 acts.

5202        2. Actions recommended pursuant to this paragraph are  
5203 subject to approval by the Legislative Budget Commission. The  
5204 certification and the final authorization shall be provided to  
5205 the Legislative Budget Commission, the legislative  
5206 appropriations committees, and the Auditor General.

5207        3. The provisions of this paragraph do not apply to  
5208 positions in the Department of Health which are funded by the  
5209 County Health Department Trust Fund.

5210        Section 63. Section 381.06014, Florida Statutes, is amended  
5211 to read:

5212        381.06014 Blood establishments.—

5213        (1) As used in this section, the term:

5214        (a) "Blood establishment" means any person, entity, or  
5215 organization, operating within the state, which examines an  
5216 individual for the purpose of blood donation or which collects,  
5217 processes, stores, tests, or distributes blood or blood  
5218 components collected from the human body for the purpose of  
5219 transfusion, for any other medical purpose, or for the  
5220 production of any biological product. A person, entity, or

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5221 organization that uses a mobile unit to conduct such activities  
5222 within the state is also a blood establishment.

5223 (b) "Volunteer donor" means a person who does not receive  
5224 remuneration, other than an incentive, for a blood donation  
5225 intended for transfusion, and the product container of the  
5226 donation from the person qualifies for labeling with the  
5227 statement "volunteer donor" under 21 C.F.R. s. 606.121.

5228 (2) An entity or organization may not hold itself out and  
5229 engage in the activities of a ~~Any~~ blood establishment in this  
5230 state ~~operating in the state may not conduct any activity~~  
5231 ~~defined in subsection (1) unless it operates in accordance that~~  
5232 ~~blood establishment is operated in a manner consistent with the~~  
5233 ~~provisions of Title 21 C.F.R. parts 211 and 600-640, Code of~~  
5234 ~~Federal Regulations.~~

5235 (3) A ~~Any~~ blood establishment determined to be operating in  
5236 the state in a manner not consistent with ~~the provisions of~~  
5237 Title 21 C.F.R. parts 211 and 600-640, ~~Code of Federal~~  
5238 ~~Regulations,~~ and in a manner that constitutes a danger to the  
5239 health or well-being of donors or recipients as evidenced by the  
5240 federal Food and Drug Administration's inspection reports and  
5241 the revocation of the blood establishment's license or  
5242 registration ~~is shall be~~ in violation of this chapter, ~~and shall~~  
5243 ~~immediately cease all operations in the state.~~

5244 ~~(4) The operation of a blood establishment in a manner not~~  
5245 ~~consistent with the provisions of Title 21 parts 211 and 600-~~  
5246 ~~640, Code of Federal Regulations, and in a manner that~~  
5247 ~~constitutes a danger to the health or well-being of blood donors~~  
5248 ~~or recipients as evidenced by the federal Food and Drug~~  
5249 ~~Administration's inspection process is declared a nuisance and~~

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5250 inimical to the public health, welfare, and safety, and must  
5251 immediately cease all operations in this state. The Agency for  
5252 Health Care Administration or any state attorney may bring an  
5253 action for an injunction to restrain such operations or enjoin  
5254 the future operation of the blood establishment.

5255 (4) A local government may not restrict access to or the  
5256 use of any public facility or infrastructure for the collection  
5257 of blood or blood components from volunteer donors based on  
5258 whether the blood establishment is operating as a for-profit or  
5259 not-for-profit organization.

5260 (5) In determining the service fee of blood or blood  
5261 components received from volunteer donors and sold to hospitals  
5262 or other health care providers, a blood establishment may not  
5263 base the service fee of the blood or blood component solely on  
5264 whether the purchasing entity is a for-profit or not-for-profit  
5265 organization.

5266 (6) A blood establishment that collects blood or blood  
5267 components from volunteer donors must disclose the following  
5268 information on its Internet website in order to educate and  
5269 inform donors and the public about the blood establishment's  
5270 activities, and the information required to be disclosed may be  
5271 cumulative for all blood establishments within a business  
5272 entity:

5273 (a) A description of the steps involved in collecting,  
5274 processing, and distributing volunteer donations.

5275 (b) By March 1 of each year, the number of units of blood  
5276 components which were:

5277 1. Produced by the blood establishment during the preceding  
5278 calendar year;

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5279 2. Obtained from other sources during the preceding  
5280 calendar year;

5281 3. Distributed during the preceding calendar year to health  
5282 care providers located outside this state. However, if the blood  
5283 establishment collects donations in a county outside this state,  
5284 distributions to health care providers in that county are  
5285 excluded. Such information shall be reported in the aggregate  
5286 for health care providers located within the United States and  
5287 its territories or outside the United States and its  
5288 territories; and

5289 4. Distributed during the preceding calendar year to  
5290 entities that are not health care providers. Such information  
5291 shall be reported in the aggregate for purchasers located within  
5292 the United States and its territories or outside the United  
5293 States and its territories.

5294 (c) The blood establishment's conflict-of-interest policy,  
5295 policy concerning related-party transactions, whistleblower  
5296 policy, and policy for determining executive compensation. If a  
5297 change occurs to any of these documents, the revised document  
5298 must be available on the blood establishment's website by the  
5299 following March 1.

5300 (d) Except for a hospital that collects blood or blood  
5301 components from volunteer donors:

5302 1. The most recent 3 years of the Return of Organization  
5303 Exempt from Income Tax, Internal Revenue Service Form 990, if  
5304 the business entity for the blood establishment is eligible to  
5305 file such return. The Form 990 must be available on the blood  
5306 establishment's website within 60 calendar days after it is  
5307 filed with the Internal Revenue Service; or

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5308       2. If the business entity for the blood establishment is  
5309 not eligible to file the Form 990 return, a balance sheet,  
5310 income statement, and statement of changes in cash flow, along  
5311 with the expression of an opinion thereon by an independent  
5312 certified public accountant who audited or reviewed such  
5313 financial statements. Such documents must be available on the  
5314 blood establishment's website within 120 days after the end of  
5315 the blood establishment's fiscal year and must remain on the  
5316 blood establishment's website for at least 36 months.

5317  
5318 A hospital that collects blood or blood components to be used  
5319 only by that hospital's licensed facilities or by a health care  
5320 provider that is a part of the hospital's business entity is  
5321 exempt from the disclosure requirements of this subsection.

5322       (7) A blood establishment is liable for a civil penalty for  
5323 failing to make the disclosures required under subsection (6).  
5324 The Department of Legal Affairs may assess a civil penalty  
5325 against the blood establishment for each day that it fails to  
5326 make such required disclosures, but the penalty may not exceed  
5327 \$10,000 per year. If multiple blood establishments operated by a  
5328 single business entity fail to meet such disclosure  
5329 requirements, the civil penalty may be assessed against only one  
5330 of the business entity's blood establishments. The Department of  
5331 Legal Affairs may terminate an action if the blood establishment  
5332 agrees to pay a stipulated civil penalty. A civil penalty so  
5333 collected accrues to the state and shall be deposited as  
5334 received into the General Revenue Fund unallocated. The  
5335 Department of Legal Affairs may terminate the action and waive  
5336 the civil penalty upon a showing of good cause by the blood



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5337 establishment as to why the required disclosures were not made.

5338 Section 64. Subsection (9) of section 393.063, Florida  
5339 Statutes, is amended, present subsections (13) through (40) of  
5340 that section are redesignated as subsections (14) through (41),  
5341 respectively, and a new subsection (13) is added to that  
5342 section, to read:

5343 393.063 Definitions.—For the purposes of this chapter, the  
5344 term:

5345 (9) "Developmental disability" means a disorder or syndrome  
5346 that is attributable to retardation, cerebral palsy, autism,  
5347 spina bifida, Down syndrome, or Prader-Willi syndrome; that  
5348 manifests before the age of 18; and that constitutes a  
5349 substantial handicap that can reasonably be expected to continue  
5350 indefinitely.

5351 (13) "Down syndrome" means a disorder that is caused by the  
5352 presence of an extra chromosome 21.

5353 Section 65. Paragraph (d) of subsection (2) of section  
5354 395.4025, Florida Statutes, is amended to read:

5355 395.4025 Trauma centers; selection; quality assurance;  
5356 records.—

5357 (2)

5358 (d)1. Notwithstanding other provisions in this section, the  
5359 department may grant up to an additional 18 months to a hospital  
5360 applicant that is unable to meet all the requirements under ~~as~~  
5361 ~~provided in~~ paragraph (c) at the time of application if the  
5362 number of applicants in the service area in which the applicant  
5363 is located is equal to or less than the service area allocation,  
5364 as provided by rule of the department.

5365 a. An applicant that is granted additional time ~~pursuant to~~

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5366 ~~this paragraph~~ shall submit a plan for departmental approval  
5367 which includes timelines and activities that the applicant  
5368 proposes to complete in order to meet application requirements.  
5369 An ~~Any~~ applicant that demonstrates an ongoing effort to complete  
5370 the activities within the timelines outlined in the plan shall  
5371 be included in the number of trauma centers when ~~at such time~~  
5372 ~~that~~ the department conducts ~~has conducted~~ a provisional review  
5373 of the application and determines ~~has determined~~ that the  
5374 application is complete and that the hospital has the critical  
5375 elements required for a trauma center.

5376 b. If construction related to a critical element is delayed  
5377 due to governmental action or inaction with respect to  
5378 regulations or permitting and a hospital applicant has  
5379 demonstrated that it has made a good faith effort to comply with  
5380 the applicable regulations or obtain the required permits, the  
5381 department shall grant an applicant that has received an  
5382 additional 18 months up to two additional 6-month extensions to  
5383 meet all the requirements under paragraph (c).

5384 2. Timeframes provided in subsections (1)-(8) shall be  
5385 stayed until the department determines that the application is  
5386 complete and that the hospital has the critical elements  
5387 required for a trauma center.

5388 Section 66. Section 400.023, Florida Statutes, is reordered  
5389 and amended to read:

5390 400.023 Civil enforcement.—

5391 (1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a  
5392 violation of rights as specified in this part has ~~are violated~~  
5393 ~~shall have~~ a cause of action against the licensee or its  
5394 management company, as identified in the state application for

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5395 nursing home licensure. However, the cause of action may not be  
5396 asserted individually against an officer, director, owner,  
5397 including an owner designated as having a controlling interest  
5398 on the state application for nursing home licensure, or agent of  
5399 a licensee or management company unless, following an  
5400 evidentiary hearing, the court determines there is sufficient  
5401 evidence in the record or proffered by the claimant which  
5402 establishes a reasonable basis for finding that the person or  
5403 entity breached, failed to perform, or acted outside the scope  
5404 of duties as an officer, director, owner, or agent, and that the  
5405 breach, failure to perform, or action outside the scope of  
5406 duties is a legal cause of actual loss, injury, death, or damage  
5407 to the resident.

5408       (2) The action may be brought by the resident or his or her  
5409 guardian, by a person or organization acting on behalf of a  
5410 resident with the consent of the resident or his or her  
5411 guardian, or by the personal representative of the estate of a  
5412 deceased resident regardless of the cause of death.

5413       (5) If the action alleges a claim for the resident's rights  
5414 or for negligence that:

5415       (a) Caused the death of the resident, the claimant must  
5416 ~~shall be required to elect either~~ survival damages pursuant to  
5417 s. 46.021 or wrongful death damages pursuant to s. 768.21. If  
5418 the claimant elects wrongful death damages, total noneconomic  
5419 damages may not exceed \$250,000, regardless of the number of  
5420 claimants.

