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LEGISLATIVE ACTION

Senate	.	House
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05/05/2011 05:15 PM	.	05/06/2011 07:42 PM
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Senator Negron moved the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 393.0661, Florida Statutes, is amended to
6 read:
7 393.0661 Home and community-based services delivery system;
8 comprehensive redesign.—The Legislature finds that the home and
9 community-based services delivery system for persons with
10 developmental disabilities and the availability of appropriated
11 funds are two of the critical elements in making services
12 available. Therefore, it is the intent of the Legislature that
13 the Agency for Persons with Disabilities shall develop and

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14 implement a comprehensive redesign of the system.
15 (1) The redesign of the home and community-based services
16 system shall include, at a minimum, all actions necessary to
17 achieve an appropriate rate structure, client choice within a
18 specified service package, appropriate assessment strategies, an
19 efficient billing process that contains reconciliation and
20 monitoring components, and a redefined role for support
21 coordinators that avoids potential conflicts of interest and
22 ensures that family/client budgets are linked to levels of need.
23 (a) The agency shall use an assessment instrument that the
24 agency deems to be reliable and valid, including, but not
25 limited to, the Department of Children and Family Services'
26 Individual Cost Guidelines or the agency's Questionnaire for
27 Situational Information. The agency may contract with an
28 external vendor or may use support coordinators to complete
29 client assessments if it develops sufficient safeguards and
30 training to ensure ongoing inter-rater reliability.
31 (b) The agency, with the concurrence of the Agency for
32 Health Care Administration, may contract for the determination
33 of medical necessity and establishment of individual budgets.
34 (2) A provider of services rendered to persons with
35 developmental disabilities pursuant to a federally approved
36 waiver shall be reimbursed according to a rate methodology based
37 upon an analysis of the expenditure history and prospective
38 costs of providers participating in the waiver program, or under
39 any other methodology developed by the Agency for Health Care
40 Administration, in consultation with the Agency for Persons with
41 Disabilities, and approved by the Federal Government in
42 accordance with the waiver.

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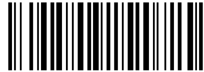
43 (3) The Agency for Health Care Administration, in
44 consultation with the agency, shall seek federal approval and
45 implement a four-tiered waiver system to serve eligible clients
46 through the developmental disabilities and family and supported
47 living waivers. For the purpose of this waiver program, eligible
48 clients shall include individuals with a diagnosis of Down
49 syndrome or a developmental disability as defined in s. 393.063.
50 The agency shall assign all clients receiving services through
51 the developmental disabilities waiver to a tier based on the
52 Department of Children and Family Services' Individual Cost
53 Guidelines, the agency's Questionnaire for Situational
54 Information, or another such assessment instrument deemed to be
55 valid and reliable by the agency; client characteristics,
56 including, but not limited to, age; and other appropriate
57 assessment methods.
58 (a) Tier one is limited to clients who have service needs
59 that cannot be met in tier two, three, or four for intensive
60 medical or adaptive needs and that are essential for avoiding
61 institutionalization, or who possess behavioral problems that
62 are exceptional in intensity, duration, or frequency and present
63 a substantial risk of harm to themselves or others. Total annual
64 expenditures under tier one may not exceed $150,000 per client
65 each year, provided that expenditures for clients in tier one
66 with a documented medical necessity requiring intensive
67 behavioral residential habilitation services, intensive
68 behavioral residential habilitation services with medical needs,
69 or special medical home care, as provided in the Developmental
70 Disabilities Waiver Services Coverage and Limitations Handbook,
71 are not subject to the $150,000 limit on annual expenditures.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72 (b) Tier two is limited to clients whose service needs
73 include a licensed residential facility and who are authorized
74 to receive a moderate level of support for standard residential
75 habilitation services or a minimal level of support for behavior
76 focus residential habilitation services, or clients in supported
77 living who receive more than 6 hours a day of in-home support
78 services. Total annual expenditures under tier two may not
79 exceed $53,625 per client each year.
80 (c) Tier three includes, but is not limited to, clients
81 requiring residential placements, clients in independent or
82 supported living situations, and clients who live in their
83 family home. Total annual expenditures under tier three may not
84 exceed $34,125 per client each year.
85 (d) Tier four includes individuals who were enrolled in the
86 family and supported living waiver on July 1, 2007, who shall be
87 assigned to this tier without the assessments required by this
88 section. Tier four also includes, but is not limited to, clients
89 in independent or supported living situations and clients who
90 live in their family home. Total annual expenditures under tier
91 four may not exceed $14,422 per client each year.
92 (e) The Agency for Health Care Administration shall also
93 seek federal approval to provide a consumer-directed option for
94 persons with developmental disabilities which corresponds to the
95 funding levels in each of the waiver tiers. The agency shall
96 implement the four-tiered waiver system beginning with tiers
97 one, three, and four and followed by tier two. The agency and
98 the Agency for Health Care Administration may adopt rules
99 necessary to administer this subsection.
100 (f) The agency shall seek federal waivers and amend

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101 contracts as necessary to make changes to services defined in
102 federal waiver programs administered by the agency as follows:
103 1. Supported living coaching services may not exceed 20
104 hours per month for persons who also receive in-home support
105 services.
106 2. Limited support coordination services is the only type
107 of support coordination service that may be provided to persons
108 under the age of 18 who live in the family home.
109 3. Personal care assistance services are limited to 180
110 hours per calendar month and may not include rate modifiers.
111 Additional hours may be authorized for persons who have
112 intensive physical, medical, or adaptive needs if such hours are
113 essential for avoiding institutionalization.
114 4. Residential habilitation services are limited to 8 hours
115 per day. Additional hours may be authorized for persons who have
116 intensive medical or adaptive needs and if such hours are
117 essential for avoiding institutionalization, or for persons who
118 possess behavioral problems that are exceptional in intensity,
119 duration, or frequency and present a substantial risk of harming
120 themselves or others. This restriction shall be in effect until
121 the four-tiered waiver system is fully implemented.
122 5. Chore services, nonresidential support services, and
123 homemaker services are eliminated. The agency shall expand the
124 definition of in-home support services to allow the service
125 provider to include activities previously provided in these
126 eliminated services.
127 6. Massage therapy, medication review, and psychological
128 assessment services are eliminated.
129 7. The agency shall conduct supplemental cost plan reviews

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130 to verify the medical necessity of authorized services for plans
131 that have increased by more than 8 percent during either of the
132 2 preceding fiscal years.
133 8. The agency shall implement a consolidated residential
134 habilitation rate structure to increase savings to the state
135 through a more cost-effective payment method and establish
136 uniform rates for intensive behavioral residential habilitation
137 services.
138 9. Pending federal approval, the agency may extend current
139 support plans for clients receiving services under Medicaid
140 waivers for 1 year beginning July 1, 2007, or from the date
141 approved, whichever is later. Clients who have a substantial
142 change in circumstances which threatens their health and safety
143 may be reassessed during this year in order to determine the
144 necessity for a change in their support plan.
145 10. The agency shall develop a plan to eliminate
146 redundancies and duplications between in-home support services,
147 companion services, personal care services, and supported living
148 coaching by limiting or consolidating such services.
149 11. The agency shall develop a plan to reduce the intensity
150 and frequency of supported employment services to clients in
151 stable employment situations who have a documented history of at
152 least 3 years' employment with the same company or in the same
153 industry.
154 (4) The geographic differential for Miami-Dade, Broward,
155 and Palm Beach Counties for residential habilitation services
156 shall be 7.5 percent.
157 (5) The geographic differential for Monroe County for
158 residential habilitation services shall be 20 percent.

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159 (6) Effective January 1, 2010, and except as otherwise
160 provided in this section, a client served by the home and
161 community-based services waiver or the family and supported
162 living waiver funded through the agency shall have his or her
163 cost plan adjusted to reflect the amount of expenditures for the
164 previous state fiscal year plus 5 percent if such amount is less
165 than the client's existing cost plan. The agency shall use
166 actual paid claims for services provided during the previous
167 fiscal year that are submitted by October 31 to calculate the
168 revised cost plan amount. If the client was not served for the
169 entire previous state fiscal year or there was any single change
170 in the cost plan amount of more than 5 percent during the
171 previous state fiscal year, the agency shall set the cost plan
172 amount at an estimated annualized expenditure amount plus 5
173 percent. The agency shall estimate the annualized expenditure
174 amount by calculating the average of monthly expenditures,
175 beginning in the fourth month after the client enrolled,
176 interrupted services are resumed, or the cost plan was changed
177 by more than 5 percent and ending on August 31, 2009, and
178 multiplying the average by 12. In order to determine whether a
179 client was not served for the entire year, the agency shall
180 include any interruption of a waiver-funded service or services
181 lasting at least 18 days. If at least 3 months of actual
182 expenditure data are not available to estimate annualized
183 expenditures, the agency may not rebase a cost plan pursuant to
184 this subsection. The agency may not rebase the cost plan of any
185 client who experiences a significant change in recipient
186 condition or circumstance which results in a change of more than
187 5 percent to his or her cost plan between July 1 and the date

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188 that a rebased cost plan would take effect pursuant to this
189 subsection.
190 (7) The agency shall collect premiums or cost sharing
191 pursuant to s. 409.906(13)(d).
192 (8) ~~(7)~~ ~~Nothing in~~ This section or related ~~in any~~
193 ~~administrative~~ rule does not ~~shall be construed to~~ prevent or
194 limit the Agency for Health Care Administration, in consultation
195 with the Agency for Persons with Disabilities, from adjusting
196 fees, reimbursement rates, lengths of stay, number of visits, or
197 number of services, or from limiting enrollment, or making any
198 other adjustment necessary to comply with the availability of
199 moneys and any limitations or directions provided ~~for~~ in the
200 General Appropriations Act.
201 (9) ~~(8)~~ The Agency for Persons with Disabilities shall
202 submit quarterly status reports to the Executive Office of the
203 Governor, the chair of the Senate Ways and Means Committee or
204 its successor, and the chair of the House Fiscal Council or its
205 successor regarding the financial status of home and community-
206 based services, including the number of enrolled individuals who
207 are receiving services through one or more programs; the number
208 of individuals who have requested services who are not enrolled
209 but who are receiving services through one or more programs,
210 with a description indicating the programs from which the
211 individual is receiving services; the number of individuals who
212 have refused an offer of services but who choose to remain on
213 the list of individuals waiting for services; the number of
214 individuals who have requested services but who are receiving no
215 services; a frequency distribution indicating the length of time
216 individuals have been waiting for services; and information

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217 concerning the actual and projected costs compared to the amount
218 of the appropriation available to the program and any projected
219 surpluses or deficits. If at any time an analysis by the agency,
220 in consultation with the Agency for Health Care Administration,
221 indicates that the cost of services is expected to exceed the
222 amount appropriated, the agency shall submit a plan in
223 accordance with subsection (8) ~~(7)~~ to the Executive Office of
224 the Governor, the chair of the Senate Ways and Means Committee
225 or its successor, and the chair of the House Fiscal Council or
226 its successor to remain within the amount appropriated. The
227 agency shall work with the Agency for Health Care Administration
228 to implement the plan so as to remain within the appropriation.
229 (10) Implementation of Medicaid waiver programs and
230 services authorized under this chapter is limited by the funds
231 appropriated for the individual budgets pursuant to s. 393.0662
232 and the four-tiered waiver system pursuant to subsection (3).
233 Contracts with independent support coordinators and service
234 providers must include provisions requiring compliance with
235 agency cost containment initiatives. The agency shall implement
236 monitoring and accounting procedures necessary to track actual
237 expenditures and project future spending compared to available
238 appropriations for Medicaid waiver programs. When necessary
239 based on projected deficits, the agency must establish specific
240 corrective action plans that incorporate corrective actions of
241 contracted providers that are sufficient to align program
242 expenditures with annual appropriations. If deficits continue
243 during the 2012-2013 fiscal year, the agency in conjunction with
244 the Agency for Health Care Administration shall develop a plan
245 to redesign the waiver program and submit the plan to the

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246 President of the Senate and the Speaker of the House of
247 Representatives by September 30, 2013. At a minimum, the plan
248 must include the following elements:
249 (a) Budget predictability.—Agency budget recommendations
250 must include specific steps to restrict spending to budgeted
251 amounts based on alternatives to the iBudget and four-tiered
252 Medicaid waiver models.
253 (b) Services.—The agency shall identify core services that
254 are essential to provide for client health and safety and
255 recommend elimination of coverage for other services that are
256 not affordable based on available resources.
257 (c) Flexibility.—The redesign shall be responsive to
258 individual needs and to the extent possible encourage client
259 control over allocated resources for their needs.
260 (d) Support coordination services.-The plan shall modify
261 the manner of providing support coordination services to improve
262 management of service utilization and increase accountability
263 and responsiveness to agency priorities.
264 (e) Reporting.—The agency shall provide monthly reports to
265 the President of the Senate and the Speaker of the House of
266 Representatives on plan progress and development on July 31,
267 2013, and August 31, 2013.
268 (f) Implementation.—The implementation of a redesigned
269 program is subject to legislative approval and shall occur no
270 later than July 1, 2014. The Agency for Health Care
271 Administration shall seek federal waivers as needed to implement
272 the redesigned plan approved by the Legislature.
273 Section 2. Subsections (13) through (40) of section
274 393.063, Florida Statutes, are renumbered as subsections (14)

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275 through (41), respectively, and a new subsection (13) is added
276 to that section to read:
277 393.063 Definitions.—For the purposes of this chapter, the
278 term:
279 (13) “Down syndrome” means a disorder caused by the
280 presence of an extra chromosome 21.
281 Section 3. Paragraph (e) of subsection (1) of section
282 408.040, Florida Statutes, is redesignated as paragraph (d), and
283 paragraph (b) and present paragraph (d) of that subsection are
284 amended to read:
285 408.040 Conditions and monitoring.—
286 (1)
287 (b) The agency may consider, in addition to the other
288 criteria specified in s. 408.035, a statement of intent by the
289 applicant that a specified percentage of the annual patient days
290 at the facility will be utilized by patients eligible for care
291 under Title XIX of the Social Security Act. Any certificate of
292 need issued to a nursing home in reliance upon an applicant’s
293 statements that a specified percentage of annual patient days
294 will be utilized by residents eligible for care under Title XIX
295 of the Social Security Act must include a statement that such
296 certification is a condition of issuance of the certificate of
297 need. The certificate-of-need program shall notify the Medicaid
298 program office and the Department of Elderly Affairs when it
299 imposes conditions as authorized in this paragraph in an area in
300 which a community diversion pilot project is implemented.
301 Effective July 1, 2012, the agency may not impose sanctions
302 related to patient day utilization by patients eligible for care
303 under Title XIX of the Social Security Act for nursing homes.

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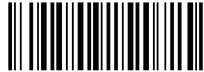
304 ~~(d) If a nursing home is located in a county in which a~~
305 ~~long-term care community diversion pilot project has been~~
306 ~~implemented under s. 430.705 or in a county in which an~~
307 ~~integrated, fixed-payment delivery program for Medicaid~~
308 ~~recipients who are 60 years of age or older or dually eligible~~
309 ~~for Medicare and Medicaid has been implemented under s.~~
310 ~~409.912(5), the nursing home may request a reduction in the~~
311 ~~percentage of annual patient days used by residents who are~~
312 ~~eligible for care under Title XIX of the Social Security Act,~~
313 ~~which is a condition of the nursing home's certificate of need.~~
314 ~~The agency shall automatically grant the nursing home's request~~
315 ~~if the reduction is not more than 15 percent of the nursing~~
316 ~~home's annual Medicaid-patient-days condition. A nursing home~~
317 ~~may submit only one request every 2 years for an automatic~~
318 ~~reduction. A requesting nursing home must notify the agency in~~
319 ~~writing at least 60 days in advance of its intent to reduce its~~
320 ~~annual Medicaid-patient-days condition by not more than 15~~
321 ~~percent. The agency must acknowledge the request in writing and~~
322 ~~must change its records to reflect the revised certificate-of-~~
323 ~~need condition. This paragraph expires June 30, 2011.~~
324 Section 4. Subsection (1) of section 408.0435, Florida
325 Statutes, is amended to read:
326 408.0435 Moratorium on nursing home certificates of need.—
327 (1) Notwithstanding the establishment of need as provided
328 for in this chapter, a certificate of need for additional
329 community nursing home beds may not be approved by the agency
330 until Medicaid managed care is implemented statewide pursuant to
331 ss. 409.961-409.985 or October 1, 2016, whichever is earlier
332 ~~July 1, 2011~~.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333 Section 5. Sections 409.016 through 409.803, Florida
334 Statutes, are designated as part I of chapter 409, Florida
335 Statutes, and entitled "SOCIAL AND ECONOMIC ASSISTANCE."
336 Section 6. Sections 409.810 through 409.821, Florida
337 Statutes, are designated as part II of chapter 409, Florida
338 Statutes, and entitled "KIDCARE."
339 Section 7. Sections 409.901 through 409.9205, Florida
340 Statutes, are designated as part III of chapter 409, Florida
341 Statutes, and entitled "MEDICAID."
342 Section 8. Section 409.9021, Florida Statutes, is amended
343 to read:
344 409.9021 Forfeiture of eligibility agreement.—As a
345 condition of Medicaid eligibility, subject to federal approval,
346 a Medicaid applicant shall agree in writing to forfeit all
347 entitlements to any goods or services provided through the
348 Medicaid program for the next 10 years if he or she has been
349 found to have committed Medicaid fraud, through judicial or
350 administrative determination~~, two times in a period of 5 years~~.
351 This provision applies only to the Medicaid recipient found to
352 have committed or participated in Medicaid ~~the~~ fraud and does
353 not apply to any family member of the recipient who was not
354 involved in the fraud.
355 Section 9. Subsections (2) and (4) and paragraph (c) of
356 subsection (5) of section 409.905, Florida Statutes, are
357 amended, and paragraph (g) is added to subsection (5), to read:
358 409.905 Mandatory Medicaid services.—The agency may make
359 payments for the following services, which are required of the
360 state by Title XIX of the Social Security Act, furnished by
361 Medicaid providers to recipients who are determined to be

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362 eligible on the dates on which the services were provided. Any
363 service under this section shall be provided only when medically
364 necessary and in accordance with state and federal law.
365 Mandatory services rendered by providers in mobile units to
366 Medicaid recipients may be restricted by the agency. Nothing in
367 this section shall be construed to prevent or limit the agency
368 from adjusting fees, reimbursement rates, lengths of stay,
369 number of visits, number of services, or any other adjustments
370 necessary to comply with the availability of moneys and any
371 limitations or directions provided for in the General
372 Appropriations Act or chapter 216.
373 (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
374 SERVICES.—The agency shall pay for early and periodic screening
375 and diagnosis of a recipient under age 21 to ascertain physical
376 and mental problems and conditions and ~~provide treatment to~~
377 ~~correct or ameliorate these problems and conditions. These~~
378 ~~services include~~ all services determined by the agency to be
379 medically necessary for the treatment, correction, or
380 amelioration of these problems and conditions, including
381 personal care, private duty nursing, durable medical equipment,
382 physical therapy, occupational therapy, speech therapy,
383 respiratory therapy, and immunizations.
384 (4) HOME HEALTH CARE SERVICES.—The agency shall pay for
385 nursing and home health aide services, supplies, appliances, and
386 durable medical equipment, necessary to assist a recipient
387 living at home. An entity that provides such services must
388 ~~pursuant to this subsection shall~~ be licensed under part III of
389 chapter 400. These services, equipment, and supplies, or
390 reimbursement therefor, may be limited as provided in the

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391 General Appropriations Act and do not include services,
392 equipment, or supplies provided to a person residing in a
393 hospital or nursing facility.
394 (a) ~~In providing home health care services,~~ The agency
395 shall ~~may~~ require prior authorization of home health services
396 ~~care~~ based on diagnosis, utilization rates, and ~~or~~ billing
397 rates. ~~The agency shall require prior authorization for visits~~
398 ~~for home health services that are not associated with a skilled~~
399 ~~nursing visit when the home health agency billing rates exceed~~
400 ~~the state average by 50 percent or more.~~ The home health agency
401 must submit the recipient's plan of care and documentation that
402 supports the recipient's diagnosis to the agency when requesting
403 prior authorization.
404 (b) The agency shall implement a comprehensive utilization
405 management program ~~that requires prior authorization~~ of all
406 private duty nursing services, an individualized treatment plan
407 that includes information about medication and treatment orders,
408 treatment goals, methods of care to be used, and plans for care
409 coordination by nurses and other health professionals. The
410 utilization management program must ~~shall~~ also include a process
411 for periodically reviewing the ongoing use of private duty
412 nursing services. The assessment of need shall be based on a
413 child's condition; ~~,~~ family support and care supplements; ~~,~~ a
414 family's ability to provide care; ~~, and~~ a family's and child's
415 schedule regarding work, school, sleep, and care for other
416 family dependents; and a determination of the medical necessity
417 for private duty nursing instead of other more cost-effective
418 in-home services. When implemented, the private duty nursing
419 utilization management program shall replace the current

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420 authorization program used by the agency ~~for Health Care~~
421 ~~Administration~~ and the Children's Medical Services program of
422 the Department of Health. The agency may competitively bid ~~on~~ a
423 contract to select a qualified organization to provide
424 utilization management of private duty nursing services. The
425 agency may ~~is authorized to~~ seek federal waivers to implement
426 this initiative.
427 (c) The agency may not pay for home health services unless
428 the services are medically necessary and:
429 1. The services are ordered by a physician.
430 2. The written prescription for the services is signed and
431 dated by the recipient's physician before the development of a
432 plan of care and before any request requiring prior
433 authorization.
434 3. The physician ordering the services is not employed,
435 under contract with, or otherwise affiliated with the home
436 health agency rendering the services. However, this subparagraph
437 does not apply to a home health agency affiliated with a
438 retirement community, of which the parent corporation or a
439 related legal entity owns a rural health clinic certified under
440 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed
441 under part II of chapter 400, or an apartment or single-family
442 home for independent living. For purposes of this subparagraph,
443 the agency may, on a case-by-case basis, provide an exception
444 for medically fragile children who are younger than 21 years of
445 age.
446 4. The physician ordering the services has examined the
447 recipient within the 30 days preceding the initial request for
448 the services and biannually thereafter.

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449 5. The written prescription for the services includes the
450 recipient’s acute or chronic medical condition or diagnosis, the
451 home health service required, and, for skilled nursing services,
452 the frequency and duration of the services.
453 6. The national provider identifier, Medicaid
454 identification number, or medical practitioner license number of
455 the physician ordering the services is listed on the written
456 prescription for the services, the claim for home health
457 reimbursement, and the prior authorization request.
458 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
459 all covered services provided for the medical care and treatment
460 of a recipient who is admitted as an inpatient by a licensed
461 physician or dentist to a hospital licensed under part I of
462 chapter 395. However, the agency shall limit the payment for
463 inpatient hospital services for a Medicaid recipient 21 years of
464 age or older to 45 days or the number of days necessary to
465 comply with the General Appropriations Act.
466 (c) The agency shall implement a methodology for
467 establishing base reimbursement rates for each hospital based on
468 allowable costs, as defined by the agency. Rates shall be
469 calculated annually and take effect July 1 of each year based on
470 the most recent complete and accurate cost report submitted by
471 each hospital. Adjustments may not be made to the rates after
472 September 30 of the state fiscal year in which the rate takes
473 effect. Errors in cost reporting or calculation of rates
474 discovered after September 30 must be reconciled in a subsequent
475 rate period. The agency may not make any adjustment to a
476 hospital’s reimbursement rate more than 5 years after a hospital
477 is notified of an audited rate established by the agency. The

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478 requirement that the agency may not make any adjustment to a
479 hospital’s reimbursement rate more than 5 years after a hospital
480 is notified of an audited rate established by the agency is
481 remedial and shall apply to actions by providers involving
482 Medicaid claims for hospital services. Hospital rates shall be
483 subject to such limits or ceilings as may be established in law
484 or described in the agency’s hospital reimbursement plan.
485 Specific exemptions to the limits or ceilings may be provided in
486 the General Appropriations Act. ~~The agency shall adjust a~~
487 ~~hospital’s current inpatient per diem rate to reflect the cost~~
488 ~~of serving the Medicaid population at that institution if:~~
489 ~~1. The hospital experiences an increase in Medicaid~~
490 ~~caseload by more than 25 percent in any year, primarily~~
491 ~~resulting from the closure of a hospital in the same service~~
492 ~~area occurring after July 1, 1995;~~
493 ~~2. The hospital’s Medicaid per diem rate is at least 25~~
494 ~~percent below the Medicaid per patient cost for that year; or~~
495 ~~3. The hospital is located in a county that has six or~~
496 ~~fewer general acute care hospitals, began offering obstetrical~~
497 ~~services on or after September 1999, and has submitted a request~~
498 ~~in writing to the agency for a rate adjustment after July 1,~~
499 ~~2000, but before September 30, 2000, in which case such~~
500 ~~hospital’s Medicaid inpatient per diem rate shall be adjusted to~~
501 ~~cost, effective July 1, 2002.~~
502
503 ~~By October 1 of each year, the agency must provide estimated~~
504 ~~costs for any adjustment in a hospital inpatient per diem rate~~
505 ~~to the Executive Office of the Governor, the House of~~
506 ~~Representatives General Appropriations Committee, and the Senate~~

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507 ~~Appropriations Committee. Before the agency implements a change~~
508 ~~in a hospital’s inpatient per diem rate pursuant to this~~
509 ~~paragraph, the Legislature must have specifically appropriated~~
510 ~~sufficient funds in the General Appropriations Act to support~~
511 ~~the increase in cost as estimated by the agency.~~
512 (g) The agency shall develop a plan to convert inpatient
513 hospital rates to a prospective payment system that categorizes
514 each case into diagnosis-related groups (DRG) and assigns a
515 payment weight based on the average resources used to treat
516 Medicaid patients in that DRG. To the extent possible, the
517 agency shall propose an adaptation of an existing prospective
518 payment system, such as the one used by Medicare, and shall
519 propose such adjustments as are necessary for the Medicaid
520 population and to maintain budget neutrality for inpatient
521 hospital expenditures. The agency shall submit the Medicaid DRG
522 plan, identifying all steps necessary for the transition and any
523 costs associated with plan implementation, to the Governor, the
524 President of the Senate, and the Speaker of the House of
525 Representatives no later than January 1, 2013.
526 Section 10. Paragraph (d) is added to subsection (13) of
527 section 409.906, Florida Statutes, to read:
528 409.906 Optional Medicaid services.—Subject to specific
529 appropriations, the agency may make payments for services which
530 are optional to the state under Title XIX of the Social Security
531 Act and are furnished by Medicaid providers to recipients who
532 are determined to be eligible on the dates on which the services
533 were provided. Any optional service that is provided shall be
534 provided only when medically necessary and in accordance with
535 state and federal law. Optional services rendered by providers

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536 in mobile units to Medicaid recipients may be restricted or
537 prohibited by the agency. Nothing in this section shall be
538 construed to prevent or limit the agency from adjusting fees,
539 reimbursement rates, lengths of stay, number of visits, or
540 number of services, or making any other adjustments necessary to
541 comply with the availability of moneys and any limitations or
542 directions provided for in the General Appropriations Act or
543 chapter 216. If necessary to safeguard the state's systems of
544 providing services to elderly and disabled persons and subject
545 to the notice and review provisions of s. 216.177, the Governor
546 may direct the Agency for Health Care Administration to amend
547 the Medicaid state plan to delete the optional Medicaid service
548 known as "Intermediate Care Facilities for the Developmentally
549 Disabled." Optional services may include:
550 (13) HOME AND COMMUNITY-BASED SERVICES.—
551 (d) The agency shall request federal approval to develop a
552 system to require payment of premiums or other cost sharing by
553 the parents of a child who is being served by a waiver under
554 this subsection if the adjusted household income is greater than
555 100 percent of the federal poverty level. The amount of the
556 premium or cost sharing shall be calculated using a sliding
557 scale based on the size of the family, the amount of the
558 parent's adjusted gross income, and the federal poverty
559 guidelines. The premium and cost sharing system developed by the
560 agency shall not adversely affect federal funding to the state.
561 After the agency receives federal approval, the Department of
562 Children and Family Services may collect income information from
563 parents of children who will be affected by this paragraph. The
564 agency shall prepare a report to include the estimated

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565 operational cost of implementing the premium and cost sharing
566 system and the estimated revenues to be collected from parents
567 of children in the waiver program. The report shall be delivered
568 to the President of the Senate and the Speaker of the House of
569 Representatives by June 30, 2012.
570 Section 11. Paragraphs (d) and (e) of subsection (5) of
571 section 409.907, Florida Statutes, are amended to read:
572 409.907 Medicaid provider agreements.—The agency may make
573 payments for medical assistance and related services rendered to
574 Medicaid recipients only to an individual or entity who has a
575 provider agreement in effect with the agency, who is performing
576 services or supplying goods in accordance with federal, state,
577 and local law, and who agrees that no person shall, on the
578 grounds of handicap, race, color, or national origin, or for any
579 other reason, be subjected to discrimination under any program
580 or activity for which the provider receives payment from the
581 agency.
582 (5) The agency:
583 (d) May enroll entities as Medicare crossover-only
584 providers for payment and claims processing purposes only. The
585 provider agreement shall:
586 1. Require that the provider be able to demonstrate to the
587 satisfaction of the agency that the provider is an eligible
588 Medicare provider and has a current provider agreement in place
589 with the Centers for Medicare and Medicaid Services.
590 2. Require the provider to notify the agency immediately in
591 writing upon being suspended or disenrolled as a Medicare
592 provider. If the provider does not provide such notification
593 within 5 business days after suspension or disenrollment,

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594 sanctions may be imposed pursuant to this chapter and the
595 provider may be required to return funds paid to the provider
596 during the period of time that the provider was suspended or
597 disenrolled as a Medicare provider.
598 3. Require the applicant to submit an attestation, as
599 approved by the agency, that the provider meets the requirements
600 of Florida Medicaid provider enrollment criteria.
601 4. Require the applicant to submit fingerprints as required
602 by the agency.
603 5.~~3.~~ Require that all records pertaining to health care
604 services provided to each of the provider's recipients be kept
605 for a minimum of 6 years. The agreement shall also require that
606 records and any information relating to payments claimed by the
607 provider for services under the agreement be delivered to the
608 agency or the Office of the Attorney General Medicaid Fraud
609 Control Unit when requested. If a provider does not provide such
610 records and information when requested, sanctions may be imposed
611 pursuant to this chapter.
612 6.~~4.~~ Disclose that the agreement is for the purposes of
613 paying and processing Medicare crossover claims only.
614
615 This paragraph pertains solely to Medicare crossover-only
616 providers. In order to become a standard Medicaid provider, the
617 requirements of this section and applicable rules must be met.
618 This paragraph does not create an entitlement or obligation of
619 the agency to enroll all Medicare providers that may be
620 considered a Medicare crossover-only provider in the Medicaid
621 program.
622 (e) Providers that are required to post a surety bond as

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623 part of the Medicaid enrollment process are excluded for
624 enrollment under paragraph (d) <u>and must complete a full Medicaid</u>
625 <u>application. The agency may establish additional criteria to</u>
626 <u>promote program integrity</u>.
627 Section 12. Paragraph (b) of subsection (2) of section
628 409.908, Florida Statutes, is amended to read:
629 409.908 Reimbursement of Medicaid providers.—Subject to
630 specific appropriations, the agency shall reimburse Medicaid
631 providers, in accordance with state and federal law, according
632 to methodologies set forth in the rules of the agency and in
633 policy manuals and handbooks incorporated by reference therein.
634 These methodologies may include fee schedules, reimbursement
635 methods based on cost reporting, negotiated fees, competitive
636 bidding pursuant to s. 287.057, and other mechanisms the agency
637 considers efficient and effective for purchasing services or
638 goods on behalf of recipients. If a provider is reimbursed based
639 on cost reporting and submits a cost report late and that cost
640 report would have been used to set a lower reimbursement rate
641 for a rate semester, then the provider’s rate for that semester
642 shall be retroactively calculated using the new cost report, and
643 full payment at the recalculated rate shall be effected
644 retroactively. Medicare-granted extensions for filing cost
645 reports, if applicable, shall also apply to Medicaid cost
646 reports. Payment for Medicaid compensable services made on
647 behalf of Medicaid eligible persons is subject to the
648 availability of moneys and any limitations or directions
649 provided for in the General Appropriations Act or chapter 216.
650 Further, nothing in this section shall be construed to prevent
651 or limit the agency from adjusting fees, reimbursement rates,

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652 lengths of stay, number of visits, or number of services, or
653 making any other adjustments necessary to comply with the
654 availability of moneys and any limitations or directions
655 provided for in the General Appropriations Act, provided the
656 adjustment is consistent with legislative intent.
657 (2)
658 (b) Subject to any limitations or directions provided for
659 in the General Appropriations Act, the agency shall establish
660 and implement a Florida Title XIX Long-Term Care Reimbursement
661 Plan (Medicaid) for nursing home care in order to provide care
662 and services in conformance with the applicable state and
663 federal laws, rules, regulations, and quality and safety
664 standards and to ensure that individuals eligible for medical
665 assistance have reasonable geographic access to such care.
666 1. The agency shall amend the long-term care reimbursement
667 plan and cost reporting system to create direct care and
668 indirect care subcomponents of the patient care component of the
669 per diem rate. These two subcomponents together shall equal the
670 patient care component of the per diem rate. Separate cost-based
671 ceilings shall be calculated for each patient care subcomponent.
672 The direct care subcomponent of the per diem rate shall be
673 limited by the cost-based class ceiling, and the indirect care
674 subcomponent may be limited by the lower of the cost-based class
675 ceiling, the target rate class ceiling, or the individual
676 provider target.
677 2. The direct care subcomponent shall include salaries and
678 benefits of direct care staff providing nursing services
679 including registered nurses, licensed practical nurses, and
680 certified nursing assistants who deliver care directly to

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681 residents in the nursing home facility. This excludes nursing
682 administration, minimum data set, and care plan coordinators,
683 staff development, and the staffing coordinator. The direct care
684 subcomponent also includes medically necessary dental care,
685 vision care, hearing care, and podiatric care.
686 3. All other patient care costs shall be included in the
687 indirect care cost subcomponent of the patient care per diem
688 rate. There shall be no costs directly or indirectly allocated
689 to the direct care subcomponent from a home office or management
690 company.
691 4. On July 1 of each year, the agency shall report to the
692 Legislature direct and indirect care costs, including average
693 direct and indirect care costs per resident per facility and
694 direct care and indirect care salaries and benefits per category
695 of staff member per facility.
696 5. In order to offset the cost of general and professional
697 liability insurance, the agency shall amend the plan to allow
698 for interim rate adjustments to reflect increases in the cost of
699 general or professional liability insurance for nursing homes.
700 This provision shall be implemented to the extent existing
701 appropriations are available.
702
703 It is the intent of the Legislature that the reimbursement plan
704 achieve the goal of providing access to health care for nursing
705 home residents who require large amounts of care while
706 encouraging diversion services as an alternative to nursing home
707 care for residents who can be served within the community. The
708 agency shall base the establishment of any maximum rate of
709 payment, whether overall or component, on the available moneys

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710 as provided for in the General Appropriations Act. The agency
711 may base the maximum rate of payment on the results of
712 scientifically valid analysis and conclusions derived from
713 objective statistical data pertinent to the particular maximum
714 rate of payment.
715 Section 13. Paragraph (c) of subsection (1) of section
716 409.9081, Florida Statutes, is amended to read:
717 409.9081 Copayments.—
718 (1) The agency shall require, subject to federal
719 regulations and limitations, each Medicaid recipient ~~to~~ pay at
720 the time of service a nominal copayment for the following
721 Medicaid services:
722 (c) Hospital emergency department visits for nonemergency
723 care: 5 percent of up to the first $300 of the Medicaid payment
724 for emergency room services, not to exceed $15. The agency shall
725 seek federal approval to require Medicaid recipients to pay $100
726 copayment for nonemergency services and care furnished in a
727 hospital emergency department. Upon waiver approval, a Medicaid
728 recipient who requests such services and care must pay a $100
729 copayment to the hospital for the nonemergency services and care
730 provided in the hospital emergency department.
731 Section 14. Subsection (10) of section 409.911, Florida
732 Statutes, is amended to read:
733 409.911 Disproportionate share program.—Subject to specific
734 allocations established within the General Appropriations Act
735 and any limitations established pursuant to chapter 216, the
736 agency shall distribute, pursuant to this section, moneys to
737 hospitals providing a disproportionate share of Medicaid or
738 charity care services by making quarterly Medicaid payments as

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739 required. Notwithstanding the provisions of s. 409.915, counties
740 are exempt from contributing toward the cost of this special
741 reimbursement for hospitals serving a disproportionate share of
742 low-income patients.
743 (10) The Agency for Health Care Administration shall create
744 a Medicaid Low-Income Pool Council by July 1, 2006. The Low-
745 Income Pool Council shall consist of 24 members, including 2
746 members appointed by the President of the Senate, 2 members
747 appointed by the Speaker of the House of Representatives, 3
748 representatives of statutory teaching hospitals, 3
749 representatives of public hospitals, 3 representatives of
750 nonprofit hospitals, 3 representatives of for-profit hospitals,
751 2 representatives of rural hospitals, 2 representatives of units
752 of local government which contribute funding, 1 representative
753 of family practice teaching hospitals, 1 representative of
754 federally qualified health centers, 1 representative from the
755 Department of Health, and 1 nonvoting representative of the
756 Agency for Health Care Administration who shall serve as chair
757 of the council. Except for a full-time employee of a public
758 entity, an individual who qualifies as a lobbyist under s.
759 11.045 or s. 112.3215 may not serve as a member of the council.
760 Of the members appointed by the Senate President, only one shall
761 be a physician. Of the members appointed by the Speaker of the
762 House of Representatives, only one shall be a physician. The
763 physician member appointed by the Senate President and the
764 physician member appointed by the Speaker of the House of
765 Representatives must be physicians who routinely take calls in a
766 trauma center, as defined in s. 395.4001, or a hospital
767 emergency department. The council shall:

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768 (a) Make recommendations on the financing of the low-income
769 pool and the disproportionate share hospital program and the
770 distribution of their funds.
771 (b) Advise the Agency for Health Care Administration on the
772 development of the low-income pool plan required by the federal
773 Centers for Medicare and Medicaid Services pursuant to the
774 Medicaid reform waiver.
775 (c) Advise the Agency for Health Care Administration on the
776 distribution of hospital funds used to adjust inpatient hospital
777 rates, rebase rates, or otherwise exempt hospitals from
778 reimbursement limits as financed by intergovernmental transfers.
779 (d) Submit its findings and recommendations to the Governor
780 and the Legislature no later than February 1 of each year.
781
782 This subsection expires October 1, 2014.
783 Section 15. Subsection (4) of section 409.91195, Florida
784 Statutes, is amended to read:
785 409.91195 Medicaid Pharmaceutical and Therapeutics
786 Committee.—There is created a Medicaid Pharmaceutical and
787 Therapeutics Committee within the agency for the purpose of
788 developing a Medicaid preferred drug list.
789 (4) Upon recommendation of the committee, the agency shall
790 adopt a preferred drug list as described in s. 409.912(37) ~~(39)~~.
791 To the extent feasible, the committee shall review all drug
792 classes included on the preferred drug list every 12 months, and
793 may recommend additions to and deletions from the preferred drug
794 list, such that the preferred drug list provides for medically
795 appropriate drug therapies for Medicaid patients which achieve
796 cost savings contained in the General Appropriations Act.

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797 Section 16. Subsection (1) of section 409.91196, Florida
798 Statutes, is amended to read:
799 409.91196 Supplemental rebate agreements; public records
800 and public meetings exemption.—
801 (1) The rebate amount, percent of rebate, manufacturer’s
802 pricing, and supplemental rebate, and other trade secrets as
803 defined in s. 688.002 that the agency has identified for use in
804 negotiations, held by the Agency for Health Care Administration
805 under s. 409.912(37)~~(39)~~(a)7. are confidential and exempt from
806 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
807 Section 17. Section 409.912, Florida Statutes, is amended
808 to read:
809 409.912 Cost-effective purchasing of health care.—The
810 agency shall purchase goods and services for Medicaid recipients
811 in the most cost-effective manner consistent with the delivery
812 of quality medical care. To ensure that medical services are
813 effectively utilized, the agency may, in any case, require a
814 confirmation or second physician’s opinion of the correct
815 diagnosis for purposes of authorizing future services under the
816 Medicaid program. This section does not restrict access to
817 emergency services or poststabilization care services as defined
818 in 42 C.F.R. part 438.114. Such confirmation or second opinion
819 shall be rendered in a manner approved by the agency. The agency
820 shall maximize the use of prepaid per capita and prepaid
821 aggregate fixed-sum basis services when appropriate and other
822 alternative service delivery and reimbursement methodologies,
823 including competitive bidding pursuant to s. 287.057, designed
824 to facilitate the cost-effective purchase of a case-managed
825 continuum of care. The agency shall also require providers to

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826 minimize the exposure of recipients to the need for acute
827 inpatient, custodial, and other institutional care and the
828 inappropriate or unnecessary use of high-cost services. The
829 agency shall contract with a vendor to monitor and evaluate the
830 clinical practice patterns of providers in order to identify
831 trends that are outside the normal practice patterns of a
832 provider's professional peers or the national guidelines of a
833 provider's professional association. The vendor must be able to
834 provide information and counseling to a provider whose practice
835 patterns are outside the norms, in consultation with the agency,
836 to improve patient care and reduce inappropriate utilization.
837 The agency may mandate prior authorization, drug therapy
838 management, or disease management participation for certain
839 populations of Medicaid beneficiaries, certain drug classes, or
840 particular drugs to prevent fraud, abuse, overuse, and possible
841 dangerous drug interactions. The Pharmaceutical and Therapeutics
842 Committee shall make recommendations to the agency on drugs for
843 which prior authorization is required. The agency shall inform
844 the Pharmaceutical and Therapeutics Committee of its decisions
845 regarding drugs subject to prior authorization. The agency is
846 authorized to limit the entities it contracts with or enrolls as
847 Medicaid providers by developing a provider network through
848 provider credentialing. The agency may competitively bid single-
849 source-provider contracts if procurement of goods or services
850 results in demonstrated cost savings to the state without
851 limiting access to care. The agency may limit its network based
852 on the assessment of beneficiary access to care, provider
853 availability, provider quality standards, time and distance
854 standards for access to care, the cultural competence of the

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855 provider network, demographic characteristics of Medicaid
856 beneficiaries, practice and provider-to-beneficiary standards,
857 appointment wait times, beneficiary use of services, provider
858 turnover, provider profiling, provider licensure history,
859 previous program integrity investigations and findings, peer
860 review, provider Medicaid policy and billing compliance records,
861 clinical and medical record audits, and other factors. Providers
862 are ~~shall~~ not ~~be~~ entitled to enrollment in the Medicaid provider
863 network. The agency shall determine instances in which allowing
864 Medicaid beneficiaries to purchase durable medical equipment and
865 other goods is less expensive to the Medicaid program than long-
866 term rental of the equipment or goods. The agency may establish
867 rules to facilitate purchases in lieu of long-term rentals in
868 order to protect against fraud and abuse in the Medicaid program
869 as defined in s. 409.913. The agency may seek federal waivers
870 necessary to administer these policies.
871 (1) The agency shall work with the Department of Children
872 and Family Services to ensure access of children and families in
873 the child protection system to needed and appropriate mental
874 health and substance abuse services. This subsection expires
875 October 1, 2014.
876 (2) The agency may enter into agreements with appropriate
877 agents of other state agencies or of any agency of the Federal
878 Government and accept such duties in respect to social welfare
879 or public aid as may be necessary to implement the provisions of
880 Title XIX of the Social Security Act and ss. 409.901-409.920.
881 This subsection expires October 1, 2016.
882 (3) The agency may contract with health maintenance
883 organizations certified pursuant to part I of chapter 641 for

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884 the provision of services to recipients. This subsection expires
885 October 1, 2014.
886 (4) The agency may contract with:
887 (a) An entity that provides no prepaid health care services
888 other than Medicaid services under contract with the agency and
889 which is owned and operated by a county, county health
890 department, or county-owned and operated hospital to provide
891 health care services on a prepaid or fixed-sum basis to
892 recipients, which entity may provide such prepaid services
893 either directly or through arrangements with other providers.
894 Such prepaid health care services entities must be licensed
895 under parts I and III of chapter 641. An entity recognized under
896 this paragraph which demonstrates to the satisfaction of the
897 Office of Insurance Regulation of the Financial Services
898 Commission that it is backed by the full faith and credit of the
899 county in which it is located may be exempted from s. 641.225.
900 This paragraph expires October 1, 2014.
901 (b) An entity that is providing comprehensive behavioral
902 health care services to certain Medicaid recipients through a
903 capitated, prepaid arrangement pursuant to the federal waiver
904 provided for by s. 409.905(5). Such entity must be licensed
905 under chapter 624, chapter 636, or chapter 641, or authorized
906 under paragraph (c) or paragraph (d), and must possess the
907 clinical systems and operational competence to manage risk and
908 provide comprehensive behavioral health care to Medicaid
909 recipients. As used in this paragraph, the term “comprehensive
910 behavioral health care services” means covered mental health and
911 substance abuse treatment services that are available to
912 Medicaid recipients. The secretary of the Department of Children

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913 and Family Services shall approve provisions of procurements
914 related to children in the department’s care or custody before
915 enrolling such children in a prepaid behavioral health plan. Any
916 contract awarded under this paragraph must be competitively
917 procured. In developing the behavioral health care prepaid plan
918 procurement document, the agency shall ensure that the
919 procurement document requires the contractor to develop and
920 implement a plan to ensure compliance with s. 394.4574 related
921 to services provided to residents of licensed assisted living
922 facilities that hold a limited mental health license. Except as
923 provided in subparagraph 5. ~~8.~~, and except in counties where the
924 Medicaid managed care pilot program is authorized pursuant to s.
925 409.91211, the agency shall seek federal approval to contract
926 with a single entity meeting these requirements to provide
927 comprehensive behavioral health care services to all Medicaid
928 recipients not enrolled in a Medicaid managed care plan
929 authorized under s. 409.91211, a provider service network
930 authorized under paragraph (d), or a Medicaid health maintenance
931 organization in an AHCA area. In an AHCA area where the Medicaid
932 managed care pilot program is authorized pursuant to s.
933 409.91211 in one or more counties, the agency may procure a
934 contract with a single entity to serve the remaining counties as
935 an AHCA area or the remaining counties may be included with an
936 adjacent AHCA area and are subject to this paragraph. Each
937 entity must offer a sufficient choice of providers in its
938 network to ensure recipient access to care and the opportunity
939 to select a provider with whom they are satisfied. The network
940 shall include all public mental health hospitals. To ensure
941 unimpaired access to behavioral health care services by Medicaid

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942 recipients, all contracts issued pursuant to this paragraph must
943 require 80 percent of the capitation paid to the managed care
944 plan, including health maintenance organizations and capitated
945 provider service networks, to be expended for the provision of
946 behavioral health care services. If the managed care plan
947 expends less than 80 percent of the capitation paid for the
948 provision of behavioral health care services, the difference
949 shall be returned to the agency. The agency shall provide the
950 plan with a certification letter indicating the amount of
951 capitation paid during each calendar year for behavioral health
952 care services pursuant to this section. The agency may reimburse
953 for substance abuse treatment services on a fee-for-service
954 basis until the agency finds that adequate funds are available
955 for capitated, prepaid arrangements.
956 1. ~~By January 1, 2001,~~ The agency shall modify the
957 contracts with the entities providing comprehensive inpatient
958 and outpatient mental health care services to Medicaid
959 recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk
960 Counties, to include substance abuse treatment services.
961 ~~2. By July 1, 2003, the agency and the Department of~~
962 ~~Children and Family Services shall execute a written agreement~~
963 ~~that requires collaboration and joint development of all policy,~~
964 ~~budgets, procurement documents, contracts, and monitoring plans~~
965 ~~that have an impact on the state and Medicaid community mental~~
966 ~~health and targeted case management programs.~~
967 2.~~3.~~ Except as provided in subparagraph 5. ~~8., by July 1,~~
968 ~~2006~~, the agency and the Department of Children and Family
969 Services shall contract with managed care entities in each AHCA
970 area except area 6 or arrange to provide comprehensive inpatient

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971 and outpatient mental health and substance abuse services
972 through capitated prepaid arrangements to all Medicaid
973 recipients who are eligible to participate in such plans under
974 federal law and regulation. In AHCA areas where eligible
975 individuals number less than 150,000, the agency shall contract
976 with a single managed care plan to provide comprehensive
977 behavioral health services to all recipients who are not
978 enrolled in a Medicaid health maintenance organization, a
979 provider service network authorized under paragraph (d), or a
980 Medicaid capitated managed care plan authorized under s.
981 409.91211. The agency may contract with more than one
982 comprehensive behavioral health provider to provide care to
983 recipients who are not enrolled in a Medicaid capitated managed
984 care plan authorized under s. 409.91211, a provider service
985 network authorized under paragraph (d), or a Medicaid health
986 maintenance organization in AHCA areas where the eligible
987 population exceeds 150,000. In an AHCA area where the Medicaid
988 managed care pilot program is authorized pursuant to s.
989 409.91211 in one or more counties, the agency may procure a
990 contract with a single entity to serve the remaining counties as
991 an AHCA area or the remaining counties may be included with an
992 adjacent AHCA area and shall be subject to this paragraph.
993 Contracts for comprehensive behavioral health providers awarded
994 pursuant to this section shall be competitively procured. Both
995 for-profit and not-for-profit corporations are eligible to
996 compete. Managed care plans contracting with the agency under
997 subsection (3) or paragraph (d), shall provide and receive
998 payment for the same comprehensive behavioral health benefits as
999 provided in AHCA rules, including handbooks incorporated by

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1000 reference. In AHCA area 11, the agency shall contract with at
1001 least two comprehensive behavioral health care providers to
1002 provide behavioral health care to recipients in that area who
1003 are enrolled in, or assigned to, the MediPass program. One of
1004 the behavioral health care contracts must be with the existing
1005 provider service network pilot project, as described in
1006 paragraph (d), for the purpose of demonstrating the cost-
1007 effectiveness of the provision of quality mental health services
1008 through a public hospital-operated managed care model. Payment
1009 shall be at an agreed-upon capitated rate to ensure cost
1010 savings. Of the recipients in area 11 who are assigned to
1011 MediPass under s. 409.9122(2)(k), a minimum of 50,000 of those
1012 MediPass-enrolled recipients shall be assigned to the existing
1013 provider service network in area 11 for their behavioral care.
1014 ~~4. By October 1, 2003, the agency and the department shall~~
1015 ~~submit a plan to the Governor, the President of the Senate, and~~
1016 ~~the Speaker of the House of Representatives which provides for~~
1017 ~~the full implementation of capitated prepaid behavioral health~~
1018 ~~care in all areas of the state.~~
1019 ~~a. Implementation shall begin in 2003 in those AHCA areas~~
1020 ~~of the state where the agency is able to establish sufficient~~
1021 ~~capitation rates.~~
1022 ~~b. If the agency determines that the proposed capitation~~
1023 ~~rate in any area is insufficient to provide appropriate~~
1024 ~~services, the agency may adjust the capitation rate to ensure~~
1025 ~~that care will be available. The agency and the department may~~
1026 ~~use existing general revenue to address any additional required~~
1027 ~~match but may not over-obligate existing funds on an annualized~~
1028 ~~basis.~~

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1029 ~~c. Subject to any limitations provided in the General~~
1030 ~~Appropriations Act, the agency, in compliance with appropriate~~
1031 ~~federal authorization, shall develop policies and procedures~~
1032 ~~that allow for certification of local and state funds.~~
1033 3.~~5.~~ Children residing in a statewide inpatient psychiatric
1034 program, or in a Department of Juvenile Justice or a Department
1035 of Children and Family Services residential program approved as
1036 a Medicaid behavioral health overlay services provider may not
1037 be included in a behavioral health care prepaid health plan or
1038 any other Medicaid managed care plan pursuant to this paragraph.
1039 ~~6. In converting to a prepaid system of delivery, the~~
1040 ~~agency shall in its procurement document require an entity~~
1041 ~~providing only comprehensive behavioral health care services to~~
1042 ~~prevent the displacement of indigent care patients by enrollees~~
1043 ~~in the Medicaid prepaid health plan providing behavioral health~~
1044 ~~care services from facilities receiving state funding to provide~~
1045 ~~indigent behavioral health care, to facilities licensed under~~
1046 ~~chapter 395 which do not receive state funding for indigent~~
1047 ~~behavioral health care, or reimburse the unsubsidized facility~~
1048 ~~for the cost of behavioral health care provided to the displaced~~
1049 ~~indigent care patient.~~
1050 4.~~7.~~ Traditional community mental health providers under
1051 contract with the Department of Children and Family Services
1052 pursuant to part IV of chapter 394, child welfare providers
1053 under contract with the Department of Children and Family
1054 Services in areas 1 and 6, and inpatient mental health providers
1055 licensed pursuant to chapter 395 must be offered an opportunity
1056 to accept or decline a contract to participate in any provider
1057 network for prepaid behavioral health services.