5421       (b) ~~If the action alleges a claim for the resident's rights~~  
5422 ~~or for negligence that~~ Did not cause the death of the resident,  
5423 the personal representative of the estate may recover damages

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5424 for the negligence that caused injury to the resident.

5425 (3) The action may be brought in any court of competent  
5426 jurisdiction to enforce such rights and to recover actual and  
5427 punitive damages for any violation of the rights of a resident  
5428 or for negligence.

5429 (10) Any resident who prevails in seeking injunctive relief  
5430 or a claim for an administrative remedy may ~~is entitled to~~  
5431 recover the costs of the action, and a reasonable attorney's fee  
5432 assessed against the defendant not to exceed \$25,000. Fees shall  
5433 be awarded solely for the injunctive or administrative relief  
5434 and not for any claim or action for damages whether such claim  
5435 or action is brought together with a request for an injunction  
5436 or administrative relief or as a separate action, except as  
5437 provided under s. 768.79 or the Florida Rules of Civil  
5438 Procedure. Sections 400.023-400.0238 provide the exclusive  
5439 remedy for a cause of action for recovery of damages for the  
5440 personal injury or death of a nursing home resident arising out  
5441 of negligence or a violation of rights specified in s. 400.022.  
5442 This section does not preclude theories of recovery not arising  
5443 out of negligence or s. 400.022 which are available to a  
5444 resident or to the agency. The provisions of chapter 766 do not  
5445 apply to any cause of action brought under ss. 400.023-400.0238.

5446 (6) ~~(2)~~ If the ~~In any~~ claim brought pursuant to this part  
5447 alleges ~~alleging~~ a violation of resident's rights or negligence  
5448 causing injury to or the death of a resident, the claimant shall  
5449 have the burden of proving, by a preponderance of the evidence,  
5450 that:

5451 (a) The defendant owed a duty to the resident;

5452 (b) The defendant breached the duty to the resident;

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5453 (c) The breach of the duty is a legal cause of loss,  
5454 injury, death, or damage to the resident; and

5455 (d) The resident sustained loss, injury, death, or damage  
5456 as a result of the breach.

5457 (12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~  
5458 create strict liability. A violation of the rights set forth in  
5459 s. 400.022 or in any other standard or guidelines specified in  
5460 this part or in any applicable administrative standard or  
5461 guidelines of this state or a federal regulatory agency is ~~shall~~  
5462 ~~be~~ evidence of negligence but may ~~shall~~ not be considered  
5463 negligence per se.

5464 (7) ~~(3)~~ In any claim brought pursuant to this section, a  
5465 licensee, person, or entity has ~~shall have~~ a duty to exercise  
5466 reasonable care. Reasonable care is that degree of care which a  
5467 reasonably careful licensee, person, or entity would use under  
5468 like circumstances.

5469 (9) ~~(4)~~ In any claim for resident's rights violation or  
5470 negligence by a nurse licensed under part I of chapter 464, such  
5471 nurse has a ~~shall have the~~ duty to exercise care consistent with  
5472 the prevailing professional standard of care for a nurse. The  
5473 prevailing professional standard of care for a nurse is ~~shall be~~  
5474 that level of care, skill, and treatment which, in light of all  
5475 relevant surrounding circumstances, is recognized as acceptable  
5476 and appropriate by reasonably prudent similar nurses.

5477 (8) ~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical  
5478 negligence of any physician rendering care or treatment to the  
5479 resident except for the administrative services of a medical  
5480 director as required in this part. ~~Nothing in~~ This subsection  
5481 does not ~~shall be construed to~~ protect a licensee, person, or

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5482 entity from liability for failure to provide a resident with  
5483 appropriate observation, assessment, nursing diagnosis,  
5484 planning, intervention, and evaluation of care by nursing staff.

5485 ~~(4)-(6)~~ The resident or the resident's legal representative  
5486 shall serve a copy of any complaint alleging in whole or in part  
5487 a violation of any rights specified in this part to the agency  
5488 ~~for Health Care Administration~~ at the time of filing the initial  
5489 complaint with the clerk of the court for the county in which  
5490 the action is pursued. ~~The requirement of~~ Providing a copy of  
5491 the complaint to the agency does not impair the resident's legal  
5492 rights or ability to seek relief for his or her claim.

5493 ~~(11)-(7)~~ An action under this part for a violation of rights  
5494 or negligence ~~recognized herein~~ is not a claim for medical  
5495 malpractice, and the provisions of s. 768.21(8) do not apply to  
5496 a claim alleging death of the resident.

5497 Section 67. Subsections (1), (2), and (3) of section  
5498 400.0237, Florida Statutes, are amended to read:

5499 400.0237 Punitive damages; pleading; burden of proof.—

5500 (1) In any action ~~for damages~~ brought under this part, a ~~no~~  
5501 claim for punitive damages is not shall be permitted unless,  
5502 based on admissible there is a reasonable showing by evidence ~~in~~  
5503 ~~the record or~~ proffered by the claimant, which would provide a  
5504 reasonable basis for recovery of such damages is demonstrated  
5505 upon applying the criteria set forth in this section. The  
5506 defendant may proffer admissible evidence to refute the  
5507 claimant's proffer of evidence to recover punitive damages. The  
5508 trial judge shall conduct an evidentiary hearing and weigh the  
5509 admissible evidence proffered by the claimant and the defendant  
5510 to ensure that there is a reasonable basis to believe that the

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5511 claimant, at trial, will be able to demonstrate by clear and  
5512 convincing evidence that the recovery of such damages is  
5513 warranted. The claimant may move to amend her or his complaint  
5514 to assert a claim for punitive damages as allowed by the rules  
5515 of civil procedure. ~~The rules of civil procedure shall be~~  
5516 ~~liberally construed so as to allow the claimant discovery of~~  
5517 ~~evidence which appears reasonably calculated to lead to~~  
5518 ~~admissible evidence on the issue of punitive damages. No~~  
5519 Discovery of financial worth may not ~~shall~~ proceed until after  
5520 the trial judge approves the pleading on ~~concerning~~ punitive  
5521 damages ~~is permitted.~~

5522 (2) A defendant, including the licensee or management  
5523 company, against whom punitive damages is sought may be held  
5524 liable for punitive damages only if the trier of fact, based on  
5525 clear and convincing evidence, finds that a specific individual  
5526 or corporate defendant actively and knowingly participated in  
5527 intentional misconduct, or engaged in conduct that constituted  
5528 gross negligence, and that conduct contributed to the loss,  
5529 damages, or injury suffered by the claimant ~~the defendant was~~  
5530 ~~personally guilty of intentional misconduct or gross negligence.~~

5531 As used in this section, the term:

5532 (a) "Intentional misconduct" means that the defendant  
5533 against whom a claim for punitive damages is sought had actual  
5534 knowledge of the wrongfulness of the conduct and the high  
5535 probability that injury or damage to the claimant would result  
5536 and, despite that knowledge, intentionally pursued that course  
5537 of conduct, resulting in injury or damage.

5538 (b) "Gross negligence" means that the defendant's conduct  
5539 was so reckless or wanting in care that it constituted a

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5540 conscious disregard or indifference to the life, safety, or  
5541 rights of persons exposed to such conduct.

5542 (3) In the case of vicarious liability of an employer,  
5543 principal, corporation, or other legal entity, punitive damages  
5544 may not be imposed for the conduct of an identified employee or  
5545 agent unless ~~only if~~ the conduct of the employee or agent meets  
5546 the criteria specified in subsection (2) and officers,  
5547 directors, or managers of the actual employer corporation or  
5548 legal entity condoned, ratified, or consented to the specific  
5549 conduct as alleged by the claimant in subsection (2).÷

5550 ~~(a) The employer, principal, corporation, or other legal~~  
5551 ~~entity actively and knowingly participated in such conduct;~~

5552 ~~(b) The officers, directors, or managers of the employer,~~  
5553 ~~principal, corporation, or other legal entity condoned,~~  
5554 ~~ratified, or consented to such conduct; or~~

5555 ~~(c) The employer, principal, corporation, or other legal~~  
5556 ~~entity engaged in conduct that constituted gross negligence and~~  
5557 ~~that contributed to the loss, damages, or injury suffered by the~~  
5558 ~~claimant.~~

5559 Section 68. Subsections (3) and (4) of section 408.7057,  
5560 Florida Statutes, are amended, present subsection (7) of that  
5561 section is redesignated as subsection (8), and a new subsection  
5562 (7) is added to that section, to read:

5563 408.7057 Statewide provider and health plan claim dispute  
5564 resolution program.—

5565 (3) The agency shall adopt rules to establish a process to  
5566 be used by the resolution organization in considering claim  
5567 disputes submitted by a provider or health plan which must  
5568 include a hearing, if requested by the respondent, and the



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5569 issuance by the resolution organization of a written  
5570 recommendation, supported by findings of fact and conclusions of  
5571 law, to the agency within 60 days after the requested  
5572 information is received by the resolution organization within  
5573 the timeframes specified by the resolution organization. ~~In no~~  
5574 ~~event shall~~ The review time may not exceed 90 days following  
5575 receipt of the initial claim dispute submission by the  
5576 resolution organization.

5577 (4) Within 30 days after receipt of the recommendation of  
5578 the resolution organization, the agency shall adopt the  
5579 recommendation as a final order subject to chapter 120.

5580 (7) This section creates a procedure for dispute resolution  
5581 and not an independent right of recovery. The conclusions of law  
5582 contained in the written recommendation of the resolution  
5583 organization must identify the provisions of law or contract  
5584 which, under the particular facts and circumstances of the case,  
5585 entitle the provider or health plan to the amount awarded, if  
5586 any.

5587 Section 69. Subsection (9) is added to section 465.014,  
5588 Florida Statutes, to read:

5589 465.014 Pharmacy technician.—

5590 (9) This section does not apply to a practitioner  
5591 authorized to dispense drugs under s. 465.0276 or any medical  
5592 personnel under the direct supervision of such practitioner if  
5593 the practitioner is treating a patient who provides proof of  
5594 insurance through a public or private payor source. Medical  
5595 personnel under the direct supervision of the practitioner may  
5596 perform all activities required by s. 465.0276.

5597 Section 70. Section 456.0635, Florida Statutes, is amended

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5598 to read:

5599 456.0635 Health care ~~Medicaid~~ fraud; disqualification for  
5600 license, certificate, or registration.—

5601 (1) ~~Medicaid~~ Fraud in the practice of a health care  
5602 profession is prohibited.

5603 (2) Each board within the jurisdiction of the department,  
5604 or the department if there is no board, shall refuse to admit a  
5605 candidate to any examination and refuse to issue ~~or renew~~ a  
5606 license, certificate, or registration to any applicant if the  
5607 candidate or applicant or any principal, officer, agent,  
5608 managing employee, or affiliated person of the applicant, ~~has~~  
5609 ~~been:~~

5610 (a) Has been convicted of, or entered a plea of guilty or  
5611 nolo contendere to, regardless of adjudication, a felony under  
5612 chapter 409, chapter 817, or chapter 893, or a similar felony  
5613 offense committed in another state or jurisdiction ~~21 U.S.C. ss.~~  
5614 ~~801-970, or 42 U.S.C. ss. 1395-1396,~~ unless the sentence and any  
5615 subsequent period of probation for such conviction or plea ~~pleas~~  
5616 ~~ended: more than 15 years prior to the date of the application;~~

5617 1. For felonies of the first or second degree, more than 15  
5618 years before the date of application.

5619 2. For felonies of the third degree, more than 10 years  
5620 before the date of application, except for felonies of the third  
5621 degree under s. 893.13(6) (a).

5622 3. For felonies of the third degree under s. 893.13(6) (a),  
5623 more than 5 years before the date of application.