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1058 5.~~8.~~ All Medicaid-eligible children, except children in
1059 area 1 and children in Highlands County, Hardee County, Polk
1060 County, or Manatee County of area 6, that are open for child
1061 welfare services in the statewide automated child welfare
1062 information ~~HomeSafeNet~~ system, shall receive their behavioral
1063 health care services through a specialty prepaid plan operated
1064 by community-based lead agencies through a single agency or
1065 formal agreements among several agencies. The specialty prepaid
1066 plan must result in savings to the state comparable to savings
1067 achieved in other Medicaid managed care and prepaid programs.
1068 Such plan must provide mechanisms to maximize state and local
1069 revenues. The specialty prepaid plan shall be developed by the
1070 agency and the Department of Children and Family Services. The
1071 agency may seek federal waivers to implement this initiative.
1072 Medicaid-eligible children whose cases are open for child
1073 welfare services in the statewide automated child welfare
1074 information ~~HomeSafeNet~~ system and who reside in AHCA area 10
1075 shall be enrolled in a capitated provider service network or
1076 other capitated managed care plan, which, in coordination with
1077 available community-based care providers specified in s.
1078 409.1671, shall provide sufficient medical, developmental, and
1079 behavioral health services to meet the needs of these children
1080 ~~are exempt from the specialty prepaid plan upon the development~~
1081 ~~of a service delivery mechanism for children who reside in area~~
1082 ~~10 as specified in s. 409.91211(3)(dd)~~.
1083
1084 This paragraph expires October 1, 2014.
1085 (c) A federally qualified health center or an entity owned
1086 by one or more federally qualified health centers or an entity

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1087 owned by other migrant and community health centers receiving
1088 non-Medicaid financial support from the Federal Government to
1089 provide health care services on a prepaid or fixed-sum basis to
1090 recipients. A federally qualified health center or an entity
1091 that is owned by one or more federally qualified health centers
1092 and is reimbursed by the agency on a prepaid basis is exempt
1093 from parts I and III of chapter 641, but must comply with the
1094 solvency requirements in s. 641.2261(2) and meet the appropriate
1095 requirements governing financial reserve, quality assurance, and
1096 patients' rights established by the agency. This paragraph
1097 expires October 1, 2014.
1098 (d)1. A provider service network, which may be reimbursed
1099 on a fee-for-service or prepaid basis. Prepaid provider service
1100 networks shall receive per-member, per-month payments. A
1101 provider service network that does not choose to be a prepaid
1102 plan shall receive fee-for-service rates with a shared savings
1103 settlement. The fee-for-service option shall be available to a
1104 provider service network only for the first 2 years of the
1105 plan's operation or until the contract year beginning September
1106 1, 2014, whichever is later. The agency shall annually conduct
1107 cost reconciliations to determine the amount of cost savings
1108 achieved by fee-for-service provider service networks for the
1109 dates of service in the period being reconciled. Only payments
1110 for covered services for dates of service within the
1111 reconciliation period and paid within 6 months after the last
1112 date of service in the reconciliation period shall be included.
1113 The agency shall perform the necessary adjustments for the
1114 inclusion of claims incurred but not reported within the
1115 reconciliation for claims that could be received and paid by the

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1116 agency after the 6-month claims processing time lag. The agency
1117 shall provide the results of the reconciliations to the fee-for-
1118 service provider service networks within 45 days after the end
1119 of the reconciliation period. The fee-for-service provider
1120 service networks shall review and provide written comments or a
1121 letter of concurrence to the agency within 45 days after receipt
1122 of the reconciliation results. This reconciliation shall be
1123 considered final.
1124 2. A provider service network which is reimbursed by the
1125 agency on a prepaid basis shall be exempt from parts I and III
1126 of chapter 641, but must comply with the solvency requirements
1127 in s. 641.2261(2) and meet appropriate financial reserve,
1128 quality assurance, and patient rights requirements as
1129 established by the agency.
1130 3. Medicaid recipients assigned to a provider service
1131 network shall be chosen equally from those who would otherwise
1132 have been assigned to prepaid plans and MediPass. The agency is
1133 authorized to seek federal Medicaid waivers as necessary to
1134 implement the provisions of this section. This subparagraph
1135 expires October 1, 2014. ~~Any contract previously awarded to a~~
1136 ~~provider service network operated by a hospital pursuant to this~~
1137 ~~subsection shall remain in effect for a period of 3 years~~
1138 ~~following the current contract expiration date, regardless of~~
1139 ~~any contractual provisions to the contrary.~~
1140 4. A provider service network is a network established or
1141 organized and operated by a health care provider, or group of
1142 affiliated health care providers, including minority physician
1143 networks and emergency room diversion programs that meet the
1144 requirements of s. 409.91211, which provides a substantial

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1145 proportion of the health care items and services under a
1146 contract directly through the provider or affiliated group of
1147 providers and may make arrangements with physicians or other
1148 health care professionals, health care institutions, or any
1149 combination of such individuals or institutions to assume all or
1150 part of the financial risk on a prospective basis for the
1151 provision of basic health services by the physicians, by other
1152 health professionals, or through the institutions. The health
1153 care providers must have a controlling interest in the governing
1154 body of the provider service network organization.
1155 (e) An entity that provides only comprehensive behavioral
1156 health care services to certain Medicaid recipients through an
1157 administrative services organization agreement. Such an entity
1158 must possess the clinical systems and operational competence to
1159 provide comprehensive health care to Medicaid recipients. As
1160 used in this paragraph, the term "comprehensive behavioral
1161 health care services" means covered mental health and substance
1162 abuse treatment services that are available to Medicaid
1163 recipients. Any contract awarded under this paragraph must be
1164 competitively procured. The agency must ensure that Medicaid
1165 recipients have available the choice of at least two managed
1166 care plans for their behavioral health care services. This
1167 paragraph expires October 1, 2014.
1168 ~~(f) An entity that provides in-home physician services to~~
1169 ~~test the cost-effectiveness of enhanced home-based medical care~~
1170 ~~to Medicaid recipients with degenerative neurological diseases~~
1171 ~~and other diseases or disabling conditions associated with high~~
1172 ~~costs to Medicaid. The program shall be designed to serve very~~
1173 ~~disabled persons and to reduce Medicaid reimbursed costs for~~

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1174 ~~inpatient, outpatient, and emergency department services. The~~
1175 ~~agency shall contract with vendors on a risk-sharing basis.~~
1176 ~~(g) Children's provider networks that provide care~~
1177 ~~coordination and care management for Medicaid-eligible pediatric~~
1178 ~~patients, primary care, authorization of specialty care, and~~
1179 ~~other urgent and emergency care through organized providers~~
1180 ~~designed to service Medicaid eligibles under age 18 and~~
1181 ~~pediatric emergency departments' diversion programs. The~~
1182 ~~networks shall provide after-hour operations, including evening~~
1183 ~~and weekend hours, to promote, when appropriate, the use of the~~
1184 ~~children's networks rather than hospital emergency departments.~~
1185 (f) ~~(h)~~ An entity authorized in s. 430.205 to contract with
1186 the agency and the Department of Elderly Affairs to provide
1187 health care and social services on a prepaid or fixed-sum basis
1188 to elderly recipients. Such prepaid health care services
1189 entities are exempt from the provisions of part I of chapter 641
1190 for the first 3 years of operation. An entity recognized under
1191 this paragraph that demonstrates to the satisfaction of the
1192 Office of Insurance Regulation that it is backed by the full
1193 faith and credit of one or more counties in which it operates
1194 may be exempted from s. 641.225. This paragraph expires October
1195 1, 2013.
1196 (g) ~~(i)~~ A Children's Medical Services Network, as defined in
1197 s. 391.021. This paragraph expires October 1, 2014.
1198 ~~(5) The Agency for Health Care Administration, in~~
1199 ~~partnership with the Department of Elderly Affairs, shall create~~
1200 ~~an integrated, fixed-payment delivery program for Medicaid~~
1201 ~~recipients who are 60 years of age or older or dually eligible~~
1202 ~~for Medicare and Medicaid. The Agency for Health Care~~

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1203 ~~Administration shall implement the integrated program initially~~
1204 ~~on a pilot basis in two areas of the state. The pilot areas~~
1205 ~~shall be Area 7 and Area 11 of the Agency for Health Care~~
1206 ~~Administration. Enrollment in the pilot areas shall be on a~~
1207 ~~voluntary basis and in accordance with approved federal waivers~~
1208 ~~and this section. The agency and its program contractors and~~
1209 ~~providers shall not enroll any individual in the integrated~~
1210 ~~program because the individual or the person legally responsible~~
1211 ~~for the individual fails to choose to enroll in the integrated~~
1212 ~~program. Enrollment in the integrated program shall be~~
1213 ~~exclusively by affirmative choice of the eligible individual or~~
1214 ~~by the person legally responsible for the individual. The~~
1215 ~~integrated program must transfer all Medicaid services for~~
1216 ~~eligible elderly individuals who choose to participate into an~~
1217 ~~integrated-care management model designed to serve Medicaid~~
1218 ~~recipients in the community. The integrated program must combine~~
1219 ~~all funding for Medicaid services provided to individuals who~~
1220 ~~are 60 years of age or older or dually eligible for Medicare and~~
1221 ~~Medicaid into the integrated program, including funds for~~
1222 ~~Medicaid home and community-based waiver services; all Medicaid~~
1223 ~~services authorized in ss. 409.905 and 409.906, excluding funds~~
1224 ~~for Medicaid nursing home services unless the agency is able to~~
1225 ~~demonstrate how the integration of the funds will improve~~
1226 ~~coordinated care for these services in a less costly manner; and~~
1227 ~~Medicare coinsurance and deductibles for persons dually eligible~~
1228 ~~for Medicaid and Medicare as prescribed in s. 409.908(13).~~
1229 ~~(a) Individuals who are 60 years of age or older or dually~~
1230 ~~eligible for Medicare and Medicaid and enrolled in the~~
1231 ~~developmental disabilities waiver program, the family and~~

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1232 ~~supported-living waiver program, the project AIDS care waiver~~
1233 ~~program, the traumatic brain injury and spinal cord injury~~
1234 ~~waiver program, the consumer-directed care waiver program, and~~
1235 ~~the program of all-inclusive care for the elderly program, and~~
1236 ~~residents of institutional care facilities for the~~
1237 ~~developmentally disabled, must be excluded from the integrated~~
1238 ~~program.~~
1239 ~~(b) Managed care entities who meet or exceed the agency's~~
1240 ~~minimum standards are eligible to operate the integrated~~
1241 ~~program. Entities eligible to participate include managed care~~
1242 ~~organizations licensed under chapter 641, including entities~~
1243 ~~eligible to participate in the nursing home diversion program,~~
1244 ~~other qualified providers as defined in s. 430.703(7), community~~
1245 ~~care for the elderly lead agencies, and other state-certified~~
1246 ~~community service networks that meet comparable standards as~~
1247 ~~defined by the agency, in consultation with the Department of~~
1248 ~~Elderly Affairs and the Office of Insurance Regulation, to be~~
1249 ~~financially solvent and able to take on financial risk for~~
1250 ~~managed care. Community service networks that are certified~~
1251 ~~pursuant to the comparable standards defined by the agency are~~
1252 ~~not required to be licensed under chapter 641. Managed care~~
1253 ~~entities who operate the integrated program shall be subject to~~
1254 ~~s. 408.7056. Eligible entities shall choose to serve enrollees~~
1255 ~~who are dually eligible for Medicare and Medicaid, enrollees who~~
1256 ~~are 60 years of age or older, or both.~~
1257 ~~(c) The agency must ensure that the capitation-rate-setting~~
1258 ~~methodology for the integrated program is actuarially sound and~~
1259 ~~reflects the intent to provide quality care in the least~~
1260 ~~restrictive setting. The agency must also require integrated-~~

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1261 ~~program providers to develop a credentialing system for service~~
1262 ~~providers and to contract with all Gold Seal nursing homes,~~
1263 ~~where feasible, and exclude, where feasible, chronically poor-~~
1264 ~~performing facilities and providers as defined by the agency.~~
1265 ~~The integrated program must develop and maintain an informal~~
1266 ~~provider grievance system that addresses provider payment and~~
1267 ~~contract problems. The agency shall also establish a formal~~
1268 ~~grievance system to address those issues that were not resolved~~
1269 ~~through the informal grievance system. The integrated program~~
1270 ~~must provide that if the recipient resides in a noncontracted~~
1271 ~~residential facility licensed under chapter 400 or chapter 429~~
1272 ~~at the time of enrollment in the integrated program, the~~
1273 ~~recipient must be permitted to continue to reside in the~~
1274 ~~noncontracted facility as long as the recipient desires. The~~
1275 ~~integrated program must also provide that, in the absence of a~~
1276 ~~contract between the integrated-program provider and the~~
1277 ~~residential facility licensed under chapter 400 or chapter 429,~~
1278 ~~current Medicaid rates must prevail. The integrated-program~~
1279 ~~provider must ensure that electronic nursing home claims that~~
1280 ~~contain sufficient information for processing are paid within 10~~
1281 ~~business days after receipt. Alternately, the integrated-program~~
1282 ~~provider may establish a capitated payment mechanism to~~
1283 ~~prospectively pay nursing homes at the beginning of each month.~~
1284 ~~The agency and the Department of Elderly Affairs must jointly~~
1285 ~~develop procedures to manage the services provided through the~~
1286 ~~integrated program in order to ensure quality and recipient~~
1287 ~~choice.~~
1288 ~~(d) The Office of Program Policy Analysis and Government~~
1289 ~~Accountability, in consultation with the Auditor General, shall~~

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1290 ~~comprehensively evaluate the pilot project for the integrated,~~
1291 ~~fixed-payment delivery program for Medicaid recipients created~~
1292 ~~under this subsection. The evaluation shall begin as soon as~~
1293 ~~Medicaid recipients are enrolled in the managed care pilot~~
1294 ~~program plans and shall continue for 24 months thereafter. The~~
1295 ~~evaluation must include assessments of each managed care plan in~~
1296 ~~the integrated program with regard to cost savings; consumer~~
1297 ~~education, choice, and access to services; coordination of care;~~
1298 ~~and quality of care. The evaluation must describe administrative~~
1299 ~~or legal barriers to the implementation and operation of the~~
1300 ~~pilot program and include recommendations regarding statewide~~
1301 ~~expansion of the pilot program. The office shall submit its~~
1302 ~~evaluation report to the Governor, the President of the Senate,~~
1303 ~~and the Speaker of the House of Representatives no later than~~
1304 ~~December 31, 2009.~~
1305 ~~(e) The agency may seek federal waivers or Medicaid state~~
1306 ~~plan amendments and adopt rules as necessary to administer the~~
1307 ~~integrated program. The agency may implement the approved~~
1308 ~~federal waivers and other provisions as specified in this~~
1309 ~~subsection.~~
1310 ~~(f) The implementation of the integrated, fixed-payment~~
1311 ~~delivery program created under this subsection is subject to an~~
1312 ~~appropriation in the General Appropriations Act.~~
1313 (5) ~~(6)~~ The agency may contract with any public or private
1314 entity otherwise authorized by this section on a prepaid or
1315 fixed-sum basis for the provision of health care services to
1316 recipients. An entity may provide prepaid services to
1317 recipients, either directly or through arrangements with other
1318 entities, if each entity involved in providing services:

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1319 (a) Is organized primarily for the purpose of providing
1320 health care or other services of the type regularly offered to
1321 Medicaid recipients;
1322 (b) Ensures that services meet the standards set by the
1323 agency for quality, appropriateness, and timeliness;
1324 (c) Makes provisions satisfactory to the agency for
1325 insolvency protection and ensures that neither enrolled Medicaid
1326 recipients nor the agency will be liable for the debts of the
1327 entity;
1328 (d) Submits to the agency, if a private entity, a financial
1329 plan that the agency finds to be fiscally sound and that
1330 provides for working capital in the form of cash or equivalent
1331 liquid assets excluding revenues from Medicaid premium payments
1332 equal to at least the first 3 months of operating expenses or
1333 $200,000, whichever is greater;
1334 (e) Furnishes evidence satisfactory to the agency of
1335 adequate liability insurance coverage or an adequate plan of
1336 self-insurance to respond to claims for injuries arising out of
1337 the furnishing of health care;
1338 (f) Provides, through contract or otherwise, for periodic
1339 review of its medical facilities and services, as required by
1340 the agency; and
1341 (g) Provides organizational, operational, financial, and
1342 other information required by the agency.
1343
1344 This subsection expires October 1, 2014.
1345 (6) ~~(7)~~ The agency may contract on a prepaid or fixed-sum
1346 basis with any health insurer that:
1347 (a) Pays for health care services provided to enrolled

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1348 Medicaid recipients in exchange for a premium payment paid by
1349 the agency;
1350 (b) Assumes the underwriting risk; and
1351 (c) Is organized and licensed under applicable provisions
1352 of the Florida Insurance Code and is currently in good standing
1353 with the Office of Insurance Regulation.
1354
1355 This subsection expires October 1, 2014.
1356 (7) ~~(8)(a)~~ The agency may contract on a prepaid or fixed-sum
1357 basis with an exclusive provider organization to provide health
1358 care services to Medicaid recipients provided that the exclusive
1359 provider organization meets applicable managed care plan
1360 requirements in this section, ss. 409.9122, 409.9123, 409.9128,
1361 and 627.6472, and other applicable provisions of law. This
1362 subsection expires October 1, 2014.
1363 ~~(b) For a period of no longer than 24 months after the~~
1364 ~~effective date of this paragraph, when a member of an exclusive~~
1365 ~~provider organization that is contracted by the agency to~~
1366 ~~provide health care services to Medicaid recipients in rural~~
1367 ~~areas without a health maintenance organization obtains services~~
1368 ~~from a provider that participates in the Medicaid program in~~
1369 ~~this state, the provider shall be paid in accordance with the~~
1370 ~~appropriate fee schedule for services provided to eligible~~
1371 ~~Medicaid recipients. The agency may seek waiver authority to~~
1372 ~~implement this paragraph.~~
1373 (8) ~~(9)~~ The Agency for Health Care Administration may
1374 provide cost-effective purchasing of chiropractic services on a
1375 fee-for-service basis to Medicaid recipients through
1376 arrangements with a statewide chiropractic preferred provider

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1377 organization incorporated in this state as a not-for-profit
1378 corporation. The agency shall ensure that the benefit limits and
1379 prior authorization requirements in the current Medicaid program
1380 shall apply to the services provided by the chiropractic
1381 preferred provider organization. This subsection expires October
1382 1, 2014.
1383 (9) ~~(10)~~ The agency shall not contract on a prepaid or
1384 fixed-sum basis for Medicaid services with an entity which knows
1385 or reasonably should know that any officer, director, agent,
1386 managing employee, or owner of stock or beneficial interest in
1387 excess of 5 percent common or preferred stock, or the entity
1388 itself, has been found guilty of, regardless of adjudication, or
1389 entered a plea of nolo contendere, or guilty, to:
1390 (a) Fraud;
1391 (b) Violation of federal or state antitrust statutes,
1392 including those proscribing price fixing between competitors and
1393 the allocation of customers among competitors;
1394 (c) Commission of a felony involving embezzlement, theft,
1395 forgery, income tax evasion, bribery, falsification or
1396 destruction of records, making false statements, receiving
1397 stolen property, making false claims, or obstruction of justice;
1398 or
1399 (d) Any crime in any jurisdiction which directly relates to
1400 the provision of health services on a prepaid or fixed-sum
1401 basis.
1402
1403 This subsection expires October 1, 2014.
1404 (10) ~~(11)~~ The agency, after notifying the Legislature, may
1405 apply for waivers of applicable federal laws and regulations as

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1406 necessary to implement more appropriate systems of health care
1407 for Medicaid recipients and reduce the cost of the Medicaid
1408 program to the state and federal governments and shall implement
1409 such programs, after legislative approval, within a reasonable
1410 period of time after federal approval. These programs must be
1411 designed primarily to reduce the need for inpatient care,
1412 custodial care and other long-term or institutional care, and
1413 other high-cost services. Prior to seeking legislative approval
1414 of such a waiver as authorized by this subsection, the agency
1415 shall provide notice and an opportunity for public comment.
1416 Notice shall be provided to all persons who have made requests
1417 of the agency for advance notice and shall be published in the
1418 Florida Administrative Weekly not less than 28 days prior to the
1419 intended action. This subsection expires October 1, 2016.
1420 (11) ~~(12)~~ The agency shall establish a postpayment
1421 utilization control program designed to identify recipients who
1422 may inappropriately overuse or underuse Medicaid services and
1423 shall provide methods to correct such misuse. This subsection
1424 expires October 1, 2014.
1425 (12) ~~(13)~~ The agency shall develop and provide coordinated
1426 systems of care for Medicaid recipients and may contract with
1427 public or private entities to develop and administer such
1428 systems of care among public and private health care providers
1429 in a given geographic area. This subsection expires October 1,
1430 2014.
1431 (13) ~~(14)(a)~~ The agency shall operate or contract for the
1432 operation of utilization management and incentive systems
1433 designed to encourage cost-effective use of services and to
1434 eliminate services that are medically unnecessary. The agency

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1435 shall track Medicaid provider prescription and billing patterns
1436 and evaluate them against Medicaid medical necessity criteria
1437 and coverage and limitation guidelines adopted by rule. Medical
1438 necessity determination requires that service be consistent with
1439 symptoms or confirmed diagnosis of illness or injury under
1440 treatment and not in excess of the patient's needs. The agency
1441 shall conduct reviews of provider exceptions to peer group norms
1442 and shall, using statistical methodologies, provider profiling,
1443 and analysis of billing patterns, detect and investigate
1444 abnormal or unusual increases in billing or payment of claims
1445 for Medicaid services and medically unnecessary provision of
1446 services. Providers that demonstrate a pattern of submitting
1447 claims for medically unnecessary services shall be referred to
1448 the Medicaid program integrity unit for investigation. In its
1449 annual report, required in s. 409.913, the agency shall report
1450 on its efforts to control overutilization as described in this
1451 subsection ~~paragraph~~. This subsection expires October 1, 2014.
1452 ~~(b) The agency shall develop a procedure for determining~~
1453 ~~whether health care providers and service vendors can provide~~
1454 ~~the Medicaid program using a business case that demonstrates~~
1455 ~~whether a particular good or service can offset the cost of~~
1456 ~~providing the good or service in an alternative setting or~~
1457 ~~through other means and therefore should receive a higher~~
1458 ~~reimbursement. The business case must include, but need not be~~
1459 ~~limited to:~~
1460 ~~1. A detailed description of the good or service to be~~
1461 ~~provided, a description and analysis of the agency's current~~
1462 ~~performance of the service, and a rationale documenting how~~
1463 ~~providing the service in an alternative setting would be in the~~

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1464 ~~best interest of the state, the agency, and its clients.~~
1465 ~~2. A cost-benefit analysis documenting the estimated~~
1466 ~~specific direct and indirect costs, savings, performance~~
1467 ~~improvements, risks, and qualitative and quantitative benefits~~
1468 ~~involved in or resulting from providing the service. The cost-~~
1469 ~~benefit analysis must include a detailed plan and timeline~~
1470 ~~identifying all actions that must be implemented to realize~~
1471 ~~expected benefits. The Secretary of Health Care Administration~~
1472 ~~shall verify that all costs, savings, and benefits are valid and~~
1473 ~~achievable.~~
1474 ~~(c) If the agency determines that the increased~~
1475 ~~reimbursement is cost-effective, the agency shall recommend a~~
1476 ~~change in the reimbursement schedule for that particular good or~~
1477 ~~service. If, within 12 months after implementing any rate change~~
1478 ~~under this procedure, the agency determines that costs were not~~
1479 ~~offset by the increased reimbursement schedule, the agency may~~
1480 ~~revert to the former reimbursement schedule for the particular~~
1481 ~~good or service.~~
1482 (14)~~(15)~~(a) The agency shall operate the Comprehensive
1483 Assessment and Review for Long-Term Care Services (CARES)
1484 nursing facility preadmission screening program to ensure that
1485 Medicaid payment for nursing facility care is made only for
1486 individuals whose conditions require such care and to ensure
1487 that long-term care services are provided in the setting most
1488 appropriate to the needs of the person and in the most
1489 economical manner possible. The CARES program shall also ensure
1490 that individuals participating in Medicaid home and community-
1491 based waiver programs meet criteria for those programs,
1492 consistent with approved federal waivers.

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1493 (b) The agency shall operate the CARES program through an
1494 interagency agreement with the Department of Elderly Affairs.
1495 The agency, in consultation with the Department of Elderly
1496 Affairs, may contract for any function or activity of the CARES
1497 program, including any function or activity required by 42
1498 C.F.R. part 483.20, relating to preadmission screening and
1499 resident review.
1500 (c) Prior to making payment for nursing facility services
1501 for a Medicaid recipient, the agency must verify that the
1502 nursing facility preadmission screening program has determined
1503 that the individual requires nursing facility care and that the
1504 individual cannot be safely served in community-based programs.
1505 The nursing facility preadmission screening program shall refer
1506 a Medicaid recipient to a community-based program if the
1507 individual could be safely served at a lower cost and the
1508 recipient chooses to participate in such program. For
1509 individuals whose nursing home stay is initially funded by
1510 Medicare and Medicare coverage is being terminated for lack of
1511 progress towards rehabilitation, CARES staff shall consult with
1512 the person making the determination of progress toward
1513 rehabilitation to ensure that the recipient is not being
1514 inappropriately disqualified from Medicare coverage. If, in
1515 their professional judgment, CARES staff believes that a
1516 Medicare beneficiary is still making progress toward
1517 rehabilitation, they may assist the Medicare beneficiary with an
1518 appeal of the disqualification from Medicare coverage. The use
1519 of CARES teams to review Medicare denials for coverage under
1520 this section is authorized only if it is determined that such
1521 reviews qualify for federal matching funds through Medicaid. The

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1522 agency shall seek or amend federal waivers as necessary to
1523 implement this section.
1524 (d) For the purpose of initiating immediate prescreening
1525 and diversion assistance for individuals residing in nursing
1526 homes and in order to make families aware of alternative long-
1527 term care resources so that they may choose a more cost-
1528 effective setting for long-term placement, CARES staff shall
1529 conduct an assessment and review of a sample of individuals
1530 whose nursing home stay is expected to exceed 20 days,
1531 regardless of the initial funding source for the nursing home
1532 placement. CARES staff shall provide counseling and referral
1533 services to these individuals regarding choosing appropriate
1534 long-term care alternatives. This paragraph does not apply to
1535 continuing care facilities licensed under chapter 651 or to
1536 retirement communities that provide a combination of nursing
1537 home, independent living, and other long-term care services.
1538 (e) By January 15 of each year, the agency shall submit a
1539 report to the Legislature describing the operations of the CARES
1540 program. The report must describe:
1541 1. Rate of diversion to community alternative programs;
1542 2. CARES program staffing needs to achieve additional
1543 diversions;
1544 3. Reasons the program is unable to place individuals in
1545 less restrictive settings when such individuals desired such
1546 services and could have been served in such settings;
1547 4. Barriers to appropriate placement, including barriers
1548 due to policies or operations of other agencies or state-funded
1549 programs; and
1550 5. Statutory changes necessary to ensure that individuals

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1551 in need of long-term care services receive care in the least
1552 restrictive environment.
1553 (f) The Department of Elderly Affairs shall track
1554 individuals over time who are assessed under the CARES program
1555 and who are diverted from nursing home placement. By January 15
1556 of each year, the department shall submit to the Legislature a
1557 longitudinal study of the individuals who are diverted from
1558 nursing home placement. The study must include:
1559 1. The demographic characteristics of the individuals
1560 assessed and diverted from nursing home placement, including,
1561 but not limited to, age, race, gender, frailty, caregiver
1562 status, living arrangements, and geographic location;
1563 2. A summary of community services provided to individuals
1564 for 1 year after assessment and diversion;
1565 3. A summary of inpatient hospital admissions for
1566 individuals who have been diverted; and
1567 4. A summary of the length of time between diversion and
1568 subsequent entry into a nursing home or death.
1569
1570 This subsection expires October 1, 2013.
1571 (15)~~(16)~~(a) The agency shall identify health care
1572 utilization and price patterns within the Medicaid program which
1573 are not cost-effective or medically appropriate and assess the
1574 effectiveness of new or alternate methods of providing and
1575 monitoring service, and may implement such methods as it
1576 considers appropriate. Such methods may include disease
1577 management initiatives, an integrated and systematic approach
1578 for managing the health care needs of recipients who are at risk
1579 of or diagnosed with a specific disease by using best practices,

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1580 prevention strategies, clinical-practice improvement, clinical
1581 interventions and protocols, outcomes research, information
1582 technology, and other tools and resources to reduce overall
1583 costs and improve measurable outcomes.
1584 (b) The responsibility of the agency under this subsection
1585 shall include the development of capabilities to identify actual
1586 and optimal practice patterns; patient and provider educational
1587 initiatives; methods for determining patient compliance with
1588 prescribed treatments; fraud, waste, and abuse prevention and
1589 detection programs; and beneficiary case management programs.
1590 1. The practice pattern identification program shall
1591 evaluate practitioner prescribing patterns based on national and
1592 regional practice guidelines, comparing practitioners to their
1593 peer groups. The agency and its Drug Utilization Review Board
1594 shall consult with the Department of Health and a panel of
1595 practicing health care professionals consisting of the
1596 following: the Speaker of the House of Representatives and the
1597 President of the Senate shall each appoint three physicians
1598 licensed under chapter 458 or chapter 459; and the Governor
1599 shall appoint two pharmacists licensed under chapter 465 and one
1600 dentist licensed under chapter 466 who is an oral surgeon. Terms
1601 of the panel members shall expire at the discretion of the
1602 appointing official. The advisory panel shall be responsible for
1603 evaluating treatment guidelines and recommending ways to
1604 incorporate their use in the practice pattern identification
1605 program. Practitioners who are prescribing inappropriately or
1606 inefficiently, as determined by the agency, may have their
1607 prescribing of certain drugs subject to prior authorization or
1608 may be terminated from all participation in the Medicaid

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1609 program.
1610 2. The agency shall also develop educational interventions
1611 designed to promote the proper use of medications by providers
1612 and beneficiaries.
1613 3. The agency shall implement a pharmacy fraud, waste, and
1614 abuse initiative that may include a surety bond or letter of
1615 credit requirement for participating pharmacies, enhanced
1616 provider auditing practices, the use of additional fraud and
1617 abuse software, recipient management programs for beneficiaries
1618 inappropriately using their benefits, and other steps that will
1619 eliminate provider and recipient fraud, waste, and abuse. The
1620 initiative shall address enforcement efforts to reduce the
1621 number and use of counterfeit prescriptions.
1622 4. By September 30, 2002, the agency shall contract with an
1623 entity in the state to implement a wireless handheld clinical
1624 pharmacology drug information database for practitioners. The
1625 initiative shall be designed to enhance the agency's efforts to
1626 reduce fraud, abuse, and errors in the prescription drug benefit
1627 program and to otherwise further the intent of this paragraph.
1628 5. By April 1, 2006, the agency shall contract with an
1629 entity to design a database of clinical utilization information
1630 or electronic medical records for Medicaid providers. This
1631 system must be web-based and allow providers to review on a
1632 real-time basis the utilization of Medicaid services, including,
1633 but not limited to, physician office visits, inpatient and
1634 outpatient hospitalizations, laboratory and pathology services,
1635 radiological and other imaging services, dental care, and
1636 patterns of dispensing prescription drugs in order to coordinate
1637 care and identify potential fraud and abuse.

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1638 6. The agency may apply for any federal waivers needed to
1639 administer this paragraph.
1640
1641 This subsection expires October 1, 2014.
1642 (16) ~~(17)~~ An entity contracting on a prepaid or fixed-sum
1643 basis shall meet the surplus requirements of s. 641.225. If an
1644 entity's surplus falls below an amount equal to the surplus
1645 requirements of s. 641.225, the agency shall prohibit the entity
1646 from engaging in marketing and preenrollment activities, shall
1647 cease to process new enrollments, and may not renew the entity's
1648 contract until the required balance is achieved. The
1649 requirements of this subsection do not apply:
1650 (a) Where a public entity agrees to fund any deficit
1651 incurred by the contracting entity; or
1652 (b) Where the entity's performance and obligations are
1653 guaranteed in writing by a guaranteeing organization which:
1654 1. Has been in operation for at least 5 years and has
1655 assets in excess of $50 million; or
1656 2. Submits a written guarantee acceptable to the agency
1657 which is irrevocable during the term of the contracting entity's
1658 contract with the agency and, upon termination of the contract,
1659 until the agency receives proof of satisfaction of all
1660 outstanding obligations incurred under the contract.
1661
1662 This subsection expires October 1, 2014.
1663 (17) ~~(18)~~(a) The agency may require an entity contracting on
1664 a prepaid or fixed-sum basis to establish a restricted
1665 insolvency protection account with a federally guaranteed
1666 financial institution licensed to do business in this state. The

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1667 entity shall deposit into that account 5 percent of the
1668 capitation payments made by the agency each month until a
1669 maximum total of 2 percent of the total current contract amount
1670 is reached. The restricted insolvency protection account may be
1671 drawn upon with the authorized signatures of two persons
1672 designated by the entity and two representatives of the agency.
1673 If the agency finds that the entity is insolvent, the agency may
1674 draw upon the account solely with the two authorized signatures
1675 of representatives of the agency, and the funds may be disbursed
1676 to meet financial obligations incurred by the entity under the
1677 prepaid contract. If the contract is terminated, expired, or not
1678 continued, the account balance must be released by the agency to
1679 the entity upon receipt of proof of satisfaction of all
1680 outstanding obligations incurred under this contract.
1681 (b) The agency may waive the insolvency protection account
1682 requirement in writing when evidence is on file with the agency
1683 of adequate insolvency insurance and reinsurance that will
1684 protect enrollees if the entity becomes unable to meet its
1685 obligations.
1686 (18) ~~(19)~~ An entity that contracts with the agency on a
1687 prepaid or fixed-sum basis for the provision of Medicaid
1688 services shall reimburse any hospital or physician that is
1689 outside the entity's authorized geographic service area as
1690 specified in its contract with the agency, and that provides
1691 services authorized by the entity to its members, at a rate
1692 negotiated with the hospital or physician for the provision of
1693 services or according to the lesser of the following:
1694 (a) The usual and customary charges made to the general
1695 public by the hospital or physician; or

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1696 (b) The Florida Medicaid reimbursement rate established for
1697 the hospital or physician.
1698
1699 This subsection expires October 1, 2014.
1700 (19) ~~(20)~~ When a merger or acquisition of a Medicaid prepaid
1701 contractor has been approved by the Office of Insurance
1702 Regulation pursuant to s. 628.4615, the agency shall approve the
1703 assignment or transfer of the appropriate Medicaid prepaid
1704 contract upon request of the surviving entity of the merger or
1705 acquisition if the contractor and the other entity have been in
1706 good standing with the agency for the most recent 12-month
1707 period, unless the agency determines that the assignment or
1708 transfer would be detrimental to the Medicaid recipients or the
1709 Medicaid program. To be in good standing, an entity must not
1710 have failed accreditation or committed any material violation of
1711 the requirements of s. 641.52 and must meet the Medicaid
1712 contract requirements. For purposes of this section, a merger or
1713 acquisition means a change in controlling interest of an entity,
1714 including an asset or stock purchase. This subsection expires
1715 October 1, 2014.
1716 (20) ~~(21)~~ Any entity contracting with the agency pursuant to
1717 this section to provide health care services to Medicaid
1718 recipients is prohibited from engaging in any of the following
1719 practices or activities:
1720 (a) Practices that are discriminatory, including, but not
1721 limited to, attempts to discourage participation on the basis of
1722 actual or perceived health status.
1723 (b) Activities that could mislead or confuse recipients, or
1724 misrepresent the organization, its marketing representatives, or

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1725 the agency. Violations of this paragraph include, but are not
1726 limited to:
1727 1. False or misleading claims that marketing
1728 representatives are employees or representatives of the state or
1729 county, or of anyone other than the entity or the organization
1730 by whom they are reimbursed.
1731 2. False or misleading claims that the entity is
1732 recommended or endorsed by any state or county agency, or by any
1733 other organization which has not certified its endorsement in
1734 writing to the entity.
1735 3. False or misleading claims that the state or county
1736 recommends that a Medicaid recipient enroll with an entity.
1737 4. Claims that a Medicaid recipient will lose benefits
1738 under the Medicaid program, or any other health or welfare
1739 benefits to which the recipient is legally entitled, if the
1740 recipient does not enroll with the entity.
1741 (c) Granting or offering of any monetary or other valuable
1742 consideration for enrollment, except as authorized by subsection
1743 (23) ~~(24)~~.
1744 (d) Door-to-door solicitation of recipients who have not
1745 contacted the entity or who have not invited the entity to make
1746 a presentation.
1747 (e) Solicitation of Medicaid recipients by marketing
1748 representatives stationed in state offices unless approved and
1749 supervised by the agency or its agent and approved by the
1750 affected state agency when solicitation occurs in an office of
1751 the state agency. The agency shall ensure that marketing
1752 representatives stationed in state offices shall market their
1753 managed care plans to Medicaid recipients only in designated

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1754 areas and in such a way as to not interfere with the recipients'
1755 activities in the state office.
1756 (f) Enrollment of Medicaid recipients.
1757 (21) ~~(22)~~ The agency may impose a fine for a violation of
1758 this section or the contract with the agency by a person or
1759 entity that is under contract with the agency. With respect to
1760 any nonwillful violation, such fine shall not exceed $2,500 per
1761 violation. In no event shall such fine exceed an aggregate
1762 amount of $10,000 for all nonwillful violations arising out of
1763 the same action. With respect to any knowing and willful
1764 violation of this section or the contract with the agency, the
1765 agency may impose a fine upon the entity in an amount not to
1766 exceed $20,000 for each such violation. In no event shall such
1767 fine exceed an aggregate amount of $100,000 for all knowing and
1768 willful violations arising out of the same action. This
1769 subsection expires October 1, 2014.
1770 (22) ~~(23)~~ A health maintenance organization or a person or
1771 entity exempt from chapter 641 that is under contract with the
1772 agency for the provision of health care services to Medicaid
1773 recipients may not use or distribute marketing materials used to
1774 solicit Medicaid recipients, unless such materials have been
1775 approved by the agency. The provisions of this subsection do not
1776 apply to general advertising and marketing materials used by a
1777 health maintenance organization to solicit both non-Medicaid
1778 subscribers and Medicaid recipients. This subsection expires
1779 October 1, 2014.
1780 (23) ~~(24)~~ Upon approval by the agency, health maintenance
1781 organizations and persons or entities exempt from chapter 641
1782 that are under contract with the agency for the provision of

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1783 health care services to Medicaid recipients may be permitted
1784 within the capitation rate to provide additional health benefits
1785 that the agency has found are of high quality, are practicably
1786 available, provide reasonable value to the recipient, and are
1787 provided at no additional cost to the state. This subsection
1788 expires October 1, 2014.
1789 (24) ~~(25)~~ The agency shall utilize the statewide health
1790 maintenance organization complaint hotline for the purpose of
1791 investigating and resolving Medicaid and prepaid health plan
1792 complaints, maintaining a record of complaints and confirmed
1793 problems, and receiving disenrollment requests made by
1794 recipients. This subsection expires October 1, 2014.
1795 (25) ~~(26)~~ The agency shall require the publication of the
1796 health maintenance organization's and the prepaid health plan's
1797 consumer services telephone numbers and the "800" telephone
1798 number of the statewide health maintenance organization
1799 complaint hotline on each Medicaid identification card issued by
1800 a health maintenance organization or prepaid health plan
1801 contracting with the agency to serve Medicaid recipients and on
1802 each subscriber handbook issued to a Medicaid recipient. This
1803 subsection expires October 1, 2014.
1804 (26) ~~(27)~~ The agency shall establish a health care quality
1805 improvement system for those entities contracting with the
1806 agency pursuant to this section, incorporating all the standards
1807 and guidelines developed by the Medicaid Bureau of the Health
1808 Care Financing Administration as a part of the quality assurance
1809 reform initiative. The system shall include, but need not be
1810 limited to, the following:
1811 (a) Guidelines for internal quality assurance programs,

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1812 including standards for:
1813 1. Written quality assurance program descriptions.
1814 2. Responsibilities of the governing body for monitoring,
1815 evaluating, and making improvements to care.
1816 3. An active quality assurance committee.
1817 4. Quality assurance program supervision.
1818 5. Requiring the program to have adequate resources to
1819 effectively carry out its specified activities.
1820 6. Provider participation in the quality assurance program.
1821 7. Delegation of quality assurance program activities.
1822 8. Credentialing and recredentialing.
1823 9. Enrollee rights and responsibilities.
1824 10. Availability and accessibility to services and care.
1825 11. Ambulatory care facilities.
1826 12. Accessibility and availability of medical records, as
1827 well as proper recordkeeping and process for record review.
1828 13. Utilization review.
1829 14. A continuity of care system.
1830 15. Quality assurance program documentation.
1831 16. Coordination of quality assurance activity with other
1832 management activity.
1833 17. Delivering care to pregnant women and infants; to
1834 elderly and disabled recipients, especially those who are at
1835 risk of institutional placement; to persons with developmental
1836 disabilities; and to adults who have chronic, high-cost medical
1837 conditions.
1838 (b) Guidelines which require the entities to conduct
1839 quality-of-care studies which:
1840 1. Target specific conditions and specific health service

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1841 delivery issues for focused monitoring and evaluation.
1842 2. Use clinical care standards or practice guidelines to
1843 objectively evaluate the care the entity delivers or fails to
1844 deliver for the targeted clinical conditions and health services
1845 delivery issues.
1846 3. Use quality indicators derived from the clinical care
1847 standards or practice guidelines to screen and monitor care and
1848 services delivered.
1849 (c) Guidelines for external quality review of each
1850 contractor which require: focused studies of patterns of care;
1851 individual care review in specific situations; and followup
1852 activities on previous pattern-of-care study findings and
1853 individual-care-review findings. In designing the external
1854 quality review function and determining how it is to operate as
1855 part of the state's overall quality improvement system, the
1856 agency shall construct its external quality review organization
1857 and entity contracts to address each of the following:
1858 1. Delineating the role of the external quality review
1859 organization.
1860 2. Length of the external quality review organization
1861 contract with the state.
1862 3. Participation of the contracting entities in designing
1863 external quality review organization review activities.
1864 4. Potential variation in the type of clinical conditions
1865 and health services delivery issues to be studied at each plan.
1866 5. Determining the number of focused pattern-of-care
1867 studies to be conducted for each plan.
1868 6. Methods for implementing focused studies.
1869 7. Individual care review.

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1870 8. Followup activities.
1871
1872 This subsection expires October 1, 2016.
1873 (27)~~(28)~~ In order to ensure that children receive health
1874 care services for which an entity has already been compensated,
1875 an entity contracting with the agency pursuant to this section
1876 shall achieve an annual Early and Periodic Screening, Diagnosis,
1877 and Treatment (EPSDT) Service screening rate of at least 60
1878 percent for those recipients continuously enrolled for at least
1879 8 months. The agency shall develop a method by which the EPSDT
1880 screening rate shall be calculated. For any entity which does
1881 not achieve the annual 60 percent rate, the entity must submit a
1882 corrective action plan for the agency’s approval. If the entity
1883 does not meet the standard established in the corrective action
1884 plan during the specified timeframe, the agency is authorized to
1885 impose appropriate contract sanctions. At least annually, the
1886 agency shall publicly release the EPSDT Services screening rates
1887 of each entity it has contracted with on a prepaid basis to
1888 serve Medicaid recipients. This subsection expires October 1,
1889 2014.
1890 (28)~~(29)~~ The agency shall perform enrollments and
1891 disenrollments for Medicaid recipients who are eligible for
1892 MediPass or managed care plans. Notwithstanding the prohibition
1893 contained in paragraph (20)~~(21)~~(f), managed care plans may
1894 perform preenrollments of Medicaid recipients under the
1895 supervision of the agency or its agents. For the purposes of
1896 this section, the term “preenrollment” means the provision of
1897 marketing and educational materials to a Medicaid recipient and
1898 assistance in completing the application forms, but does not

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1899 include actual enrollment into a managed care plan. An
1900 application for enrollment may not be deemed complete until the
1901 agency or its agent verifies that the recipient made an
1902 informed, voluntary choice. The agency, in cooperation with the
1903 Department of Children and Family Services, may test new
1904 marketing initiatives to inform Medicaid recipients about their
1905 managed care options at selected sites. The agency may contract
1906 with a third party to perform managed care plan and MediPass
1907 enrollment and disenrollment services for Medicaid recipients
1908 and may adopt rules to administer such services. The agency may
1909 adjust the capitation rate only to cover the costs of a third-
1910 party enrollment and disenrollment contract, and for agency
1911 supervision and management of the managed care plan enrollment
1912 and disenrollment contract. This subsection expires October 1,
1913 2014.
1914 (29)~~(30)~~ Any lists of providers made available to Medicaid
1915 recipients, MediPass enrollees, or managed care plan enrollees
1916 shall be arranged alphabetically showing the provider's name and
1917 specialty and, separately, by specialty in alphabetical order.
1918 This subsection expires October 1, 2014.
1919 (30)~~(31)~~ The agency shall establish an enhanced managed
1920 care quality assurance oversight function, to include at least
1921 the following components:
1922 (a) At least quarterly analysis and followup, including
1923 sanctions as appropriate, of managed care participant
1924 utilization of services.
1925 (b) At least quarterly analysis and followup, including
1926 sanctions as appropriate, of quality findings of the Medicaid
1927 peer review organization and other external quality assurance

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1928 programs.
1929 (c) At least quarterly analysis and followup, including
1930 sanctions as appropriate, of the fiscal viability of managed
1931 care plans.
1932 (d) At least quarterly analysis and followup, including
1933 sanctions as appropriate, of managed care participant
1934 satisfaction and disenrollment surveys.
1935 (e) The agency shall conduct regular and ongoing Medicaid
1936 recipient satisfaction surveys.
1937
1938 The analyses and followup activities conducted by the agency
1939 under its enhanced managed care quality assurance oversight
1940 function shall not duplicate the activities of accreditation
1941 reviewers for entities regulated under part III of chapter 641,
1942 but may include a review of the finding of such reviewers. This
1943 subsection expires October 1, 2014.
1944 (31) ~~(32)~~ Each managed care plan that is under contract with
1945 the agency to provide health care services to Medicaid
1946 recipients shall annually conduct a background check with the
1947 Department of Law Enforcement of all persons with ownership
1948 interest of 5 percent or more or executive management
1949 responsibility for the managed care plan and shall submit to the
1950 agency information concerning any such person who has been found
1951 guilty of, regardless of adjudication, or has entered a plea of
1952 nolo contendere or guilty to, any of the offenses listed in s.
1953 435.04. This subsection expires October 1, 2014.
1954 (32) ~~(33)~~ The agency shall, by rule, develop a process
1955 whereby a Medicaid managed care plan enrollee who wishes to
1956 enter hospice care may be disenrolled from the managed care plan

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1957 within 24 hours after contacting the agency regarding such
1958 request. The agency rule shall include a methodology for the
1959 agency to recoup managed care plan payments on a pro rata basis
1960 if payment has been made for the enrollment month when
1961 disenrollment occurs. This subsection expires October 1, 2014.
1962 (33)~~(34)~~ The agency and entities that contract with the
1963 agency to provide health care services to Medicaid recipients
1964 under this section or ss. 409.91211 and 409.9122 must comply
1965 with the provisions of s. 641.513 in providing emergency
1966 services and care to Medicaid recipients and MediPass
1967 recipients. Where feasible, safe, and cost-effective, the agency
1968 shall encourage hospitals, emergency medical services providers,
1969 and other public and private health care providers to work
1970 together in their local communities to enter into agreements or
1971 arrangements to ensure access to alternatives to emergency
1972 services and care for those Medicaid recipients who need
1973 nonemergent care. The agency shall coordinate with hospitals,
1974 emergency medical services providers, private health plans,
1975 capitated managed care networks as established in s. 409.91211,
1976 and other public and private health care providers to implement
1977 the provisions of ss. 395.1041(7), 409.91255(3)(g), 627.6405,
1978 and 641.31097 to develop and implement emergency department
1979 diversion programs for Medicaid recipients. This subsection
1980 expires October 1, 2014.
1981 (34)~~(35)~~ All entities providing health care services to
1982 Medicaid recipients shall make available, and encourage all
1983 pregnant women and mothers with infants to receive, and provide
1984 documentation in the medical records to reflect, the following:
1985 (a) Healthy Start prenatal or infant screening.

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1986 (b) Healthy Start care coordination, when screening or
1987 other factors indicate need.
1988 (c) Healthy Start enhanced services in accordance with the
1989 prenatal or infant screening results.
1990 (d) Immunizations in accordance with recommendations of the
1991 Advisory Committee on Immunization Practices of the United
1992 States Public Health Service and the American Academy of
1993 Pediatrics, as appropriate.
1994 (e) Counseling and services for family planning to all
1995 women and their partners.
1996 (f) A scheduled postpartum visit for the purpose of
1997 voluntary family planning, to include discussion of all methods
1998 of contraception, as appropriate.
1999 (g) Referral to the Special Supplemental Nutrition Program
2000 for Women, Infants, and Children (WIC).
2001
2002 This subsection expires October 1, 2014.
2003 (35) ~~(36)~~ Any entity that provides Medicaid prepaid health
2004 plan services shall ensure the appropriate coordination of
2005 health care services with an assisted living facility in cases
2006 where a Medicaid recipient is both a member of the entity's
2007 prepaid health plan and a resident of the assisted living
2008 facility. If the entity is at risk for Medicaid targeted case
2009 management and behavioral health services, the entity shall
2010 inform the assisted living facility of the procedures to follow
2011 should an emergent condition arise. This subsection expires
2012 October 1, 2014.
2013 ~~(37) The agency may seek and implement federal waivers~~
2014 ~~necessary to provide for cost-effective purchasing of home~~

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2015 ~~health services, private duty nursing services, transportation,~~
2016 ~~independent laboratory services, and durable medical equipment~~
2017 ~~and supplies through competitive bidding pursuant to s. 287.057.~~
2018 ~~The agency may request appropriate waivers from the federal~~
2019 ~~Health Care Financing Administration in order to competitively~~
2020 ~~bid such services. The agency may exclude providers not selected~~
2021 ~~through the bidding process from the Medicaid provider network.~~
2022 (36) ~~(38)~~ The agency shall enter into agreements with not-
2023 for-profit organizations based in this state for the purpose of
2024 providing vision screening. This subsection expires October 1,
2025 2014.
2026 (37) ~~(39)~~(a) The agency shall implement a Medicaid
2027 prescribed-drug spending-control program that includes the
2028 following components:
2029 1. A Medicaid preferred drug list, which shall be a listing
2030 of cost-effective therapeutic options recommended by the
2031 Medicaid Pharmacy and Therapeutics Committee established
2032 pursuant to s. 409.91195 and adopted by the agency for each
2033 therapeutic class on the preferred drug list. At the discretion
2034 of the committee, and when feasible, the preferred drug list
2035 should include at least two products in a therapeutic class. The
2036 agency may post the preferred drug list and updates to the
2037 preferred drug list on an Internet website without following the
2038 rulemaking procedures of chapter 120. Antiretroviral agents are
2039 excluded from the preferred drug list. The agency shall also
2040 limit the amount of a prescribed drug dispensed to no more than
2041 a 34-day supply unless the drug products’ smallest marketed
2042 package is greater than a 34-day supply, or the drug is
2043 determined by the agency to be a maintenance drug in which case

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2044 a 100-day maximum supply may be authorized. The agency is
2045 authorized to seek any federal waivers necessary to implement
2046 these cost-control programs and to continue participation in the
2047 federal Medicaid rebate program, or alternatively to negotiate
2048 state-only manufacturer rebates. The agency may adopt rules to
2049 implement this subparagraph. The agency shall continue to
2050 provide unlimited contraceptive drugs and items. The agency must
2051 establish procedures to ensure that:
2052 a. There is a response to a request for prior consultation
2053 by telephone or other telecommunication device within 24 hours
2054 after receipt of a request for prior consultation; and
2055 b. A 72-hour supply of the drug prescribed is provided in
2056 an emergency or when the agency does not provide a response
2057 within 24 hours as required by sub-subparagraph a.
2058 2. Reimbursement to pharmacies for Medicaid prescribed
2059 drugs shall be set at the lesser of: the average wholesale price
2060 (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC)
2061 plus 4.75 percent, the federal upper limit (FUL), the state
2062 maximum allowable cost (SMAC), or the usual and customary (UAC)
2063 charge billed by the provider.
2064 3. The agency shall develop and implement a process for
2065 managing the drug therapies of Medicaid recipients who are using
2066 significant numbers of prescribed drugs each month. The
2067 management process may include, but is not limited to,
2068 comprehensive, physician-directed medical-record reviews, claims
2069 analyses, and case evaluations to determine the medical
2070 necessity and appropriateness of a patient's treatment plan and
2071 drug therapies. The agency may contract with a private
2072 organization to provide drug-program-management services. The

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2073 Medicaid drug benefit management program shall include
2074 initiatives to manage drug therapies for HIV/AIDS patients,
2075 patients using 20 or more unique prescriptions in a 180-day
2076 period, and the top 1,000 patients in annual spending. The
2077 agency shall enroll any Medicaid recipient in the drug benefit
2078 management program if he or she meets the specifications of this
2079 provision and is not enrolled in a Medicaid health maintenance
2080 organization.
2081 4. The agency may limit the size of its pharmacy network
2082 based on need, competitive bidding, price negotiations,
2083 credentialing, or similar criteria. The agency shall give
2084 special consideration to rural areas in determining the size and
2085 location of pharmacies included in the Medicaid pharmacy
2086 network. A pharmacy credentialing process may include criteria
2087 such as a pharmacy's full-service status, location, size,
2088 patient educational programs, patient consultation, disease
2089 management services, and other characteristics. The agency may
2090 impose a moratorium on Medicaid pharmacy enrollment when it is
2091 determined that it has a sufficient number of Medicaid-
2092 participating providers. The agency must allow dispensing
2093 practitioners to participate as a part of the Medicaid pharmacy
2094 network regardless of the practitioner's proximity to any other
2095 entity that is dispensing prescription drugs under the Medicaid
2096 program. A dispensing practitioner must meet all credentialing
2097 requirements applicable to his or her practice, as determined by
2098 the agency.
2099 5. The agency shall develop and implement a program that
2100 requires Medicaid practitioners who prescribe drugs to use a
2101 counterfeit-proof prescription pad for Medicaid prescriptions.