5624

5625 Notwithstanding s. 120.60, for felonies in which the defendant  
5626 entered a plea of guilty or nolo contendere in an agreement with

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5627 the court to enter a pretrial intervention or drug diversion  
5628 program, the board, or the department if there is no board, may  
5629 not approve or deny the application for a license, certificate,  
5630 or registration until final resolution of the case;

5631 (b) Has been convicted of, or entered a plea of guilty or  
5632 nolo contendere to, regardless of adjudication, a felony under  
5633 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the  
5634 sentence and any subsequent period of probation for such  
5635 conviction or plea ended more than 15 years before the date of  
5636 the application;

5637 (c) ~~(b)~~ Has been terminated for cause from the Florida  
5638 Medicaid program pursuant to s. 409.913, unless the applicant  
5639 has been in good standing with the Florida Medicaid program for  
5640 the most recent 5 years;

5641 (d) ~~(c)~~ Has been terminated for cause, pursuant to the  
5642 appeals procedures established by the state ~~or Federal~~  
5643 Government, from any other state Medicaid program ~~or the federal~~  
5644 Medicare program, unless the applicant has been in good standing  
5645 with a state Medicaid program ~~or the federal Medicare program~~  
5646 for the most recent 5 years and the termination occurred at  
5647 least 20 years before ~~prior to~~ the date of the application; ~~or-~~

5648 (e) Is currently listed on the United States Department of  
5649 Health and Human Services Office of Inspector General's List of  
5650 Excluded Individuals and Entities.

5651  
5652 This subsection does not apply to applicants for initial  
5653 licensure or certification who were enrolled in an educational  
5654 or training program on or before July 1, 2010, which was  
5655 recognized by a board or, if there is no board, recognized by

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5656 the department, and who applied for licensure after July 1,  
5657 2010.

5658 (3) The department shall refuse to renew a license,  
5659 certificate, or registration of any applicant if the candidate  
5660 or applicant or any principal, officer, agent, managing  
5661 employee, or affiliated person of the applicant:

5662 (a) Has been convicted of, or entered a plea of guilty or  
5663 nolo contendere to, regardless of adjudication, a felony under:  
5664 chapter 409, chapter 817, or chapter 893, or a similar felony  
5665 offense committed in another state or jurisdiction since July 1,  
5666 2010;

5667 (b) Has been convicted of, or entered a plea of guilty or  
5668 nolo contendere to, regardless of adjudication, a felony under  
5669 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396 since July 1,  
5670 2010;

5671 (c) Has been terminated for cause from the Florida Medicaid  
5672 program pursuant to s. 409.913, unless the applicant has been in  
5673 good standing with the Florida Medicaid program for the most  
5674 recent 5 years;

5675 (d) Has been terminated for cause, pursuant to the appeals  
5676 procedures established by the state, from any other state  
5677 Medicaid program, unless the applicant has been in good standing  
5678 with a state Medicaid program for the most recent 5 years and  
5679 the termination occurred at least 20 years before the date of  
5680 the application; or

5681 (e) Is currently listed on the United States Department of  
5682 Health and Human Services Office of Inspector General's List of  
5683 Excluded Individuals and Entities.

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5685 For felonies in which the defendant entered a plea of guilty or  
5686 nolo contendere in an agreement with the court to enter a  
5687 pretrial intervention or drug diversion program, the department  
5688 may not approve or deny the application for a renewal of a  
5689 license, certificate, or registration until the final resolution  
5690 of the case.

5691 (4)~~(3)~~ Licensed health care practitioners shall report  
5692 allegations of health care ~~Medicaid~~ fraud to the department,  
5693 regardless of the practice setting in which the alleged Medicaid  
5694 fraud occurred.

5695 (5)~~(4)~~ The acceptance by a licensing authority of a  
5696 candidate's relinquishment of a license which is offered in  
5697 response to or anticipation of the filing of administrative  
5698 charges alleging health care ~~Medicaid~~ fraud or similar charges  
5699 constitutes the permanent revocation of the license.

5700 Section 71. Subsection (6) of section 456.036, Florida  
5701 Statutes, is amended to read:

5702 456.036 Licenses; active and inactive status; delinquency.—

5703 (6) (a) Except as provided in paragraph (b), a delinquent  
5704 licensee must affirmatively apply with a complete application,  
5705 as defined by rule of the board, or the department if there is  
5706 no board, for active or inactive status during the licensure  
5707 cycle in which a licensee becomes delinquent. Failure by a  
5708 delinquent licensee to become active or inactive before the  
5709 expiration of the current licensure cycle renders the license  
5710 null without any further action by the board or the department.  
5711 Any subsequent licensure shall be as a result of applying for  
5712 and meeting all requirements imposed on an applicant for new  
5713 licensure.

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5714       (b) A delinquent licensee whose license becomes delinquent  
5715 before the final resolution of a case under s. 456.0635(3) must  
5716 affirmatively apply by submitting a complete application, as  
5717 defined by rule of the board, or the department if there is no  
5718 board, for active or inactive status during the licensure cycle  
5719 in which the case achieves final resolution by order of the  
5720 court. Failure by a delinquent licensee to become active or  
5721 inactive before the expiration of that licensure cycle renders  
5722 the license null without any further action by the board or the  
5723 department. Any subsequent licensure shall be as a result of  
5724 applying for and meeting all requirements imposed on an  
5725 applicant for new licensure.

5726       Section 72. Section 458.3167, Florida Statutes, is created  
5727 to read:

5728       458.3167 Expert witness certificate.-

5729       (1) A physician who holds an active and valid license to  
5730 practice allopathic medicine in any other state or in Canada,  
5731 who submits an application form prescribed by the board to  
5732 obtain a certificate to provide expert testimony and pays the  
5733 application fee, and who has not had a previous expert witness  
5734 certificate revoked by the board shall be issued a certificate  
5735 to provide expert testimony.

5736       (2) A physician possessing an expert witness certificate  
5737 may use the certificate only to give a verified written medical  
5738 expert opinion as provided in s. 766.203 and to provide expert  
5739 testimony concerning the prevailing professional standard of  
5740 care for medical negligence litigation pending in this state  
5741 against a physician licensed under this chapter or chapter 459.

5742       (3) An application for an expert witness certificate must

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5743 be approved or denied within 5 business days after receipt of a  
5744 completed application. An application that is not approved or  
5745 denied within the required time period is deemed approved. An  
5746 applicant seeking to claim certification by default shall notify  
5747 the board, in writing, of the intent to rely on the default  
5748 certification provision of this subsection. In such case, s.  
5749 458.327 does not apply, and the applicant may provide expert  
5750 testimony as provided in subsection (2).

5751 (4) All licensure fees, other than the initial certificate  
5752 application fee, including the neurological injury compensation  
5753 assessment, are waived for those persons obtaining an expert  
5754 witness certificate. The possession of an expert witness  
5755 certificate alone does not entitle the physician to engage in  
5756 the practice of medicine as defined in s. 458.305.

5757 (5) The board shall adopt rules to administer this section,  
5758 including rules setting the amount of the expert witness  
5759 certificate application fee, which may not exceed \$50. An expert  
5760 witness certificate expires 2 years after the date of issuance.

5761 Section 73. Subsection (11) is added to section 458.331,  
5762 Florida Statutes, present paragraphs (oo) through (qq) of  
5763 subsection (1) of that section are redesignated as paragraphs  
5764 (pp) through (rr), respectively, and a new paragraph (oo) is  
5765 added to that subsection, to read:

5766 458.331 Grounds for disciplinary action; action by the  
5767 board and department.—

5768 (1) The following acts constitute grounds for denial of a  
5769 license or disciplinary action, as specified in s. 456.072(2):

5770 (oo) Providing misleading, deceptive, or fraudulent expert  
5771 witness testimony related to the practice of medicine.

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5772       (11) The purpose of this section is to facilitate uniform  
5773 discipline for those acts made punishable under this section  
5774 and, to this end, a reference to this section constitutes a  
5775 general reference under the doctrine of incorporation by  
5776 reference.

5777       Section 74. Section 459.0078, Florida Statutes, is created  
5778 to read:

5779       459.0078 Expert witness certificate.-

5780       (1) A physician who holds an active and valid license to  
5781 practice osteopathic medicine in any other state or in Canada,  
5782 who submits an application form prescribed by the board to  
5783 obtain a certificate to provide expert testimony and pays the  
5784 application fee, and who has not had a previous expert witness  
5785 certificate revoked by the board shall be issued a certificate  
5786 to provide expert testimony.

5787       (2) A physician possessing an expert witness certificate  
5788 may use the certificate only to give a verified written medical  
5789 expert opinion as provided in s. 766.203 and to provide expert  
5790 testimony concerning the prevailing professional standard of  
5791 care for medical negligence litigation pending in this state  
5792 against a physician licensed under this chapter or chapter 458.

5793       (3) An application for an expert witness certificate must  
5794 be approved or denied within 5 business days after receipt of a  
5795 completed application. An application that is not approved or  
5796 denied within the required time period is deemed approved. An  
5797 applicant seeking to claim certification by default shall notify  
5798 the board, in writing, of the intent to rely on the default  
5799 certification provision of this subsection. In such case, s.  
5800 459.013 does not apply, and the applicant may provide expert



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5801 testimony as provided in subsection (2).

5802 (4) All licensure fees, other than the initial certificate  
5803 application fee, including the neurological injury compensation  
5804 assessment, are waived for those persons obtaining an expert  
5805 witness certificate. The possession of an expert witness  
5806 certificate alone does not entitle the physician to engage in  
5807 the practice of osteopathic medicine as defined in s. 459.003.

5808 (5) The board shall adopt rules to administer this section,  
5809 including rules setting the amount of the expert witness  
5810 certificate application fee, which may not exceed \$50. An expert  
5811 witness certificate expires 2 years after the date of issuance.

5812 Section 75. Subsection (11) is added to section 459.015,  
5813 Florida Statutes, present paragraphs (qq) through (ss) of  
5814 subsection (1) of that section are redesignated as paragraphs  
5815 (rr) through (tt), respectively, and a new paragraph (qq) is  
5816 added to that subsection, to read:

5817 459.015 Grounds for disciplinary action; action by the  
5818 board and department.—

5819 (1) The following acts constitute grounds for denial of a  
5820 license or disciplinary action, as specified in s. 456.072(2):

5821 (qq) Providing misleading, deceptive, or fraudulent expert  
5822 witness testimony related to the practice of osteopathic  
5823 medicine.

5824 (11) The purpose of this section is to facilitate uniform  
5825 discipline for those acts made punishable under this section  
5826 and, to this end, a reference to this section constitutes a  
5827 general reference under the doctrine of incorporation by  
5828 reference.

5829 Section 76. Subsection (23) of section 499.003, Florida

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5830 Statutes, is amended to read:

5831 499.003 Definitions of terms used in this part.—As used in  
5832 this part, the term:

5833 (23) "Health care entity" means a closed pharmacy or any  
5834 person, organization, or business entity that provides  
5835 diagnostic, medical, surgical, or dental treatment or care, or  
5836 chronic or rehabilitative care, but does not include any  
5837 wholesale distributor or retail pharmacy licensed under state  
5838 law to deal in prescription drugs. However, a blood  
5839 establishment is a health care entity that may engage in the  
5840 wholesale distribution of prescription drugs under s.  
5841 499.01(2)(g)1.c.