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2102 The agency shall require the use of standardized counterfeit-
2103 proof prescription pads by Medicaid-participating prescribers or
2104 prescribers who write prescriptions for Medicaid recipients. The
2105 agency may implement the program in targeted geographic areas or
2106 statewide.
2107 6. The agency may enter into arrangements that require
2108 manufacturers of generic drugs prescribed to Medicaid recipients
2109 to provide rebates of at least 15.1 percent of the average
2110 manufacturer price for the manufacturer's generic products.
2111 These arrangements shall require that if a generic-drug
2112 manufacturer pays federal rebates for Medicaid-reimbursed drugs
2113 at a level below 15.1 percent, the manufacturer must provide a
2114 supplemental rebate to the state in an amount necessary to
2115 achieve a 15.1-percent rebate level.
2116 7. The agency may establish a preferred drug list as
2117 described in this subsection, and, pursuant to the establishment
2118 of such preferred drug list, it is authorized to negotiate
2119 supplemental rebates from manufacturers that are in addition to
2120 those required by Title XIX of the Social Security Act and at no
2121 less than 14 percent of the average manufacturer price as
2122 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
2123 the federal or supplemental rebate, or both, equals or exceeds
2124 29 percent. There is no upper limit on the supplemental rebates
2125 the agency may negotiate. The agency may determine that specific
2126 products, brand-name or generic, are competitive at lower rebate
2127 percentages. Agreement to pay the minimum supplemental rebate
2128 percentage will guarantee a manufacturer that the Medicaid
2129 Pharmaceutical and Therapeutics Committee will consider a
2130 product for inclusion on the preferred drug list. However, a

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2131 pharmaceutical manufacturer is not guaranteed placement on the
2132 preferred drug list by simply paying the minimum supplemental
2133 rebate. Agency decisions will be made on the clinical efficacy
2134 of a drug and recommendations of the Medicaid Pharmaceutical and
2135 Therapeutics Committee, as well as the price of competing
2136 products minus federal and state rebates. The agency is
2137 authorized to contract with an outside agency or contractor to
2138 conduct negotiations for supplemental rebates. For the purposes
2139 of this section, the term “supplemental rebates” means cash
2140 rebates. Effective July 1, 2004, value-added programs as a
2141 substitution for supplemental rebates are prohibited. The agency
2142 is authorized to seek any federal waivers to implement this
2143 initiative.
2144 8. The Agency for Health Care Administration shall expand
2145 home delivery of pharmacy products. To assist Medicaid patients
2146 in securing their prescriptions and reduce program costs, the
2147 agency shall expand its current mail-order-pharmacy diabetes-
2148 supply program to include all generic and brand-name drugs used
2149 by Medicaid patients with diabetes. Medicaid recipients in the
2150 current program may obtain nondiabetes drugs on a voluntary
2151 basis. This initiative is limited to the geographic area covered
2152 by the current contract. The agency may seek and implement any
2153 federal waivers necessary to implement this subparagraph.
2154 9. The agency shall limit to one dose per month any drug
2155 prescribed to treat erectile dysfunction.
2156 10.a. The agency may implement a Medicaid behavioral drug
2157 management system. The agency may contract with a vendor that
2158 has experience in operating behavioral drug management systems
2159 to implement this program. The agency is authorized to seek

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2160 federal waivers to implement this program.
2161 b. The agency, in conjunction with the Department of
2162 Children and Family Services, may implement the Medicaid
2163 behavioral drug management system that is designed to improve
2164 the quality of care and behavioral health prescribing practices
2165 based on best practice guidelines, improve patient adherence to
2166 medication plans, reduce clinical risk, and lower prescribed
2167 drug costs and the rate of inappropriate spending on Medicaid
2168 behavioral drugs. The program may include the following
2169 elements:
2170 (I) Provide for the development and adoption of best
2171 practice guidelines for behavioral health-related drugs such as
2172 antipsychotics, antidepressants, and medications for treating
2173 bipolar disorders and other behavioral conditions; translate
2174 them into practice; review behavioral health prescribers and
2175 compare their prescribing patterns to a number of indicators
2176 that are based on national standards; and determine deviations
2177 from best practice guidelines.
2178 (II) Implement processes for providing feedback to and
2179 educating prescribers using best practice educational materials
2180 and peer-to-peer consultation.
2181 (III) Assess Medicaid beneficiaries who are outliers in
2182 their use of behavioral health drugs with regard to the numbers
2183 and types of drugs taken, drug dosages, combination drug
2184 therapies, and other indicators of improper use of behavioral
2185 health drugs.
2186 (IV) Alert prescribers to patients who fail to refill
2187 prescriptions in a timely fashion, are prescribed multiple same-
2188 class behavioral health drugs, and may have other potential

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2189 medication problems.
2190 (V) Track spending trends for behavioral health drugs and
2191 deviation from best practice guidelines.
2192 (VI) Use educational and technological approaches to
2193 promote best practices, educate consumers, and train prescribers
2194 in the use of practice guidelines.
2195 (VII) Disseminate electronic and published materials.
2196 (VIII) Hold statewide and regional conferences.
2197 (IX) Implement a disease management program with a model
2198 quality-based medication component for severely mentally ill
2199 individuals and emotionally disturbed children who are high
2200 users of care.
2201 11.a. The agency shall implement a Medicaid prescription
2202 drug management system. The agency may contract with a vendor
2203 that has experience in operating prescription drug management
2204 systems in order to implement this system. Any management system
2205 that is implemented in accordance with this subparagraph must
2206 rely on cooperation between physicians and pharmacists to
2207 determine appropriate practice patterns and clinical guidelines
2208 to improve the prescribing, dispensing, and use of drugs in the
2209 Medicaid program. The agency may seek federal waivers to
2210 implement this program.
2211 b. The drug management system must be designed to improve
2212 the quality of care and prescribing practices based on best
2213 practice guidelines, improve patient adherence to medication
2214 plans, reduce clinical risk, and lower prescribed drug costs and
2215 the rate of inappropriate spending on Medicaid prescription
2216 drugs. The program must:
2217 (I) Provide for the development and adoption of best

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2218 practice guidelines for the prescribing and use of drugs in the
2219 Medicaid program, including translating best practice guidelines
2220 into practice; reviewing prescriber patterns and comparing them
2221 to indicators that are based on national standards and practice
2222 patterns of clinical peers in their community, statewide, and
2223 nationally; and determine deviations from best practice
2224 guidelines.
2225 (II) Implement processes for providing feedback to and
2226 educating prescribers using best practice educational materials
2227 and peer-to-peer consultation.
2228 (III) Assess Medicaid recipients who are outliers in their
2229 use of a single or multiple prescription drugs with regard to
2230 the numbers and types of drugs taken, drug dosages, combination
2231 drug therapies, and other indicators of improper use of
2232 prescription drugs.
2233 (IV) Alert prescribers to patients who fail to refill
2234 prescriptions in a timely fashion, are prescribed multiple drugs
2235 that may be redundant or contraindicated, or may have other
2236 potential medication problems.
2237 (V) Track spending trends for prescription drugs and
2238 deviation from best practice guidelines.
2239 (VI) Use educational and technological approaches to
2240 promote best practices, educate consumers, and train prescribers
2241 in the use of practice guidelines.
2242 (VII) Disseminate electronic and published materials.
2243 (VIII) Hold statewide and regional conferences.
2244 (IX) Implement disease management programs in cooperation
2245 with physicians and pharmacists, along with a model quality-
2246 based medication component for individuals having chronic

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2247 medical conditions.
2248 12. The agency is authorized to contract for drug rebate
2249 administration, including, but not limited to, calculating
2250 rebate amounts, invoicing manufacturers, negotiating disputes
2251 with manufacturers, and maintaining a database of rebate
2252 collections.
2253 13. The agency may specify the preferred daily dosing form
2254 or strength for the purpose of promoting best practices with
2255 regard to the prescribing of certain drugs as specified in the
2256 General Appropriations Act and ensuring cost-effective
2257 prescribing practices.
2258 14. The agency may require prior authorization for
2259 Medicaid-covered prescribed drugs. The agency may, but is not
2260 required to, prior-authorize the use of a product:
2261 a. For an indication not approved in labeling;
2262 b. To comply with certain clinical guidelines; or
2263 c. If the product has the potential for overuse, misuse, or
2264 abuse.
2265
2266 The agency may require the prescribing professional to provide
2267 information about the rationale and supporting medical evidence
2268 for the use of a drug. The agency may post prior authorization
2269 criteria and protocol and updates to the list of drugs that are
2270 subject to prior authorization on an Internet website without
2271 amending its rule or engaging in additional rulemaking.
2272 15. The agency, in conjunction with the Pharmaceutical and
2273 Therapeutics Committee, may require age-related prior
2274 authorizations for certain prescribed drugs. The agency may
2275 preauthorize the use of a drug for a recipient who may not meet

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2276 the age requirement or may exceed the length of therapy for use
2277 of this product as recommended by the manufacturer and approved
2278 by the Food and Drug Administration. Prior authorization may
2279 require the prescribing professional to provide information
2280 about the rationale and supporting medical evidence for the use
2281 of a drug.
2282 16. The agency shall implement a step-therapy prior
2283 authorization approval process for medications excluded from the
2284 preferred drug list. Medications listed on the preferred drug
2285 list must be used within the previous 12 months prior to the
2286 alternative medications that are not listed. The step-therapy
2287 prior authorization may require the prescriber to use the
2288 medications of a similar drug class or for a similar medical
2289 indication unless contraindicated in the Food and Drug
2290 Administration labeling. The trial period between the specified
2291 steps may vary according to the medical indication. The step-
2292 therapy approval process shall be developed in accordance with
2293 the committee as stated in s. 409.91195(7) and (8). A drug
2294 product may be approved without meeting the step-therapy prior
2295 authorization criteria if the prescribing physician provides the
2296 agency with additional written medical or clinical documentation
2297 that the product is medically necessary because:
2298 a. There is not a drug on the preferred drug list to treat
2299 the disease or medical condition which is an acceptable clinical
2300 alternative;
2301 b. The alternatives have been ineffective in the treatment
2302 of the beneficiary’s disease; or
2303 c. Based on historic evidence and known characteristics of
2304 the patient and the drug, the drug is likely to be ineffective,

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2305 or the number of doses have been ineffective.
2306
2307 The agency shall work with the physician to determine the best
2308 alternative for the patient. The agency may adopt rules waiving
2309 the requirements for written clinical documentation for specific
2310 drugs in limited clinical situations.
2311 17. The agency shall implement a return and reuse program
2312 for drugs dispensed by pharmacies to institutional recipients,
2313 which includes payment of a $5 restocking fee for the
2314 implementation and operation of the program. The return and
2315 reuse program shall be implemented electronically and in a
2316 manner that promotes efficiency. The program must permit a
2317 pharmacy to exclude drugs from the program if it is not
2318 practical or cost-effective for the drug to be included and must
2319 provide for the return to inventory of drugs that cannot be
2320 credited or returned in a cost-effective manner. The agency
2321 shall determine if the program has reduced the amount of
2322 Medicaid prescription drugs which are destroyed on an annual
2323 basis and if there are additional ways to ensure more
2324 prescription drugs are not destroyed which could safely be
2325 reused. The agency's conclusion and recommendations shall be
2326 reported to the Legislature by December 1, 2005.
2327 (b) The agency shall implement this subsection to the
2328 extent that funds are appropriated to administer the Medicaid
2329 prescribed-drug spending-control program. The agency may
2330 contract all or any part of this program to private
2331 organizations.
2332 (c) The agency shall submit quarterly reports to the
2333 Governor, the President of the Senate, and the Speaker of the

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2334 House of Representatives which must include, but need not be
2335 limited to, the progress made in implementing this subsection
2336 and its effect on Medicaid prescribed-drug expenditures.
2337 (38)~~(40)~~ Notwithstanding the provisions of chapter 287, the
2338 agency may, at its discretion, renew a contract or contracts for
2339 fiscal intermediary services one or more times for such periods
2340 as the agency may decide; however, all such renewals may not
2341 combine to exceed a total period longer than the term of the
2342 original contract.
2343 (39)~~(41)~~ The agency shall provide for the development of a
2344 demonstration project by establishment in Miami-Dade County of a
2345 long-term-care facility licensed pursuant to chapter 395 to
2346 improve access to health care for a predominantly minority,
2347 medically underserved, and medically complex population and to
2348 evaluate alternatives to nursing home care and general acute
2349 care for such population. Such project is to be located in a
2350 health care condominium and colocated with licensed facilities
2351 providing a continuum of care. The establishment of this project
2352 is not subject to the provisions of s. 408.036 or s. 408.039.
2353 This subsection expires October 1, 2013.
2354 (40)~~(42)~~ The agency shall develop and implement a
2355 utilization management program for Medicaid-eligible recipients
2356 for the management of occupational, physical, respiratory, and
2357 speech therapies. The agency shall establish a utilization
2358 program that may require prior authorization in order to ensure
2359 medically necessary and cost-effective treatments. The program
2360 shall be operated in accordance with a federally approved waiver
2361 program or state plan amendment. The agency may seek a federal
2362 waiver or state plan amendment to implement this program. The

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2363 agency may also competitively procure these services from an
2364 outside vendor on a regional or statewide basis. This subsection
2365 expires October 1, 2014.
2366 (41) ~~(43)~~ The agency shall ~~may~~ contract on a prepaid or
2367 fixed-sum basis with appropriately licensed prepaid dental
2368 health plans to provide dental services. This subsection expires
2369 October 1, 2014.
2370 (42) ~~(44)~~ The Agency for Health Care Administration shall
2371 ensure that any Medicaid managed care plan as defined in s.
2372 409.9122(2)(f), whether paid on a capitated basis or a shared
2373 savings basis, is cost-effective. For purposes of this
2374 subsection, the term “cost-effective” means that a network’s
2375 per-member, per-month costs to the state, including, but not
2376 limited to, fee-for-service costs, administrative costs, and
2377 case-management fees, if any, must be no greater than the
2378 state’s costs associated with contracts for Medicaid services
2379 established under subsection (3), which may be adjusted for
2380 health status. The agency shall conduct actuarially sound
2381 adjustments for health status in order to ensure such cost-
2382 effectiveness and shall annually publish the results on its
2383 Internet website. Contracts established pursuant to this
2384 subsection which are not cost-effective may not be renewed. This
2385 subsection expires October 1, 2014.
2386 (43) ~~(45)~~ Subject to the availability of funds, the agency
2387 shall mandate a recipient’s participation in a provider lock-in
2388 program, when appropriate, if a recipient is found by the agency
2389 to have used Medicaid goods or services at a frequency or amount
2390 not medically necessary, limiting the receipt of goods or
2391 services to medically necessary providers after the 21-day

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2392 appeal process has ended, for a period of not less than 1 year.
2393 The lock-in programs shall include, but are not limited to,
2394 pharmacies, medical doctors, and infusion clinics. The
2395 limitation does not apply to emergency services and care
2396 provided to the recipient in a hospital emergency department.
2397 The agency shall seek any federal waivers necessary to implement
2398 this subsection. The agency shall adopt any rules necessary to
2399 comply with or administer this subsection. This subsection
2400 expires October 1, 2014.
2401 (44)~~(46)~~ The agency shall seek a federal waiver for
2402 permission to terminate the eligibility of a Medicaid recipient
2403 who has been found to have committed fraud, through judicial or
2404 administrative determination, two times in a period of 5 years.
2405 ~~(47) The agency shall conduct a study of available~~
2406 ~~electronic systems for the purpose of verifying the identity and~~
2407 ~~eligibility of a Medicaid recipient. The agency shall recommend~~
2408 ~~to the Legislature a plan to implement an electronic~~
2409 ~~verification system for Medicaid recipients by January 31, 2005.~~
2410 (45)~~(48)~~(a) A provider is not entitled to enrollment in the
2411 Medicaid provider network. The agency may implement a Medicaid
2412 fee-for-service provider network controls, including, but not
2413 limited to, competitive procurement and provider credentialing.
2414 If a credentialing process is used, the agency may limit its
2415 provider network based upon the following considerations:
2416 beneficiary access to care, provider availability, provider
2417 quality standards and quality assurance processes, cultural
2418 competency, demographic characteristics of beneficiaries,
2419 practice standards, service wait times, provider turnover,
2420 provider licensure and accreditation history, program integrity

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2421 history, peer review, Medicaid policy and billing compliance
2422 records, clinical and medical record audit findings, and such
2423 other areas that are considered necessary by the agency to
2424 ensure the integrity of the program.
2425 (b) The agency shall limit its network of durable medical
2426 equipment and medical supply providers. For dates of service
2427 after January 1, 2009, the agency shall limit payment for
2428 durable medical equipment and supplies to providers that meet
2429 all the requirements of this paragraph.
2430 1. Providers must be accredited by a Centers for Medicare
2431 and Medicaid Services deemed accreditation organization for
2432 suppliers of durable medical equipment, prosthetics, orthotics,
2433 and supplies. The provider must maintain accreditation and is
2434 subject to unannounced reviews by the accrediting organization.
2435 2. Providers must provide the services or supplies directly
2436 to the Medicaid recipient or caregiver at the provider location
2437 or recipient's residence or send the supplies directly to the
2438 recipient's residence with receipt of mailed delivery.
2439 Subcontracting or consignment of the service or supply to a
2440 third party is prohibited.
2441 3. Notwithstanding subparagraph 2., a durable medical
2442 equipment provider may store nebulizers at a physician's office
2443 for the purpose of having the physician's staff issue the
2444 equipment if it meets all of the following conditions:
2445 a. The physician must document the medical necessity and
2446 need to prevent further deterioration of the patient's
2447 respiratory status by the timely delivery of the nebulizer in
2448 the physician's office.
2449 b. The durable medical equipment provider must have written

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2450 documentation of the competency and training by a Florida-
2451 licensed registered respiratory therapist of any durable medical
2452 equipment staff who participate in the training of physician
2453 office staff for the use of nebulizers, including cleaning,
2454 warranty, and special needs of patients.
2455 c. The physician's office must have documented the training
2456 and competency of any staff member who initiates the delivery of
2457 nebulizers to patients. The durable medical equipment provider
2458 must maintain copies of all physician office training.
2459 d. The physician's office must maintain inventory records
2460 of stored nebulizers, including documentation of the durable
2461 medical equipment provider source.
2462 e. A physician contracted with a Medicaid durable medical
2463 equipment provider may not have a financial relationship with
2464 that provider or receive any financial gain from the delivery of
2465 nebulizers to patients.
2466 4. Providers must have a physical business location and a
2467 functional landline business phone. The location must be within
2468 the state or not more than 50 miles from the Florida state line.
2469 The agency may make exceptions for providers of durable medical
2470 equipment or supplies not otherwise available from other
2471 enrolled providers located within the state.
2472 5. Physical business locations must be clearly identified
2473 as a business that furnishes durable medical equipment or
2474 medical supplies by signage that can be read from 20 feet away.
2475 The location must be readily accessible to the public during
2476 normal, posted business hours and must operate at least 5 hours
2477 per day and at least 5 days per week, with the exception of
2478 scheduled and posted holidays. The location may not be located

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2479 within or at the same numbered street address as another
2480 enrolled Medicaid durable medical equipment or medical supply
2481 provider or as an enrolled Medicaid pharmacy that is also
2482 enrolled as a durable medical equipment provider. A licensed
2483 orthotist or prosthetist that provides only orthotic or
2484 prosthetic devices as a Medicaid durable medical equipment
2485 provider is exempt from this paragraph.
2486 6. Providers must maintain a stock of durable medical
2487 equipment and medical supplies on site that is readily available
2488 to meet the needs of the durable medical equipment business
2489 location's customers.
2490 7. Providers must provide a surety bond of $50,000 for each
2491 provider location, up to a maximum of 5 bonds statewide or an
2492 aggregate bond of $250,000 statewide, as identified by Federal
2493 Employer Identification Number. Providers who post a statewide
2494 or an aggregate bond must identify all of their locations in any
2495 Medicaid durable medical equipment and medical supply provider
2496 enrollment application or bond renewal. Each provider location's
2497 surety bond must be renewed annually and the provider must
2498 submit proof of renewal even if the original bond is a
2499 continuous bond. A licensed orthotist or prosthetist that
2500 provides only orthotic or prosthetic devices as a Medicaid
2501 durable medical equipment provider is exempt from the provisions
2502 in this paragraph.
2503 8. Providers must obtain a level 2 background screening, in
2504 accordance with chapter 435 and s. 408.809, for each provider
2505 employee in direct contact with or providing direct services to
2506 recipients of durable medical equipment and medical supplies in
2507 their homes. This requirement includes, but is not limited to,

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2508 repair and service technicians, fitters, and delivery staff. The
2509 provider shall pay for the cost of the background screening.
2510 9. The following providers are exempt from subparagraphs 1.
2511 and 7.:
2512 a. Durable medical equipment providers owned and operated
2513 by a government entity.
2514 b. Durable medical equipment providers that are operating
2515 within a pharmacy that is currently enrolled as a Medicaid
2516 pharmacy provider.
2517 c. Active, Medicaid-enrolled orthopedic physician groups,
2518 primarily owned by physicians, which provide only orthotic and
2519 prosthetic devices.
2520 (46) ~~(49)~~ The agency shall contract with established
2521 minority physician networks that provide services to
2522 historically underserved minority patients. The networks must
2523 provide cost-effective Medicaid services, comply with the
2524 requirements to be a MediPass provider, and provide their
2525 primary care physicians with access to data and other management
2526 tools necessary to assist them in ensuring the appropriate use
2527 of services, including inpatient hospital services and
2528 pharmaceuticals.
2529 (a) The agency shall provide for the development and
2530 expansion of minority physician networks in each service area to
2531 provide services to Medicaid recipients who are eligible to
2532 participate under federal law and rules.
2533 (b) The agency shall reimburse each minority physician
2534 network as a fee-for-service provider, including the case
2535 management fee for primary care, if any, or as a capitated rate
2536 provider for Medicaid services. Any savings shall be shared with

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2537 the minority physician networks pursuant to the contract.
2538 (c) For purposes of this subsection, the term “cost-
2539 effective” means that a network’s per-member, per-month costs to
2540 the state, including, but not limited to, fee-for-service costs,
2541 administrative costs, and case-management fees, if any, must be
2542 no greater than the state’s costs associated with contracts for
2543 Medicaid services established under subsection (3), which shall
2544 be actuarially adjusted for case mix, model, and service area.
2545 The agency shall conduct actuarially sound audits adjusted for
2546 case mix and model in order to ensure such cost-effectiveness
2547 and shall annually publish the audit results on its Internet
2548 website. Contracts established pursuant to this subsection which
2549 are not cost-effective may not be renewed.
2550 (d) The agency may apply for any federal waivers needed to
2551 implement this subsection.
2552
2553 This subsection expires October 1, 2014.
2554 (47) ~~(50)~~ To the extent permitted by federal law and as
2555 allowed under s. 409.906, the agency shall provide reimbursement
2556 for emergency mental health care services for Medicaid
2557 recipients in crisis stabilization facilities licensed under s.
2558 394.875 as long as those services are less expensive than the
2559 same services provided in a hospital setting.
2560 (48) ~~(51)~~ The agency shall work with the Agency for Persons
2561 with Disabilities to develop a home and community-based waiver
2562 to serve children and adults who are diagnosed with familial
2563 dysautonomia or Riley-Day syndrome caused by a mutation of the
2564 IKBKAP gene on chromosome 9. The agency shall seek federal
2565 waiver approval and implement the approved waiver subject to the

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2566 availability of funds and any limitations provided in the
2567 General Appropriations Act. The agency may adopt rules to
2568 implement this waiver program.
2569 (49) ~~(52)~~ The agency shall implement a program of all-
2570 inclusive care for children. The program of all-inclusive care
2571 for children shall be established to provide in-home hospice-
2572 like support services to children diagnosed with a life-
2573 threatening illness and enrolled in the Children's Medical
2574 Services network to reduce hospitalizations as appropriate. The
2575 agency, in consultation with the Department of Health, may
2576 implement the program of all-inclusive care for children after
2577 obtaining approval from the Centers for Medicare and Medicaid
2578 Services.
2579 (50) ~~(53)~~ Before seeking an amendment to the state plan for
2580 purposes of implementing programs authorized by the Deficit
2581 Reduction Act of 2005, the agency shall notify the Legislature.
2582 (51) The agency may not pay for psychotropic medication
2583 prescribed for a child in the Medicaid program without the
2584 express and informed consent of the child's parent or legal
2585 guardian. The physician shall document the consent in the
2586 child's medical record and provide the pharmacy with a signed
2587 attestation of this documentation with the prescription. The
2588 express and informed consent or court authorization for a
2589 prescription of psychotropic medication for a child in the
2590 custody of the Department of Children and Family Services shall
2591 be obtained pursuant to s. 39.407.
2592 Section 18. Section 409.91207, Florida Statutes, is
2593 repealed.
2594 Section 19. Paragraphs (e), (l), (p), (w), and (dd) of

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2595 subsection (3) of section 409.91211, Florida Statutes, are
2596 amended to read:
2597 409.91211 Medicaid managed care pilot program.—
2598 (3) The agency shall have the following powers, duties, and
2599 responsibilities with respect to the pilot program:
2600 (e) To implement policies and guidelines for phasing in
2601 financial risk for approved provider service networks that, for
2602 purposes of this paragraph, include the Children's Medical
2603 Services Network, over the period of the waiver and the
2604 extension thereof. These policies and guidelines must include an
2605 option for a provider service network to be paid fee-for-service
2606 rates. For any provider service network established in a managed
2607 care pilot area, the option to be paid fee-for-service rates
2608 must include a savings-settlement mechanism that is consistent
2609 with s. 409.912(42)~~(44)~~. This model must be converted to a risk-
2610 adjusted capitated rate by the beginning of the final year of
2611 operation under the waiver extension, and may be converted
2612 earlier at the option of the provider service network. Federally
2613 qualified health centers may be offered an opportunity to accept
2614 or decline a contract to participate in any provider network for
2615 prepaid primary care services.
2616 (l) To implement a system that prohibits capitated managed
2617 care plans, their representatives, and providers employed by or
2618 contracted with the capitated managed care plans from recruiting
2619 persons eligible for or enrolled in Medicaid, from providing
2620 inducements to Medicaid recipients to select a particular
2621 capitated managed care plan, and from prejudicing Medicaid
2622 recipients against other capitated managed care plans. The
2623 system shall require the entity performing choice counseling to

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2624 determine if the recipient has made a choice of a plan or has
2625 opted out because of duress, threats, payment to the recipient,
2626 or incentives promised to the recipient by a third party. If the
2627 choice counseling entity determines that the decision to choose
2628 a plan was unlawfully influenced or a plan violated any of the
2629 provisions of s. 409.912(20) ~~(21)~~, the choice counseling entity
2630 shall immediately report the violation to the agency's program
2631 integrity section for investigation. Verification of choice
2632 counseling by the recipient shall include a stipulation that the
2633 recipient acknowledges the provisions of this subsection.
2634 (p) To implement standards for plan compliance, including,
2635 but not limited to, standards for quality assurance and
2636 performance improvement, standards for peer or professional
2637 reviews, grievance policies, and policies for maintaining
2638 program integrity. The agency shall develop a data-reporting
2639 system, seek input from managed care plans in order to establish
2640 requirements for patient-encounter reporting, and ensure that
2641 the data reported is accurate and complete.
2642 1. In performing the duties required under this section,
2643 the agency shall work with managed care plans to establish a
2644 uniform system to measure and monitor outcomes for a recipient
2645 of Medicaid services.
2646 2. The system shall use financial, clinical, and other
2647 criteria based on pharmacy, medical services, and other data
2648 that is related to the provision of Medicaid services,
2649 including, but not limited to:
2650 a. The Health Plan Employer Data and Information Set
2651 (HEDIS) or measures that are similar to HEDIS.
2652 b. Member satisfaction.