5842 Section 77. Subsection (21) of section 499.005, Florida  
5843 Statutes, is amended to read:

5844 499.005 Prohibited acts.—It is unlawful for a person to  
5845 perform or cause the performance of any of the following acts in  
5846 this state:

5847 (21) The wholesale distribution of any prescription drug  
5848 that was:

5849 (a) Purchased by a public or private hospital or other  
5850 health care entity; or

5851 (b) Donated or supplied at a reduced price to a charitable  
5852 organization,

5853  
5854 unless the wholesale distribution of the prescription drug is  
5855 authorized in s. 499.01(2)(g)1.c.

5856 Section 78. Paragraphs (a) and (g) of subsection (2) of  
5857 section 499.01, Florida Statutes, are amended to read:

5858 499.01 Permits.—

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5859 (2) The following permits are established:

5860 (a) *Prescription drug manufacturer permit.*—A prescription  
5861 drug manufacturer permit is required for any person that is a  
5862 manufacturer of a prescription drug and that manufactures or  
5863 distributes such prescription drugs in this state.

5864 1. A person that operates an establishment permitted as a  
5865 prescription drug manufacturer may engage in wholesale  
5866 distribution of prescription drugs manufactured at that  
5867 establishment and must comply with all of the provisions of this  
5868 part, except s. 499.01212, and the rules adopted under this  
5869 part, except s. 499.01212, which ~~that~~ apply to a wholesale  
5870 distributor.

5871 2. A prescription drug manufacturer must comply with all  
5872 appropriate state and federal good manufacturing practices.

5873 3. A blood establishment, as defined in s. 381.06014,  
5874 operating in a manner consistent with the provisions of Title 21  
5875 C.F.R. parts 211 and 600-640 and manufacturing only the  
5876 prescription drugs described in s. 499.003(54)(d) is not  
5877 required to be permitted as a prescription drug manufacturer  
5878 under this paragraph or to register its products under s.  
5879 499.015.

5880 (g) *Restricted prescription drug distributor permit.*—

5881 1. A restricted prescription drug distributor permit is  
5882 required for:

5883 a. Any person located in this state that engages in the  
5884 distribution of a prescription drug, which distribution is not  
5885 considered "wholesale distribution" under s. 499.003(54)(a).

5886 b. ~~1.~~ Any ~~A~~ person located in this state who engages in the  
5887 receipt or distribution of a prescription drug in this state for

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5888 the purpose of processing its return or its destruction ~~must~~  
5889 ~~obtain a permit as a restricted prescription drug distributor~~ if  
5890 such person is not the person initiating the return, the  
5891 prescription drug wholesale supplier of the person initiating  
5892 the return, or the manufacturer of the drug.

5893 c. A blood establishment located in this state which  
5894 collects blood and blood components only from volunteer donors  
5895 as defined in s. 381.06014 or pursuant to an authorized  
5896 practitioner's order for medical treatment or therapy and  
5897 engages in the wholesale distribution of a prescription drug not  
5898 described in s. 499.003(54)(d) to a health care entity. The  
5899 health care entity receiving a prescription drug distributed  
5900 under this sub-subparagraph must be licensed as a closed  
5901 pharmacy or provide health care services at that establishment.  
5902 The blood establishment must operate in accordance with s.  
5903 381.06014 and may distribute only:

5904 (I) Prescription drugs indicated for a bleeding or clotting  
5905 disorder or anemia;

5906 (II) Blood-collection containers approved under s. 505 of  
5907 the federal act;

5908 (III) Drugs that are blood derivatives, or a recombinant or  
5909 synthetic form of a blood derivative;

5910 (IV) Prescription drugs that are identified in rules  
5911 adopted by the department and that are essential to services  
5912 performed or provided by blood establishments and authorized for  
5913 distribution by blood establishments under federal law; or

5914 (V) To the extent authorized by federal law, drugs  
5915 necessary to collect blood or blood components from volunteer  
5916 blood donors; for blood establishment personnel to perform

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5917 therapeutic procedures under the direction and supervision of a  
5918 licensed physician; and to diagnose, treat, manage, and prevent  
5919 any reaction of either a volunteer blood donor or a patient  
5920 undergoing a therapeutic procedure performed under the direction  
5921 and supervision of a licensed physician,

5922  
5923 as long as all of the health care services provided by the blood  
5924 establishment are related to its activities as a registered  
5925 blood establishment or the health care services consist of  
5926 collecting, processing, storing, or administering human  
5927 hematopoietic stem cells or progenitor cells or performing  
5928 diagnostic testing of specimens if such specimens are tested  
5929 together with specimens undergoing routine donor testing.

5930 2. Storage, handling, and recordkeeping of these  
5931 distributions by a person required to be permitted as a  
5932 restricted prescription drug distributor must comply with the  
5933 requirements for wholesale distributors under s. 499.0121, but  
5934 not those set forth in s. 499.01212 if the distribution occurs  
5935 pursuant to sub-subparagraph 1.a. or sub-subparagraph 1.b.

5936 3. A person who applies for a permit as a restricted  
5937 prescription drug distributor, or for the renewal of such a  
5938 permit, must provide to the department the information required  
5939 under s. 499.012.

5940 4. The department may adopt rules regarding the  
5941 distribution of prescription drugs by hospitals, health care  
5942 entities, charitable organizations, ~~or~~ other persons not  
5943 involved in wholesale distribution, and blood establishments,  
5944 which rules are necessary for the protection of the public  
5945 health, safety, and welfare.

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5946 Section 79. Subsection (4) is added to section 626.9541,  
5947 Florida Statutes, to read:

5948 626.9541 Unfair methods of competition and unfair or  
5949 deceptive acts or practices defined.—

5950 (4) WELLNESS OR HEALTH IMPROVEMENT PROGRAMS.—

5951 (a) An insurer issuing a group or individual health benefit  
5952 plan may offer a voluntary wellness or health improvement  
5953 program and may encourage or reward participation in the program  
5954 by authorizing rewards or incentives, including, but not limited  
5955 to, merchandise, gift cards, debit cards, premium discounts or  
5956 rebates, contributions to a member's health savings account, or  
5957 modifications to copayment, deductible, or coinsurance amounts.

5958 (b) An insurer may require a health benefit plan member to  
5959 provide verification, such as an affirming statement from the  
5960 member's physician, that the member's medical condition makes it  
5961 unreasonably difficult or inadvisable to participate in the  
5962 wellness or health improvement program.

5963 (c) A reward or incentive offered under this subsection is  
5964 not an insurance benefit or violation of this section if it is  
5965 disclosed in the policy or certificate. This subsection does not  
5966 prohibit insurers from offering other incentives or rewards for  
5967 adherence to a wellness or health improvement program if  
5968 otherwise authorized by state or federal law.

5969 Section 80. Paragraph (b) of subsection (1) of section  
5970 627.4147, Florida Statutes, is amended to read:

5971 627.4147 Medical malpractice insurance contracts.—

5972 (1) In addition to any other requirements imposed by law,  
5973 each self-insurance policy ~~as~~ authorized under s. 627.357 or s.  
5974 624.462 or insurance policy providing coverage for claims

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5975 arising out of the rendering of, or the failure to render,  
5976 medical care or services, including those of the Florida Medical  
5977 Malpractice Joint Underwriting Association, must ~~shall~~ include:

5978 (b)1. ~~Except as provided in subparagraph 2., a clause~~  
5979 ~~authorizing the insurer or self-insurer to determine, to make,~~  
5980 ~~and to conclude, without the permission of the insured, any~~  
5981 ~~offer of admission of liability and for arbitration pursuant to~~  
5982 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~  
5983 ~~is within the policy limits. It is against public policy for any~~  
5984 ~~insurance or self-insurance policy to contain a clause giving~~  
5985 ~~the insured the exclusive right to veto any offer for admission~~  
5986 ~~of liability and for arbitration made pursuant to s. 766.106,~~  
5987 ~~settlement offer, or offer of judgment, when such offer is~~  
5988 ~~within the policy limits. However, any offer of admission of~~  
5989 ~~liability, settlement offer, or offer of judgment made by an~~  
5990 ~~insurer or self-insurer shall be made in good faith and in the~~  
5991 ~~best interests of the insured.~~

5992 1.2.a. With respect to dentists licensed under chapter 466,  
5993 a clause clearly stating whether or not the insured has the  
5994 exclusive right to veto any offer of admission of liability and  
5995 for arbitration pursuant to s. 766.106, settlement offer, or  
5996 offer of judgment if the offer is within policy limits. An  
5997 insurer or self-insurer may ~~shall~~ not make or conclude, without  
5998 the permission of the insured, any offer of admission of  
5999 liability and for arbitration pursuant to s. 766.106, settlement  
6000 offer, or offer of judgment, if such offer is outside the policy  
6001 limits. However, any offer for admission of liability and for  
6002 arbitration made under s. 766.106, settlement offer, or offer of  
6003 judgment made by an insurer or self-insurer must ~~shall~~ be made

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6004 in good faith and in the best interest of the insured.

6005 ~~2.b.~~ If the policy contains a clause stating the insured  
6006 does not have the exclusive right to veto any offer or admission  
6007 of liability and for arbitration made pursuant to s. 766.106,  
6008 settlement offer or offer of judgment, the insurer or self-  
6009 insurer shall provide to the insured or the insured's legal  
6010 representative by certified mail, return receipt requested, a  
6011 copy of the final offer of admission of liability and for  
6012 arbitration made pursuant to s. 766.106, settlement offer or  
6013 offer of judgment and at the same time such offer is provided to  
6014 the claimant. A copy of any final agreement reached between the  
6015 insurer and claimant shall also be provided to the insurer or  
6016 his or her legal representative by certified mail, return  
6017 receipt requested within ~~not more than~~ 10 days after affecting  
6018 such agreement.

6019 Section 81. Present subsections (15) through (21) of  
6020 section 641.19, Florida Statutes, are renumbered as subsections  
6021 (16) through (22), respectively, and a new subsection (15) is  
6022 added to that section, to read:

6023 641.19 Definitions.—As used in this part, the term:

6024 (15) "Provider service network" means a network established  
6025 or organized and operated by a health care provider or group of  
6026 affiliated health care providers, including minority physician  
6027 networks and emergency room diversion programs that meet the  
6028 requirements of s. 409.91211, which directly provides a  
6029 substantial proportion of the health care items and services  
6030 under a contract and may make arrangements with physicians,  
6031 other health care practitioners, health care institutions, or  
6032 any combination of such practitioners or institutions to assume



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6033 all or part of the financial risk on a prospective basis for the  
6034 provision of basic health services by such physicians,  
6035 practitioners, or institutions. The health care providers  
6036 operating the provider service network must have a controlling  
6037 interest in the governing body of the network.

6038 Section 82. Section 641.2019, Florida Statutes, is created  
6039 to read:

6040 641.2019 Provider service network certificate of  
6041 authority.—Notwithstanding any other provisions of this chapter,  
6042 a provider service network, including a prepaid provider service  
6043 network described under s. 409.912(4)(d), which meets all of the  
6044 applicable requirements of this part may apply for and obtain a  
6045 health care provider certificate pursuant to part III of this  
6046 chapter and a certificate of authority pursuant to this part  
6047 which states that the network is authorized to operate a  
6048 certified provider service network under this chapter. A  
6049 certified provider service network has the same rights and  
6050 responsibilities as a health maintenance organization certified  
6051 under this part.

6052 Section 83. Subsection (13) of section 641.47, Florida  
6053 Statutes, is amended to read:

6054 641.47 Definitions.—As used in this part, the term:

6055 (13) "Organization" means a ~~any~~ health maintenance  
6056 organization as defined in s. 641.19, ~~a~~ ~~and any~~ prepaid health  
6057 clinic as defined in s. 641.402, and a provider service network  
6058 as defined in s. 641.19.

6059 Section 84. Section 641.49, Florida Statutes, is amended to  
6060 read:

6061 641.49 Health care provider certificate ~~certification of~~

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6062 ~~health maintenance organization and prepaid health clinic as~~  
6063 ~~health care providers; application procedure.-~~

6064 (1) No person or governmental unit shall establish,  
6065 conduct, or maintain a health maintenance organization, or a  
6066 prepaid health clinic, or provider service network in this state  
6067 without first obtaining a health care provider certificate under  
6068 this part.

6069 (2) The office may ~~shall~~ not issue a certificate of  
6070 authority under part I or part II of this chapter to any  
6071 applicant which does not possess a valid health care provider  
6072 certificate issued by the agency under this part.

6073 (3) Each application for a health care provider certificate  
6074 shall be on a form prescribed by the agency. The following  
6075 information and documents shall be submitted by an applicant and  
6076 maintained, after certification under this part, by each  
6077 organization and shall be available for inspection or  
6078 examination by the agency at the offices of an organization at  
6079 any time during regular business hours. The agency shall give  
6080 reasonable notice to an organization before ~~prior to~~ any onsite  
6081 inspection or examination of its records or premises conducted  
6082 under this section. The agency may require that the following  
6083 information or documents be submitted with the application:

6084 (a) A copy of the articles of incorporation and all  
6085 amendments to the articles.

6086 (b) A copy of the bylaws, rules and regulations, or similar  
6087 form of document, if any, regulating the conduct of the affairs  
6088 of the applicant or organization.

6089 (c) A list of the names, addresses, and official capacities  
6090 with the applicant or organization of the persons who are to be

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6091 responsible for the conduct of the affairs of the applicant or  
6092 organization, including all officers and directors of the  
6093 corporation. Such persons must ~~shall~~ fully disclose to the  
6094 agency and the directors of the applicant or organization the  
6095 extent and nature of any contracts or arrangements between them  
6096 and the applicant or organization, including any possible  
6097 conflicts of interest.

6098 (d) The name and address of the applicant and the name by  
6099 which the applicant or organization is to be known.

6100 (e) A statement generally describing the applicant or  
6101 organization and its operations.

6102 (f) A copy of the form for each group and individual  
6103 contract, certificate, subscriber handbook, and any other  
6104 similar documents issued to subscribers.

6105 (g) A statement describing the manner in which health care  
6106 services shall be regularly available.

6107 (h) A statement that the applicant has an established  
6108 network of health care providers which is capable of providing  
6109 the health care services that are to be offered by the  
6110 organization.

6111 (i) The locations at which health care services shall be  
6112 regularly available to subscribers.

6113 (j) The type of health care personnel engaged to provide  
6114 the health care services and the quantity of the personnel of  
6115 each type.

6116 (k) A statement giving the present and projected number of  
6117 subscribers to be enrolled annually ~~yearly~~ for the next 3 years.

6118 (l) A statement indicating the source of emergency services  
6119 and care on a 24-hour basis.

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6120 (m) A statement that the physicians employed by the  
6121 applicant have been formally organized as a medical staff and  
6122 that the applicant's governing body has designated a chief of  
6123 medical staff.

6124 (n) A statement describing the manner in which the  
6125 applicant or organization assures the maintenance of a medical  
6126 records system in accordance with accepted medical records'  
6127 standards and practices.

6128 (o) If general anesthesia is to be administered in a  
6129 facility not licensed by the agency, a copy of architectural  
6130 plans that meet the requirements for institutional occupancy  
6131 (NFPA 101 Life Safety Code, current edition as adopted by the  
6132 State Fire Marshal).

6133 (p) A description of the applicant's or organization's  
6134 internal quality assurance program, including committee  
6135 structure, as required under s. 641.51.

6136 (q) A description and supporting documentation concerning  
6137 how the applicant or health maintenance organization will comply  
6138 with internal risk management program requirements under s.  
6139 641.55.

6140 (r) An explanation of how coverage for emergency services  
6141 and care is to be effected outside the applicant's or health  
6142 maintenance organization's stated geographic area.

6143 (s) A statement and map describing with reasonable accuracy  
6144 the specific geographic area to be served.

6145 (t) A nonrefundable application fee of \$1,000.

6146 (u) Such additional information as the agency may  
6147 reasonably require.

6148 Section 85. Paragraph (b) of subsection (2) of section

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6149 430.705, Florida Statutes, is amended to read:

6150 430.705 Implementation of the long-term care community  
6151 diversion pilot projects.—

6152 (2)

6153 (b) The department shall select providers that meet all of  
6154 the following criteria. Providers shall:

6155 1. Have a plan administrator who is dedicated to the  
6156 diversion pilot project and project staff who perform the  
6157 necessary project administrative functions, including data  
6158 collection, reporting, and analysis.

6159 2. Demonstrate the ability to provide program enrollees  
6160 with a choice of care provider by contracting with multiple  
6161 providers that provide the same type of service.

6162 3. Demonstrate through performance or other documented  
6163 means the capacity for prompt payment of claims as specified  
6164 under s. 641.3155.

6165 4. Maintain an insolvency protection account in a bank or  
6166 savings and loan association located in the state with a balance  
6167 of at least \$100,000 into which monthly deposits equal to at  
6168 least 5 percent of premiums received under the project are made  
6169 until the balance equals 2 percent of the total contract amount.  
6170 The account shall be established with such terms as to ensure  
6171 that funds are ~~may only be~~ withdrawn only with the signature  
6172 approval of designated department representatives.

6173 5. Maintain a surplus of at least \$1.5 million as  
6174 determined by the department. Each applicant and each provider  
6175 shall furnish to the department initial and annual unqualified  
6176 audited financial statements prepared by a certified public  
6177 accountant that expressly confirm that the applicant or provider

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6178 satisfies this surplus requirement. The department may approve a  
6179 waiver of compliance with the surplus requirement for an  
6180 existing diversion provider. The department's approval of the  
6181 ~~this waiver is~~ is ~~must be~~ contingent on the provider demonstrating  
6182 proof to the department that the entity has posted and maintains  
6183 a \$1.5 million performance bond, which is written by an insurer  
6184 licensed to transact insurance in this state, in lieu of meeting  
6185 the surplus requirement. The department may not approve a waiver  
6186 of compliance with the surplus requirement that extends beyond  
6187 June 30, 2006. As used in this subparagraph, the term:

6188 a. "Existing diversion provider" means an entity that is  
6189 approved by the department on or before June 30, 2005, to  
6190 provide services to consumers through any long-term care  
6191 community diversion pilot project authorized under ss. 430.701-  
6192 430.709.

6193 b. "Surplus" has the same meaning as in s. 641.19~~(19)~~.

6194 Section 86. Present subsection (12) of section 766.102,  
6195 Florida Statutes, is redesignated as subsection (13), and a new  
6196 subsection (12) is added to that section, to read:

6197 766.102 Medical negligence; standards of recovery; expert  
6198 witness.—

6199 (12) If a physician licensed under chapter 458 or chapter  
6200 459 is a party against whom, or on whose behalf, expert  
6201 testimony about the prevailing professional standard of care is  
6202 offered, the expert witness must otherwise meet the requirements  
6203 of this section and be licensed as a physician under chapter 458  
6204 or chapter 459, or must possess a valid expert witness  
6205 certificate issued under s. 458.3167 or s. 459.0078.

6206 Section 87. Subsection (1) of section 766.104, Florida

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6207 Statutes, is amended to read:

6208       766.104 Pleading in medical negligence cases; claim for  
6209 punitive damages; authorization for release of records for  
6210 investigation.-

6211       (1) An ~~No~~ action ~~shall be filed~~ for personal injury or  
6212 wrongful death arising out of medical negligence, whether in  
6213 tort or in contract, may not be filed unless the attorney filing  
6214 the action has made a reasonable investigation, as permitted by  
6215 the circumstances, to determine that there are grounds for a  
6216 good faith belief that there has been negligence in the care or  
6217 treatment of the claimant.

6218       (a) The complaint or initial pleading must ~~shall~~ contain a  
6219 certificate of counsel that such reasonable investigation gave  
6220 rise to a good faith belief that grounds exist for an action  
6221 against each named defendant. For purposes of this section, good  
6222 faith may be shown ~~to exist~~ if the claimant or his or her  
6223 counsel has received a written opinion, ~~which shall not be~~  
6224 subject to discovery by an opposing party, of an expert as  
6225 defined in s. 766.102 that there appears to be evidence of  
6226 medical negligence. If the court determines that the ~~such~~  
6227 certificate of counsel was not made in good faith and that no  
6228 justiciable issue was presented against a health care provider  
6229 that fully cooperated in providing informal discovery, the court  
6230 shall award attorney's fees and taxable costs against claimant's  
6231 counsel, and ~~shall~~ submit the matter to The Florida Bar for  
6232 disciplinary review of the attorney.

6233       (b) If the cause of action requires the plaintiff to  
6234 establish the breach of a standard of care other than negligence  
6235 in order to impose liability or secure specified damages arising

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6236 out of the rendering of, or the failure to render, medical care  
6237 or services, and the plaintiff intends to pursue such liability  
6238 or damages, the investigation and certification required by this  
6239 subsection must demonstrate grounds for a good faith belief that  
6240 the requirement is satisfied.

6241 Section 88. Subsection (5) of section 766.106, Florida  
6242 Statutes, is amended to read:

6243 766.106 Notice before filing action for medical negligence;  
6244 presuit screening period; offers for admission of liability and  
6245 for arbitration; informal discovery; review.—

6246 (5) DISCOVERY AND ADMISSIBILITY.—No statement, discussion,  
6247 written document, report, or other work product generated by the  
6248 presuit screening process is discoverable or admissible in any  
6249 civil action for any purpose by the opposing party. All  
6250 participants, including, but not limited to, physicians,  
6251 investigators, witnesses, and employees or associates of the  
6252 defendant, are immune from civil liability arising from  
6253 participation in the presuit screening process. This subsection  
6254 does not prohibit a physician licensed under chapter 458 or  
6255 chapter 459, or a physician who holds a certificate to provide  
6256 expert testimony under s. 458.3167 or s. 459.0078, who submits a  
6257 verified written expert medical opinion from being subject to  
6258 disciplinary action pursuant to s. 456.073.

6259 Section 89. Subsection (11) of section 766.1115, Florida  
6260 Statutes, is amended to read:

6261 766.1115 Health care providers; creation of agency  
6262 relationship with governmental contractors.—

6263 (11) APPLICABILITY.—

6264 (a) This section applies to incidents occurring on or after



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6265 April 17, 1992.

6266 (b) This section does not apply to any health care contract  
6267 entered into by the Department of Corrections which is subject  
6268 to s. 768.28(10)(a).

6269 (c) This section does not apply to any affiliation  
6270 agreement or other contract subject to s. 768.28(10)(f).

6271 (d) ~~Nothing in~~ This section does not reduce or limit ~~in any~~  
6272 ~~way reduces or limits~~ the rights of the state or any of its  
6273 agencies or subdivisions to any benefit currently provided under  
6274 s. 768.28.

6275 Section 90. Section 766.1183, Florida Statutes, is created  
6276 to read:

6277 766.1183 Standard of care for Medicaid providers.-

6278 (1) As used in this section:

6279 (a) The terms "applicant," "medical assistance," "medical  
6280 services," and "Medicaid recipient" have the same meaning as in  
6281 s. 409.901.

6282 (b) The term "provider" means a health care provider as  
6283 defined in s. 766.202, an ambulance provider licensed under  
6284 chapter 401, or an entity that qualifies for an exemption under  
6285 s. 400.9905(4)(e). The term includes:

6286 1. Any person or entity for whom a provider is vicariously  
6287 liable; and

6288 2. Any person or entity whose liability is based solely on  
6289 such person or entity being vicariously liable for the actions  
6290 of a provider.