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2653 c. Provider satisfaction.
2654 d. Report cards on plan performance and best practices.
2655 e. Compliance with the requirements for prompt payment of
2656 claims under ss. 627.613, 641.3155, and 641.513.
2657 f. Utilization and quality data for the purpose of ensuring
2658 access to medically necessary services, including
2659 underutilization or inappropriate denial of services.
2660 3. The agency shall require the managed care plans that
2661 have contracted with the agency to establish a quality assurance
2662 system that incorporates the provisions of s. 409.912(26) ~~(27)~~
2663 and any standards, rules, and guidelines developed by the
2664 agency.
2665 4. The agency shall establish an encounter database in
2666 order to compile data on health services rendered by health care
2667 practitioners who provide services to patients enrolled in
2668 managed care plans in the demonstration sites. The encounter
2669 database shall:
2670 a. Collect the following for each type of patient encounter
2671 with a health care practitioner or facility, including:
2672 (I) The demographic characteristics of the patient.
2673 (II) The principal, secondary, and tertiary diagnosis.
2674 (III) The procedure performed.
2675 (IV) The date and location where the procedure was
2676 performed.
2677 (V) The payment for the procedure, if any.
2678 (VI) If applicable, the health care practitioner’s
2679 universal identification number.
2680 (VII) If the health care practitioner rendering the service
2681 is a dependent practitioner, the modifiers appropriate to

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2682 indicate that the service was delivered by the dependent
2683 practitioner.
2684 b. Collect appropriate information relating to prescription
2685 drugs for each type of patient encounter.
2686 c. Collect appropriate information related to health care
2687 costs and utilization from managed care plans participating in
2688 the demonstration sites.
2689 5. To the extent practicable, when collecting the data the
2690 agency shall use a standardized claim form or electronic
2691 transfer system that is used by health care practitioners,
2692 facilities, and payors.
2693 6. Health care practitioners and facilities in the
2694 demonstration sites shall electronically submit, and managed
2695 care plans participating in the demonstration sites shall
2696 electronically receive, information concerning claims payments
2697 and any other information reasonably related to the encounter
2698 database using a standard format as required by the agency.
2699 7. The agency shall establish reasonable deadlines for
2700 phasing in the electronic transmittal of full encounter data.
2701 8. The system must ensure that the data reported is
2702 accurate and complete.
2703 (w) To implement procedures to minimize the risk of
2704 Medicaid fraud and abuse in all plans operating in the Medicaid
2705 managed care pilot program authorized in this section.
2706 1. The agency shall ensure that applicable provisions of
2707 this chapter and chapters 414, 626, 641, and 932 which relate to
2708 Medicaid fraud and abuse are applied and enforced at the
2709 demonstration project sites.
2710 2. Providers must have the certification, license, and

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2711 credentials that are required by law and waiver requirements.
2712 3. The agency shall ensure that the plan is in compliance
2713 with s. 409.912(20) and (21) and (22).
2714 4. The agency shall require that each plan establish
2715 functions and activities governing program integrity in order to
2716 reduce the incidence of fraud and abuse. Plans must report
2717 instances of fraud and abuse pursuant to chapter 641.
2718 5. The plan shall have written administrative and
2719 management arrangements or procedures, including a mandatory
2720 compliance plan, which are designed to guard against fraud and
2721 abuse. The plan shall designate a compliance officer who has
2722 sufficient experience in health care.
2723 6.a. The agency shall require all managed care plan
2724 contractors in the pilot program to report all instances of
2725 suspected fraud and abuse. A failure to report instances of
2726 suspected fraud and abuse is a violation of law and subject to
2727 the penalties provided by law.
2728 b. An instance of fraud and abuse in the managed care plan,
2729 including, but not limited to, defrauding the state health care
2730 benefit program by misrepresentation of fact in reports, claims,
2731 certifications, enrollment claims, demographic statistics, or
2732 patient-encounter data; misrepresentation of the qualifications
2733 of persons rendering health care and ancillary services; bribery
2734 and false statements relating to the delivery of health care;
2735 unfair and deceptive marketing practices; and false claims
2736 actions in the provision of managed care, is a violation of law
2737 and subject to the penalties provided by law.
2738 c. The agency shall require that all contractors make all
2739 files and relevant billing and claims data accessible to state

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2740 regulators and investigators and that all such data is linked
2741 into a unified system to ensure consistent reviews and
2742 investigations.
2743 (dd) To implement service delivery mechanisms within a
2744 specialty plan in area 10 to provide behavioral health care
2745 services to Medicaid-eligible children whose cases are open for
2746 child welfare services in the HomeSafeNet system. These services
2747 must be coordinated with community-based care providers as
2748 specified in s. 409.1671, where available, and be sufficient to
2749 meet the developmental, behavioral, and emotional needs of these
2750 children. Children in area 10 who have an open case in the
2751 HomeSafeNet system shall be enrolled into the specialty plan.
2752 These service delivery mechanisms must be implemented no later
2753 than July 1, 2011, in AHCA area 10 in order for the children in
2754 AHCA area 10 to remain exempt from the statewide plan under s.
2755 409.912(4)(b)5.~~8.~~ An administrative fee may be paid to the
2756 specialty plan for the coordination of services based on the
2757 receipt of the state share of that fee being provided through
2758 intergovernmental transfers.
2759 Section 20. Effective October 1, 2014, section 409.91211,
2760 Florida Statutes, is repealed.
2761 Section 21. Section 409.9122, Florida Statutes, is amended
2762 to read:
2763 409.9122 Mandatory Medicaid managed care enrollment;
2764 programs and procedures.—
2765 (1) It is the intent of the Legislature that the MediPass
2766 program be cost-effective, provide quality health care, and
2767 improve access to health services, and that the program be
2768 statewide. This subsection expires October 1, 2014.

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2769 (2)(a) The agency shall enroll in a managed care plan or
2770 MediPass all Medicaid recipients, except those Medicaid
2771 recipients who are: in an institution; enrolled in the Medicaid
2772 medically needy program; or eligible for both Medicaid and
2773 Medicare. Upon enrollment, individuals will be able to change
2774 their managed care option during the 90-day opt out period
2775 required by federal Medicaid regulations. The agency is
2776 authorized to seek the necessary Medicaid state plan amendment
2777 to implement this policy. However, to the extent permitted by
2778 federal law, the agency may enroll in a managed care plan or
2779 MediPass a Medicaid recipient who is exempt from mandatory
2780 managed care enrollment, provided that:
2781 1. The recipient’s decision to enroll in a managed care
2782 plan or MediPass is voluntary;
2783 2. If the recipient chooses to enroll in a managed care
2784 plan, the agency has determined that the managed care plan
2785 provides specific programs and services which address the
2786 special health needs of the recipient; and
2787 3. The agency receives any necessary waivers from the
2788 federal Centers for Medicare and Medicaid Services.
2789
2790 ~~The agency shall develop rules to establish policies by which~~
2791 ~~exceptions to the mandatory managed care enrollment requirement~~
2792 ~~may be made on a case-by-case basis. The rules shall include the~~
2793 ~~specific criteria to be applied when making a determination as~~
2794 ~~to whether to exempt a recipient from mandatory enrollment in a~~
2795 ~~managed care plan or MediPass.~~ School districts participating in
2796 the certified school match program pursuant to ss. 409.908(21)
2797 and 1011.70 shall be reimbursed by Medicaid, subject to the

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2798 limitations of s. 1011.70(1), for a Medicaid-eligible child
2799 participating in the services as authorized in s. 1011.70, as
2800 provided for in s. 409.9071, regardless of whether the child is
2801 enrolled in MediPass or a managed care plan. Managed care plans
2802 shall make a good faith effort to execute agreements with school
2803 districts regarding the coordinated provision of services
2804 authorized under s. 1011.70. County health departments
2805 delivering school-based services pursuant to ss. 381.0056 and
2806 381.0057 shall be reimbursed by Medicaid for the federal share
2807 for a Medicaid-eligible child who receives Medicaid-covered
2808 services in a school setting, regardless of whether the child is
2809 enrolled in MediPass or a managed care plan. Managed care plans
2810 shall make a good faith effort to execute agreements with county
2811 health departments regarding the coordinated provision of
2812 services to a Medicaid-eligible child. To ensure continuity of
2813 care for Medicaid patients, the agency, the Department of
2814 Health, and the Department of Education shall develop procedures
2815 for ensuring that a student’s managed care plan or MediPass
2816 provider receives information relating to services provided in
2817 accordance with ss. 381.0056, 381.0057, 409.9071, and 1011.70.
2818 (b) A Medicaid recipient shall not be enrolled in or
2819 assigned to a managed care plan or MediPass unless the managed
2820 care plan or MediPass has complied with the quality-of-care
2821 standards specified in paragraphs (3)(a) and (b), respectively.
2822 (c) Medicaid recipients shall have a choice of managed care
2823 plans or MediPass. The Agency for Health Care Administration,
2824 the Department of Health, the Department of Children and Family
2825 Services, and the Department of Elderly Affairs shall cooperate
2826 to ensure that each Medicaid recipient receives clear and easily

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2827 understandable information that meets the following
2828 requirements:
2829 1. Explains the concept of managed care, including
2830 MediPass.
2831 2. Provides information on the comparative performance of
2832 managed care plans and MediPass in the areas of quality,
2833 credentialing, preventive health programs, network size and
2834 availability, and patient satisfaction.
2835 3. Explains where additional information on each managed
2836 care plan and MediPass in the recipient's area can be obtained.
2837 4. Explains that recipients have the right to choose their
2838 managed care coverage at the time they first enroll in Medicaid
2839 and again at regular intervals set by the agency. However, if a
2840 recipient does not choose a managed care plan or MediPass, the
2841 agency will assign the recipient to a managed care plan or
2842 MediPass according to the criteria specified in this section.
2843 5. Explains the recipient's right to complain, file a
2844 grievance, or change managed care plans or MediPass providers if
2845 the recipient is not satisfied with the managed care plan or
2846 MediPass.
2847 (d) The agency shall develop a mechanism for providing
2848 information to Medicaid recipients for the purpose of making a
2849 managed care plan or MediPass selection. Examples of such
2850 mechanisms may include, but not be limited to, interactive
2851 information systems, mailings, and mass marketing materials.
2852 Managed care plans and MediPass providers are prohibited from
2853 providing inducements to Medicaid recipients to select their
2854 plans or from prejudicing Medicaid recipients against other
2855 managed care plans or MediPass providers.

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2856 (e) Medicaid recipients who are already enrolled in a
2857 managed care plan or MediPass shall be offered the opportunity
2858 to change managed care plans or MediPass providers on a
2859 staggered basis, as defined by the agency. All Medicaid
2860 recipients shall have 30 days in which to make a choice of
2861 managed care plans or MediPass providers. Those Medicaid
2862 recipients who do not make a choice shall be assigned in
2863 accordance with paragraph (f). To facilitate continuity of care,
2864 for a Medicaid recipient who is also a recipient of Supplemental
2865 Security Income (SSI), prior to assigning the SSI recipient to a
2866 managed care plan or MediPass, the agency shall determine
2867 whether the SSI recipient has an ongoing relationship with a
2868 MediPass provider or managed care plan, and if so, the agency
2869 shall assign the SSI recipient to that MediPass provider or
2870 managed care plan. Those SSI recipients who do not have such a
2871 provider relationship shall be assigned to a managed care plan
2872 or MediPass provider in accordance with paragraph (f).
2873 (f) If a Medicaid recipient does not choose a managed care
2874 plan or MediPass provider, the agency shall assign the Medicaid
2875 recipient to a managed care plan or MediPass provider. Medicaid
2876 recipients eligible for managed care plan enrollment who are
2877 subject to mandatory assignment but who fail to make a choice
2878 shall be assigned to managed care plans until an enrollment of
2879 35 percent in MediPass and 65 percent in managed care plans, of
2880 all those eligible to choose managed care, is achieved. Once
2881 this enrollment is achieved, the assignments shall be divided in
2882 order to maintain an enrollment in MediPass and managed care
2883 plans which is in a 35 percent and 65 percent proportion,
2884 respectively. Thereafter, assignment of Medicaid recipients who

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2885 fail to make a choice shall be based proportionally on the
2886 preferences of recipients who have made a choice in the previous
2887 period. Such proportions shall be revised at least quarterly to
2888 reflect an update of the preferences of Medicaid recipients. The
2889 agency shall disproportionately assign Medicaid-eligible
2890 recipients who are required to but have failed to make a choice
2891 of managed care plan or MediPass~~, including children, and who~~
2892 ~~would be assigned to the MediPass program~~ to the ~~children's~~
2893 ~~networks as described in s. 409.912(4)(g),~~ Children's Medical
2894 Services Network as defined in s. 391.021, exclusive provider
2895 organizations, provider service networks, minority physician
2896 networks, and pediatric emergency department diversion programs
2897 authorized by this chapter or the General Appropriations Act, in
2898 such manner as the agency deems appropriate, until the agency
2899 has determined that the networks and programs have sufficient
2900 numbers to be operated economically. For purposes of this
2901 paragraph, when referring to assignment, the term "managed care
2902 plans" includes health maintenance organizations, exclusive
2903 provider organizations, provider service networks, minority
2904 physician networks, Children's Medical Services Network, and
2905 pediatric emergency department diversion programs authorized by
2906 this chapter or the General Appropriations Act. When making
2907 assignments, the agency shall take into account the following
2908 criteria:
2909 1. A managed care plan has sufficient network capacity to
2910 meet the need of members.
2911 2. The managed care plan or MediPass has previously
2912 enrolled the recipient as a member, or one of the managed care
2913 plan's primary care providers or MediPass providers has

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2914 previously provided health care to the recipient.
2915 3. The agency has knowledge that the member has previously
2916 expressed a preference for a particular managed care plan or
2917 MediPass provider as indicated by Medicaid fee-for-service
2918 claims data, but has failed to make a choice.
2919 4. The managed care plan's or MediPass primary care
2920 providers are geographically accessible to the recipient's
2921 residence.
2922 (g) When more than one managed care plan or MediPass
2923 provider meets the criteria specified in paragraph (f), the
2924 agency shall make recipient assignments consecutively by family
2925 unit.
2926 (h) The agency may not engage in practices that are
2927 designed to favor one managed care plan over another or that are
2928 designed to influence Medicaid recipients to enroll in MediPass
2929 rather than in a managed care plan or to enroll in a managed
2930 care plan rather than in MediPass. This subsection does not
2931 prohibit the agency from reporting on the performance of
2932 MediPass or any managed care plan, as measured by performance
2933 criteria developed by the agency.
2934 (i) After a recipient has made his or her selection or has
2935 been enrolled in a managed care plan or MediPass, the recipient
2936 shall have 90 days to exercise the opportunity to voluntarily
2937 disenroll and select another managed care plan or MediPass.
2938 After 90 days, no further changes may be made except for good
2939 cause. Good cause includes, but is not limited to, poor quality
2940 of care, lack of access to necessary specialty services, an
2941 unreasonable delay or denial of service, or fraudulent
2942 enrollment. The agency shall develop criteria for good cause

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2943 disenrollment for chronically ill and disabled populations who
2944 are assigned to managed care plans if more appropriate care is
2945 available through the MediPass program. The agency must make a
2946 determination as to whether cause exists. However, the agency
2947 may require a recipient to use the managed care plan's or
2948 MediPass grievance process prior to the agency's determination
2949 of cause, except in cases in which immediate risk of permanent
2950 damage to the recipient's health is alleged. The grievance
2951 process, when utilized, must be completed in time to permit the
2952 recipient to disenroll by the first day of the second month
2953 after the month the disenrollment request was made. If the
2954 managed care plan or MediPass, as a result of the grievance
2955 process, approves an enrollee's request to disenroll, the agency
2956 is not required to make a determination in the case. The agency
2957 must make a determination and take final action on a recipient's
2958 request so that disenrollment occurs no later than the first day
2959 of the second month after the month the request was made. If the
2960 agency fails to act within the specified timeframe, the
2961 recipient's request to disenroll is deemed to be approved as of
2962 the date agency action was required. Recipients who disagree
2963 with the agency's finding that cause does not exist for
2964 disenrollment shall be advised of their right to pursue a
2965 Medicaid fair hearing to dispute the agency's finding.
2966 (j) The agency shall apply for a federal waiver from the
2967 Centers for Medicare and Medicaid Services to lock eligible
2968 Medicaid recipients into a managed care plan or MediPass for 12
2969 months after an open enrollment period. After 12 months'
2970 enrollment, a recipient may select another managed care plan or
2971 MediPass provider. However, nothing shall prevent a Medicaid

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2972 recipient from changing primary care providers within the
2973 managed care plan or MediPass program during the 12-month
2974 period.
2975 (k) When a Medicaid recipient does not choose a managed
2976 care plan or MediPass provider, the agency shall assign the
2977 Medicaid recipient to a managed care plan, except in those
2978 counties in which there are fewer than two managed care plans
2979 accepting Medicaid enrollees, in which case assignment shall be
2980 to a managed care plan or a MediPass provider. Medicaid
2981 recipients in counties with fewer than two managed care plans
2982 accepting Medicaid enrollees who are subject to mandatory
2983 assignment but who fail to make a choice shall be assigned to
2984 managed care plans until an enrollment of 35 percent in MediPass
2985 and 65 percent in managed care plans, of all those eligible to
2986 choose managed care, is achieved. Once that enrollment is
2987 achieved, the assignments shall be divided in order to maintain
2988 an enrollment in MediPass and managed care plans which is in a
2989 35 percent and 65 percent proportion, respectively. For purposes
2990 of this paragraph, when referring to assignment, the term
2991 “managed care plans” includes exclusive provider organizations,
2992 provider service networks, Children’s Medical Services Network,
2993 minority physician networks, and pediatric emergency department
2994 diversion programs authorized by this chapter or the General
2995 Appropriations Act. When making assignments, the agency shall
2996 take into account the following criteria:
2997 1. A managed care plan has sufficient network capacity to
2998 meet the need of members.
2999 2. The managed care plan or MediPass has previously
3000 enrolled the recipient as a member, or one of the managed care

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3001 plan’s primary care providers or MediPass providers has
3002 previously provided health care to the recipient.
3003 3. The agency has knowledge that the member has previously
3004 expressed a preference for a particular managed care plan or
3005 MediPass provider as indicated by Medicaid fee-for-service
3006 claims data, but has failed to make a choice.
3007 4. The managed care plan’s or MediPass primary care
3008 providers are geographically accessible to the recipient’s
3009 residence.
3010 5. The agency has authority to make mandatory assignments
3011 based on quality of service and performance of managed care
3012 plans.
3013 (l) If the Medicaid recipient is diagnosed with HIV/AIDS
3014 and resides in Broward, Miami-Dade, or Palm Beach Counties, the
3015 agency shall assign the Medicaid recipient to a managed care
3016 plan that is a health maintenance organization authorized under
3017 chapter 641, is under contract with the agency on July 1, 2011,
3018 and offers a delivery system through a university-based teaching
3019 and research-oriented organization that specializes in providing
3020 health care services and treatment for individuals diagnosed
3021 with HIV/AIDS.
3022 (m) ~~(l)~~ Notwithstanding the provisions of chapter 287, the
3023 agency may, at its discretion, renew cost-effective contracts
3024 for choice counseling services once or more for such periods as
3025 the agency may decide. However, all such renewals may not
3026 combine to exceed a total period longer than the term of the
3027 original contract.
3028
3029 This subsection expires October 1, 2014.

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3030 (3)(a) The agency shall establish quality-of-care standards
3031 for managed care plans. These standards shall be based upon, but
3032 are not limited to:
3033 1. Compliance with the accreditation requirements as
3034 provided in s. 641.512.
3035 2. Compliance with Early and Periodic Screening, Diagnosis,
3036 and Treatment screening requirements.
3037 3. The percentage of voluntary disenrollments.
3038 4. Immunization rates.
3039 5. Standards of the National Committee for Quality
3040 Assurance and other approved accrediting bodies.
3041 6. Recommendations of other authoritative bodies.
3042 7. Specific requirements of the Medicaid program, or
3043 standards designed to specifically assist the unique needs of
3044 Medicaid recipients.
3045 8. Compliance with the health quality improvement system as
3046 established by the agency, which incorporates standards and
3047 guidelines developed by the Medicaid Bureau of the Health Care
3048 Financing Administration as part of the quality assurance reform
3049 initiative.
3050 (b) For the MediPass program, the agency shall establish
3051 standards which are based upon, but are not limited to:
3052 1. Quality-of-care standards which are comparable to those
3053 required of managed care plans.
3054 2. Credentialing standards for MediPass providers.
3055 3. Compliance with Early and Periodic Screening, Diagnosis,
3056 and Treatment screening requirements.
3057 4. Immunization rates.
3058 5. Specific requirements of the Medicaid program, or

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3059 standards designed to specifically assist the unique needs of
3060 Medicaid recipients.
3061
3062 This subsection expires October 1, 2014.
3063 (4)(a) Each female recipient may select as her primary care
3064 provider an obstetrician/gynecologist who has agreed to
3065 participate as a MediPass primary care case manager.
3066 (b) The agency shall establish a complaints and grievance
3067 process to assist Medicaid recipients enrolled in the MediPass
3068 program to resolve complaints and grievances. The agency shall
3069 investigate reports of quality-of-care grievances which remain
3070 unresolved to the satisfaction of the enrollee.
3071
3072 This subsection expires October 1, 2014.
3073 (5)(a) The agency shall work cooperatively with the Social
3074 Security Administration to identify beneficiaries who are
3075 jointly eligible for Medicare and Medicaid and shall develop
3076 cooperative programs to encourage these beneficiaries to enroll
3077 in a Medicare participating health maintenance organization or
3078 prepaid health plans.
3079 (b) The agency shall work cooperatively with the Department
3080 of Elderly Affairs to assess the potential cost-effectiveness of
3081 providing MediPass to beneficiaries who are jointly eligible for
3082 Medicare and Medicaid on a voluntary choice basis. If the agency
3083 determines that enrollment of these beneficiaries in MediPass
3084 has the potential for being cost-effective for the state, the
3085 agency shall offer MediPass to these beneficiaries on a
3086 voluntary choice basis in the counties where MediPass operates.
3087

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3088 This subsection expires October 1, 2014.
3089 (6) MediPass enrolled recipients may receive up to 10
3090 visits of reimbursable services by participating Medicaid
3091 physicians licensed under chapter 460 and up to four visits of
3092 reimbursable services by participating Medicaid physicians
3093 licensed under chapter 461. Any further visits must be by prior
3094 authorization by the MediPass primary care provider. However,
3095 nothing in this subsection may be construed to increase the
3096 total number of visits or the total amount of dollars per year
3097 per person under current Medicaid rules, unless otherwise
3098 provided for in the General Appropriations Act. This subsection
3099 expires October 1, 2014.
3100 ~~(7) The agency shall investigate the feasibility of~~
3101 ~~developing managed care plan and MediPass options for the~~
3102 ~~following groups of Medicaid recipients:~~
3103 ~~(a) Pregnant women and infants.~~
3104 ~~(b) Elderly and disabled recipients, especially those who~~
3105 ~~are at risk of nursing home placement.~~
3106 ~~(c) Persons with developmental disabilities.~~
3107 ~~(d) Qualified Medicare beneficiaries.~~
3108 ~~(e) Adults who have chronic, high-cost medical conditions.~~
3109 ~~(f) Adults and children who have mental health problems.~~
3110 ~~(g) Other recipients for whom managed care plans and~~
3111 ~~MediPass offer the opportunity of more cost-effective care and~~
3112 ~~greater access to qualified providers.~~
3113 ~~(8)(a) The agency shall encourage the development of public~~
3114 ~~and private partnerships to foster the growth of health~~
3115 ~~maintenance organizations and prepaid health plans that will~~
3116 ~~provide high-quality health care to Medicaid recipients.~~