6291 (c) The term "wrongful manner" means in bad faith or with  
6292 malicious purpose or in a manner exhibiting wanton and willful  
6293 disregard of human rights, safety, or property, and shall be

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6294 construed in conformity with the standard set forth in s.  
6295 768.28(9)(a).

6296 (2) A provider is not liable in excess of \$200,000 per  
6297 claimant or \$300,000 per occurrence for any cause of action  
6298 arising out of the rendering of, or the failure to render,  
6299 medical services to a Medicaid recipient, except as provided  
6300 under subsection (3). However, a judgment may be claimed and  
6301 rendered in excess of the amounts set forth in this subsection.  
6302 That portion of the judgment that exceeds these amounts may be  
6303 reported to the Legislature, but may be paid in part or in whole  
6304 by the state only by further act of the Legislature.

6305 (3) A provider may be liable for an amount in excess of  
6306 \$200,000 per claimant or \$300,000 per occurrence only if the  
6307 claimant pleads and proves, by clear and convincing evidence,  
6308 that the provider acted in a wrongful manner. If the claimant so  
6309 pleads, the court, after a reasonable opportunity for discovery,  
6310 shall conduct a hearing before trial to determine if there is a  
6311 reasonable basis in evidence to conclude that the provider acted  
6312 in a wrongful manner. A claim for wrongful conduct is not  
6313 permitted, to the extent it exceeds the amounts set forth in  
6314 subsection (2), unless the claimant makes the showing required  
6315 by this subsection.

6316 (4) At the time an application for medical assistance is  
6317 submitted, the Department of Children and Family Services shall  
6318 furnish the applicant with written notice of the provisions of  
6319 this section.

6320 (5) This section does not limit or exclude the application  
6321 of any law, including s. 766.118, which places limitations upon  
6322 the recovery of civil damages.

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6323 (6) This section does not apply to any claim for damages to  
6324 which s. 768.28 applies.

6325 Section 91. Section 766.1184, Florida Statutes, is created  
6326 to read:

6327 766.1184 Standard of care; low-income pool recipient.-

6328 (1) As used in this section, the term:

6329 (a) "Low-income pool recipient" means a low-income  
6330 individual who is uninsured or underinsured and who receives  
6331 primary care services from a provider which are delivered  
6332 exclusively using funding received by that provider under  
6333 proviso language accompanying specific appropriation 191 of the  
6334 2010-2011 fiscal year General Appropriations Act to establish  
6335 new or expand existing primary care clinics for low-income  
6336 persons who are uninsured or underinsured.

6337 (b) "Provider" means a health care provider, as defined in  
6338 s. 766.202, which received funding under proviso language  
6339 accompanying specific appropriation 191 of the fiscal year 2010-  
6340 11 General Appropriations Act to establish new or expand  
6341 existing primary care clinics for low-income persons who are  
6342 uninsured or underinsured. The term includes:

6343 1. Any person or entity for whom a provider is vicariously  
6344 liable; and

6345 2. Any person or entity whose liability is based solely on  
6346 such person or entity being vicariously liable for the actions  
6347 of a provider.

6348 (c) "Wrongful manner" means in bad faith or with malicious  
6349 purpose or in a manner exhibiting wanton and willful disregard  
6350 of human rights, safety, or property, and shall be construed in  
6351 conformity with the standard set forth in s. 768.28(9)(a).

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6352  
6353 The funding of the provider's primary care clinic must have been  
6354 awarded pursuant to a plan approved by the Legislative Budget  
6355 Commission, and must be the subject of an agreement between the  
6356 provider and the Agency for Health Care Administration,  
6357 following the competitive solicitation of proposals to use low-  
6358 income pool grant funds to provide primary care services in  
6359 general acute hospitals, county health departments, faith-based  
6360 and community clinics, and federally qualified health centers to  
6361 uninsured or underinsured persons.

6362 (2) A provider is not liable in excess of \$200,000 per  
6363 claimant or \$300,000 per occurrence for any cause of action  
6364 arising out of the rendering of, or the failure to render,  
6365 primary care services to a low-income pool recipient, except as  
6366 provided under subsection (3). However, a judgment may be  
6367 claimed and rendered in excess of the amounts set forth in this  
6368 subsection. That portion of the judgment that exceeds these  
6369 amounts may be reported to the Legislature, but may be paid in  
6370 part or in whole by the state only by further act of the  
6371 Legislature.

6372 (3) A provider may be liable for an amount in excess of  
6373 \$200,000 per claimant or \$300,000 per occurrence only if the  
6374 claimant pleads and proves, by clear and convincing evidence,  
6375 that the provider acted in a wrongful manner. If the claimant so  
6376 pleads, the court, after a reasonable opportunity for discovery,  
6377 shall conduct a hearing before trial to determine if there is a  
6378 reasonable basis in evidence to conclude that the provider acted  
6379 in a wrongful manner. A claim for wrongful conduct is not  
6380 permitted, to the extent it exceeds the amounts set forth in

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6381 subsection (2), unless the claimant makes the showing required  
6382 by this subsection.

6383 (4) In order for this section to apply, the provider must:

6384 (a) Develop, implement, and maintain policies and  
6385 procedures to:

6386 1. Ensure that funds described in subsection (1) are used  
6387 exclusively to serve low-income persons who are uninsured or  
6388 underinsured;

6389 2. Determine whether funds described in subsection (1) are  
6390 being used to provide primary care services to a particular  
6391 person; and

6392 3. Identify whether an individual receiving primary care  
6393 services is a low-income pool recipient to whom the provisions  
6394 of this section apply.

6395 (b) Furnish a low-income pool recipient with written notice  
6396 of the provisions of this section before providing primary care  
6397 services to the recipient.

6398 (c) Be in compliance with the terms of any agreement  
6399 between the provider and the Agency for Health Care  
6400 Administration governing the receipt of the funds described in  
6401 subsection (1).

6402 (5) This section does not limit or exclude the application  
6403 of any law, including s. 766.118, which places limitations upon  
6404 the recovery of civil damages.

6405 (6) This section does not apply to any claim for damages to  
6406 which s. 768.28 applies.

6407 Section 92. Subsection (4) of section 766.202, Florida  
6408 Statutes, is amended to read:

6409 766.202 Definitions; ss. 766.201-766.212.—As used in ss.

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6410 766.201-766.212, the term:

6411 (4) "Health care provider" means any hospital, ambulatory  
6412 surgical center, or mobile surgical facility as defined and  
6413 licensed under chapter 395; a birth center licensed under  
6414 chapter 383; any person licensed under chapter 458, chapter 459,  
6415 chapter 460, chapter 461, chapter 462, chapter 463, part I of  
6416 chapter 464, chapter 466, chapter 467, part XIV of chapter 468,  
6417 or chapter 486; a clinical lab licensed under chapter 483; a  
6418 health maintenance organization certificated under part I of  
6419 chapter 641; a blood bank; a plasma center; an industrial  
6420 clinic; a renal dialysis facility; or a professional association  
6421 partnership, corporation, joint venture, or other association  
6422 for professional activity by health care providers.

6423 Section 93. Subsection (5) is added to section 766.203,  
6424 Florida Statutes, to read:

6425 766.203 Presuit investigation of medical negligence claims  
6426 and defenses by prospective parties.-

6427 (5) STANDARDS OF CARE.-If the cause of action that is the  
6428 basis for the litigation requires the plaintiff to establish the  
6429 breach of a standard of care other than negligence in order to  
6430 impose liability or secure specified damages arising out of the  
6431 rendering of, or the failure to render, medical care or  
6432 services, and the plaintiff intends to pursue such liability or  
6433 damages, the presuit investigations required of the claimant and  
6434 the prospective defendant by this section must ascertain that  
6435 there are reasonable grounds to believe that the requirement is  
6436 satisfied.

6437 Section 94. Paragraph (b) of subsection (9) of section  
6438 768.28, Florida Statutes, is amended, and paragraphs (f) and (g)

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6439 are added to subsection (10) of that section, to read:

6440       768.28 Waiver of sovereign immunity in tort actions;  
6441 recovery limits; limitation on attorney fees; statute of  
6442 limitations; exclusions; indemnification; risk management  
6443 programs.—

6444       (9)

6445       (b) As used in this subsection, the term:

6446       1. "Employee" includes any volunteer firefighter.

6447       2. "Officer, employee, or agent" includes, but is not  
6448 limited to, any health care provider when providing services  
6449 pursuant to s. 766.1115;~~7~~ any member of the Florida Health  
6450 Services Corps, as defined in s. 381.0302, who provides  
6451 uncompensated care to medically indigent persons referred by the  
6452 Department of Health; any nonprofit independent college or  
6453 university located and chartered in this state which owns or  
6454 operates an accredited medical school, and its employees or  
6455 agents, when providing patient services pursuant to paragraph  
6456 (10) (f);~~7~~ and any public defender or her or his employee or  
6457 agent, including, among others, an assistant public defender and  
6458 an investigator.

6459       (10)

6460       (f) For purposes of this section, any nonprofit independent  
6461 college or university located and chartered in this state which  
6462 owns or operates an accredited medical school, or any of its  
6463 employees or agents, and which has agreed in an affiliation  
6464 agreement or other contract to provide, or to permit its  
6465 employees or agents to provide, patient services as agents of a  
6466 teaching hospital, is considered an agent of the teaching  
6467 hospital while acting within the scope of and pursuant to

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6468 guidelines established in the contract. To the extent allowed by  
6469 law, the contract must provide for the indemnification of the  
6470 state, up to the limits set out in this chapter, by the agent  
6471 for any liability incurred which was caused by the negligence of  
6472 the college or university or its employees or agents.

6473 1. For purposes of this paragraph, the term:

6474 a. "Employee or agent" means an officer, employee, agent,  
6475 or servant of a nonprofit independent college or university  
6476 located and chartered in this state which owns or operates an  
6477 accredited medical school, including, but not limited to, the  
6478 faculty of the medical school, any health care practitioner or  
6479 licensee as defined in s. 456.001 for which the college or  
6480 university is vicariously liable, and the staff or administrator  
6481 of the medical school.

6482 b. "Patient services" mean:

6483 (I) Comprehensive health care services as defined in s.  
6484 641.19, including any related administrative service, provided  
6485 to patients in a teaching hospital or in a health care facility  
6486 that is a part of a nonprofit independent college or university  
6487 located and chartered in this state which owns or operates an  
6488 accredited medical school, pursuant to an affiliation agreement  
6489 or other contract with a teaching hospital;

6490 (II) Training and supervision of interns, residents, and  
6491 fellows providing patient services in a teaching hospital or in  
6492 a health care facility that is a part of a nonprofit independent  
6493 college or university located and chartered in this state which  
6494 owns or operates an accredited medical school, pursuant to an  
6495 affiliation agreement or other contract with a teaching  
6496 hospital;



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6497 (III) Participation in medical research protocols; or  
6498 (IV) Training and supervision of medical students in a  
6499 teaching hospital or in a health care facility owned by a not-  
6500 for-profit college or university that owns or operates an  
6501 accredited medical school, pursuant to an affiliation agreement  
6502 or other contract with a teaching hospital.

6503 c. "Teaching hospital" means a teaching hospital as defined  
6504 in s. 408.07 which is owned or operated by the state, a county  
6505 or municipality, a public health trust, a special taxing  
6506 district, a governmental entity having health care  
6507 responsibilities, or a not-for-profit entity that operates such  
6508 facilities as an agent of the state or a political subdivision  
6509 of the state under a lease or other contract.

6510 2. The teaching hospital or the medical school, or its  
6511 employees or agents, must provide written notice to each  
6512 patient, or the patient's legal representative, receipt of which  
6513 must be acknowledged in writing, that the college or university  
6514 that owns or operates the medical school and the employees or  
6515 agents of that college or university are acting as agents of the  
6516 teaching hospital and that the exclusive remedy for injury or  
6517 damage suffered as the result of any act or omission of the  
6518 teaching hospital, the college or university that owns or  
6519 operates the medical school, or the employees or agents of the  
6520 college or university while acting within the scope of duties  
6521 pursuant to the affiliation agreement or other contract with a  
6522 teaching hospital, is by commencement of an action pursuant to  
6523 the provisions of this section.

6524 3. This paragraph does not designate any employee providing  
6525 contracted patient services in a teaching hospital as an

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6526 employee or agent of the state for purposes of chapter 440.  
6527 (g) Providers or vendors, 75 percent of whose client  
6528 population consists of individuals with a developmental  
6529 disability as defined in ss. 393.063 and 400.960, individuals  
6530 who are blind or severely handicapped individuals as defined in  
6531 s. 413.033, individuals who have a mental illness as defined  
6532 under s. 394.455, or individuals who have any combination of  
6533 these conditions, which have contractually agreed to act on  
6534 behalf of the Agency for Persons with Disabilities, the Agency  
6535 for Health Care Administration, the Division of Blind Services  
6536 in the Department of Education, or the Mental Health Program  
6537 Office of the Department of Children and Family Services to  
6538 provide services to such individuals, and their employees or  
6539 agents, are considered agents of the state, solely with respect  
6540 to the provision of such services while acting within the scope  
6541 of and pursuant to guidelines established by contract, a  
6542 Medicaid waiver agreement, or rule. The contracts for such  
6543 services must provide for the indemnification of the state by  
6544 the agent for any liabilities incurred up to the limits  
6545 specified in this section.

6546 Section 95. Legislative findings and intent.—

6547 (1) The Legislature finds that:

6548 (a) Access to high-quality, comprehensive, and affordable  
6549 health care for all persons in this state is a necessary state  
6550 goal and that teaching hospitals play an intrinsic and essential  
6551 role in providing that access.

6552 (b) Graduate medical education, provided by nonprofit  
6553 independent colleges and universities located and chartered in  
6554 this state which own or operate medical schools, helps provide

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6555 the comprehensive specialty training needed by medical school  
6556 graduates to develop and refine the skills essential to the  
6557 provision of high-quality health care for our state residents.  
6558 Much of that education and training is provided in teaching  
6559 hospitals under the direct supervision of medical faculty who  
6560 provide guidance, training, and oversight, and serve as role  
6561 models to their students.

6562 (c) A large proportion of medical care is provided in  
6563 teaching hospitals that serve as safety nets for many indigent  
6564 and underserved patients who otherwise might not receive the  
6565 medical help they need. Resident physician training that takes  
6566 place in such hospitals provides much of the care provided to  
6567 this population. Medical faculty, supervising such training and  
6568 care, are a vital link between educating and training resident  
6569 physicians and ensuring the provision of quality care for  
6570 indigent and underserved residents. Physicians that assume this  
6571 role are often called upon to juggle the demands of patient  
6572 care, teaching, research, health policy, and budgetary issues  
6573 related to the programs they administer.

6574 (d) While teaching hospitals are afforded sovereign  
6575 immunity protections under s. 768.28, Florida Statutes, the  
6576 nonprofit independent colleges and universities located and  
6577 chartered in this state which own or operate medical schools and  
6578 which enter into affiliation agreements or contracts with the  
6579 teaching hospitals to provide patient services are not afforded  
6580 such sovereign immunity protections.

6581 (e) The employees or agents of nonprofit independent  
6582 colleges and universities located and chartered in this state  
6583 which enter into affiliation agreements or contracts with

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6584 teaching hospitals to provide patient services do not have the  
6585 same level of protection against liability claims as teaching  
6586 hospitals and their employees and agents that provide the same  
6587 patient services to the same patients. Thus, these colleges and  
6588 universities and their employees and agents are  
6589 disproportionately affected by claims arising out of alleged  
6590 medical malpractice and other allegedly negligent acts. Given  
6591 the recent growth in medical schools and medical education  
6592 programs and ongoing efforts to support, strengthen, and  
6593 increase physician residency training positions and medical  
6594 faculty in both existing and newly designated teaching  
6595 hospitals, this exposure and the consequent disparity in  
6596 liability exposure will continue to increase. The vulnerability  
6597 of these colleges and universities to claims of medical  
6598 malpractice will only add to the current physician workforce  
6599 crisis in Florida and can be alleviated only through legislative  
6600 action.

6601 (f) Ensuring that the employees and agents of nonprofit  
6602 independent colleges and universities located and chartered in  
6603 this state which own or operated medical schools are able to  
6604 continue to treat patients, provide graduate medical education,  
6605 supervise medical students, engage in research, and provide  
6606 administrative support and services in teaching hospitals is an  
6607 overwhelming public necessity.

6608 (2) The Legislature intends that:

6609 (a) Employees and agents of nonprofit independent colleges  
6610 and universities located and chartered in this state which own  
6611 or operate medical schools, who provide patient services as  
6612 agents of a teaching hospital be immune from lawsuits in the

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6613 same manner and to the same extent as employees and agents of  
6614 teaching hospitals in this state under existing law, and that  
6615 such colleges and universities and their employees and agents  
6616 not be held personally liable in tort or named as a party  
6617 defendant in an action while providing patient services in a  
6618 teaching hospital, unless such services are provided in bad  
6619 faith, with malicious purpose, or in a manner exhibiting wanton  
6620 and willful disregard of human rights, safety, or property.

6621 (b) Nonprofit independent private colleges and universities  
6622 located and chartered in this state which own or operate medical  
6623 schools and which permit their employees or agents to provide  
6624 patient services in teaching hospitals pursuant to an  
6625 affiliation agreement or other contract, be afforded sovereign  
6626 immunity protections under s. 768.28, Florida Statutes.

6627 (3) The Legislature declares that there is an overwhelming  
6628 public necessity for extending the state's sovereign immunity to  
6629 nonprofit independent colleges and universities located and  
6630 chartered in this state which own or operate medical schools and  
6631 provide patient services in teaching hospitals, and to their  
6632 employees and agents, and that there is no alternative method of  
6633 meeting such public necessity.

6634 (4) The terms "employee or agent," "patient services," and  
6635 "teaching hospital" used in this section have the same meaning  
6636 as the terms defined in s. 768.28, Florida Statutes, as amended  
6637 by this act.

6638 Section 96. Section 1004.41, Florida Statutes, is amended  
6639 to read:

6640 1004.41 University of Florida; J. Hillis Miller Health  
6641 Center.—

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6642 (1) There is established the J. Hillis Miller Health Center  
6643 at the University of Florida, including campuses at Gainesville  
6644 and Jacksonville and affiliated teaching hospitals, which shall  
6645 include the following colleges:

6646 (a) College of Dentistry.

6647 (b) College of Public Health and Health Professions.

6648 (c) College of Medicine.

6649 (d) College of Nursing.

6650 (e) College of Pharmacy.

6651 (f) College of Veterinary Medicine and related teaching  
6652 hospitals.

6653 (2) Each college of the health center shall be ~~se~~  
6654 maintained and operated so as to comply with the standards  
6655 approved by a nationally recognized association for  
6656 accreditation.

6657 (3) (a) The University of Florida Health Center Operations  
6658 and Maintenance Trust Fund shall be administered by the  
6659 University of Florida Board of Trustees. Funds shall be credited  
6660 to the trust fund from the sale of goods and services performed  
6661 by the University of Florida Veterinary Medicine Teaching  
6662 Hospital. The purpose of the trust fund is to support the  
6663 instruction, research, and service missions of the University of  
6664 Florida College of Veterinary Medicine.

6665 (b) Notwithstanding ~~the provisions of~~ s. 216.301, and  
6666 pursuant to s. 216.351, any balance in the trust fund at the end  
6667 of any fiscal year shall remain in the trust fund and ~~shall~~ be  
6668 available for carrying out the purposes of the trust fund.

6669 (4) (a) The University of Florida Board of Trustees shall  
6670 lease the hospital facilities of the health center known as ~~the~~

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6671 Shands Teaching Hospital and Clinics on the Gainesville campus  
6672 of the University of Florida and all furnishings, equipment, and  
6673 other chattels or choses in action used in the operation of  
6674 Shands Teaching Hospital and Clinics ~~the hospital,~~ to Shands  
6675 Teaching Hospital and Clinics, Inc., a private not-for-profit  
6676 corporation organized ~~solely~~ for the primary purpose of  
6677 supporting the University of Florida Board of Trustees' health  
6678 affairs mission of community service and patient care, education  
6679 and training of health professionals, and clinical research. In  
6680 furtherance of that primary purpose, Shands Teaching Hospital  
6681 and Clinics, Inc., shall operate ~~operating~~ the hospital and  
6682 ancillary health care facilities as deemed ~~of the health center~~  
6683 ~~and other health care facilities and programs determined to be~~  
6684 necessary by the board of Shands Teaching Hospital and Clinics,  
6685 Inc. ~~the nonprofit corporation.~~ The rental for the hospital  
6686 facilities shall be an amount equal to the debt service on bonds  
6687 or revenue certificates issued solely for capital improvements  
6688 to the hospital facilities or as otherwise provided by law.

6689 (b) The University of Florida Board of Trustees shall  
6690 provide in the lease or by separate contract or agreement with  
6691 Shands Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~  
6692 ~~corporation~~ for the following:

6693 1. Approval of the articles of incorporation of Shands  
6694 Teaching Hospital and Clinics, Inc., ~~the not-for-profit~~  
6695 ~~corporation~~ by the University of Florida Board of Trustees. and  
6696 ~~the~~

6697 2. Governance of Shands Teaching Hospital and Clinics,  
6698 Inc., ~~the not-for-profit corporation~~ by a board of directors  
6699 appointed, subject to removal, and chaired by the President of

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6700 the University of Florida, or his or her designee, and vice  
6701 chaired by the Vice President for Health Affairs of the  
6702 University of Florida, or his or her designee.

6703 ~~3.2. The Use of hospital facilities and personnel in~~  
6704 support of community service and patient care, ~~the~~ research  
6705 programs, ~~and of the teaching roles~~ role of the health center.

6706 ~~4.3. The Continued recognition of the collective bargaining~~  
6707 units and collective bargaining agreements as currently composed  
6708 and recognition of the certified labor organizations  
6709 representing those units and agreements.

6710 ~~5.4. The Use of hospital facilities and personnel in~~  
6711 connection with research programs conducted by the health  
6712 center.

6713 ~~6.5. Reimbursement to Shands Teaching Hospital and Clinics,~~  
6714 Inc., ~~the hospital~~ for indigent patients, state-mandated  
6715 programs, underfunded state programs, and costs to Shands  
6716 Teaching Hospital and Clinics, Inc., ~~the hospital~~ for support of  
6717 the teaching and research programs of the health center. Such  
6718 reimbursement shall be appropriated to either the health center  
6719 or Shands Teaching Hospital and Clinics, Inc., ~~the hospital~~ each  
6720 year by the Legislature after review and approval of the request  
6721 for funds.