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3117 ~~(b) Subject to the availability of moneys and any~~
3118 ~~limitations established by the General Appropriations Act or~~
3119 ~~chapter 216, the agency is authorized to enter into contracts~~
3120 ~~with traditional providers of health care to low-income persons~~
3121 ~~to assist such providers with the technical aspects of~~
3122 ~~cooperatively developing Medicaid prepaid health plans.~~
3123 ~~1. The agency may contract with disproportionate share~~
3124 ~~hospitals, county health departments, federally initiated or~~
3125 ~~federally funded community health centers, and counties that~~
3126 ~~operate either a hospital or a community clinic.~~
3127 ~~2. A contract may not be for more than $100,000 per year,~~
3128 ~~and no contract may be extended with any particular provider for~~
3129 ~~more than 2 years. The contract is intended only as seed or~~
3130 ~~development funding and requires a commitment from the~~
3131 ~~interested party.~~
3132 ~~3. A contract must require participation by at least one~~
3133 ~~community health clinic and one disproportionate share hospital.~~
3134 (7)~~(9)~~(a) The agency shall develop and implement a
3135 comprehensive plan to ensure that recipients are adequately
3136 informed of their choices and rights under all Medicaid managed
3137 care programs and that Medicaid managed care programs meet
3138 acceptable standards of quality in patient care, patient
3139 satisfaction, and financial solvency.
3140 (b) The agency shall provide adequate means for informing
3141 patients of their choice and rights under a managed care plan at
3142 the time of eligibility determination.
3143 (c) The agency shall require managed care plans and
3144 MediPass providers to demonstrate and document plans and
3145 activities, as defined by rule, including outreach and followup,

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3146 undertaken to ensure that Medicaid recipients receive the health
3147 care service to which they are entitled.
3148
3149 This subsection expires October 1, 2014.
3150 (8)(10) The agency shall consult with Medicaid consumers
3151 and their representatives on an ongoing basis regarding
3152 measurements of patient satisfaction, procedures for resolving
3153 patient grievances, standards for ensuring quality of care,
3154 mechanisms for providing patient access to services, and
3155 policies affecting patient care. This subsection expires October
3156 1, 2014.
3157 (9)(11) The agency may extend eligibility for Medicaid
3158 recipients enrolled in licensed and accredited health
3159 maintenance organizations for the duration of the enrollment
3160 period or for 6 months, whichever is earlier, provided the
3161 agency certifies that such an offer will not increase state
3162 expenditures. This subsection expires October 1, 2013.
3163 (10)(12) A managed care plan that has a Medicaid contract
3164 shall at least annually review each primary care physician's
3165 active patient load and shall ensure that additional Medicaid
3166 recipients are not assigned to physicians who have a total
3167 active patient load of more than 3,000 patients. As used in this
3168 subsection, the term "active patient" means a patient who is
3169 seen by the same primary care physician, or by a physician
3170 assistant or advanced registered nurse practitioner under the
3171 supervision of the primary care physician, at least three times
3172 within a calendar year. Each primary care physician shall
3173 annually certify to the managed care plan whether or not his or
3174 her patient load exceeds the limits established under this

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3175 subsection and the managed care plan shall accept such
3176 certification on face value as compliance with this subsection.
3177 The agency shall accept the managed care plan's representations
3178 that it is in compliance with this subsection based on the
3179 certification of its primary care physicians, unless the agency
3180 has an objective indication that access to primary care is being
3181 compromised, such as receiving complaints or grievances relating
3182 to access to care. If the agency determines that an objective
3183 indication exists that access to primary care is being
3184 compromised, it may verify the patient load certifications
3185 submitted by the managed care plan's primary care physicians and
3186 that the managed care plan is not assigning Medicaid recipients
3187 to primary care physicians who have an active patient load of
3188 more than 3,000 patients. This subsection expires October 1,
3189 2014.
3190 (11) ~~(13)~~ Effective July 1, 2003, the agency shall adjust
3191 the enrollee assignment process of Medicaid managed prepaid
3192 health plans for those Medicaid managed prepaid plans operating
3193 in Miami-Dade County which have executed a contract with the
3194 agency for a minimum of 8 consecutive years in order for the
3195 Medicaid managed prepaid plan to maintain a minimum enrollment
3196 level of 15,000 members per month. When assigning enrollees
3197 pursuant to this subsection, the agency shall give priority to
3198 providers that initially qualified under this subsection until
3199 such providers reach and maintain an enrollment level of 15,000
3200 members per month. A prepaid health plan that has a statewide
3201 Medicaid enrollment of 25,000 or more members is not eligible
3202 for enrollee assignments under this subsection. This subsection
3203 expires October 1, 2014.

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3204 (12) ~~(14)~~ The agency shall include in its calculation of the
3205 hospital inpatient component of a Medicaid health maintenance
3206 organization's capitation rate any special payments, including,
3207 but not limited to, upper payment limit or disproportionate
3208 share hospital payments, made to qualifying hospitals through
3209 the fee-for-service program. The agency may seek federal waiver
3210 approval or state plan amendment as needed to implement this
3211 adjustment.
3212 (13) The agency shall develop a process to enable any
3213 recipient with access to employer-sponsored health care coverage
3214 to opt out of all eligible plans in the Medicaid program and to
3215 use Medicaid financial assistance to pay for the recipient's
3216 share of cost in any such employer-sponsored coverage.
3217 Contingent on federal approval, the agency shall also enable
3218 recipients with access to other insurance or related products
3219 that provide access to health care services created pursuant to
3220 state law, including any plan or product available pursuant to
3221 the Florida Health Choices Program or any health exchange, to
3222 opt out. The amount of financial assistance provided for each
3223 recipient may not exceed the amount of the Medicaid premium that
3224 would have been paid to a plan for that recipient.
3225 (14) The agency shall maintain and operate the Medicaid
3226 Encounter Data System to collect, process, store, and report on
3227 covered services provided to all Florida Medicaid recipients
3228 enrolled in prepaid managed care plans.
3229 (a) Prepaid managed care plans shall submit encounter data
3230 electronically in a format that complies with the Health
3231 Insurance Portability and Accountability Act provisions for
3232 electronic claims and in accordance with deadlines established

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3233 by the agency. Prepaid managed care plans must certify that the
3234 data reported is accurate and complete.
3235 (b) The agency is responsible for validating the data
3236 submitted by the plans. The agency shall develop methods and
3237 protocols for ongoing analysis of the encounter data that
3238 adjusts for differences in characteristics of prepaid plan
3239 enrollees to allow comparison of service utilization among plans
3240 and against expected levels of use. The analysis shall be used
3241 to identify possible cases of systemic underutilization or
3242 denials of claims and inappropriate service utilization such as
3243 higher-than-expected emergency department encounters. The
3244 analysis shall provide periodic feedback to the plans and enable
3245 the agency to establish corrective action plans when necessary.
3246 One of the focus areas for the analysis shall be the use of
3247 prescription drugs.
3248 (15) The agency may establish a per-member, per-month
3249 payment for Medicare Advantage Special Needs members that are
3250 also eligible for Medicaid as a mechanism for meeting the
3251 state's cost-sharing obligation. The agency may also develop a
3252 per-member, per-month payment only for Medicaid-covered services
3253 for which the state is responsible. The agency shall develop a
3254 mechanism to ensure that such per-member, per-month payment
3255 enhances the value to the state and enrolled members by limiting
3256 cost sharing, enhances the scope of Medicare supplemental
3257 benefits that are equal to or greater than Medicaid coverage for
3258 select services, and improves care coordination.
3259 (16) The agency shall establish, and managed care plans
3260 shall use, a uniform method of accounting for and reporting
3261 medical and nonmedical costs.

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3262 (a) Managed care plans shall submit financial data
3263 electronically in a format that complies with the uniform
3264 accounting procedures established by the agency. Managed care
3265 plans must certify that the data reported is accurate and
3266 complete.
3267 (b) The agency is responsible for validating the financial
3268 data submitted by the plans. The agency shall develop methods
3269 and protocols for ongoing analysis of data that adjusts for
3270 differences in characteristics of plan enrollees to allow
3271 comparison among plans and against expected levels of
3272 expenditures. The analysis shall be used to identify possible
3273 cases of overspending on administrative costs or under spending
3274 on medical services.
3275 (17) The agency shall establish and maintain an information
3276 system to make encounter data, financial data, and other
3277 measures of plan performance to the public and any interested
3278 party.
3279 (a) Information submitted by the managed care plans shall
3280 be available online as well as in other formats.
3281 (b) Periodic agency reports shall be published that include
3282 provide summary as well as plan specific measures of financial
3283 performance and service utilization.
3284 (c) Any release of the financial and encounter data
3285 submitted by managed care plans shall ensure the confidentiality
3286 of personal health information.
3287 (18) The agency may, on a case-by-case basis, exempt a
3288 recipient from mandatory enrollment in a managed care plan when
3289 the recipient has a unique, time-limited disease or condition-
3290 related circumstance and managed care enrollment will interfere

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3291 with ongoing care because the recipient’s provider does not
3292 participate in the managed care plans available in the
3293 recipient’s area.
3294 (19) The agency shall contract with a single provider
3295 service network to function as a managing entity for the
3296 MediPass program in all counties with fewer than two prepaid
3297 plans. The contractor shall be responsible for implementing
3298 preauthorization procedures, case management programs, and
3299 utilization management initiatives in order to improve care
3300 coordination and patient outcomes while reducing costs. The
3301 contractor may earn an administrative fee, if the fee is less
3302 than any savings determined by the reconciliation process
3303 pursuant to s. 409.912(4)(d)1. This subsection expires October
3304 1, 2014, or upon full implementation of the managed medical
3305 assistance program, whichever is sooner.
3306 (20) Subject to federal approval, the agency shall contract
3307 with a single provider service network to function as a third-
3308 party administrator and managing entity for the Medically Needy
3309 program in all counties. The contractor shall provide care
3310 coordination and utilization management in order to achieve more
3311 cost-effective services for Medically Needy enrollees. To
3312 facilitate the care management functions of the provider service
3313 network, enrollment in the network shall be for a continuous 6-
3314 month period or until the end of the contract between the
3315 provider service network and the agency, whichever is sooner.
3316 Beginning the second month after the determination of
3317 eligibility, the contractor may collect a monthly premium from
3318 each Medically Needy recipient provided the premium does not
3319 exceed the enrollee’s share of cost as determined by the

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3320 Department of Children and Family Services. The contractor must
3321 provide a 90-day grace period before disenrolling a Medically
3322 Needy recipient for failure to pay premiums. The contractor may
3323 earn an administrative fee, if the fee is less than any savings
3324 determined by the reconciliation process pursuant to s.
3325 409.912(4)(d)1. Premium revenue collected from the recipients
3326 shall be deducted from the contractor's earned savings. This
3327 subsection expires October 1, 2014, or upon full implementation
3328 of the managed medical assistance program, whichever is sooner.
3329 Section 22. Subsection (15) of section 430.04, Florida
3330 Statutes, is amended to read:
3331 430.04 Duties and responsibilities of the Department of
3332 Elderly Affairs.—The Department of Elderly Affairs shall:
3333 (15) Administer all Medicaid waivers and programs relating
3334 to elders and their appropriations. The waivers include, but are
3335 not limited to:
3336 (a) The Alzheimer's Dementia-Specific Medicaid Waiver as
3337 established in s. 430.502(7), (8), and (9).
3338 (a)(b) The Assisted Living for the Frail Elderly Waiver.
3339 (b)(c) The Aged and Disabled Adult Waiver.
3340 (c)(d) The Adult Day Health Care Waiver.
3341 (d)(e) The Consumer-Directed Care Plus Program as defined
3342 in s. 409.221.
3343 (e)(f) The Program of All-inclusive Care for the Elderly.
3344 (f)(g) The Long-Term Care Community-Based Diversion Pilot
3345 Project as described in s. 430.705.
3346 (g)(h) The Channeling Services Waiver for Frail Elders.
3347
3348 The department shall develop a transition plan for recipients

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3349 receiving services in long-term care Medicaid waivers for elders
3350 or disabled adults on the date eligible plans become available
3351 in each recipient’s region defined in s. 409.981(2) to enroll
3352 those recipients in eligible plans. This subsection expires
3353 October 1, 2014.
3354 Section 23. Section 430.2053, Florida Statutes, is amended
3355 to read:
3356 430.2053 Aging resource centers.—
3357 (1) The department, in consultation with the Agency for
3358 Health Care Administration and the Department of Children and
3359 Family Services, shall develop pilot projects for aging resource
3360 centers. ~~By October 31, 2004, the department, in consultation~~
3361 ~~with the agency and the Department of Children and Family~~
3362 ~~Services, shall develop an implementation plan for aging~~
3363 ~~resource centers and submit the plan to the Governor, the~~
3364 ~~President of the Senate, and the Speaker of the House of~~
3365 ~~Representatives. The plan must include qualifications for~~
3366 ~~designation as a center, the functions to be performed by each~~
3367 ~~center, and a process for determining that a current area agency~~
3368 ~~on aging is ready to assume the functions of an aging resource~~
3369 ~~center.~~
3370 ~~(2) Each area agency on aging shall develop, in~~
3371 ~~consultation with the existing community care for the elderly~~
3372 ~~lead agencies within their planning and service areas, a~~
3373 ~~proposal that describes the process the area agency on aging~~
3374 ~~intends to undertake to transition to an aging resource center~~
3375 ~~prior to July 1, 2005, and that describes the area agency’s~~
3376 ~~compliance with the requirements of this section. The proposals~~
3377 ~~must be submitted to the department prior to December 31, 2004.~~

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3378 ~~The department shall evaluate all proposals for readiness and,~~
3379 ~~prior to March 1, 2005, shall select three area agencies on~~
3380 ~~aging which meet the requirements of this section to begin the~~
3381 ~~transition to aging resource centers. Those area agencies on~~
3382 ~~aging which are not selected to begin the transition to aging~~
3383 ~~resource centers shall, in consultation with the department and~~
3384 ~~the existing community care for the elderly lead agencies within~~
3385 ~~their planning and service areas, amend their proposals as~~
3386 ~~necessary and resubmit them to the department prior to July 1,~~
3387 ~~2005. The department may transition additional area agencies to~~
3388 ~~aging resource centers as it determines that area agencies are~~
3389 ~~in compliance with the requirements of this section.~~
3390 ~~(3) The Auditor General and the Office of Program Policy~~
3391 ~~Analysis and Government Accountability (OPPAGA) shall jointly~~
3392 ~~review and assess the department's process for determining an~~
3393 ~~area agency's readiness to transition to an aging resource~~
3394 ~~center.~~
3395 ~~(a) The review must, at a minimum, address the~~
3396 ~~appropriateness of the department's criteria for selection of an~~
3397 ~~area agency to transition to an aging resource center, the~~
3398 ~~instruments applied, the degree to which the department~~
3399 ~~accurately determined each area agency's compliance with the~~
3400 ~~readiness criteria, the quality of the technical assistance~~
3401 ~~provided by the department to an area agency in correcting any~~
3402 ~~weaknesses identified in the readiness assessment, and the~~
3403 ~~degree to which each area agency overcame any identified~~
3404 ~~weaknesses.~~
3405 ~~(b) Reports of these reviews must be submitted to the~~
3406 ~~appropriate substantive and appropriations committees in the~~

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3407 ~~Senate and the House of Representatives on March 1 and September~~
3408 ~~1 of each year until full transition to aging resource centers~~
3409 ~~has been accomplished statewide, except that the first report~~
3410 ~~must be submitted by February 1, 2005, and must address all~~
3411 ~~readiness activities undertaken through December 31, 2004. The~~
3412 ~~perspectives of all participants in this review process must be~~
3413 ~~included in each report.~~
3414 (2)~~(4)~~ The purposes of an aging resource center shall be:
3415 (a) To provide Florida's elders and their families with a
3416 locally focused, coordinated approach to integrating information
3417 and referral for all available services for elders with the
3418 eligibility determination entities for state and federally
3419 funded long-term-care services.
3420 (b) To provide for easier access to long-term-care services
3421 by Florida's elders and their families by creating multiple
3422 access points to the long-term-care network that flow through
3423 one established entity with wide community recognition.
3424 (3)~~(5)~~ The duties of an aging resource center are to:
3425 (a) Develop referral agreements with local community
3426 service organizations, such as senior centers, existing elder
3427 service providers, volunteer associations, and other similar
3428 organizations, to better assist clients who do not need or do
3429 not wish to enroll in programs funded by the department or the
3430 agency. The referral agreements must also include a protocol,
3431 developed and approved by the department, which provides
3432 specific actions that an aging resource center and local
3433 community service organizations must take when an elder or an
3434 elder's representative seeking information on long-term-care
3435 services contacts a local community service organization prior

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3436 to contacting the aging resource center. The protocol shall be
3437 designed to ensure that elders and their families are able to
3438 access information and services in the most efficient and least
3439 cumbersome manner possible.
3440 (b) Provide an initial screening of all clients who request
3441 long-term-care services to determine whether the person would be
3442 most appropriately served through any combination of federally
3443 funded programs, state-funded programs, locally funded or
3444 community volunteer programs, or private funding for services.
3445 (c) Determine eligibility for the programs and services
3446 listed in subsection (9) ~~(11)~~ for persons residing within the
3447 geographic area served by the aging resource center and
3448 determine a priority ranking for services which is based upon
3449 the potential recipient’s frailty level and likelihood of
3450 institutional placement without such services.
3451 (d) Manage the availability of financial resources for the
3452 programs and services listed in subsection (9) ~~(11)~~ for persons
3453 residing within the geographic area served by the aging resource
3454 center.
3455 (e) When financial resources become available, refer a
3456 client to the most appropriate entity to begin receiving
3457 services. The aging resource center shall make referrals to lead
3458 agencies for service provision that ensure that individuals who
3459 are vulnerable adults in need of services pursuant to s.
3460 415.104(3)(b), or who are victims of abuse, neglect, or
3461 exploitation in need of immediate services to prevent further
3462 harm and are referred by the adult protective services program,
3463 are given primary consideration for receiving community-care-
3464 for-the-elderly services in compliance with the requirements of

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3465 s. 430.205(5)(a) and that other referrals for services are in
3466 compliance with s. 430.205(5)(b).
3467 (f) Convene a work group to advise in the planning,
3468 implementation, and evaluation of the aging resource center. The
3469 work group shall be comprised of representatives of local
3470 service providers, Alzheimer's Association chapters, housing
3471 authorities, social service organizations, advocacy groups,
3472 representatives of clients receiving services through the aging
3473 resource center, and any other persons or groups as determined
3474 by the department. The aging resource center, in consultation
3475 with the work group, must develop annual program improvement
3476 plans that shall be submitted to the department for
3477 consideration. The department shall review each annual
3478 improvement plan and make recommendations on how to implement
3479 the components of the plan.
3480 (g) Enhance the existing area agency on aging in each
3481 planning and service area by integrating, either physically or
3482 virtually, the staff and services of the area agency on aging
3483 with the staff of the department's local CARES Medicaid ~~nursing~~
3484 ~~home~~ preadmission screening unit and a sufficient number of
3485 staff from the Department of Children and Family Services'
3486 Economic Self-Sufficiency Unit necessary to determine the
3487 financial eligibility for all persons age 60 and older residing
3488 within the area served by the aging resource center that are
3489 seeking Medicaid services, Supplemental Security Income, and
3490 food assistance.
3491 <u>(h) Assist clients who request long-term care services in</u>
3492 <u>being evaluated for eligibility for enrollment in the Medicaid</u>
3493 <u>long-term care managed care program as eligible plans become</u>

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3494 available in each of the regions pursuant to s. 409.981(2).
3495 (i) Provide enrollment and coverage information to Medicaid
3496 managed long-term care enrollees as qualified plans become
3497 available in each of the regions pursuant to s. 409.981(2).
3498 (j) Assist Medicaid recipients enrolled in the Medicaid
3499 long-term care managed care program with informally resolving
3500 grievances with a managed care network and assist Medicaid
3501 recipients in accessing the managed care network's formal
3502 grievance process as eligible plans become available in each of
3503 the regions defined in s. 409.981(2).
3504 (4) (6) The department shall select the entities to become
3505 aging resource centers based on each entity's readiness and
3506 ability to perform the duties listed in subsection (3) (5) and
3507 the entity's:
3508 (a) Expertise in the needs of each target population the
3509 center proposes to serve and a thorough knowledge of the
3510 providers that serve these populations.
3511 (b) Strong connections to service providers, volunteer
3512 agencies, and community institutions.
3513 (c) Expertise in information and referral activities.
3514 (d) Knowledge of long-term-care resources, including
3515 resources designed to provide services in the least restrictive
3516 setting.
3517 (e) Financial solvency and stability.
3518 (f) Ability to collect, monitor, and analyze data in a
3519 timely and accurate manner, along with systems that meet the
3520 department's standards.
3521 (g) Commitment to adequate staffing by qualified personnel
3522 to effectively perform all functions.

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3523 (h) Ability to meet all performance standards established
3524 by the department.
3525 (5) ~~(7)~~ The aging resource center shall have a governing
3526 body which shall be the same entity described in s. 20.41(7),
3527 and an executive director who may be the same person as
3528 described in s. 20.41(7). The governing body shall annually
3529 evaluate the performance of the executive director.
3530 (6) ~~(8)~~ The aging resource center may not be a provider of
3531 direct services other than information and referral services,
3532 and screening.
3533 (7) ~~(9)~~ The aging resource center must agree to allow the
3534 department to review any financial information the department
3535 determines is necessary for monitoring or reporting purposes,
3536 including financial relationships.
3537 (8) ~~(10)~~ The duties and responsibilities of the community
3538 care for the elderly lead agencies within each area served by an
3539 aging resource center shall be to:
3540 (a) Develop strong community partnerships to maximize the
3541 use of community resources for the purpose of assisting elders
3542 to remain in their community settings for as long as it is
3543 safely possible.
3544 (b) Conduct comprehensive assessments of clients that have
3545 been determined eligible and develop a care plan consistent with
3546 established protocols that ensures that the unique needs of each
3547 client are met.
3548 (9) ~~(11)~~ The services to be administered through the aging
3549 resource center shall include those funded by the following
3550 programs:
3551 (a) Community care for the elderly.

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3552 (b) Home care for the elderly.
3553 (c) Contracted services.
3554 (d) Alzheimer's disease initiative.
3555 (e) Aged and disabled adult Medicaid waiver. This paragraph
3556 expires October 1, 2013.
3557 (f) Assisted living for the frail elderly Medicaid waiver.
3558 This paragraph expires October 1, 2013.
3559 (g) Older Americans Act.
3560 (10) ~~(12)~~ The department shall, prior to designation of an
3561 aging resource center, develop by rule operational and quality
3562 assurance standards and outcome measures to ensure that clients
3563 receiving services through all long-term-care programs
3564 administered through an aging resource center are receiving the
3565 appropriate care they require and that contractors and
3566 subcontractors are adhering to the terms of their contracts and
3567 are acting in the best interests of the clients they are
3568 serving, consistent with the intent of the Legislature to reduce
3569 the use of and cost of nursing home care. The department shall
3570 by rule provide operating procedures for aging resource centers,
3571 which shall include:
3572 (a) Minimum standards for financial operation, including
3573 audit procedures.
3574 (b) Procedures for monitoring and sanctioning of service
3575 providers.
3576 (c) Minimum standards for technology utilized by the aging
3577 resource center.
3578 (d) Minimum staff requirements which shall ensure that the
3579 aging resource center employs sufficient quality and quantity of
3580 staff to adequately meet the needs of the elders residing within

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3581 the area served by the aging resource center.
3582 (e) Minimum accessibility standards, including hours of
3583 operation.
3584 (f) Minimum oversight standards for the governing body of
3585 the aging resource center to ensure its continuous involvement
3586 in, and accountability for, all matters related to the
3587 development, implementation, staffing, administration, and
3588 operations of the aging resource center.
3589 (g) Minimum education and experience requirements for
3590 executive directors and other executive staff positions of aging
3591 resource centers.
3592 (h) Minimum requirements regarding any executive staff
3593 positions that the aging resource center must employ and minimum
3594 requirements that a candidate must meet in order to be eligible
3595 for appointment to such positions.
3596 (11) ~~(13)~~ In an area in which the department has designated
3597 an area agency on aging as an aging resource center, the
3598 department and the agency shall not make payments for the
3599 services listed in subsection (9) ~~(11)~~ and the Long-Term Care
3600 Community Diversion Project for such persons who were not
3601 screened and enrolled through the aging resource center. The
3602 department shall cease making payments for recipients in
3603 eligible plans as eligible plans become available in each of the
3604 regions defined in s. 409.981(2).
3605 (12) ~~(14)~~ Each aging resource center shall enter into a
3606 memorandum of understanding with the department for
3607 collaboration with the CARES unit staff. The memorandum of
3608 understanding shall outline the staff person responsible for
3609 each function and shall provide the staffing levels necessary to

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3610 carry out the functions of the aging resource center.
3611 (13) ~~(15)~~ Each aging resource center shall enter into a
3612 memorandum of understanding with the Department of Children and
3613 Family Services for collaboration with the Economic Self-
3614 Sufficiency Unit staff. The memorandum of understanding shall
3615 outline which staff persons are responsible for which functions
3616 and shall provide the staffing levels necessary to carry out the
3617 functions of the aging resource center.
3618 (14) ~~(16)~~ If any of the state activities described in this
3619 section are outsourced, either in part or in whole, the contract
3620 executing the outsourcing shall mandate that the contractor or
3621 its subcontractors shall, either physically or virtually,
3622 execute the provisions of the memorandum of understanding
3623 instead of the state entity whose function the contractor or
3624 subcontractor now performs.
3625 (15) ~~(17)~~ In order to be eligible to begin transitioning to
3626 an aging resource center, an area agency on aging board must
3627 ensure that the area agency on aging which it oversees meets all
3628 of the minimum requirements set by law and in rule.
3629 ~~(18) The department shall monitor the three initial~~
3630 ~~projects for aging resource centers and report on the progress~~
3631 ~~of those projects to the Governor, the President of the Senate,~~
3632 ~~and the Speaker of the House of Representatives by June 30,~~
3633 ~~2005. The report must include an evaluation of the~~
3634 ~~implementation process.~~
3635 (16) ~~(19)~~(a) Once an aging resource center is operational,
3636 the department, in consultation with the agency, may develop
3637 capitation rates for any of the programs administered through
3638 the aging resource center. Capitation rates for programs shall

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3639 be based on the historical cost experience of the state in
3640 providing those same services to the population age 60 or older
3641 residing within each area served by an aging resource center.
3642 Each capitated rate may vary by geographic area as determined by
3643 the department.
3644 (b) The department and the agency may determine for each
3645 area served by an aging resource center whether it is
3646 appropriate, consistent with federal and state laws and
3647 regulations, to develop and pay separate capitated rates for
3648 each program administered through the aging resource center or
3649 to develop and pay capitated rates for service packages which
3650 include more than one program or service administered through
3651 the aging resource center.
3652 (c) Once capitation rates have been developed and certified
3653 as actuarially sound, the department and the agency may pay
3654 service providers the capitated rates for services when
3655 appropriate.
3656 (d) The department, in consultation with the agency, shall
3657 annually reevaluate and recertify the capitation rates,
3658 adjusting forward to account for inflation, programmatic
3659 changes.
3660 ~~(20) The department, in consultation with the agency, shall~~
3661 ~~submit to the Governor, the President of the Senate, and the~~
3662 ~~Speaker of the House of Representatives, by December 1, 2006, a~~
3663 ~~report addressing the feasibility of administering the following~~
3664 ~~services through aging resource centers beginning July 1, 2007:~~
3665 ~~(a) Medicaid nursing home services.~~
3666 ~~(b) Medicaid transportation services.~~
3667 ~~(c) Medicaid hospice care services.~~

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3668 ~~(d) Medicaid intermediate care services.~~
3669 ~~(e) Medicaid prescribed drug services.~~
3670 ~~(f) Medicaid assistive care services.~~
3671 ~~(g) Any other long-term-care program or Medicaid service.~~
3672 (17)~~(21)~~ This section shall not be construed to allow an
3673 aging resource center to restrict, manage, or impede the local
3674 fundraising activities of service providers.
3675 Section 24. Effective October 1, 2013, sections 430.701,
3676 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707,
3677 430.708, and 430.709, Florida Statutes, are repealed.
3678 Section 25. Sections 409.9301, 409.942, 409.944, 409.945,
3679 409.946, 409.953, and 409.9531, Florida Statutes, are renumbered
3680 as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and
3681 402.87, Florida Statutes, respectively.
3682 Section 26. Paragraph (a) of subsection (1) of section
3683 443.111, Florida Statutes, is amended to read:
3684 443.111 Payment of benefits.—
3685 (1) MANNER OF PAYMENT.—Benefits are payable from the fund
3686 in accordance with rules adopted by the Agency for Workforce
3687 Innovation, subject to the following requirements:
3688 (a) Benefits are payable by mail or electronically.
3689 Notwithstanding s. 402.82(4) ~~s. 409.942(4)~~, the agency may
3690 develop a system for the payment of benefits by electronic funds
3691 transfer, including, but not limited to, debit cards, electronic
3692 payment cards, or any other means of electronic payment that the
3693 agency deems to be commercially viable or cost-effective.
3694 Commodities or services related to the development of such a
3695 system shall be procured by competitive solicitation, unless
3696 they are purchased from a state term contract pursuant to s.