6722 7. Audit of the financial statements of Shands Teaching  
6723 Hospital and Clinics, Inc., in accordance with generally  
6724 accepted accounting principles as prescribed by the Governmental  
6725 Accounting Standards Board for a separate corporation affiliated  
6726 with a governmental entity that holds a voting majority interest  
6727 of the affiliated corporation's governing board. The financial  
6728 statements shall be provided to the University of Florida Board



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6729 of Trustees for attachment to its audited financial statement  
6730 that is provided to the Auditor General. The University of  
6731 Florida may obtain additional financial information from Shands  
6732 Teaching Hospital and Clinics, Inc., upon request by the Auditor  
6733 General. This subparagraph applies equally to any not-for-profit  
6734 subsidiary of Shands Teaching Hospitals and Clinics, Inc., which  
6735 directly delivers health care services and also qualifies as an  
6736 instrumentality of the state under the governance control and  
6737 the primary purpose standards specified in this section.

6738 (c) The University of Florida Board of Trustees may, with  
6739 the approval of the Legislature, increase the hospital  
6740 facilities or remodel or renovate them if, provided that the  
6741 rental paid by Shands Teaching Hospital and Clinics, Inc., the  
6742 hospital for such new, remodeled, or renovated facilities is  
6743 sufficient to amortize the costs thereof over a reasonable  
6744 period of time or fund the debt service for any bonds or revenue  
6745 certificates issued to finance such improvements.

6746 (d) The University of Florida Board of Trustees may is  
6747 authorized to provide to Shands Teaching Hospital and Clinics,  
6748 Inc., the not-for-profit corporation leasing the hospital  
6749 facilities and its not-for-profit subsidiaries and affiliates,  
6750 and any successor corporation that acts in support of the board  
6751 of trustees, comprehensive general liability insurance,  
6752 including professional liability, from a self-insurance trust  
6753 program established pursuant to s. 1004.24.

6754 (e) Shands Teaching Hospital and Clinics, Inc., in support  
6755 of the health affairs mission of the University of Florida Board  
6756 of Trustees and with the board's prior approval, may create or  
6757 have created for-profit or not-for-profit subsidiaries and

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6758 affiliates, or both. The University of Florida Board of  
6759 Trustees, which may act through the president of the university  
6760 or his or her designee, may control Shands Teaching Hospital and  
6761 Clinics, Inc. For purposes of sovereign immunity pursuant to s.  
6762 768.28(2), Shands Teaching Hospital and Clinics, Inc., and any  
6763 not-for-profit subsidiary that directly delivers health care  
6764 services and whose governing board is chaired by the president  
6765 of the university or his or her designee and is controlled by  
6766 the University of Florida Board of Trustees, that may act  
6767 through the president of the university or his or her designee,  
6768 and whose primary purpose is the support of the University of  
6769 Florida Board of Trustees' health affairs mission, shall be  
6770 conclusively deemed a corporation primarily acting as an  
6771 instrumentality of the state.

6772 (f) ~~(e)~~ If ~~in the event that~~ the lease of Shands Teaching  
6773 Hospital and Clinics ~~the hospital facilities~~ to Shands Teaching  
6774 Hospital and Clinics, Inc., ~~the not-for-profit corporation~~ is  
6775 terminated for any reason, the University of Florida Board of  
6776 Trustees shall resume management and operation of Shands  
6777 Teaching Hospital and Clinics ~~the hospital facilities~~. In such  
6778 event, the University of Florida Board of Trustees may use ~~is~~  
6779 ~~authorized to utilize~~ revenues generated from the operation of  
6780 Shands Teaching Hospital and Clinics ~~the hospital facilities~~ to  
6781 pay the costs and expenses of operating the hospital facility  
6782 for the remainder of the fiscal year in which such termination  
6783 occurs.

6784 (5) (a) Shands Jacksonville Medical Center, Inc., and its  
6785 parent, Shands Jacksonville HealthCare, Inc., are private not-  
6786 for-profit corporations organized primarily to support the

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6787 health affairs mission of the University of Florida Board of  
6788 Trustees in community service and patient care, education and  
6789 training of health affairs professionals, and clinical research.  
6790 Shands Jacksonville Medical Center, Inc., is a teaching hospital  
6791 affiliated with the University of Florida Board of Trustees and  
6792 is located, in part, on the Jacksonville Campus of the  
6793 University of Florida. Shands Jacksonville Medical Center, Inc.,  
6794 and Shands Jacksonville HealthCare, Inc., in support of the  
6795 health affairs mission of the University of Florida Board of  
6796 Trustees and with its prior approval, may create or have created  
6797 for-profit or not-for-profit subsidiaries or affiliates, or  
6798 both.

6799 (b) The University of Florida Board of Trustees shall  
6800 provide in the lease or by separate contract or agreement with  
6801 Shands Jacksonville Medical Center, Inc., and Shands  
6802 Jacksonville HealthCare, Inc., for the following:

6803 1. Approval of the articles of incorporation of Shands  
6804 Jacksonville Medical Center, Inc., and of Shands Jacksonville  
6805 HealthCare, Inc., by the University of Florida Board of  
6806 Trustees, which may act through the president of the university  
6807 or his or her designee. In approving the articles of  
6808 incorporation of Shands Jacksonville Medical Center, Inc., and  
6809 of Shands Jacksonville HealthCare, Inc., the president of the  
6810 university, or his or her designee, may act as the chair of the  
6811 board of directors, or the president of the university or his or  
6812 her designee or members of the University of Florida Board of  
6813 Trustees may act as the approving body of Shands Jacksonville  
6814 Medical Center, Inc., or Shands Jacksonville HealthCare, Inc.

6815 2. Governance of Shands Jacksonville Medical Center, Inc.,

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6816 and of Shands Jacksonville HealthCare, Inc., by boards of  
6817 directors appointed, subject to removal, and chaired by the  
6818 President of the University of Florida, or his or her designee.  
6819 One director of each board may be so appointed after being  
6820 nominated by the mayor of the City of Jacksonville subject to  
6821 the applicable standards for directors of such board. If there  
6822 is a vice chair of the board of directors of Shands Jacksonville  
6823 Medical Center, Inc., or Shands Jacksonville HealthCare, Inc.,  
6824 the Vice President for Health Affairs of the University of  
6825 Florida, or his or her designee or the designee of the president  
6826 of the university, shall hold that position.

6827 3. Use of the Shands Jacksonville Medical Center, Inc.,  
6828 hospital facilities and personnel in support of community  
6829 service and patient care, research programs, and the teaching  
6830 roles of the health center of the University of Florida Board of  
6831 Trustees.

6832 4. Reimbursement to Shands Jacksonville Medical Center,  
6833 Inc., for indigent patients, state-mandated programs,  
6834 underfunded state programs, and costs to the not-for-profit  
6835 corporation for support of the teaching and research programs of  
6836 the health center. Such reimbursement shall be appropriated to  
6837 the health center or the not-for-profit corporation each year by  
6838 the Legislature after review and approval of the request for  
6839 funds.

6840 5. Audit of the financial statements of Shands Jacksonville  
6841 Medical Center, Inc., and Shands Jacksonville HealthCare, Inc.,  
6842 in accordance with generally accepted accounting principles as  
6843 prescribed by the Governmental Accounting Standards Board for a  
6844 separate corporation affiliated with a governmental entity that

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6845 holds a voting majority interest of the affiliated corporation's  
6846 governing board. The financial statements shall be provided to  
6847 the University of Florida Board of Trustees for attachment to  
6848 its audited financial statement that is provided to the Auditor  
6849 General. The University of Florida may obtain additional  
6850 financial information from Shands Jacksonville Medical Center,  
6851 Inc., and Shands Jacksonville HealthCare, Inc., upon request by  
6852 the Auditor General. This subparagraph applies equally to any  
6853 not-for-profit subsidiary that directly delivers health care  
6854 services and also qualifies as an instrumentality of the state  
6855 under the governance control and primary purpose standards  
6856 specified in this section.

6857 (c) The University of Florida Board of Trustees, which may  
6858 act through the president of the university or his or her  
6859 designee, may control Shands Jacksonville Medical Center, Inc.,  
6860 and Shands Jacksonville HealthCare, Inc.

6861 (d) For purposes of sovereign immunity pursuant to s.  
6862 768.28(2), Shands Jacksonville Medical Center, Inc., Shands  
6863 Jacksonville HealthCare, Inc., and any not-for-profit subsidiary  
6864 that directly delivers health care services and whose governing  
6865 board is chaired by the President of the University of Florida  
6866 or his or her designee and is controlled by the University of  
6867 Florida Board of Trustees, that may act through the president of  
6868 the university or his or designee, and whose primary purpose is  
6869 the support of the University of Florida Board of Trustees'  
6870 health affairs mission, shall be conclusively deemed  
6871 corporations primarily acting as instrumentalities of the state.

6872 (e) ~~(f)~~ The University of Florida Board of Trustees may ~~is~~  
6873 authorized to provide to Shands Jacksonville HealthCare, Inc.,

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6874 and Shands Jacksonville Medical Center, Inc., and any of their  
6875 ~~its~~ not-for-profit subsidiaries and affiliates and any successor  
6876 corporation that acts in support of the board of trustees,  
6877 comprehensive general liability coverage, including professional  
6878 liability, from the self-insurance programs established pursuant  
6879 to s. 1004.24.

6880 Section 97. Sections 409.9121, 409.919, and 624.915,  
6881 Florida Statutes, are repealed.

6882 Section 98. Section 409.942, Florida Statutes, is  
6883 transferred and renumbered as section 414.29, Florida Statutes.

6884 Section 99. Paragraph (a) of subsection (1) of section  
6885 443.111, Florida Statutes, is amended to read:

6886 443.111 Payment of benefits.—

6887 (1) MANNER OF PAYMENT.—Benefits are payable from the fund  
6888 in accordance with rules adopted by the Agency for Workforce  
6889 Innovation, subject to the following requirements:

6890 (a) Benefits are payable by mail or electronically.  
6891 Notwithstanding s. 414.29 ~~409.942(4)~~, the agency may develop a  
6892 system for the payment of benefits by electronic funds transfer,  
6893 including, but not limited to, debit cards, electronic payment  
6894 cards, or any other means of electronic payment that the agency  
6895 deems to be commercially viable or cost-effective. Commodities  
6896 or services related to the development of such a system shall be  
6897 procured by competitive solicitation, unless they are purchased  
6898 from a state term contract pursuant to s. 287.056. The agency  
6899 shall adopt rules necessary to administer the system.

6900 Section 100. Sections 409.944, 409.945, and 409.946,  
6901 Florida Statutes, are transferred and renumbered as sections  
6902 163.464, 163.465, and 163.466, Florida Statutes, respectively.

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6903           Section 101. Sections 409.953 and 409.9531, Florida  
6904 Statutes, are transferred and renumbered as sections 402.81 and  
6905 402.82, Florida Statutes, respectively.

6906           Section 102. The Agency for Health Care Administration  
6907 shall submit a reorganizational plan to the Governor, the  
6908 Speaker of the House of Representatives, and the President of  
6909 the Senate by January 1, 2012, which converts the agency from a  
6910 check-writing and fraud-chasing agency into a contract  
6911 compliance and monitoring agency.

6912           Section 103. Effective December 1, 2011, if the Legislature  
6913 has not received a letter from the Governor stating that the  
6914 federal Centers for Medicare and Medicaid has approved the  
6915 waivers necessary to implement the Medicaid managed care reforms  
6916 contained in this act, the State of Florida shall withdraw from  
6917 the Medicaid program effective December 31, 2011.

6918           Section 104. If any provision of this act or its  
6919 application to any person or circumstance is held invalid, the  
6920 invalidity does not affect other provisions or applications of  
6921 the act which can be given effect without the invalid provision  
6922 or application, and to this end the provisions of this act are  
6923 severable.

6924           Section 105. This act shall take effect upon becoming a  
6925 law.