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3697 287.056. The agency shall adopt rules necessary to administer
3698 the system.
3699 Section 27. Subsection (4) of section 641.386, Florida
3700 Statutes, is amended to read:
3701 641.386 Agent licensing and appointment required;
3702 exceptions.—
3703 (4) All agents and health maintenance organizations shall
3704 comply with and be subject to the applicable provisions of ss.
3705 641.309 and 409.912(20) ~~(21)~~, and all companies and entities
3706 appointing agents shall comply with s. 626.451, when marketing
3707 for any health maintenance organization licensed pursuant to
3708 this part, including those organizations under contract with the
3709 Agency for Health Care Administration to provide health care
3710 services to Medicaid recipients or any private entity providing
3711 health care services to Medicaid recipients pursuant to a
3712 prepaid health plan contract with the Agency for Health Care
3713 Administration.
3714 Section 28. Subsections (6) and (7) of section 766.118,
3715 Florida Statutes, are renumbered as subsections (7) and (8),
3716 respectively, and a new subsection (6) is added to that section,
3717 to read:
3718 766.118 Determination of noneconomic damages.—
3719 (6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A
3720 PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID
3721 RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with
3722 respect to a cause of action for personal injury or wrongful
3723 death arising from medical negligence of a practitioner
3724 committed in the course of providing medical services and
3725 medical care to a Medicaid recipient, regardless of the number

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3726 of such practitioner defendants providing the services and care,
3727 noneconomic damages may not exceed $300,000 per claimant, unless
3728 the claimant pleads and proves, by clear and convincing
3729 evidence, that the practitioner acted in a wrongful manner. A
3730 practitioner providing medical services and medical care to a
3731 Medicaid recipient is not liable for more than $200,000 in
3732 noneconomic damages, regardless of the number of claimants,
3733 unless the claimant pleads and proves, by clear and convincing
3734 evidence, that the practitioner acted in a wrongful manner. The
3735 fact that a claimant proves that a practitioner acted in a
3736 wrongful manner does not preclude the application of the
3737 limitation on noneconomic damages prescribed elsewhere in this
3738 section. For purposes of this subsection:
3739 (a) The terms "medical services," "medical care," and
3740 "Medicaid recipient" have the same meaning as provided in s.
3741 409.901.
3742 (b) The term "practitioner," in addition to the meaning
3743 prescribed in subsection (1), includes any hospital, ambulatory
3744 surgical center, or mobile surgical facility as defined and
3745 licensed under chapter 395.
3746 (c) The term "wrongful manner" means in bad faith or with
3747 malicious purpose or in a manner exhibiting wanton and willful
3748 disregard of human rights, safety, or property, and shall be
3749 construed in conformity with the standard set forth in s.
3750 768.28(9)(a).
3751 Section 29. The Agency for Health Care Administration shall
3752 develop a plan for implementing a plan for medically needy
3753 Medicaid enrollees pursuant to s. 409.975(8), Florida Statutes,
3754 as created in HB 7107 or similar legislation that is adopted in

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3755 the same legislative session or an extension thereof and becomes
3756 law, and shall immediately seek federal approval to implement
3757 that subsection. The plan shall include a preliminary
3758 calculation of actuarially sound rates and estimated fiscal
3759 impact.
3760 Section 30. The Agency for Health Care Administration shall
3761 develop a reorganization plan for realignment of administrative
3762 resources of the Medicaid program to respond to changes in
3763 functional responsibilities and priorities necessary for
3764 implementation of HB 7107 or similar legislation that is adopted
3765 in the same legislative session or an extension thereof and
3766 becomes law. The plan shall assess the agency's current
3767 capabilities, identify shifts in staffing and other resources
3768 necessary to strengthen procurement and contract monitoring
3769 functions, and establish an implementation timeline. The plan
3770 shall be submitted to the Governor, the Speaker of the House of
3771 Representatives, and the President of the Senate by August 1,
3772 2011.
3773 Section 31. Subsection (1) of section 393.0662, Florida
3774 Statutes, is amended to read:
3775 393.0662 Individual budgets for delivery of home and
3776 community-based services; iBudget system established.—The
3777 Legislature finds that improved financial management of the
3778 existing home and community-based Medicaid waiver program is
3779 necessary to avoid deficits that impede the provision of
3780 services to individuals who are on the waiting list for
3781 enrollment in the program. The Legislature further finds that
3782 clients and their families should have greater flexibility to
3783 choose the services that best allow them to live in their

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3784 community within the limits of an established budget. Therefore,
3785 the Legislature intends that the agency, in consultation with
3786 the Agency for Health Care Administration, develop and implement
3787 a comprehensive redesign of the service delivery system using
3788 individual budgets as the basis for allocating the funds
3789 appropriated for the home and community-based services Medicaid
3790 waiver program among eligible enrolled clients. The service
3791 delivery system that uses individual budgets shall be called the
3792 iBudget system.
3793 (1) The agency shall establish an individual budget,
3794 referred to as an iBudget, for each individual served by the
3795 home and community-based services Medicaid waiver program. The
3796 funds appropriated to the agency shall be allocated through the
3797 iBudget system to eligible, Medicaid-enrolled clients. For the
3798 iBudget system, eligible clients shall include individuals with
3799 a diagnosis of Down syndrome or a developmental disability as
3800 defined in s. 393.063. The iBudget system shall be designed to
3801 provide for: enhanced client choice within a specified service
3802 package; appropriate assessment strategies; an efficient
3803 consumer budgeting and billing process that includes
3804 reconciliation and monitoring components; a redefined role for
3805 support coordinators that avoids potential conflicts of
3806 interest; a flexible and streamlined service review process; and
3807 a methodology and process that ensures the equitable allocation
3808 of available funds to each client based on the client's level of
3809 need, as determined by the variables in the allocation
3810 algorithm.
3811 (a) In developing each client's iBudget, the agency shall
3812 use an allocation algorithm and methodology. The algorithm shall

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3813 use variables that have been determined by the agency to have a
3814 statistically validated relationship to the client’s level of
3815 need for services provided through the home and community-based
3816 services Medicaid waiver program. The algorithm and methodology
3817 may consider individual characteristics, including, but not
3818 limited to, a client’s age and living situation, information
3819 from a formal assessment instrument that the agency determines
3820 is valid and reliable, and information from other assessment
3821 processes.
3822 (b) The allocation methodology shall provide the algorithm
3823 that determines the amount of funds allocated to a client’s
3824 iBudget. The agency may approve an increase in the amount of
3825 funds allocated, as determined by the algorithm, based on the
3826 client having one or more of the following needs that cannot be
3827 accommodated within the funding as determined by the algorithm
3828 and having no other resources, supports, or services available
3829 to meet the need:
3830 1. An extraordinary need that would place the health and
3831 safety of the client, the client’s caregiver, or the public in
3832 immediate, serious jeopardy unless the increase is approved. An
3833 extraordinary need may include, but is not limited to:
3834 a. A documented history of significant, potentially life-
3835 threatening behaviors, such as recent attempts at suicide,
3836 arson, nonconsensual sexual behavior, or self-injurious behavior
3837 requiring medical attention;
3838 b. A complex medical condition that requires active
3839 intervention by a licensed nurse on an ongoing basis that cannot
3840 be taught or delegated to a nonlicensed person;
3841 c. A chronic comorbid condition. As used in this

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3842 subparagraph, the term “comorbid condition” means a medical
3843 condition existing simultaneously but independently with another
3844 medical condition in a patient; or
3845 d. A need for total physical assistance with activities
3846 such as eating, bathing, toileting, grooming, and personal
3847 hygiene.
3848
3849 However, the presence of an extraordinary need alone does not
3850 warrant an increase in the amount of funds allocated to a
3851 client’s iBudget as determined by the algorithm.
3852 2. A significant need for one-time or temporary support or
3853 services that, if not provided, would place the health and
3854 safety of the client, the client’s caregiver, or the public in
3855 serious jeopardy, unless the increase is approved. A significant
3856 need may include, but is not limited to, the provision of
3857 environmental modifications, durable medical equipment, services
3858 to address the temporary loss of support from a caregiver, or
3859 special services or treatment for a serious temporary condition
3860 when the service or treatment is expected to ameliorate the
3861 underlying condition. As used in this subparagraph, the term
3862 “temporary” means a period of fewer than 12 continuous months.
3863 However, the presence of such significant need for one-time or
3864 temporary supports or services alone does not warrant an
3865 increase in the amount of funds allocated to a client’s iBudget
3866 as determined by the algorithm.
3867 3. A significant increase in the need for services after
3868 the beginning of the service plan year that would place the
3869 health and safety of the client, the client’s caregiver, or the
3870 public in serious jeopardy because of substantial changes in the

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3871 client's circumstances, including, but not limited to, permanent
3872 or long-term loss or incapacity of a caregiver, loss of services
3873 authorized under the state Medicaid plan due to a change in age,
3874 or a significant change in medical or functional status which
3875 requires the provision of additional services on a permanent or
3876 long-term basis that cannot be accommodated within the client's
3877 current iBudget. As used in this subparagraph, the term "long-
3878 term" means a period of 12 or more continuous months. However,
3879 such significant increase in need for services of a permanent or
3880 long-term nature alone does not warrant an increase in the
3881 amount of funds allocated to a client's iBudget as determined by
3882 the algorithm.
3883
3884 The agency shall reserve portions of the appropriation for the
3885 home and community-based services Medicaid waiver program for
3886 adjustments required pursuant to this paragraph and may use the
3887 services of an independent actuary in determining the amount of
3888 the portions to be reserved.
3889 (c) A client's iBudget shall be the total of the amount
3890 determined by the algorithm and any additional funding provided
3891 pursuant to paragraph (b). A client's annual expenditures for
3892 home and community-based services Medicaid waiver services may
3893 not exceed the limits of his or her iBudget. The total of all
3894 clients' projected annual iBudget expenditures may not exceed
3895 the agency's appropriation for waiver services.
3896 Section 32. Section 409.902, Florida Statutes, is amended
3897 to read:
3898 409.902 Designated single state agency; payment
3899 requirements; program title; release of medical records.—

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3900 (1) The Agency for Health Care Administration is designated
3901 as the single state agency authorized to make payments for
3902 medical assistance and related services under Title XIX of the
3903 Social Security Act. These payments shall be made, subject to
3904 any limitations or directions provided for in the General
3905 Appropriations Act, only for services included in the program,
3906 shall be made only on behalf of eligible individuals, and shall
3907 be made only to qualified providers in accordance with federal
3908 requirements for Title XIX of the Social Security Act and the
3909 provisions of state law. This program of medical assistance is
3910 designated the "Medicaid program." The Department of Children
3911 and Family Services is responsible for Medicaid eligibility
3912 determinations, including, but not limited to, policy, rules,
3913 and the agreement with the Social Security Administration for
3914 Medicaid eligibility determinations for Supplemental Security
3915 Income recipients, as well as the actual determination of
3916 eligibility. As a condition of Medicaid eligibility, subject to
3917 federal approval, the Agency for Health Care Administration and
3918 the Department of Children and Family Services shall ensure that
3919 each recipient of Medicaid consents to the release of her or his
3920 medical records to the Agency for Health Care Administration and
3921 the Medicaid Fraud Control Unit of the Department of Legal
3922 Affairs.
3923 (2) Eligibility is restricted to United States citizens and
3924 to lawfully admitted noncitizens who meet the criteria provided
3925 in s. 414.095(3).
3926 (a) Citizenship or immigration status must be verified. For
3927 noncitizens, this includes verification of the validity of
3928 documents with the United States Citizenship and Immigration

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3929 Services using the federal SAVE verification process.
3930 (b) State funds may not be used to provide medical services
3931 to individuals who do not meet the requirements of this
3932 subsection unless the services are necessary to treat an
3933 emergency medical condition or are for pregnant women. Such
3934 services are authorized only to the extent provided under
3935 federal law and in accordance with federal regulations as
3936 provided in 42 C.F.R. s. 440.255.
3937 Section 33. Subsection (22) is added to section 641.19,
3938 Florida Statutes, to read:
3939 641.19 Definitions.—As used in this part, the term:
3940 (22) "Provider service network" means a network authorized
3941 under s. 409.912(4)(d), reimbursed on a prepaid basis, operated
3942 by a health care provider or group of affiliated health care
3943 providers, and which directly provides health care services
3944 under a Medicare, Medicaid, or Healthy Kids contract.
3945 Section 34. Section 641.2019, Florida Statutes, is created
3946 to read:
3947 641.2019 Provider service network certificate of
3948 authority.—A prepaid provider service network that applies for
3949 and obtains a health care provider certificate pursuant to part
3950 III of this chapter, meets the surplus requirements of s.
3951 641.225, and meets all other applicable requirements of this
3952 part may obtain a certificate of authority under s. 641.21. A
3953 certified provider service network has the same rights and
3954 responsibilities as a health maintenance organization certified
3955 under this part.
3956 Section 35. Subsection (2) of section 641.2261, Florida
3957 Statutes, is amended to read:

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3958 641.2261 Application of solvency requirements to provider-
3959 sponsored organizations and Medicaid provider service networks.—
3960 (2) Except for a provider service network seeking to obtain
3961 a certificate of authority under s. 641.2019, the solvency
3962 requirements in 42 C.F.R. s. 422.350, subpart H, and the
3963 solvency requirements established in approved federal waivers
3964 pursuant to chapter 409 apply to a Medicaid provider service
3965 network rather than the solvency requirements of this part.
3966 Section 36. If any provision of this act or its application
3967 to any person or circumstance is held invalid, the invalidity
3968 does not affect other provisions or applications of the act
3969 which can be given effect without the invalid provision or
3970 application, and to this end the provisions of this act are
3971 severable.
3972 Section 37. Except as otherwise expressly provided in this
3973 act, this act shall take effect July 1, 2011, if HB 7107 or
3974 similar legislation is adopted in the same legislative session
3975 or an extension thereof and becomes law.
3976
3977 ================= T I T L E A M E N D M E N T ================
3978 And the title is amended as follows:
3979 Delete everything before the enacting clause
3980 and insert:
3981 A bill to be entitled
3982 An act relating to Medicaid; amending s. 393.0661,
3983 F.S.; requiring the Agency for Persons with
3984 Disabilities to collect premiums or cost sharing for a
3985 home and community-based delivery system; providing
3986 that implementation of Medicaid waiver programs and

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3987 services authorized under ch. 393, F.S., are subject
3988 to certain funding limitations; requiring that certain
3989 provisions relating to agency cost containment
3990 initiatives be included in contracts with independent
3991 support coordinators and service providers; providing
3992 for establishment of agency corrective action plans
3993 and redesign of the waiver program under certain
3994 circumstances; requiring the plan to be submitted to
3995 the Legislature; amending s. 393.063, F.S.; defining
3996 the term "Down syndrome"; amending s. 408.040, F.S.;
3997 prohibiting the agency from imposing sanctions related
3998 to patient day utilization by patients eligible for
3999 care under Title XIX of the Social Security Act for a
4000 nursing home, effective on a specified date; amending
4001 s. 408.0435, F.S.; extending the certificate-of-need
4002 moratorium for additional community nursing home beds;
4003 designating ss. 409.016-409.803, F.S., as pt. I of ch.
4004 409, F.S., and entitling the part "Social and Economic
4005 Assistance"; designating ss. 409.810-409.821, F.S., as
4006 pt. II of ch. 409, F.S., and entitling the part
4007 "Kidcare"; designating ss. 409.901-409.9205, F.S., as
4008 part III of ch. 409, F.S., and entitling the part
4009 "Medicaid"; amending s. 409.9021, F.S.; revising the
4010 time period during which a Medicaid applicant must
4011 agree to forfeiture of all entitlements upon a
4012 judicial or administrative finding of fraud; amending
4013 s. 409.905, F.S.; requiring the Agency for Health Care
4014 Administration to set reimbursements rates for
4015 hospitals that provide Medicaid services based on

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4016 allowable-cost reporting from the hospitals; removing
4017 requirements for prior authorization for the provision
4018 of certain services; providing the methodology for the
4019 rate calculation and adjustments; requiring the rates
4020 to be subject to certain limits or ceilings;
4021 authorizing the agency to require prior authorization
4022 of home health services under certain conditions;
4023 providing that exemptions to the limits or ceilings
4024 may be provided in the General Appropriations Act;
4025 deleting provisions relating to agency adjustments to
4026 a hospital’s inpatient per diem rate; directing the
4027 agency to develop a plan to convert inpatient hospital
4028 rates to a prospective payment system that categorizes
4029 each case into diagnosis-related groups; requiring a
4030 report to the Governor and Legislature; amending s.
4031 409.906, F.S.; providing conditions under which the
4032 agency shall seek federal approval to develop a system
4033 to require payment of premiums or other cost sharing
4034 by the parents of certain children receiving Medicaid
4035 home and community-based waiver services; authorizing
4036 the Department of Children and Family Services to
4037 collect certain income information; requiring a report
4038 to the Legislature; amending s. 409.907, F.S.;
4039 providing additional requirements for provider
4040 agreements for Medicare crossover providers; providing
4041 that the agency is not obligated to enroll certain
4042 providers as Medicare crossover providers; specifying
4043 additional requirements for certain providers;
4044 providing the agency may establish additional criteria

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4045 for providers to promote program integrity; amending
4046 s. 409.908, F.S.; revising provisions relating to
4047 reimbursement of Medicaid direct care providers to
4048 include additional, specified medically necessary
4049 care; amending s. 409.9081, F.S.; providing conditions
4050 for copayments by Medicaid recipients for nonemergency
4051 care and services provided in a hospital emergency;
4052 amending s. 409.911, F.S.; providing for expiration of
4053 the Medicaid Low-Income Pool Council; amending s.
4054 409.912, F.S.; providing payment requirements for
4055 provider service networks; providing for the
4056 expiration of various provisions relating to agency
4057 contracts and agreements with certain entities on
4058 specified dates to conform to the reorganization of
4059 Medicaid managed care; requiring the agency to
4060 contract on a prepaid or fixed-sum basis with certain
4061 prepaid dental health plans; eliminating obsolete
4062 provisions and updating provisions, to conform;
4063 amending ss. 409.91195 and 409.91196, F.S.; conforming
4064 cross-references; repealing s. 409.91207, F.S.,
4065 relating to the medical home pilot project; amending
4066 s. 409.91211, F.S.; conforming cross-references;
4067 providing for future repeal of s. 409.91211, F.S.,
4068 relating to the Medicaid managed care pilot program;
4069 amending s. 409.9122, F.S.; providing for the
4070 expiration of provisions relating to mandatory
4071 enrollment in a Medicaid managed care plan or MediPass
4072 on specified dates to conform to the reorganization of
4073 Medicaid managed care; eliminating obsolete

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4074 provisions; providing for the agency to assign
4075 Medicaid recipients with HIV/AIDS in specified
4076 counties to a managed care plan that is a health
4077 maintenance organization under certain conditions;
4078 requiring the agency to develop a process to enable
4079 any recipient with access to employer-sponsored
4080 coverage to opt out of eligible plans in the Medicaid
4081 program; requiring the agency, contingent on federal
4082 approval, to enable recipients with access to other
4083 coverage or related products that provide access to
4084 specified health care services to opt out of eligible
4085 plans in the Medicaid program; requiring the agency to
4086 maintain and operate the Medicaid Encounter Data
4087 System; requiring the agency to conduct a review of
4088 encounter data and publish the results of the review
4089 before adjusting rates for prepaid plans; authorizing
4090 the agency to establish a designated payment for
4091 specified Medicare Advantage Special Needs members;
4092 authorizing the agency to develop a designated payment
4093 for Medicaid-only covered services for which the state
4094 is responsible; requiring the agency to establish, and
4095 managed care plans to use, a uniform method of
4096 accounting for and reporting medical and nonmedical
4097 costs; authorizing the agency to create exceptions to
4098 mandatory enrollment in managed care under specified
4099 circumstances; requiring the agency to contract with a
4100 provider service network to function as a third-party
4101 administrator and managing entity for the MediPass
4102 program; providing contract provisions; providing for

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4103 the expiration of such contract requirements on a
4104 specified date; requiring the agency to contract with
4105 a single provider service network to function as a
4106 third-party administrator and managing entity for the
4107 Medically Needy program; providing contract
4108 provisions; providing for the expiration of such
4109 contract requirements on a specified date; amending s.
4110 430.04, F.S.; eliminating obsolete provisions;
4111 requiring the Department of Elderly Affairs to develop
4112 a transition plan for specified elders and disabled
4113 adults receiving long-term care Medicaid services when
4114 eligible plans become available; providing for
4115 expiration of the plan; amending s. 430.2053, F.S.;
4116 eliminating obsolete provisions; providing additional
4117 duties of aging resource centers; providing an
4118 additional exception to direct services that may not
4119 be provided by an aging resource center; providing an
4120 expiration date for certain services administered
4121 through aging resource centers; providing for the
4122 cessation of specified payments by the department as
4123 eligible plans become available; providing for a
4124 memorandum of understanding between the agency and
4125 aging resource centers under certain circumstances;
4126 eliminating provisions requiring reports; repealing s.
4127 430.701, F.S., relating to legislative findings and
4128 intent and approval for action relating to provider
4129 enrollment levels; repealing s. 430.702, F.S.,
4130 relating to the Long-Term Care Community Diversion
4131 Pilot Project Act; repealing s. 430.703, F.S.,

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4132 relating to definitions; repealing s. 430.7031, F.S.,
4133 relating to the nursing home transition program;
4134 repealing s. 430.704, F.S., relating to evaluation of
4135 long-term care through the pilot projects; repealing
4136 s. 430.705, F.S., relating to implementation of long-
4137 term care community diversion pilot projects;
4138 repealing s. 430.706, F.S., relating to quality of
4139 care; repealing s. 430.707, F.S., relating to
4140 contracts; repealing s. 430.708, F.S., relating to
4141 certificate of need; repealing s. 430.709, F.S.,
4142 relating to reports and evaluations; renumbering ss.
4143 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953,
4144 and 409.9531, F.S., as ss. 402.81, 402.82, 402.83,
4145 402.84, 402.85, 402.86, and 402.87, F.S.,
4146 respectively; amending ss. 443.111 and 641.386, F.S.;
4147 conforming cross-references; amending s. 766.118,
4148 F.S.; providing a limitation on noneconomic damages
4149 for negligence of practitioners providing medical
4150 services and medical care to Medicaid recipients;
4151 defining terms for purposes of the limitation;
4152 requiring the agency to develop a plan to implement
4153 and seek federal approval for the medically needy
4154 program for Medicaid enrollees; requiring the agency
4155 to develop a reorganization plan for realignment of
4156 administrative resources of the Medicaid program;
4157 requiring the plan to be submitted to the Governor and
4158 Legislature; amending s. 393.0662, F.S.; including
4159 certain individuals with Down syndrome or a
4160 developmental disability as eligible to participate in

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4161 the iBudget system; amending s. 409.902, F.S.;
4162 restricting Medicaid eligibility to citizens of the
4163 United States who meet certain criteria; amending s.
4164 641.19, F.S.; defining the term "provider service
4165 network" for purposes of pt. I of ch. 641, F.S.;
4166 creating s. 641.2019, F.S.; providing conditions under
4167 which a prepaid provider service network may obtain a
4168 certificate of authority under s. 641.21, F.S.;
4169 amending s. 641.2261, F.S.; providing an exception for
4170 provider service networks from certain federal
4171 solvency requirements; providing for severability;
4172 providing effective dates and a contingent effective
4173 date.